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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Notice of Opportunity for Hearing on Compliance of Minnesota State Plan Provisions Concerning Program Integrity and Fraud, Waste, and Abuse With Title XIX (Medicaid) of the Social Security Act

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice of opportunity for a hearing; compliance of Minnesota Medicaid State Plan—program integrity requirements relating to prevention, detection, and investigation of fraud, waste, and abuse.

DATES: Requests to participate in the hearing as a party must be received by the presiding officer within 15 days of the date of this Federal Register notice.

FOR FURTHER INFORMATION CONTACT: Benjamin R. Cohen, Hearing Officer, Centers for Medicare & Medicaid Services, 7111 Security Boulevard, Suite B1-15-15, Baltimore, MD 21244, 410-786-3169.

SUPPLEMENTARY INFORMATION: This notice announces the opportunity, pursuant to section 1904 of the Social Security Act (the Act), for an administrative hearing concerning the finding of the Administrator of the Centers for Medicare & Medicaid Services (CMS) that the State of Minnesota is substantially out of compliance with federal requirements in section 1902(a)(64) of the Act and federal regulations at 42 CFR Part 455, Subpart A, which implement various provisions of Title XIX of the Act, including section 1902(a)(4). in administering its Medicaid state plan because the Minnesota Medicaid agency fails to adequately identify, prevent, and address fraud, waste, and abuse (FWA) in its Medicaid program.

This finding will be the basis for withholding federal financial participation (FFP) from Minnesota's Medicaid program, as described in more detail in the letter below. The withholding will end when the Minnesota Medicaid agency fully and satisfactorily implements a corrective

action plan (CAP) to bring its program integrity operations into compliance with federal requirements.

CMS supports state efforts to appropriately address FWA, and federal law and regulations provide mechanisms to do so. Federal law and regulations require states to maintain effective administrative controls, conduct audits, cooperate with federal integrity efforts, enforce accountability, and protect Medicaid funds from FWA. Investigations by CMS, the Department of Health and Human Services Office of Inspector General (HHS OIG), the Department of Justice (DOJ), the Federal Bureau of Investigation (FBI), and other federal partners have identified widespread and ongoing FWA in Minnesota's Medicaid program and repeated failures by the State to adequately address it.

CMS has found that Minnesota's policies, practices, and oversight mechanisms violate section 1902(a)(64) of the Act, which requires states to ensure their state plans provide mechanisms to receive reports of alleged FWA and to compile and analyze related data. CMS has further found that Minnesota's policies, practices, and oversight mechanisms violate federal regulations at 42 CFR Part 455, Subpart A, which require states to implement methods for identifying, investigating, and referring suspected Medicaid fraud, including pathways to receive complaints from any source and methods for identifying questionable practices.
CMS has raised these issues previously with the State but Minnesota has been unable to resolve the State's ongoing FWA issues.

Minnesota will have an opportunity for a hearing on these findings. Minnesota will have 10 days from the date of the notice letter to request such a hearing. If a request for hearing is timely submitted, the hearing will be convened by the designated hearing as soon as practicable but no sooner than 30 days after the date of this Federal Register notice, or a later date by agreement of the parties and the Hearing Officer, at the CMS Regional Office in Chicago, Illinois, in accordance with the procedures set forth in federal regulations at 42 CFR part 430,

subpart D. The Hearing Officer also should be notified if the Minnesota Medicaid agency requests a hearing but cannot meet the timeframe expressed in this notice.

The Hearing Officer designated for this matter is: Benjamin R. Cohen, Hearing Officer, Centers for Medicare & Medicaid Services, 7111 Security Boulevard, Suite B1-15-15, Baltimore, MD 21244.

If a final determination is made that the Minnesota Medicaid agency has failed to comply substantially with these requirements in the administration of its Medicaid state plan, after a hearing or absent a hearing request, consistent with the provisions of section 1904 of the Act, CMS will begin withholding federal funds as specified in the letter below. Such withholding will continue until the Minnesota Medicaid agency comes into compliance with section 1902(a)(64) of the Act and federal regulations at 42 CFR Part 455, Subpart A, by fully and satisfactorily implementing a comprehensive CAP that addresses FWA in the 14 high-risk service areas referenced in the letter below to bring the program into compliance with the federal requirements.

Details about the facts relating to Minnesota's practices are set forth in the letter notifying Minnesota of the Administrator's finding. The following issue will be considered at any requested hearing:

Whether Minnesota has failed to substantially comply with the requirements of section 1902(a)(64) of the Act and federal regulations at 42 CFR Part 455, Subpart A, which implement various provisions of Title XIX of the Social Security Act, including section 1902(a)(4).

Beginning in July 2024, CMS began working with the State to address concerns of potential fraud in the housing stabilization services (HSS) program through Unified Program Integrity Contractor (UPIC) audits. In April 2025, CMS and its UPIC presented the State with preliminary findings from audits of the 3 HSS providers for input about payment policies and state exceptions to rules. Shortly thereafter,in June 2025, the State requested the audits be transferred to the State for investigation. In August, October, and November 2025, CMS

continued discussions with the state to address issues with closing the HSS program, reviewing provider enrollment actions, and redesigning the State's program integrity operations, among other issues. On December 5, 2025, CMS formally notified the Minnesota Medicaid Director of these concerns and directed the State to submit a comprehensive CAP by December 31, 2025. Finally, in December 2025, CMS met onsite with state agency staff and law enforcement and observed firsthand the deficiencies in the state's ability to proactively identify potential Medicaid FWA. While the State submitted a document labeled as a CAP to CMS on December 31, 2025, CMS has determined that it is deficient. The submitted plan relies heavily on temporary or future-contingent measures, lacks enforceable timelines and performance metrics, acknowledges current noncompliance with key federal requirements, and provides limited assurance of accountability for past misconduct. For the reasons stated above and in the below letter, CMS has determined that Minnesota Medicaid agency is not in compliance with the federal statute and regulations.

The letter notifying Minnesota of the details concerning this compliance issue, the proposed withholding of FFP, opportunity for a hearing and possibility of postponing and ultimately avoiding withholding by coming into compliance reads as follows:

January 6, 2026

The Honorable Tim Walz

Governor of Minnesota

130 State Capitol

75 Rev. Dr. Martin Luther King Jr.

Blvd. St. Paul, MD 55155G

Dear Governor Walz:

This letter provides notice and an opportunity for a hearing on a finding by the Centers for Medicare & Medicaid Services (CMS) of significant noncompliance with applicable statutory and regulatory requirements in the operation of the Minnesota Medicaid program, because the

Minnesota Medicaid agency fails to adequately identify, prevent, and address fraud in its Medicaid program.

As described further in this letter, federal law and regulation require states to maintain effective administrative controls, conduct audits, cooperate with federal integrity efforts, enforce accountability, and protect Medicaid funds from fraud, waste, and abuse (FWA). As has been widely reported—and acknowledged by the State of Minnesota—there is significant and ongoing fraud within Minnesota's Medicaid program. Investigations by the CMS, the Department of Health and Human Services Office of Inspector General (HHS OIG), the Department of Justice (DOJ), the Federal Bureau of Investigation (FBI), and other federal partners have identified widespread FWA in Minnesota's Medicaid program and repeated failures by the State to adequately address it.

These investigations have revealed schemes involving billing for services not rendered, services billed at levels not supported by documentation, and exploitation of vulnerable Medicaid beneficiaries for financial gain. Federal law enforcement has identified complex fraud schemes involving networks of providers operating across multiple high-risk service categories, including services delivered through Minnesota's home and community-based services system.

CMS has been engaged in numerous on-site and virtual discussions with state agency staff to discuss the known fraud schemes and severe lack of state oversight mechanisms in place to meet minimum oversight requirements. Specifically, in December 2025, CMS met onsite with state agency staff and law enforcement to see firsthand the historical deficiencies in the state's ability to proactively identify potential Medicaid FWA. The lack of processes to receive reports and compile data on allegations of FWA demonstrates that the state is not in compliance with section 1902(a)(64) of the Social Security Act (the Act). States are required to ensure their state plan provides a mechanism to receive reports from beneficiaries and others and compile data concerning alleged instances of waste, fraud, and abuse relating to the operation of the Medicaid Act. In addition, pursuant to 42 CFR 455, Subpart A, States are required to implement methods

for identifying, investigating, and referring suspected Medicaid fraud. These methods must include a pathway to receive complaints of Medicaid fraud or abuse from any source and methods for identifying any questionable practices. This information and related data sources must be used to pursue robust preliminary and full investigations, as appropriate, as well as refer cases to law enforcement, if applicable. These regulatory authorities reflect one of the core pillars of state Medicaid oversight that CMS expects every state to have in place effectively. We have raised these issues to the state and as we discuss below, the state has been unable to resolve it's inability to maintain compliance, resulting in its inability to identify or prevent widespread fraud, waste and abuse of the program.

Pursuant to section 1904 of the Social Security Act and 42 CFR 430.35, CMS is providing the Minnesota Medicaid agency with an opportunity for a hearing on these findings of noncompliance with statutory and regulatory requirements. If these findings are upheld or unchallenged following this opportunity for a hearing, a portion of federal financial participation (FFP), as specified in more detail below, will be withheld until CMS makes a finding that the State has come into compliance with the statute and regulations.

The factual details of the findings, the withholding, how the Minnesota Medicaid agency can request a hearing on the findings, and the steps Minnesota can take to avoid sanctions by coming into compliance are described below.

Factual Findings

CMS's concerns are not limited to isolated incidents. Minnesota has historically had significant deficiencies in proactively identifying suspected Medicaid FWA, primarily through limitations in data analytics and monitoring. These limitations have become prolific in many areas of the state's Medicaid program and are well documented in CMS and other oversight agency audit reports. For example, CMS conducted an audit of the State's Personal Care Services program in 2019, which resulted in numerous findings and recommendations that reflect

the State's deficiencies in basic oversight efforts.[1] The State's own Office of the Legislative Auditor released a report in 2021 about the deficiencies in the PCS program.[2] In addition, the HHS OIG documented the state's failure to effectively oversee its Nonemergent Medical Transportation (NEMT) program in a 2017 report.[3]

Recent investigations have focused on fourteen high-risk Medicaid services that the State itself has identified as particularly vulnerable to fraud (linked here: https://mn.gov/dhs/program-integrity/). According to CMS analysis of Minnesota Medicaid data, these fourteen programs consume $3.75 billion in federal and state taxpayer resources. CMS analysis of Minnesota Medicaid data shows extraordinary growth in provider enrollment and payments for several of these services that is inconsistent with beneficiary growth and service utilization trends. Despite warning signs that have been evident for years, the State has not implemented sufficient safeguards to prevent ongoing improper payments.

Applicable Statutory and Regulatory Provisions

Pursuant to § 1902(a)(64) of the Act, States are required to ensure their state plan provides a mechanism to receive reports from beneficiaries and others and compile data concerning alleged instances of waste, fraud, and abuse relating to the operation of the Medicaid Act. In addition, pursuant to 42 CFR 455, Subpart A, State are required to implement methods for identifying, investigating, and referring suspected Medicaid fraud. These methods must include a pathway to receive complaints of Medicaid fraud or abuse from any source and methods for identifying any questionable practices. This information and related data sources must be used to pursue robust preliminary and full investigations, as appropriate, as well as refer cases to law enforcement, if applicable.

Prior CMS oversight work has identified consistent non-compliance with the State's

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[1] https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/fraudabuseforprofs/downloads/mnfy18.pdf.
[2] https://www.auditor.leg.state.mn.us/ped/updates/2021/dhspca.pdf.
[3] https://oig.hhs.gov/reports/all/2017/minnesota-did-not-always-comply-with-federal-and-state-requirements-for-claims-submitted-for-the-nonemergency-medical-transportation-program/.

ability to proactively identify suspected Medicaid FWA, primarily through limitations in data analytics and monitoring. It should also be mentioned that Minnesota's submission of its quarterly expenditure reports through the Form CMS-64, includes a certification that the state is operating under the authority of its approved Medicaid state plan.

Discussions with the State Medicaid Agency

Beginning in July 2024, CMS began working with the State to address concerns of potential fraud in the housing stabilization program (HSS) through Unified Program Integrity Contractor (UPIC) audits. In April 2025, CMS and its UPIC presented the State with preliminary findings from the 3 HSS providers for input about payment policies and state exceptions to rules. Shortly after, in June 2025, the State requested the audits be transferred to the State for investigation. In August, October, and November 2025, CMS continued discussions with the state to address issues with closing the HSS program, reviewing provider enrollment actions, and redesigning the State's program integrity operations, among other issues. On December 5, 2025, CMS formally notified the Minnesota Medicaid Director of these concerns and directed the State to submit a comprehensive corrective action plan (CAP) by December 31, 2025.

Finally, as noted previously, in December 2025, CMS met onsite with state agency staff and law enforcement to see firsthand the historical deficiencies in the state's ability to proactively identify potential Medicaid FWA.

While the State submitted a document labeled as a CAP to CMS on December 31, 2025, CMS has determined that it is deficient. The plan relies heavily on temporary or future-contingent measures, lacks enforceable timelines and performance metrics, acknowledges current noncompliance with key federal requirements, and provides limited assurance of accountability for past misconduct.

Given the widespread concerns that these fraudulent activities were undertaken by individuals with ties outside of the U.S. and that some of the funds were then transferred outside of the U.S., CMS sees nothing in the CAP that would result in the State being able to understand

ownership or corporate structure of providers and how the State will work with law enforcement to assure that no Medicaid funds are used to support criminal international entities.

The CAP largely emphasizes prospective controls while providing limited assurance of meaningful accountability for past misconduct. Although the State references a forthcoming historical claims review, it does not commit to specific enforcement actions, recovery targets, referral thresholds, or timelines for resolving identified overpayments or fraud. Absent clear commitments to corrective financial remedies and sanctions, the CAP does not adequately protect the fiscal integrity of the Medicaid program. The CAP also fails to adequately address how claim editing will be applied, such as whether those edits will deny payments or whether the data will identify claims with attributes appropriate for additional scrutiny, such as outlier billers, utilization trends in high-risk services, and other appropriate flags. The CAP should also include how artificial intelligence and other modern automated methods will be used to address the rampant fraud in the program, and how performance of these methods will be assessed.

Additionally, Minnesota's draft Program Integrity Playbook identifies additional vulnerabilities and gaps in its oversight operations that are not addressed in the CAP. CMS expects Minnesota to also address the outstanding issues in its updated CAP. For example:

- ***Prior Authorization Program*:** Please provide additional details on Minnesota's assessment

  of its prior authorization program and enhancements that are needed.

- ***Provider Training and Education*:** Please specify what enhancements or changes Minnesota proposes to make its provider training and education efforts more effective, such as pre-enrollment training; post-enrollment training; billing and documentation training; fraud, waste, and abuse training; and compliance and legal obligations training, among any others identified by the state.

- ***DHS Employee Training and Education*:** Please specify what enhancements or changes Minnesota proposes to make to its DHS employee training and education efforts to

identify, evaluate, and mitigate fraud, waste, and abuse in the state's Medicaid program.

- ***Surveillance and Utilization Review (SURS)*:** Minnesota stated in its draft Program Integrity Playbook that is implementing a formal SURS system. Please provide additional information the status of the SURS system, its capabilities, and how it will feed into the state's broader program integrity efforts and lead generating activities.

- ***Managed Care Oversight*:** Please include information as to how the state plans to enhance oversight of its managed care plans (MCPs). This includes relevant state-MCP contract language (including any barriers within existing contract language that need to be addressed), the state's ability to conduct data analytics on managed care claims and spending, processes for and evaluations of referring potential fraud from the MCP to the state/law enforcement (including implementation of payment suspensions), and recovery of identified overpayments, among any other issues identified by the state.

Focused Financial Reviews of Expenditures on the CMS-64

Given the severity and persistence of these deficiencies, CMS must take additional steps to protect the integrity of the Medicaid program and federal taxpayer dollars. Pursuant to section 1903 of the Social Security Act and implementing regulations in 42 CFR 430 Subpart C, CMS has the authority to conduct reviews of state expenditures reported on the quarter Form CMS-64 Accordingly, CMS intends to immediately initiate a focused CMS-64 review of all fourteen high-risk services self-identified by the state starting with the most recently certified CMS-64 (Quarter Four of Federal Fiscal Year 2025). As necessary, CMS intends to issue deferral or disallowance of any FFP claimed by the state that does not meet applicable federal requirements.

Determination of Non-Compliance and FFP Withholding

The CMS has concluded that the Minnesota Medicaid agency is operating its program in substantial noncompliance with federal requirements described in sections 1902(a)(64) of the Act, generally requiring the State to ensure sufficient controls to prevent, detect, and address

fraud, waste, and abuse.

Subject to the state's opportunity for a hearing, CMS will withhold a portion of FFP from the Minnesota Medicaid quarterly claim of expenditures on the Form CMS-64 until such time as the Minnesota Medicaid agency is, and continues to be, in compliance with the federal requirements. The quarterly withholding will be calculated based on the federal share for one quarter's amount of the previous calendar year's annual total paid expenditures for the fourteen high-risk services, estimated as $515,154,947.56, or an alternative substantiated amount per quarter based on evidence provided by the state to the Administrator or his designee of an accurate amount of fraudulent expenditures. This amount may increase based on additional findings of fraud or insufficient progress towards mitigating fraud—until Minnesota demonstrates full and sustained compliance with federal Medicaid requirements. The withholding will end when the Minnesota Medicaid agency fully and satisfactorily implements a comprehensive CAP that addresses FWA in the 14 high-risk service areas to bring the program into compliance with the federal requirements.

Opportunity to Request a Hearing

The State has 10 days from the date of this letter to request a hearing. If a request for hearing is submitted timely, the hearing will be convened by the designated hearing officer below, 30 days after the date of the Federal Register notice, at the CMS Regional Office in Chicago, Illinois, in accordance with the procedures set forth in federal regulations at 42 CFR part 430, subpart D. The Hearing Officer also should be notified if the Minnesota Medicaid agency requests a hearing but cannot meet the timeframe expressed in this notice. The Hearing Officer designated for this matter is:

Ben Cohen

Centers for Medicare & Medicaid

Services 7111 Security Blvd, Suite B1-

15-15 Baltimore, MD, 21244

At issue in any such hearing will be:

a. Whether the evidence establishes that Minnesota has failed to substantially comply with the federal requirements described in section 1902(a)(64) of the Social Security Act and the federal regulations implementing those provisions.

b. Whether Minnesota's failure to substantially comply with those federal requirements supports the partial withholding of FFP imposed by CMS.

If the Minnesota Medicaid agency plans to come into compliance with the federal requirements, the Minnesota Medicaid agency should submit, by January 30, 2026 a revised comprehensive CAP including the timeframe for implementation and any performance or quality metrics the state will use to evaluate effectiveness of the actions.

CMS will continue to exercise strong oversight of State actions to address these issues. CMS will review and negotiate the terms of an acceptable corrective action plan and will monitor progress closely. Our goal is to have the Minnesota Medicaid agency come into compliance, and CMS continues to be available to provide technical assistance to help achieve this outcome.

Should you not request a hearing within 5 days of this letter, the withholding of funds will be imposed, contingent on the State's progress toward compliance as discussed above.

Please provide any response or questions regarding this matter to Kimberly.Brandt@cms.hhs.gov.

Mehmet Oz, M.D.

Administrator

Centers for Medicare & Medicaid Services

Cc: John Connolly

Minnesota Medicaid Director

Dan Brillman

Director, Center for Medicaid & CHIP Services, Centers for Medicare & Medicaid Services

Kimberly Brandt

Acting Director, Center for Program Integrity, Centers for Medicare & Medicaid Services

Dated: January 6, 2026.

Mehmet C. Oz, M.D.

Administrator, Centers for Medicare & Medicaid Services.

The Administrator of the Centers for Medicare & Medicaid Services (CMS), Mehmet Oz, having reviewed and approved this document, authorizes Evell J. Barco Holland, who is the Federal Register Liaison, to electronically sign this document for purposes of publication in the **Federal Register**.

Evell J. Barco Holland,

Federal Register Liaison,

Centers for Medicare & Medicaid Services.

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