UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MINNESOTA

State of Minnesota, by and through its Attorney General Keith Ellison, and Shireen Gandhi, in her official capacity as the Commissioner of the Minnesota Department of Human Services,

Plaintiffs,

vs.

Dr. Mehmet Oz, in his official capacity as Administrator for the Centers for Medicare and Medicaid Services; the Centers for Medicare and Medicaid Services; Robert F. Kennedy, Jr., in his official capacity as Secretary of the U.S. Department of Health and Human Services; U.S. Department of Health and Human Services,

Defendants.

Civ. No.: 26-cv-1701

PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER AND EXPEDITED PRELIMINARY INJUNCTION

Plaintiffs State of Minnesota, by and through its Attorney General Keith Ellison, and Shireen Gandhi, in her official capacity as the Commissioner of the Minnesota Department of Human Services, move the Court under Fed. R. Civ. P. 65 and D. Minn. L.R. 7.1(d), for a temporary restraining order and expedited preliminary injunction that prohibits and vacates Defendants Dr. Mehmet Oz, in his official capacity as Administrator for the Centers for Medicare and Medicaid Services; the Centers for Medicare and Medicaid Services; Robert F. Kennedy, Jr., in his official capacity as Secretary of the U.S. Department of Health and Human Services; and U.S. Department of Health and Human

Services, from immediately withholding $243,790,260 from Plaintiffs as stated in Defendants' February 25, 2026 deferral notice.

Plaintiffs do not seek an *ex parte* temporary restraining order, and they do not object to Defendants responding before a hearing on the motion. Plaintiffs do, however, request an expedited handling of this matter, by Friday, March 6, 2026, due to the serious consequences of Defendants' actions. Plaintiffs ask the Court to set an appropriate briefing schedule based off that hearing date and request a ruling on their Motion as soon as possible.

Plaintiffs' motion is based on their submissions to the Court, including their memorandum of law in support of its motion, the supporting declarations, any forthcoming reply memorandum, arguments of counsel, and the other documents on record with the Court.

(Signature on next page)

Dated: March 2, 2026

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Dr. Mehmet Oz, in his official capacity as Administrator for the Centers for Medicare and Medicaid Services; the Centers for Medicare and Medicaid Services; Robert F. Kennedy, Jr., in his official capacity as Secretary of the U.S. Department of Health and Human Services; U.S. Department of Health and Human Services,

Defendants.

Civil File No. 26-cv-1701

MEMORANDUM OF LAW IN SUPPORT OF PLAINTIFFS' MOTION FOR A TEMPORARY RESTRAINING ORDER

INTRODUCTION

Congress designed Medicaid to be a "cooperative program of shared financial responsibility" between the states and the federal government. Lately, however, the federal government has instead weaponized Medicaid against Minnesota as political punishment. This unfortunately comes as no surprise, as President Trump promised in early January "reckoning and retribution" against "Minnesota Democrats":

> Minnesota Democrats love the unrest that anarchists and professional agitators are causing because it gets the spotlight off of the 19 Billion Dollars that was stolen by really bad and deranged people. FEAR NOT, GREAT

> PEOPLE OF MINNESOTA, THE DAY OF RECKONING AND RETRIBUTION IS COMING!

Donald J. Trump (@realDonaldTrump), Truth Social (Jan. 13, 2026, at 7:40 a.m.), https://truthsocial.com/@realDonaldTrump/posts/115888070937502023 (emphasis in original).

The threats have become reality. In addition to the Immigration and Customs Enforcement "Surge"—which terrorized Minnesotans for weeks on the feeble pretense that noncitizens were to blame for Medicaid fraud in the State—the Trump Administration is now improperly withholding hundreds of millions of Medicaid dollars from the State.

It started on January 6th, when the Administration announced that more than $2 billion annually would be withheld from Minnesota based on the State's purported "noncompliance" with the Medicaid Act. Minnesota has initiated the administrative appeal process, but it still has not, to date, been told how it is noncompliant or what it can do to remedy the Administration's concerns. While that is a problem in and of itself, it is not the subject of this lawsuit. What the Administration did next, however, is.

Impatient that the mechanism it chose to withhold the $2 billion from Minnesota afforded the state due process, the Administration "deferred" $259,505,491 of the State's fourth-quarter Medicaid payment on February 25th. Centers for Medicare and Medicaid Services ("CMS") Administrator Oz further boasted that if "Minnesota fails to clean up the systems," it would "rack up a billion dollars of deferred payments this year." Medicaid deferrals have never been used in this way and do not grant CMS the authority to categorically deny Minnesota Medicaid dollars across entire service areas, as is being done

here; rather, it is an auditing tool CMS employs to question "a claim or any portion of a claim" for which there is a lack of supporting documentation showing that payment to a Medicaid provider is warranted.

This deferral came one day after President Trump named Vice President Vance as his "anti-fraud czar" and gave him a convenient action on which to hold a press conference in which he could be seen to "turn the screws" on Minnesota—as he put it. By immediately denying Minnesota substantial Medicaid dollars for the very Medicaid services for which it is challenging the federal government's January 6 claim of "noncompliance," the deferral effectively denies Minnesota the due process it is entitled.

Unless the deferral is quickly reversed, the State will be irreparably harmed. The Administration has already stated that the deferral will recur every quarter, and a recurring deferral at this scale will cripple the state budget and require the State to make cuts to Medicaid services, which would directly harm Minnesotans unable to receive necessary medical care. Minnesota therefore asks this Court for a Temporary Restraining Order blocking the deferral and restoring federal Medicaid funding to the State.

FACTUAL BACKGROUND

The Administration's actions precipitating this lawsuit and motion do not sit in isolation; they lie atop an extensive statutory, regulatory, and administrative foundation. This includes the cooperative federal–state nature of Medicaid and the methods the federal government can use to ensure compliance with the Medicaid Act (as well as those methods' limitations). Accordingly, the State begins by laying out this foundation before turning to the Administration's unprecedented actions.

I. MEDICAID IS DESIGNED TO BE A COOPERATIVE FEDERAL–STATE PROGRAM.

The federal–state Medicaid relationship has routinely been very cooperative. Even a few months ago, the Administration's recent conduct toward Minnesota would have been unthinkable.

A. The Medicaid Program.

The Medicaid program provides funding for states to furnish medical assistance on behalf of individuals "whose income and resources are insufficient to meet the costs of necessary medical services." 42 U.S.C. § 1396-1. Medicaid is a jointly funded federal–state program that is administered by the states in accordance with federal requirements and under the oversight of the Centers for Medicare and Medicaid Services ("CMS"). *See Ark. Dep't of Health & Hum. Servs. v. Ahlborn*, 547 U.S. 268, 275 (2006). It was designed as a "cooperative program of shared financial responsibility," and nothing in the Medicaid Act "suggests that Congress intended to require a participating State to assume the full costs of providing any health services in its Medicaid plan." *Harris v. McRae*, 448 U.S. 297, 308, 309 (1980). The public assistance programs authorized under a State's Medicaid program are "intended to operate as partnerships between the states and the federal government." *Dep't of Soc. Servs., Div. of Fam. Servs. v. Bowen*, 804 F.2d 1035, 1041 (8th Cir. 1986) (Heaney, J., dissenting).

B. Consistent with this intent, CMS has historically worked cooperatively with the State on concerns over compliance or documentation.

While a state's participation in Medicaid is optional, states electing to participate must comply with Title XIX of the Social Security Act and all applicable federal

regulations. If a state does not do so, it jeopardizes its federal funding. *See* 45 C.F.R. § 75.371; 42 C.F.R. § 430.35.

Historically, if CMS had concerns with claim documentation or a state's compliance with applicable Medicaid statutes or regulations, it would work directly with the state to cure any deficiencies. Hultman Decl., ¶ 6. This process may take months or even years. *Id*. It has always been a collaborative process, involving myriad conversations with representatives of both agencies and exchanges of documents. *Id*. If, after these attempts to resolve the issue, CMS continues to have concerns, it has three options available (relevant to this lawsuit): deferral, disallowance, or a finding of noncompliance.

1. *Deferral.* If CMS questions whether a claim submitted by a state is an allowable reimbursement, CMS can defer payment and ask the State for additional documentation to substantiate the claim. 42 C.F.R. § 430.40. If CMS defers payment, it must "identif[y] the type and amount of the deferred claim and specif[y] the reason for deferral." *Id.*, § 430.40(b)(1)(i). Based on the information it receives from the State, CMS will determine whether to pay the claim or to disallow it. *Id.*, § 430.40(e)(1).

2. *Disallowance.* Relatedly, if CMS determines that a claim submitted by a State is not allowable under the Medicaid Act, it will issue to the State a disallowance letter. 42 C.F.R. § 430.42(a). The State is then expected to adjust future expenditures to account for the amount that was disallowed. *Id.*, § 430.42(a)(7). A State has administrative appeal rights available to it, which ultimately are reviewable in federal district court. *Id.*, § 430.42(f). Deferrals and disallowances are intended to address "a narrow item or class of items" that "do not, in some general sense, affect the working of the program or federal–

state cooperation." *Massachusetts v. Departmental Grant Appeals Bd.*, 698 F.2d 22, 25 (1st Cir. 1983).

3. *Noncompliance.* Finally, if CMS concludes a State's Medicaid plan does not comply with the Medicaid Act or that a state has failed to substantially comply with any provision, it can withhold payments to the State, but only after providing the State with reasonable notice and an opportunity for a hearing. 42 C.F.R. § 430.35(a). In other words, issues of compliance "touch[] on matters of far-reaching importance, affecting the overall Medicaid program." *Departmental Grant Appeals Bd.*, 698 F.2d at 27.

II. CONSISTENT WITH MEDICAID'S FEDERAL–STATE PARTNERSHIP, MINNESOTA HAS MADE MASSIVE EFFORTS TO IDENTIFY AND ADDRESS FRAUD, IN COORDINATION WITH CMS.

On September 17, 2025, Governor Walz issued Executive Order 25-10, which directed DHS and other state agencies to implement a wide range of anti-fraud directives, including:

- Establishing a proactive, data-driven post-payment review program for Medicaid providers and claims and deploying advanced analytics and risk-scoring models to identify high-risk providers, claims, and service patterns for targeted review.
- Identifying programs that present a high risk of fraud, waste, and abuse and recommending programmatic changes, including termination of the HSS program;
- Implementing a temporary licensing moratorium as authorized under state law and requesting that CMS allow MDHS to implement moratoria;
- Subjecting providers who present identified risk factors to prepayment review;
- Immediately disenrolling all Minnesota Health Care Program enrolled providers who have not billed Medicaid in the last 12 months;
- Submitting a request for funds from any available state accounts to modernize systems to better prevent and detect fraud, waste, and abuse;

- Requesting any and all assistance from CMS and other federal partners to ensure that MDHS's program integrity measures are in line with national program integrity standards; and

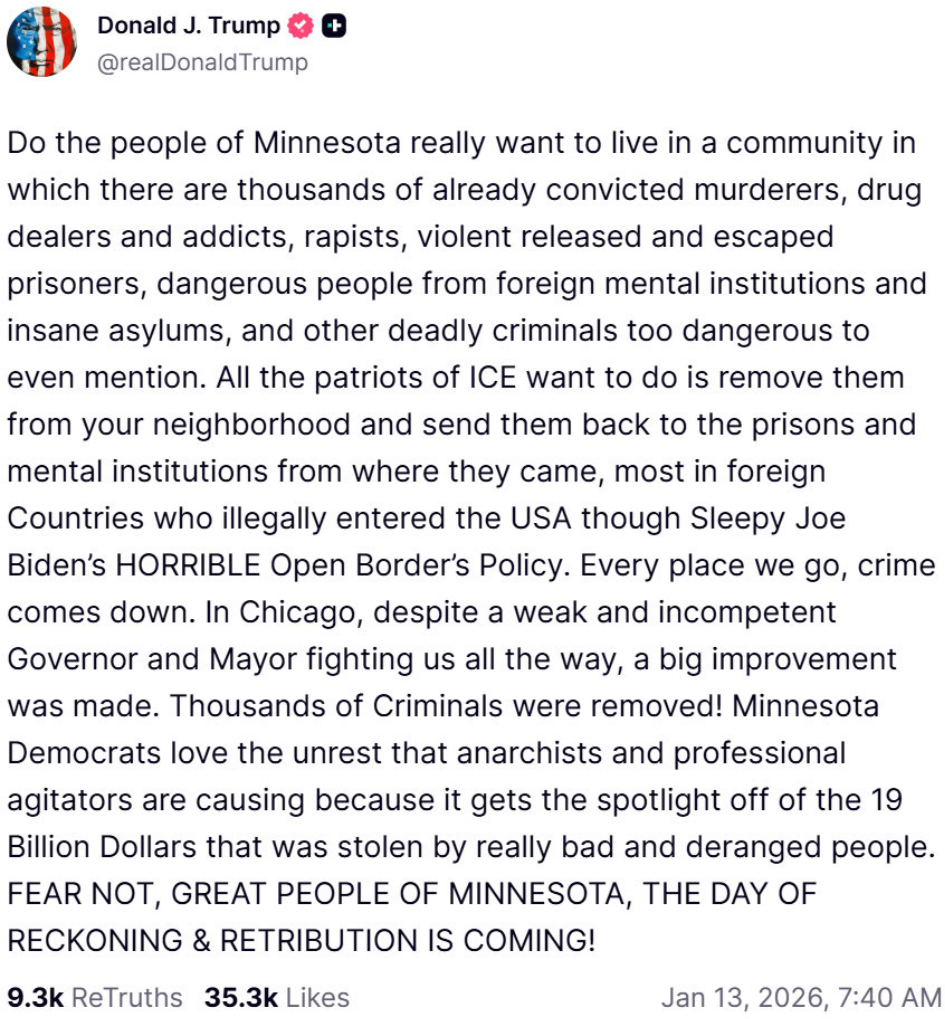
- Hiring an external consultant to assess MDHS and make recommendations on reorganization to more effectively serve as the State's Medicaid agency, with a focus on program integrity and anti-fraud efforts, including through suggested policies, procedures, systems changes, structural changes, staffing levels.

Connolly Decl., ¶ 5; Brennaman Decl., Ex. 1.

Minnesota then identified providers of fourteen service types as high-risk based on programmatic vulnerabilities, investigations, and analysis. Connolly Decl., ¶ 6. The agency initiated enhanced prepayment review for all fee-for-service claims involving these fourteen services, a twenty-four-month licensing moratorium for Home and Community Based Service providers, an additional moratorium for Adult Day services, and it ended enrollment of new autism service providers. *Id*. In October 2025 alone, DHS also disenrolled over 800 inactive healthcare providers to further protect against fraudulent billing. *Id*.

III. IN THE FACE OF MINNESOTA'S SIGNIFICANT EFFORTS TO COMBAT FRAUD, THE ADMINISTRATION HAS CARRIED OUT THE PRESIDENT'S PROMISE OF "RECKONING AND RETRIBUTION" AGAINST MINNESOTA.

On January 13, 2026, President Trump posted to Truth Social a promise that "reckoning" and "retribution" was coming to Minnesota:



Donald J. Trump
@realDonaldTrump

Do the people of Minnesota really want to live in a community in which there are thousands of already convicted murderers, drug dealers and addicts, rapists, violent released and escaped prisoners, dangerous people from foreign mental institutions and insane asylums, and other deadly criminals too dangerous to even mention. All the patriots of ICE want to do is remove them from your neighborhood and send them back to the prisons and mental institutions from where they came, most in foreign Countries who illegally entered the USA though Sleepy Joe Biden's HORRIBLE Open Border's Policy. Every place we go, crime comes down. In Chicago, despite a weak and incompetent Governor and Mayor fighting us all the way, a big improvement was made. Thousands of Criminals were removed! Minnesota Democrats love the unrest that anarchists and professional agitators are causing because it gets the spotlight off of the 19 Billion Dollars that was stolen by really bad and deranged people. FEAR NOT, GREAT PEOPLE OF MINNESOTA, THE DAY OF RECKONING & RETRIBUTION IS COMING!

9.3k ReTruths **35.3k** Likes Jan 13, 2026, 7:40 AM

Donald J. Trump (@realDonaldTrump), Truth Social (Jan. 13, 2026, at 7:40 a.m.), https://truthsocial.com/@realDonaldTrump/posts/115888070937502023. Since then, Minnesota has been subject to the ICE Surge, a continuing litigation over a threatened quarterly Medicaid withholding of $515 million, and now a Q4 2025 Medicaid deferral of

$259 million.[1] In short, just as President Trump promised would happen, the federal government has weaponized Medicaid as political punishment and coercion.

A. CMS threatens withholding of federal Medicaid dollars despite Minnesota taking all steps recommended by CMS.

On December 5, 2025, Dr. Oz sent Minnesota a letter accusing the State of "not taking fraud seriously" and demanding that "Minnesota must take additional steps now," including submitting a Corrective Action Plan to the federal government by the end of the year. Brennaman Decl., Ex. 2.

While Minnesota disagreed that it was not taking fraud seriously, it nevertheless agreed to take all the steps required in Dr. Oz's letter. This included providing weekly updates to CMS, imposing a six-month enrollment moratorium on high-risk providers, and enacting off-cycle revalidation[2] for all provider enrollments. Connolly Decl., ¶ 8.

Moreover, throughout December and early January, Minnesota consulted with CMS about what it wanted addressed in a Corrective Action Plan and whether its Plan—which

[1] That is not all. Since December 2025, the Trump Administration has undertaken a pattern or practice of punitive actions directed at Minnesota across multiple agencies. *See, e.g.,* threatened withholding of SNAP-related administrative funding tied to accelerated verification demands, resulting in a court injunction; actions to halt or suspend SBA-related funding streams affecting Minnesota partners and borrowers; attempted freezing of more than $10 billion in federal child-care and family-assistance funding administered through HHS/ACF (enjoined); termination or threatened clawback of CDC public-health infrastructure grant funding affecting Minnesota (enjoined or challenged); litigation and demands seeking unredacted voter-registration data from Minnesota; and threatened or initiated federal civil-rights enforcement actions in other program areas, including Title IX-related enforcement steps against Minnesota education entities, and more.

[2] Providers of Medicaid services are periodically reviewed and revalidated by the state to ensure that they continue to be eligible for receipt of Medicaid dollars. Off-cycle revalidation simply means that such review is happening now—not on the normal cycle.

the State submitted to CMS on December 31, 2025—could be improved. *Id.* ¶¶ 9–10; *see also* Brennaman Decl., Ex. 8. On January 5, 2026, DHS disenrolled roughly 4,300 out-of-network and out-of-state managed care providers, pursuant to CMS's direction. Connolly Decl., ¶ 8. The next day, January 6, the parties had their first weekly standing meeting, at which DHS actively invited feedback from CMS on the Corrective Action Plan and requested guidance on any modifications CMS believed was necessary. *Id.* ¶ 9. CMS representatives offered no substantive comments at that time but expressed willingness to work with the State after reviewing the plan in detail. *Id.* The parties also discussed the rollout of the provider enrollment moratorium, with CMS requesting operational details, giving advice on timing, and offering to assist where needed. *Id*.

At no time did CMS staff suggest that the Corrective Action Plan—which was drawn from previous statements by, and discussions with, CMS—was deficient or would form the basis for withholding federal financial participation, absent any notice to the State of alleged deficiencies. *Id.* ¶ 10.

B. CMS Finds Minnesota Noncompliant With Medicaid Act On January 6, 2026.

Later that same day, Dr. Oz provided notice to Minnesota that CMS considered the State in violation of certain provisions of the Medicaid Act related to fraud, waste, and abuse. Brennaman Decl., Ex. 3 (the "compliance action"). The action targeted 14 Medicaid service areas that Minnesota had identified as "high-risk" for fraud in October of 2025, and which the state was already taking intensive action to remedy, as noted above. Connolly Decl., ¶ 11. Despite the fact that Minnesota had already identified these areas as

having vulnerabilities, and was taking action—in coordination with CMS—to address the vulnerabilities, CMS indicated it would withhold more than $515M quarterly, which it stated was the entire quarterly "expenditures for the fourteen high risk services" by the federal government. *Id*. Dr. Oz declared Minnesota's Corrective Action Plan "deficient" for failing to include topics that were never requested of, or discussed with, CMS. *Id.* ¶ 12.

Minnesota appealed the noncompliance decision on January 9, 2026. *Id*. ¶ 13; Brennaman Decl., Ex. 4. CMS cannot withhold the federal dollars from the State until after that appeal process is complete, and the process gives Minnesota substantial process to contest the finding. 42 C.F.R 430.35(a). That includes receiving CMS's entire administrative file on which it based its noncompliance allegation, a hearing at which the State can present evidence and cross-examine witnesses, discovery to the full extent allowed under the Federal Rules of Civil Procedure, and post-hearing briefing. *See, generally,* 42 C.F.R. §§ 430.60 – 430.104. Minnesota has not yet received CMS's administrative file, and to date no hearing has been scheduled.[3] Brennaman Decl., ¶ 6.

[3] Minnesota has not been told how it is noncompliant with federal statutes or regulations. The "Factual Findings" in the January 6, 2026, Notice do not demonstrate, or even suggest, noncompliance with any of the requirements of 1902(a)(64) or 42 CFR 455, Subpart A. Brennaman Decl., Ex. 3, at 2. Minnesota asked for an Amended notice to remedy this defect, but this request was denied by the administrative hearing officer. *Id*. ¶ 7. Minnesota has asked CMS repeatedly for information and detail regarding the claimed noncompliance, but CMS has refused to provide any information. *Id.*

C. DHS Submitted A Revised Corrective Action Plan on January 30, In Collaboration With CMS.

The January 6, 2026 Notice of Noncompliance required Minnesota to submit to CMS "a revised comprehensive corrective action plan" by January 30, 2026. *Id*. at Ex. 3. Throughout January, during its weekly meetings with CMS, Minnesota attempted to coordinate with CMS about the Corrective Action Plan to ensure the revised plan would address all the issues of which CMS was concerned. Connolly Decl., ¶ 15.

Minnesota submitted its revised and more detailed Corrective Action Plan on January 30, 2026. *See id.* ¶ 16; Brennaman Decl., Ex. 5. Since that date, at each of the weekly meetings DHS had with CMS, Minnesota asked CMS for its reaction and comments to the revised plan. Connolly Decl., ¶ 16. Many of the initiatives in the Corrective Action Plan are time sensitive, or require an enormous outlay of time, effort, or resources to accomplish, and so Minnesota has wanted to ensure, throughout the month of February (including at a meeting it had with CMS the morning CMS issued the deferral notice at issue in this lawsuit), that CMS was not going to have major problems or revisions to the Corrective Action Plan. *Id.* At the February 25 meeting, CMS told Minnesota Medicaid Director John Connolly that CMS had no feedback, but that written feedback would be forthcoming at some point in the future. *Id.*

D. CMS Defers $243 million[4] in Medicaid from Minnesota.

Later that same day, CMS served Minnesota with a sweeping and unprecedented Notice of Deferral (the "Deferral"), Brennaman Decl., Ex. 6, the effect of which immediately denies the State $243 million by reducing the State's federal funds account by that amount. Hultman Decl., ¶ 2.

1. Dr. Oz stated the Deferral was due to Minnesota's failure to enact an acceptable Corrective Action Plan.

Vice President Vance and Dr. Oz held a press conference on February 25, 2026—the day after the President appointed the Vice President as his antifraud czar—to announce the deferral. Neither the Vice President nor Dr. Oz stated anything about deficiencies with particular claims or a lack of documentation, which is the purpose of deferral actions. Instead, Dr. Oz said the deferral was issued because Minnesota failed to provide an adequate corrective action plan:

> So on December the 7th, we sent a letter to Governor Walz asking for a corrective action plan, which is a mechanism for us to extract from the state what they think they can do to fix the problems. The answer we got back at the end of the month, which was what the deadline was, was inadequate.

The White House, *Vice President Vance and Administrator Oz Announce Actions to Address Fraud, Waste, and Abuse*, at 21:27 (YouTube, Feb. 25, 2026), https://www.youtube.com/watch?v=mRJN72K2lYw [hereinafter Deferral Press Conference]. Dr Oz added, "This quarter-billion-dollar deferment is hopefully going to

[4] The Deferral defers a total of $259,505,491, but the State's lawsuit specifically challenges only $243,790,260 of that deferral (hereafter, the "$243 million"), relating to the 14 services identified as "high-risk." *See generally* Complaint. The State does not concede that the remainder of the deferral is proper, but it is not subject to this litigation.

get on the radar screen for the State of Minnesota and make sure they are responsive to our requests." *Id.* at 11:24. Dr. Oz further explained that the only way Minnesota could receive the deferred funds was by providing, and complying with, a corrective action plan he deemed sufficient: "[W]e will give them the money, but we're going to hold it and only release it after they propose and act on a comprehensive corrective action plan to solve the problem." *Id.* at 11:37.

Dr. Oz also warned that there would be future deferrals: "If Minnesota fails to clean up the systems, the state will rack up a billion dollars of deferred payments this year." *Id.* at 11:46. Vice President Vance stated that the deferral was done to "turn the screws" on Minnesota "so that they take this fraud seriously." *Id.* at 19:01. The Vice President further expressed that "if Minnesota had done a better job of combating the fraud, we would not be here at this press conference today." *Id.* at 31:35. He added that the federal government "decided to temporarily halt certain amounts of Medicaid funding that are going to the State of Minnesota in order to ensure that the State of Minnesota takes its obligations seriously." *Id.* at 0:53.

2. The Deferral is ultra-vires, premature, and unsubstantiated.

Under 42 C.F.R. § 430.40, a deferral grants CMS the authority to temporarily pause payment of a specific claim or portion of a claim for Federal Financial Participation (FFP) if the Administrator questions its allowability and requires additional information for resolution. This action is taken by excluding the amount from the state's quarterly grant award within 60 days of receiving the state's quarterly expenditure report. *Id.* A deferral does not trigger the same formal due process protections as a withholding—such as the

right to a prior evidentiary hearing. *Id.* To be valid, the written notice of deferral must satisfy a three-part test by (1) identifying the specific type of claim, (2) stating the exact amount being deferred, and (3) specifying the reason for the deferral. *Id.*

CMS's February 25, 2026, deferral is remarkable in several ways. First, the size of the deferral is unprecedented. The largest prior quarterly deferral Minnesota recalls is $10,966,609. Hultman Decl., ¶ 2. Second, the deferral process is an auditing measure that focuses on a "claim or any portion of a claim" and provides a process whereby CMS can obtain "documents and materials the regional office then believes are necessary to determine the allowability of the claim." 42 C.F.R. § 430.40(a), (b)(1)(2). It is not a basis for CMS to withhold wide swaths of Medicaid funding unrelated to specifically questioned claims, and it has not been used in that way in the past by another administration. *See* Hultman Decl., ¶ 5.

Third, the deferral notice provides no detail regarding the bases for the deferral. *See* Brennaman Decl., Ex. 6. CMS breaks down the $243 million into two buckets. CMS is withholding $164 million from the State because of "questionable variances." *See* Hultman Decl., ¶ 4. Minnesota does not understand what claims are at issue, or what documents are needed to resolve CMS's questions with respect to these "variances." *Id.* ¶ 7. The same is true for the remaining $79.5 million, which CMS states is "associated with reimbursement claims submitted to the state by specific providers that [CMS has] identified as high-risk for fraud or aberrant billing practices based on historical billing and CMS data analytics." Brennaman Decl., Ex. 6. But Minnesota does not know what "specific providers" CMS is referring to or what CMS's "data analysis" uncovered. Hultman Decl., ¶ 7. It also does not

understand of what "claims or parts of claims" are at issue and what information CMS would need to "determine the allowability of the claim." 42 C.F.R. § 430.40(a), (b)(1)(2).

Fourth, CMS already has information from the State and is withholding money from the State before it has finished conducting a review, Hultman Decl., ¶ 3, making the whole deferral a sham—there is no reason CMS cannot take the time it needs to review the information and make a disallowance later (following the due process required). DHS provided CMS with data it requested related to the issues that ultimately formed part of the basis for the deferral on February 5, and CMS admitted it has not had time to review it. *Id*. The regulatory basis for a deferral is for CMS to obtain missing information to substantiate a claim, 42 C.F.R. § 430.40(b)(1)(ii), but CMS concedes that it has not reviewed the information that Minnesota has provided and that, instead, its review is "ongoing." *See* Brennaman Decl., Ex. 6. Indeed, under normal circumstances, the concerns raised in the deferral notice would be the basis for CMS to conduct a review or an audit to investigate. Hultman Decl., ¶ 4. The effect is that CMS is depriving Minnesota of Medicaid dollars while it reviews information already in its possession to see whether any problem actually exists. *Id*. ¶¶ 5–6. Again, nothing prevents CMS from making a disallowance after it takes the time it needs to do its investigation into the "variances" and "aberrant billing practices" for specific providers, to see whether there is a real problem. *See* 42 C.F.R. 430.42.

Finally, Administrator Oz's requested cure—an acceptable corrective action plan—is not consistent with CMS's deferral authority. CMS deferral authority is about clarifying audit detail, not a corrective action plan. This further illustrates that this deferral is a pretext

and a sham, and was done in order to withhold federal funds before proving Minnesota's alleged noncompliance with federal statutes and regulations in a hearing, as required.

3. The deferral process provides no recourse to Minnesota.

The deferral process can be, and often is, dragged out indefinitely by CMS. Specifically, once Minnesota provides documents and materials to substantiate the claim, CMS has 90 days to "determine the allowability of the claim." 42 C.F.R. § 430.40(c)(5). In practice, however, CMS often evades this deadline by claiming that the state's documentation is insufficient, or that more documents are needed. Hultman Decl., ¶ 8. This can, and in the past has, often led to long delays in obtaining deferred funding that is later determined by CMS to have been allowable. *Id*. Also, even aside from these delays, there is a lengthy administrative appeals process to the Departmental Appeals Board within CMS if it ultimately disallows the claims. 42 C.F.R. § 430.42(f). In short, if this Court forces Minnesota to exhaust administrative remedies, Minnesota will not be able to effectively challenge these improper and arbitrary withholdings in federal court for many months, or even years, by which point CMS could defer—as it has already promised to do—several hundred million, or billions of dollars. Hultman Decl., ¶ 9. Between this and Administrator Oz's public statements that he has no intention of releasing funds based on documentation alone—but instead that an acceptable corrective action plan is needed—the deferral process is futile.

IV. UNLESS QUICKLY REVERSED, THE DEFERRAL WILL IRREPARABLY HARM MINNESOTA.

To state the obvious, $243 million per quarter is a lot of money for a state the size of Minnesota, and it is an amount of money that provides support to a large number of Minnesotans who rely on Medicaid. Connolly Decl., ¶ 18. That number represents, for example, the equivalent to complete quarterly federal defunding for Assertive Community Treatment Mental Health Services, Adult Rehabilitative Mental Health Services, Intensive Residential Treatment Services, and Nonemergency Medical Transportation Services. *Id*. These programs provide services to 160,000 Minnesotans, many with significant needs. *Id*. These are important services that provide intensive nonresidential treatment and rehabilitative mental healthcare; services that help mentally ill individuals develop and enhance psychiatric stability; services providing stability and support to prevent hospitalization; and transportation services to get to and from nonemergency medical service appointments. Cuts to these or similar Medicaid programs will severely impact Minnesotans who rely on these services.

The withholding of federal funding will require—in particular if funding is delayed or denied for a protracted period, or if the withholdings occur quarterly, as has been threatened—the State to make cuts to Medicaid services. *Id.* The Legislature funds Medicaid based on the then-current state budget forecast and assumes it is fully reimbursed for those services as agreed upon between the federal government and the Minnesota Department of Human Services ("DHS"). Minge Decl., ¶¶ 2–3. The State's loss of $243 million in fourth quarter Medicaid expenditures related to fourteen service areas that it

already made will have significant impacts on the state's budget and forecast. *Id.* ¶ 3. This amount represents 7.2% of the projected federal share that Minnesota receives each quarter and would require Minnesota Management and Budget and DHS to identify cuts to services absent a legislative appropriation that covers this shortfall. *Id.*

While Dr. Oz has repeatedly claimed the State can use a "rainy day fund" to cover this loss in federal funds, that is simply not true. *See* Deferral Press Conference at 12:00–12:12. Assuming he is referring to the budget reserve account found in Minnesota Statutes section 16A.152, the State may only use the budget reserve "when a negative budgetary balance is projected and when objective measures, such as reduced growth in total wages, retail sales, or employment reflect downturns in the state's economy." Minge Decl., ¶ 4. None of those circumstances is presented by the Administrator's determination in CMS's February 25, 2026 letter to State Medicaid Director John Connolly. *Id.*

V. THE PRESENT LAWSUIT.

Minnesota filed this lawsuit to protect the vulnerable people of Minnesota who rely on Medicaid for their health care, and to prevent the federal government from end-running the process to which Minnesota is entitled to challenge the Administration's erroneous belief that the State is not in compliance with Medicaid statutes and regulations. It seeks a temporary restraining order or preliminary injunction on an expedited basis[5] to ensure

[5] Plaintiffs do not seek an *ex parte* temporary restraining order, and they do not object to Defendants responding before a hearing on the motion. Plaintiffs do, however, ask that the Court hear this matter on an expedited basis due to the serious consequences of Defendants' actions.

Defendants follow the law before depriving the state of hundreds of millions, if not billions, of dollars in federal Medicaid funding.

STANDARD OF REVIEW

In deciding whether to issue a preliminary injunction,[6] the Court must consider four factors: "(1) the threat of irreparable harm to the movant; (2) the state of balance between this harm and the injury that granting the injunction will inflict on other parties litigant; (3) the probability that movant will succeed on the merits; and (4) the public interest." *Dataphase Sys. Inc. v. C.L. Sys., Inc.*, 640 F.2d 109, 114 (8th Cir. 1981).[7] While no factor is determinative, the probability of success is the most significant. *Home Instead, Inc. v. Florance*, 721 F.3d 494, 497 (8th Cir. 2013). Generally, courts require a movant to show it has a "fair chance of prevailing" on the merits of a claim. *Planned Parenthood Minn. v. Rounds*, 530 F.3d 724, 732 (8th Cir. 2008). A movant "need not show that it has a greater than fifty per cent likelihood of success." *Sleep No. Corp. v. Young*, 33 F.4th 1012, 1017 (8th Cir. 2022).

[6] Minnesota seeks either expedited handling of its preliminary injunction motion or a temporary restraining order. *See* L.R. 7.1(d). "[T]he standard for analyzing a motion for a temporary restraining order is the same as a motion for a preliminary injunction," but the duration of the order is generally limited to 14 days. *Tumey v. Mycroft AI, Inc.*, 27 F.4th 657, 665 (8th Cir. 2022) (citing Fed. R. Civ. P. 65).

[7] The Administrative Procedure Act authorizes courts "to postpone the effective date of an agency action or to preserve status or rights pending conclusion of the review proceedings." 5 U.S.C. § 705. There is "substantial overlap" between the factors for a § 705 stay and a preliminary injunction. *Nken v. Holder*, 556 U.S. 418, 434 (2009).

ARGUMENT

Through the Deferral, Defendants do what they could not in the compliance action: immediately withhold millions of dollars of Medicaid funding to Minnesota. But Defendants' attempt to end-run the procedural safeguards provided in the compliance action run afoul of the Constitution, the Administrative Procedure Act, and the deferral regulation itself. The Court should enjoin Defendants from enforcing this notice and order that they immediately distribute the $243 million CMS improperly deferred.

I. THE STATE HAS A FAIR CHANCE OF PREVAILING IN THIS LAWSUIT.

The State's due process, APA, and Spending Clause claims all stem from the same problem: the law does not permit CMS to immediately withhold millions of federal Medicaid dollars, under the guise of a "deferral." The State has a fair chance of prevailing on any of these claims.

A. Procedural Due Process Claim (Count I): CMS's Deferral Action End-Runs The Procedural Protections Provided To MDHS In The Compliance Action.

In January, CMS took the extraordinary action of finding the State of Minnesota in noncompliance with certain statutory and regulatory Medicaid requirements due, in large part, to the federal government's belief that Minnesota had not done enough to protect Medicaid funds from fraud, waste, and abuse. Brennaman Decl., Ex. 3. As part of this compliance action, CMS withheld $515 million, which CMS claimed to be "the federal share for one quarter's amount of the previous calendar year's annual total paid expenditures for the fourteen high-risk services." *Id.* at 5. CMS stated "[t]he withholding will end" when DHS "fully and satisfactorily" implements a corrective action plan that

addresses fraud, waste, and abuse in the fourteen high-risk service areas. *Id.* Because DHS initiated the administrative appeal process, none of the threatened funds can be withheld until the conclusion of the appeal process. 42 C.F.R. §§ 430.35(a), 430.104(a).

Evidently unsatisfied that Defendants had to wait to withhold hundreds of millions of dollars until after DHS had received due process, Defendants initiated the present deferral action to immediately target much of the same Medicaid funding that is at issue in the compliance matter. Indeed, of the $259 million that CMS withheld, over $243 million—that is, 94%—was due to CMS's focus on the same "fourteen high-risk Medicaid service areas identified as particularly vulnerable to fraud or abuse" that are at issue in the compliance case. Brennaman Decl., Ex. 6, at 2. And like the compliance matter, Dr. Oz conditioned lifting the deferral on Minnesota "propos[ing] and act[ing] on a comprehensive corrective action plan to solve the [fraud] problem," *see* Deferral Press Conference, at 11:37, despite such information being outside the scope of the type of information on which CMS is permitted to base a deferral. Defendants' decision to immediately defer $243 million dollars end-runs the procedures and process provided to Minnesota in the compliance action in violation of Minnesota's procedural due process rights.

To succeed on a procedural due process claim, a plaintiff must show that the government (1) deprived a party of a protected life, liberty, or property interest, and (2) failed to provide adequate procedural rights before impinging upon the protected interest. *Schmidt v. Des Moines Pub. Schs.*, 655 F.3d 811, 817 (8th Cir. 2011). A liberty interest can arise from two sources: the Constitution or a federal statute. *See United States v. Johnson*, 703 F.3d 464, 469 (8th Cir. 2013).

Here, Minnesota has a protected liberty interest in the process it is provided in the compliance matter—process Minnesota receives *before* CMS withholds hundreds of millions of dollars. *See* 42 C.F.R. § 430.35. But by initiating the present Deferral that targets the same funding at issue in the compliance matter, Defendants have effectively deprived Minnesota of that process.

It is true that, under different circumstances, the federal government can defer Medicaid payments to the State for "a narrow item or class of items" that "do not, in some general sense, affect the working of the program or federal–state cooperation." *Massachusetts v. Departmental Grant Appeals Bd.*, 698 F.2d 22, 25 (1st Cir. 1983); *see also* 42 C.F.R. §§ 430.40, 430.42. But when "refusal of FFP touches on matters of far-reaching importance, affecting the overall Medicaid program," courts have "treat[ed] the dispute as involving compliance" and not as a disallowance.[8] *Departmental Grant Appeals Bd.*, 698 F.2d at 27. To determine whether a claim is a disallowance or functionally a compliance matter, courts look at: (1) whether the matter might have "fit comfortably" within the noncompliance statute, (2) whether the matter "is of such a character, by reason of its generality and importance, as to point towards inclusion under the compliance rather than the disallowance rubric," and (3) the government's chosen procedures and label, though that is not dispositive. *Id.*

[8] If a State cannot substantiate a deferred claim, it results in a disallowance. 42 C.F.R. § 430.40(c)(5) ("The current Designee has 90 days, after all documentation is available in readily reviewable form, to determine the allowability of the claim."), (e)(1) ("The Administrator or current Designee gives the State written notice of his or her decision to pay or disallow a deferred claim.").

All three factors are met. *First*, not only *could* this matter "fit comfortably" as part of the noncompliance statutory scheme, the issue of whether the State can correct the purported deficiencies identified by the federal government as part of a corrective action plan is precisely what is already at issue in the compliance matter. *Second*, the amount of money at issue is so massive that its character screeches inclusion under the compliance matter. As discussed above, this deferral amounts to a number that represents a complete quarterly federal defunding of four Medicaid services that serve over 160,000 Minnesotans. Connolly Decl., ¶ 18. Dr. Oz even admitted this is a "massive action to defer funds to [Minnesota]." Deferral Press Conference, at 9:50. *Third*, while the government has chosen to label this matter as a deferral, Dr. Oz indicated that even if the State could show that every dollar of the deferred money was properly paid by the State, Minnesota would still not receive it until Minnesota "propose[s] and act[s] on a comprehensive corrective action plan to solve the [fraud] problem." *Id.* at 11:37. But coming into purported compliance with Medicaid regulations is the purpose of a compliance action, not a deferral. *Compare* 42 C.F.R. §§ 430.35, 430.60, *with id.* §§ 430.40, 430.42; *see also* 42 C.F.R. § 430.35(a) ("Hearings [in a compliance action] are generally not called until a reasonable effort has been made to resolve the issues through conferences and discussions. These may be continued even if a date and place have been set for the hearing.").

By pursuing this enormous withholding of federal funds through a deferral, CMS is end-running the procedures the State is entitled to (and in fact, going through right now) and immediately taking away hundreds of millions of dollars meant to help the most

vulnerable of Minnesotans. The State is likely to succeed on the merits of its procedural due process claim and accordingly, the Court should enjoin CMS from deferring payment.[9]

B. APA Claims (Counts II and III): The deferral notice does not comply with federal regulations because it is arbitrary, capricious, and contrary to law, and it is procedurally deficient.

The Court need not even consider whether the State has a fair chance of prevailing on its APA claims because, as discussed, Defendants are depriving Minnesota of due process. The State nevertheless has a fair chance of prevailing on these claims because the Deferral is arbitrary, capricious, and contrary to law, and it is procedurally deficient.

1. The Deferral notice is a final agency action.

Two conditions must be established for an agency action to be final. First, "the action must mark the consummation of the agency's decision-making process and not be merely tentative or interlocutory in nature." *Union Pac. R.R. Co. v. U.S. R.R. Ret. Bd.*, 162 F.4th 908, 917 (8th Cir. 2025). Second, "the action must be one by which rights or obligations have been determined, or from which legal consequences will flow." *Id.* (quoting *Bennett v. Spear*, 520 U.S. 154, 177–78 (1997)). To meet this second condition, "the agency action must inflict some legal injury upon the party seeking judicial review, either compelling affirmative action or prohibiting otherwise lawful action." *Id.*

[9] Minnesota also has a protected property interest in the $243 million, and it was deprived of that interest without due process when Defendants immediately withheld that funding without a substantiated deferral pursuant to 42 C.F.R. § 430.40. *Bd. of Regents v. Roth*, 408 U.S. 564, 577 (1972) ("Property interests . . . are created and their dimensions are defined by existing rules or understandings that stem from an independent source such as state law-rules or understandings that secure certain benefits and that support claims of entitlement to those benefits.").

Both conditions are met here. First, the Deferral is not "merely tentative or interlocutory in nature." Rather, it is a final decision by the agency that it will use the deferral process to immediately withhold $243 million in Medicaid money. It "mark[s] the consummation of [CMS's] decision-making process" to deprive Minnesota of the procedures it is entitled to as part of a compliance action before money is withheld. *E.g.*, *Texas Children's Hosp. v. Burwell*, 76 F. Supp. 3d 224, 239–41 (D.D.C. 2014) (finding CMS's decision to bypass notice and comment rulemaking when modifying its methodology to calculate certain Medicaid payment limits was a final agency action).

Second, concrete legal consequences flow from CMS's decision. Not only does it immediately withhold $243 million, it initiates a process where the burden is on the State to establish the allowability of a deferred claim, *compare* 42 C.F.R. § 430.40(b)(2) (stating the State must establish the allowability of a deferred claim), *with* 42 C.F.R. § 430.35(a)(2) (stating the Administrator must show the state is in "substantial noncompliance" with federal law). It also deprives Minnesota of a discovery period and a contested hearing where the State can present evidence and examine witnesses. *Compare* 42 C.F.R. § 430.40 (providing no right to discovery or a hearing following deferral), *with* 42 C.F.R. § 430.86 (permitting discovery in compliance actions). In short, CMS's decision to end-run the compliance matter by initiating this deferral action results in significant legal consequences to Minnesota. The notice is thus a final agency action and subject to the APA.[10]

[10] *See California v. U.S. Dep't of Agric.*, 800 F. Supp. 3d 1015, 1024 (N.D. Cal. 2025), *modified on other grounds by* No. 25-CV-06310-MMC, 2025 WL 2772872 (N.D. Cal. Sept. 29, 2025) (finding an agency's letter that demanded actions and stated that failure to
(Footnote Continued on Next Page.)

2. The Deferral is arbitrary, capricious, and contrary to law.

An agency action is arbitrary and capricious if it "has relied on factors Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." *Missouri ex rel. Bailey v. U.S. Dep't of Interior, Bureau of Reclamation*, 73 F.4th 570, 576–77 (8th Cir. 2023). Although the scope of review is narrow, the agency must still provide "a satisfactory explanation for its action[,] including a 'rational connection between the facts found and the choice made.'" *Motor Vehicle Mfrs. Ass'n of the United States, Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983) (internal quotation marks omitted).

A deferral notice must, among other things, ask the State "to make available all documents and materials the regional office then believes are necessary to determine the

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comply "may trigger noncompliance procedures" was a final agency decision because the statute that authorizes such a procedure provides the consequences that flow from failing to comply, despite the permissive language); *Texas v. Brooks-LaSure*, 680 F. Supp. 3d 791, 805 (E.D. Tex. 2023) (finding agency bulletin a final agency action because it had practical binding effect in that the affected parties were reasonably led to believe that failure to conform would bring adverse consequences); *Minnesota v. U.S. Dep't of Agriculture*, No. 25-cv-4767, 2026 WL 125180, at *9 n.6 (D. Minn. Jan. 16, 2026) (finding an agency's Recertification Letter to be a final agency action because it determined the State of Minnesota's obligations and the consequences flowing from its failure to comply with those obligations); *see also Fairbanks N. Star Borough v. U.S. Army Corps of Eng'rs*, 543 F.3d 586, 593–94 (9th Cir. 2008) (explaining that the second *Bennett* prong is not established where "rights and obligations remain unchanged."); *Nat'l Ass'n of Home Builders v. Norton*, 415 F.3d 8, 15 (D.C.Cir.2005) ("[I]f the practical effect of the agency action is not a certain change in the legal obligations of a party, the action is non-final for the purpose of judicial review.").

allowability of the claim." 42 C.F.R. § 430.40(b)(1)(ii). It is ultimately "the responsibility of the State to establish the allowability of a deferred claim." *Id.* § 430.40(b)(2). Thus, a state that receives a deferral notice can recoup the withheld federal dollars if it simply provides documentation that the claim at issue was properly paid.

The deferral notice instructs DHS to provide "all documents and materials that it believes support the allowability of the [claims at issue]." Brennaman Decl., Ex. 7, at 2. But DHS has already provided this documentation to CMS, and CMS concedes it has not reviewed it. *Supra* p. 16. A deferral in this context makes no sense, either logically or legally. CMS must have a need for additional information to defer funds. *See* 42 C.F.R. § 430.40(a)(1). CMS received data from DHS related to this issue on February 5, and CMS's own deferral letter admits its review is "ongoing" (i.e., it has the data but has not reviewed it yet). Brennaman Decl., Ex. 6. Logically, CMS cannot simultaneously claim that it needs more information (i.e., the deferral's stated basis) and that it has not reviewed what it already received. And legally, CMS cannot issue a deferral when it does not actually "need[] additional information." *See* 42 C.F.R. § 430.40(a)(1).

Why, then, would CMS issue a notice of deferral to obtain documents it already has in its possession but has admitted it has not had time to review? Because, as Dr. Oz and Vice President Vance boasted, this deferral has nothing to do with obtaining documentation to verify claims, as required by the regulations. Both officials made clear that the only way for Minnesota to recoup the withheld money is for Minnesota to act on a corrective action plan that meets their approval. *See* Deferral Press Conference, at 11:37 (Dr. Oz stating that the federal government will "only release [the money] after they propose and act on a

comprehensive corrective action plan"); *id.* at 0:53 (Vance stating, "We have decided to temporarily halt certain amounts of Medicaid funding that are going to the State of Minnesota in order to ensure that the State of Minnesota takes its obligations seriously."). Notably, Dr. Oz stated that if Minnesota does not do so, "the state will rack up a billion dollars of deferred payments this year." *Id.* at 11:46.

Nothing about this purported corrective action plan is mentioned in the deferral notice. *See generally* Brennaman Decl., Ex. 7. Nor should it be, as a deferral action is retrospective—CMS is looking at past claims and considering past documentation to determine whether the State should be reimbursed. 42 C.F.R. § 430.40(a), (b). But the statements by Dr. Oz and Vice President Vance show this Deferral is forward-looking; that is, that DHS's *future* actions will determine whether this money is ever released.[11] Remarkably, Dr. Oz stated that Minnesota could see additional quarter-billion-dollar deferrals if it does not submit the corrective action plan sought by the federal government. Deferral Press Conference, at 11:46. Such a statement makes no sense as part of a deferral because Defendants have no way of knowing whether any future claims submitted by Minnesota will have deficiencies that require CMS to defer payments. Instead, Dr. Oz's statements demonstrate he has pre-judged future quarterly reports without any factual basis, and that he has no intention of releasing funds based on documentation alone. Moreover, the State submitted its corrective action plan weeks ago and has received no indication from CMS that it is deficient, or any way in which it is deficient.

[11] Likewise, the compliance action is prospective. *See* 42 C.F.R. § 430.35.

Because Dr. Oz and the Vice President have laid bare that this deferral has nothing to do with substantiating particular claims with documentation, which is the required use of a deferral under federal regulations, CMS's action is arbitrary, capricious, and contrary to the regulatory scheme. *See Fed. Commc'ns Comm'n v. Prometheus Radio Project*, 592 U.S. 414, 423 (2021) (an agency is action is arbitrary and capricious when it is not "reasonable and reasonably explained"). CMS's action should be enjoined.[12]

2. The Deferral is without observance of procedure required by law.

Not only is the Deferral arbitrary, capricious, and contrary to law, but it also fails to follow the required procedure outlined in the deferral regulation. *See* 5 U.S.C. § 706(2)(D) (stating that a reviewing court shall set aside an agency action that is "without observance of procedure required by law").

CMS's own regulations state that a notice of deferral must "identif[y] the type and amount of the deferred claim and specif[y] the reason for deferral." 42 C.F.R.

[12] For these same reasons, the State has a fair chance of prevailing on its ultra vires claim (Count V). Courts recognize "a right to equitable relief where an agency's action was ultra vires—that is, unauthorized by any law and in violation of the rights of the individual." *Nuclear Regulatory Commission v. Texas*, 605 U.S. 665, 665 (2025) (quotation omitted). While an ultra vires claim is narrow, it nevertheless applies "when an agency has taken action entirely in excess of its delegated powers and contrary to a *specific prohibition* in a statute. *Id.* at 681 (quotation omitted); *see Leedom v. Kyne*, 358 U.S. 184, 188–89 (1958) (sustaining an ultra vires claim when an agency plainly attempted to exercise power that had been withheld under an Act). Here, CMS's regulations state that CMS can defer federal financial participation dollars for particular claims, and a State can lift the deferral by providing sufficient documentation to the agency. The regulation, however, prohibits CMS from conditioning the lifting of a deferral on anything other than the state providing documentation for the claim. *See* 42 C.F.R. § 430.40(a) (detailing the mandatory criteria for a deferral). In other words, the regulation prohibits CMS from deferring federal dollars until DHS provides what CMS considers an adequate corrective action plan.

§ 430.40(b)(1)(i). Here, the notice falls woefully short of providing the State with any information about the particular claims at issue or the specific reasons for the deferral. As to the $243 million deferred, the only information the notice provided was that it was "attributable to CMS's ongoing review of state expenditures." Brennaman Decl., Ex. 7, at 2. It does not identify what those "state expenditures" are, nor does it provide any information about particular claims that could be at issue. It only states that the "focus" was on "fourteen high-risk Medicaid service areas identified as particularly vulnerable to fraud or abuse," but it does not state that the deferred dollars *only* come from those programs. While CMS breaks this $243 million down into two buckets, this breakdown provides equally vague information:

> - CMS has identified $164,198,916 FFP for other practitioner, personal care, and home and community-based services lines that have questionable variances and raise concerns about allowability of the claimed expenditures.
>
> - Additionally, CMS has identified $79,591,344 FFP claimed by the state associated with reimbursement claims submitted to the state by specific providers that we have identified as high-risk for fraud or aberrant billing practices based on historical billing and CMS data analytics.

Id.

The purpose of a deferral notice is to give the State sufficient information so it can "make available all the documents and materials" necessary for CMS to determine whether the claim is allowable, as it "is the responsibility of the State to establish the allowability of a deferred claim." 42 C.F.R. § 430.40(b)(1)(ii), (b)(2). But nothing in this notice provides the State with specific information about the particular claims at issue:

- It does not indicate what the "questionable variances" are that cause CMS concern.
- It does not identify the "specific providers" CMS identified as "high-risk for fraud."
- It does not identify the "aberrant billing practices" that led to the deferral.

The State, thus, is left to guess at what documentation CMS would deem acceptable to resolve the unspecified issues that led to this deferral.[13] The vagueness of the notice effectively blocks Minnesota from establishing whether the "claims" at issue are allowable, which not only undermines the entire purpose of CMS's own administrative process for deferrals, but also makes it legally impossible for the State to discharge its burden to establish allowability of the deferred claims. *See* 42 C.F.R. § 430.40(b)(2).

The notice fails to provide the procedure required by section 430.40 because it does not identify the type and amount of the deferred claim or specify the reason for denial. This serious deficiency is just one more reason why Defendants' unprecedented action should be enjoined.

C. Constitutional Claim (Count IV): CMS's deferral is coercive in violation of the Spending Clause.

It follows that Minnesota has a fair chance to succeed on its Spending Clause claim because the deferral of nearly a quarter billion dollars is meant to coerce Minnesota into Defendants' desired corrective action plan.

[13] While the State has been able to make an educated guess as to what CMS is seeking based on previous conversations with the agency, nothing in this notice provides sufficient specificity such that the State can determine whether CMS leadership will deem its documentation acceptable.

Congress may impose conditions on states' acceptance of federal funds, but "the conditions must be set out unambiguously."[14] *Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy*, 548 U.S. 291, 296 (2006) (citations omitted). This is so States can "exercise their choice knowingly, cognizant of the consequences of their participation." *South Dakota v. Dole*, 483 U.S. 203, 206 (1987) (quoting *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981)). "Though Congress' power to legislate under the spending power is broad, it does not include surprising participating States with post acceptance or 'retroactive' conditions." *Pennhurst*, 451 U.S. at 25. "Respecting [the] limitation" that a "State voluntarily and knowingly accepts" conditions on federal funds is "critical to ensuring that Spending Clause legislation does not undermine the status of the States as independent sovereigns in our federal system." *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 577 (2012) ("NFIB") (quoting *Pennhurst*, 451 U.S. at 17); *see also NFIB*, 567 U.S. at 581 (finding that the Medicaid provisions of the ACA were coercive and beyond "mild encouragement" allowed under the Spending Clause, and more akin to a "gun to the head").

[14] These Spending Clause limitations apply equally to the Executive Branch. *See, e.g.*, *City of Santa Clara v. Noem*, No. 25-CV-08330-WHO, 2025 WL 3251660, at *34 (N.D. Cal. Nov. 21, 2025); *California v. U.S. Dep't of Transp.*, 788 F. Supp. 3d 316, 322–23 (D.R.I. 2025); *see also City of Los Angeles v. Barr*, 929 F.3d 1163, 1176 (9th Cir. 2019) (holding that the Spending Clause "appl[ies] to agency-drawn conditions on grants to states and localities just as they do to conditions Congress directly places on grants[,]" and there is "no reason why the addition of an agency middleman either expands or contracts Congress's power to 'provide for the general Welfare'" (quoting U.S. Const. art. I, § 8, cl. 1)).

Here, Defendants have imposed post-acceptance or retroactive conditions on the State's Medicaid funding that were not contemplated when the State elected to participate in the Medicaid program. Minnesota knew that if the federal government believed the State was out of compliance with the Medicaid Act, the federal government could withhold federal dollars following the administrative procedures in 42 U.S.C. ch. 1396c. It also knew that if the federal government believed that particular claims lacked sufficient documentation or were not allowed, it could defer paying the State until it provided sufficient documentation to substantiate those claims. 42 C.F.R. § 430.40. What it did not know, however, was that the federal government could immediately defer hundreds of millions of dollars every quarter, with no due process, based purely on Defendants' desire for Minnesota to create, and comply with, a corrective action plan that meets Defendants' ever-changing standards and regardless of DHS's relentless efforts to collaborate with CMS as encouraged by the regulations. *See* 42 C.F.R. §§ 430.35(a), 430.60(b). This is, plain and simple, a retroactive, post-acceptance condition. *See NFIB*, 567 U.S. at 580 ("When, for example, such conditions take the form of threats to terminate other significant independent grants, the conditions are properly viewed as a means of pressuring the States to accept policy changes.").

Defendants have not been shy that the basis for this deferral is not to substantiate disputed claims but to coerce the State into enacting the policies that Dr. Oz and Vice President Vance deem acceptable. *See supra* pp. 13–14. This retroactive, post-acceptance condition on continued federal funding for Minnesota violates the Spending Clause.

II. MINNESOTA WILL SUFFER IRREPARABLE HARM WITHOUT A PRELIMINARY INJUNCTION.

Irreparable harm exists "when a party has no adequate remedy at law, typically because its injuries cannot be fully compensated through an award of damages." *Gen. Motors Corp. v. Harry Brown's LLC*, 563 F.3d 312, 319 (8th Cir. 2009). Absent interim relief, Minnesota will suffer irreparable harm for a number of reasons.

As discussed above, this withholding is the latest in a pattern of "reckoning and retribution" against the state of Minnesota—political punishment meant to hurt a blue state. And the immediate loss of $243 million will hurt Minnesota and its citizens. The immediate withholding of federal funding, especially if funding is delayed or denied for a protracted period or assuming Dr. Oz follows through with his promise to defer every quarter, would require the State to make cuts to Medicaid services, which would directly harm Minnesotans unable to receive necessary medical care. *See supra* p. 18. The sheer amount of this deferral is so massive, it is equivalent to cutting off all federal funding for multiple Medicaid programs. *Id.* Minnesota's Medicaid budget assumed federal matching funds, and absent a legislative appropriation to make up the shortfall, DHS will have to cut Medicaid programs. *Id.* And contrary to Dr. Oz's claim, Minnesota does not have a "rainy day" fund it can use to make up the budget shortfall caused by the Deferral. *Id.*

III. THE BALANCE OF HARMS AND PUBLIC INTEREST SUPPORT ENJOINING DEFENDANTS.

The third and fourth factors—harm to the opposing party and the public interest—merge when the government opposes preliminary relief. *Morehouse Enters., LLC v. Bureau of Alcohol, Tobacco, Firearms & Explosives*, 78 F.4th 1011, 1018 (8th Cir. 2023).

As discussed above, the public faces imminent harm to their detriment from the loss of $243 million. *See supra* pp. 18, 35. Defendants face absolutely no hardship from an injunction. As an initial matter, "there is substantial public interest in a federal agency following its own regulations . . . and in Americans trusting their own government to follow the rule of law." *Shaik v. Noem*, No. 25-cv-1584, 2025 WL 1170447, at *3 (D. Minn. Apr. 22, 2025). Further, Defendants are already pursuing a noncompliance action against Minnesota related to fraud; if they are successful, they could recover significantly more than they are deferring in the present matter. Moreover, nothing prevents CMS from disallowing a claim in the future if, after it reviews the documentation DHS provided, it concludes that a claim was improperly paid. *See* 42 C.F.R. § 430.42. Further, CMS can withhold—as it has threatened to do—if it can prove noncompliance by Minnesota after discovery and a hearing, in its noncompliance action. And finally, to the extent Defendants have legitimate concerns about fraud, they could simply respond to DHS's continued inquiries and requests for input on the State's corrective action plan. But CMS has refused to provide any feedback to the State, despite the State's relentless efforts to collaborate with CMS.

CONCLUSION

Minnesota asks this Court to enjoin Defendants from immediately deferring over $243 million in Medicaid from the State and prevent Defendants from end-running the procedures granted to Minnesota in the compliance action.

(Signature on next page)

Dated: March 2, 2026

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UNITED STATES DISTRICT COURT

DISTRICT OF MINNESOTA

Case No.

State of Minnesota, by and through its Attorney General Keith Ellison, and Shireen Gandhi, in her official capacity as the Commissioner of the Minnesota Department of Human Services,

Plaintiffs,

vs.

Dr. Mehmet Oz, in his official capacity as Administrator for the Centers for Medicare and Medicaid Services; the Centers for Medicare and Medicaid Services; Robert F. Kennedy, Jr., in his official capacity as Secretary of the U.S. Department of Health and Human Services; U.S. Department of Health and Human Services,

Defendants.

DECLARATION OF NATE BRENNAMAN

I, Nate Brennaman, hereby declare as follows:

1. I am an Assistant Attorney General at the Minnesota Attorney General's Office. I am familiar with the litigation related to Administrator Oz's January 6, 2026, Notice of Noncompliance. I am also familiar with the Notice of Deferral that was provided to the Minnesota Department of Human Services on February 25, 2026 and have personal knowledge of the facts in this declaration.

2. Attached as Exhibit #1 is a true and correct copy of Governor Walz's September 17, 2025, Executive Order EO 25-10.

3. Attached as Exhibit #2 is a true and correct copy of the December 5, 2025 Letter from Administrator Oz to John Connolly.

4. Attached as Exhibit #3 is a true and correct copy of the January 6, 2026, Notice of Noncompliance from Administrator Oz to Governor Walz.

5. Attached as Exhibit #4 is a true and correct copy of the January 9, 2026, letter from John Connolly to Administrator Oz.

6. In the Compliance Action initiated by CMS's January 6, 2026, Notice, Minnesota has not yet received CMS's investigative file, and to date no hearing has been scheduled.

7. In the Compliance Action, Minnesota asked the designated hearing officer for an Amended Notice so that it could obtain detail about how it allegedly was noncompliant with federal statutes and regulations. This request was denied by the administrative hearing officer. Minnesota has also asked CMS repeatedly for information and detail regarding the claimed noncompliance, but CMS has refused to provide any information.

8. Attached as Exhibit #5 is a true and correct copy of the Minnesota Department of Human Services' January 30, 2026, revised and more detailed Corrective Action Plan.

9. Attached as Exhibit #6 is a true and correct copy of the February 25, 2026 Notice of Deferral from Dorthy Ferguson to John Connolly.

10. Attached as Exhibit #7 is a true and correct copy of the Minnesota Department of Human Services December 31, 2025, Corrective Action Plan.

I declare under penalty of perjury that everything I have stated in this document is true and correct.

Executed on: March 2, 2026
Hennepin County
State of Minnesota

Nate Brennaman

State of Minnesota, et al.
v.
Dr. Mehmet Oz, et al.
U.S. District Court No. 26-cv-1701

DECLARATION OF NATE BRENNAMAN

Exhibit 1

STATE *of* MINNESOTA

Executive Department Governor Tim Walz

Executive Order 25-10

Empowering State Agencies to Continue Combatting Fraud

I, Tim Walz, Governor of the State of Minnesota, by the authority vested in me by the Constitution and applicable statutes, issue the following executive order:

Fraud perpetrated against the State is unacceptable and my administration will not tolerate the abuse or misuse of public funds. The State oversees a number of public programs intended to help our most vulnerable populations, including people with disabilities, those with housing insecurity, and children who need medical assistance services. We have seen ever-evolving criminal schemes focused on taking advantage of Minnesota's programs and our culture of generosity. These criminal activities erode public trust and take from those who need the most support.

Fraud committed against the State has several root causes. The legislature created programs that prioritized access, but did not always include the safeguards necessary to protect programs against predatory or fraudulent providers. Similarly, the federal government approved programs that were novel but did not have the internal controls needed to prevent fraud. All the while, leaders in communities where fraud is prevalent stayed silent.

My administration has made numerous advances in response to these evolving scams and fraudulent schemes. We have created new inspector general positions, like at the Minnesota Department of Education. We have increased agency authority to stop fraudulent payments and allow for better data sharing. We have added new criminal statutes, like those barring kickbacks. And we created a new Financial Crimes and Fraud Section at the Bureau of Criminal Apprehension ("BCA"), creating a centralized fraud investigative unit operated by law enforcement.

More recently, I have installed new leadership at the Department of Human Services ("DHS") with an emphasis on fraud prevention, including Temporary Commissioner Shireen Gandhi and Inspector General James Clark. My administration continues to assist the Minnesota Attorney General's Office, the United States Attorney's Office, and other law enforcement and prosecution agencies to ensure that fraudsters are brought to justice. But there is more to do, and State agencies need the resources and clear direction to continue the fight against fraud.

Fraud is never acceptable and my administration will continue to bring everyone to the table to help solve this problem. As financial stewards of public funds, I am ordering agencies to show the public all the efforts they have taken and continue to take to stop and prevent fraud. I am ordering agencies to use their new data sharing abilities to create a Statewide Office of Inspector General ("OIG") Coordinating Council to collaborate and stop fraud across the enterprise. And, I'm ordering agencies to take an even harder look at programs and end the ones that pose too much risk.

We have always taken a zero-tolerance approach on this issue and will continue to root out those individuals who use the most vulnerable as a shield to enrich themselves. We must ensure that agencies have the ability to make necessary administrative changes to stop fraud, organize across the enterprise effectively to root out fraud, and have all possible tools to refer criminal behavior for future prosecution.

For these reasons, I order as follows:

1. DHS will, to the maximum extent allowed by law:

    a. Publish information about program integrity actions taken by the agency so that the public can know of the efforts to prevent fraud, waste, and abuse.

    b. Direct the DHS Inspector General to:

        i. Establish a proactive, data-driven post-payment review program for Medicaid providers and claims and deploy advanced analytics and risk-scoring models to identify high-risk providers, claims, and service patterns for targeted review.

        ii. Identify DHS programs that present a high risk of fraud, waste, and abuse and:

            1. Recommend programmatic changes, up to and including terminating high-risk programs. The recommendation to terminate a program shall include consideration of whether there are alternative services available to meet the needs of vulnerable Minnesotans;

            2. Implement a temporary licensing moratorium, both directly under Minnesota Statutes, section 245A.03, subdivision 7a, and by requesting that the Centers for Medicare & Medicaid Services ("CMS") allow DHS to implement moratoria; and

            3. Ensure that all providers in these programs have a unique identifier that will allow the agency to better track funds across agency programs.

    c. Subject providers who present identified risk factors to prepayment review.

    d. Immediately disenroll all Minnesota Health Care Program enrolled providers who have not billed Medicaid in the last 12 months.

    e. Submit a request for funds from any available state accounts to modernize systems to better prevent and detect fraud, waste, and abuse.

    f. Request any and all assistance from CMS and other federal partners to ensure that DHS' program integrity measures are in line with national program integrity standards.

    g. Hire an external consultant to assess DHS and make recommendations on reorganization to more effectively serve as the State's Medicaid agency. The consultant's review should focus on program integrity and anti-fraud efforts, including suggested policies, procedures, system changes, organizational structure

changes, staffing levels, and program integrity considerations that should be part of any state legislation that proposes to expand or create new covered Medicaid services. The consultant should also provide guidance how to best utilize partnerships with counties, Tribal Nations, and managed care organizations to minimize fraud and optimize efficient service delivery.

2. The Department of Public Safety ("DPS") will:

    a. Convene and lead a Statewide OIG Coordinating Council made up of the Superintendent of the BCA (or designee), representatives from offices of each agency's inspector general's office, representatives of the Financial Crimes and Fraud Section of the BCA, the Internal Controls and Accountability Unit at Minnesota Management and Budget ("MMB"), the Grants Management team at the Minnesota Department of Administration, and other agency representatives who bring expertise in program integrity, audit, or internal controls. The Statewide OIG Coordinating Council will:

        i. Meet monthly to use the new data sharing provisions set out in the recently adopted Minn. Laws 2025, Ch. 39, Art. 2, Sec. 16 to share investigative data and trends that could improve outcomes at other agencies;

        ii. Develop data sharing, investigative best practices, and program integrity review processes for all new publicly funded programs; and

        iii. Assist agencies in securing specialized audit, inspector, or other skillsets as needed.

    b. Enter into interagency agreements with state agencies that do not have an existing OIG to provide additional criminal investigative support as needed.

    c. Collaborate with the Minnesota Attorney General's Office to provide additional criminal investigative support for Medicaid programs upon request if resources are available.

3. MMB will:

    a. Coordinate an interagency workgroup to combat fraud through prevention, early identification, mitigation, culture and learning.

    b. Conduct a comprehensive review of existing state job classifications and create a job class family to establish a clear career pathway for state roles dedicated to program integrity, accountability, and fraud detection.

    c. Lead an enterprise agency work group to create job specific training and education standards for state employees whose jobs are dedicated to preventing fraud waste and abuse.

    d. Create required training for all state employees on the topic of ethical conduct, and preventing fraud, waste, and abuse.

4. Minnesota IT Services will assist DHS and other requesting agencies with technological support, including available financial support, to improve data analysis and fraud detection technological capabilities.

5. All state agencies, meaning the departments and agencies listed in Minnesota Statutes, section 15.06, subdivision 1, in addition to the Office of Higher Education, Office of Cannabis Management, Direct Care and Treatment, and the Department of Military Affairs, will:

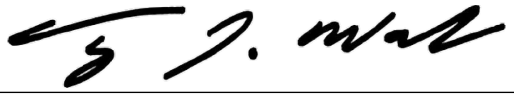
    a. Gather, combine, and analyze data to identify, prevent, or eliminate the fraudulent use of State funds, resources, or programs.

    b. Refer suspected fraud cases to the Department of Revenue for tax fraud investigation, in addition to referring all allegations of suspected fraud to the BCA and the Office of the Legislative Auditor.

This Executive Order is effective fifteen days after publication in the State Register and filing with the Secretary of State. It will remain in effect until rescinded by proper authority or until it expires in accordance with Minnesota Statutes 2024, section 4.035, subdivision 3.

A determination that any provision of this Executive Order is invalid will not affect the enforceability of any other provision of this Executive Order. Rather, the invalid provision will be modified to the extent necessary so that it is enforceable.

Signed on September 17, 2025.



Tim Walz, GOVERNOR

Filed According to Law:

Steve Simon, SECRETARY OF STATE

State of Minnesota, et al.
v.
Dr. Mehmet Oz, et al.
U.S. District Court No. 26-cv-1701

DECLARATION OF NATE BRENNAMAN

Exhibit 2

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

December 5, 2025

John Connolly
Deputy Commissioner and State Medicaid Director
Minnesota Department of Human Services
540 Cedar Street
St. Paul, MN 55164-0983

Dear Mr. Connolly:

As has been widely reported—and as acknowledged by the State of Minnesota—there is significant and ongoing fraud within Minnesota's Medicaid program. Fraud investigations from the Centers for Medicare & Medicaid Services, Department of Health and Human Services Office of the Inspector General (OIG), Department of Justice (DOJ), Federal Bureau of Investigation (FBI), and other federal agencies have identified widespread fraud in Minnesota Medicaid, and repeated failures on the part of Minnesota to adequately address it. (See Appendix A for a sampling of cases and audit reports that demonstrate this repeated failure.)

Fraud cases have involved individuals or entities billing Minnesota for services never provided, or not provided at the level billed, and using complex international crime rings that exploit vulnerable populations for extreme financial gain. A recent FBI investigation, for example, identified a Somali national who allegedly recruited and employed numerous unqualified individuals to furnish autism services on behalf of a Medicaid provider she controlled and offered kickbacks to parents of Medicaid-enrolled children for allowing their children's identities to be used to commit fraud. This provider is alleged to have fraudulently billed $14 million in Medicaid claims for services purportedly, but not actually, furnished to clients by these individuals.[1]

The widespread fraud in Minnesota has not gone unnoticed, even within the state itself. During the 2025 legislative session, a bill was enacted that introduced new provisions to combat fraud, specifically focusing on autism services. The legislature also passed bills for new licensing requirements for autism service providers and to create a House Oversight Committee to hold hearings on fraud. Whistleblowers and state employees have long complained that Minnesota's

[1] District of Minnesota | First Defendant Charged in Autism Fraud Scheme | United States Department of Justice

executive branch is not taking fraud allegations seriously and not providing proper oversight of the Medicaid program.[2]

Minnesota's own Medicaid data showed incredible service utilization trends reflective of suspicious usage that would have been obvious to even casual observers. CMS' analysis of Minnesota Medicaid data shows, for example, that between 2023 and 2025 the number of adult companion service providers increased by 131% with a corresponding increase in Medicaid payments by 234%, all while the number of purported recipients only increased by 24%. In that same time period, total Medicaid payments for 13 of the 14 high-risk service types[3] increased from $2.8 billion to $3.6 billion.

In response to mounting public pressure involving fraud in other government services, Governor Walz recently suspended Medicaid payments and implemented a 90-day pre-payment review for all claims involving 14 Medicaid services that, by the state's own admission,[4] are recognized as targets of systemic fraud. On December 1, 2025, Minnesota also announced that it would be issuing a temporary licensing moratorium for licensed Home and Community-Based Services (HCBS), openly acknowledging that Minnesota licensors outpaced the needs of enrolled participants and were unable to "contribute to effective program integrity oversight."[5]

Minnesota Must Take Additional Steps Now

While Minnesota has taken steps in the right direction, they are insufficient to adequately address a problem that has been years in the making. Even the Minnesota State Auditor recognizes that you cannot audit your way out of fraud."[6] CMS agrees—widespread fraud requires widespread remediation. Accordingly, CMS strongly urges Minnesota to take the following actions, most of which have been addressed in a separate letter to Governor Walz:

1. **Meet with CMS to provide weekly updates on its progress in executing its action plan to address widespread fraud in the state.** Representatives from the CMS Center for Program Integrity and/or Center for Medicaid and CHIP Services will participate and are ready to provide appropriate technical assistance. Please contact Evan Godfrey (Evan.Godfrey@cms.hhs.gov) as soon as possible to schedule these meetings. CMS also plans to schedule a site visit with Minnesota program integrity leadership and staff in January 2026, by which time we expect to see that significant progress has been made.

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[2] For example, *see* Chairman Comer Launches Investigation into Massive Fraud in Minnesota's Social Services System on Governor Walz's Watch

[3] These services include Housing Stabilization Services (Benefit discontinued on 11/1/25); Early Intensive Developmental Behavioral Intervention (Moratorium in place, effective 11/1/25); Integrated Community Supports Nonemergency Medical Transportation; Peer Recovery Services; Adult Rehabilitative Mental Health Services; Adult Day Services; Personal Care Assistance/Community First Services & Supports; Recuperative Care; Individualized Home Support; Adult Companion Services; Night Supervision; Assertive Community Treatment; Intensive Residential Treatment Services. 2024 payment data for recuperative care is unavailable.

[4] Governor Walz Orders Third-Party Audit of Medicaid Billing at DHS

[5] Minnesota Department of Human Services Memo (December 1, 2025)

[6] Minnesota fraud allegations: Department of Human Services halt payments to another program

During this visit, CMS may request access to state systems to conduct additional data analytics, and we expect Minnesota to take whatever steps are necessary to grant that access.

2. **Impose a six-month Medicaid enrollment moratorium for all high-risk providers.** Minnesota enacted a licensing moratorium on HCBS providers, which includes many of the 14 known high-risk service types. This action signals the state's recognition of serious concerns within this provider category but stops short of the necessary action and demands the next step: a moratorium on Medicaid enrollment for these same provider types to stop further harm to the program. CMS' provider enrollment team is ready to assist Minnesota with implementing this moratorium as soon as possible, including expediting the required approval process. The federal Medicaid moratorium regulation can be found at 42 CFR § 455.470.

3. **Develop a corrective action plan that assures CMS and the American people that Minnesota is going to address this rampant fraud.** Efforts by legislators, complaints filed by whistleblowers, and monumental spikes in payments were largely ignored by the state. A thorough corrective action plan, submitted for CMS' review and approval, that the state then faithfully implements is critical for the legitimacy of Minnesota's Medicaid program. CMS will meet with the state on at least a weekly basis to monitor progress and provide technical assistance.

4. **Enact an off-cycle revalidation effort for all provider enrollments currently in place.** Although not addressed in the letter sent to Governor Walz, based on Minnesota's identification of fraud in high-risk service areas and the number of providers arrested and convicted, CMS strongly recommends that enrollments of providers in all 14 high-risk services be revalidated as soon as practicable to ensure bad actors do not remain in the Medicaid program. This may include redesignations of these provider types at the "high" risk level if they are not already so designated. The federal Medicaid revalidation regulation at 42 CFR § 455.414 mandates revalidation *at least* every five years, but states are permitted to conduct revalidations on a more frequent cycle or off-cycle as needed. *See also* 42 CFR 455.452.

If Minnesota refuses to take these meaningful steps and/or make adequate progress to address fraud in its Medicaid program, **CMS may use its authority to withhold future Federal Financial Participation (FFP), in whole or in part**, under section 1904 of the Social Security Act.

Please provide a response to this letter by December 22, 2025, including Minnesota's timeline for the start and end of the above actions, to Evan Godfrey (Evan.Godfrey@cms.hhs.gov).

Sincerely,

Kim Brandt
Chief Operating Officer and Deputy Administrator, CMS
Acting Director, Center for Program Integrity

Daniel Brillman
Deputy Administrator, CMS
Director, Center for Medicaid and CHIP Services

Appendix A: Examples Demonstrating Inadequacy of Minnesota Program Integrity Oversight

- Centers for Medicare & Medicaid Services, *Minnesota Personal Care Services Focused Program Integrity Review* (January 2019).
- Department of Health and Human Services Office of Inspector General, *Minnesota Did Not Always Comply With Federal and State Requirements for Claims Submitted for the Nonemergency Medical Transportation Program* (September 15, 2017).
- Department of Health and Human Services Office of Inspector General, *Minnesota Did Not Comply With Federal Waiver and State Requirements for 18 of 20 Family Adult Foster Care Homes Reviewed* (October 31, 2017).
- Department of Health and Human Services Office of Inspector General, *Minnesota Did Not Comply With Federal Waiver and State Requirements for All 20 Adult Day Care Centers Reviewed* (May 30, 2018).
- Department of Health and Human Services Office of Inspector General, *Minnesota Medicaid Fraud Control Unit: 2022 Inspection* (September 4, 2023).
- KSTP, *Feds Auditing Minnesota DHS Over Medicaid Fraud* (September 3, 2025).
- Minnesota Attorney General, *Abdifatah Yusuf found guilty of bilking Medicaid program out of over $7.2 million* (August 12, 2025).
- Minnesota Attorney General, *Two plead guilty to Medicaid fraud in case Attorney General Ellison investigated jointly with U.S. Attorney's Office* (October 22, 2025).
- Office of Governor Tim Walz & Lt. Governor Peggy Flanagan, *Governor Walz Orders Third-Party Audit of Medicaid Billing at DHS* (October 29, 2025).
- Office of the Legislative Auditor, *DHS Oversight of Personal Care Assistance* (March 16, 2020).
- Office of the Legislative Auditor, *Home- and Community-Based Services: Financial Oversight* (February 21, 2017).
- United States Department of Justice, *Defendants Charged in First Wave of Housing Stabilization Fraud Cases* (September 18, 2025).
- United States Department of Justice, *First Defendant Charged in Autism Fraud Scheme* (September 24, 2025).
- United States Department of Justice, *Three Indicted In Medicaid Fraud Conspiracy Scheme* (December 19, 2024).

State of Minnesota, et al.
v.
Dr. Mehmet Oz, et al.
U.S. District Court No.
26-cv-1701

DECLARATION OF NATE BRENNAMAN

Exhibit 3

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

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,

[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/

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 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.

Sincerely,

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

State of Minnesota, et al.
v.
Dr. Mehmet Oz, et al.
U.S. District Court No.
26-cv-1701

DECLARATION OF NATE BRENNAMAN

Exhibit 4

DEPARTMENT OF HUMAN SERVICES

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

January 9, 2026

Dr. Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Appeal from January 6, 2026, Notice of Noncompliance

Dear Administrator Oz:

I write in response to your January 6, 2026, letter and notice of noncompliance ("Notice"), attached as Exhibit 1. The Minnesota Department of Human Services ("DHS" or "State") disagrees with, and hereby appeals, your decision to withhold needed Medicaid dollars from Minnesota. DHS, on behalf of the State, requests that a hearing be scheduled for the issues raised in your Notice, pursuant to 42 CFR, Part 430, Subpart D. Your stated bases for withholding Medicaid funds from Minnesota, and the threatened amount of withholding, are legally baseless.

As an initial matter, the Notice is legally deficient. You do not provide a hearing date and time, as required by the federal regulations. 42 C.F.R. § 430.70. You also have arbitrarily demanded a response within 5 days, which is not a requirement of the State under Subpart D. *See* 42 CFR, Part 430, Subpart D.

CMS has also not identified facts or law that either warrant the threatened withholding or provide notice sufficient for the State to prepare for hearing. Indeed, CMS admits it has conducted no recent audit to support its Notice but instead relies on off-topic and out-of-date 2017-2021 reports that are of little relevance to the issues currently facing the state. To the extent that CMS appears to be taking aim at the Minnesota state plan itself, it should be noted that CMS *approved* that plan. Minnesota contests that the plan is deficient, but to the extent it does not contain certain legally required provisions pursuant to 42 U.S.C. § 1396a(64) and 42 C.F.R.455, Subpart A, it was incumbent upon CMS to bring such issues to the State's attention before approving the plan.

Moreover, there are no facts to support the withholding of *all* federal dollars for fourteen separate benefits. Even if plan noncompliance is proven at hearing, CMS's withholding should be limited to the

scope of noncompliance; there is no basis to eliminate funding to the benefits entirely. Also, even if CMS's intent is to eliminate all funding for these benefits, CMS has miscalculated, and overstated, the federal quarterly share.

In any event, DHS looks forward to the opportunity to prove, at hearing, that its state plan meets the requirements of 42 U.S.C. § 1396a(64) and 42 C.F.R.455, Subpart A, and that no federal withholding of Medicaid dollars to Minnesota is warranted.

In fact, since October 2024, DHS has been focused on rooting out fraud, strengthening program integrity, and protecting our public programs from bad actors. These efforts have included:

- beginning in October 2024, the implementation of a comprehensive on-site audit process for autism service providers, prompting an aggressive Early Intensive Developmental and Behavioral Intervention ("EIDBI") program integrity legislative package and additional anti-fraud requests to shift oversight from a tip-based investigative model to a proactive model based on data analytics;
- in early 2025, designating EIDBI and Housing Stabilization Services ("HSS") as high-risk to provide additional program integrity tools;
- on August 1, 2025, requesting CMS's assistance in taking the unprecedented step of terminating the HSS benefit to protect the fiscal integrity of the State's Medicaid program, leading to CMS's approval to shutter the HSS benefit at the end of October 2025;
- in September 2025, accelerating and expanding our efforts to combat fraud by executing a wide range of anti-fraud directives contained in Governor Walz's Executive Order EO 25-10;
- as discussed in DHS's October 27, 2025, correspondence to CMS, identifying providers of 14 total service types as high-risk based on programmatic vulnerabilities, investigations, and analysis by DHS, and initiating enhanced prepayment review for all fee-for-service claims involving these services, a 24-month licensing moratorium for Home and Community Based Services providers, an additional licensing moratorium for Adult Day Services, and a stop in enrollment of new autism service providers; and
- acting to further safeguard against fraudulent billing by disenrolling inactive health care providers, with over 800 such providers disenrolled in October 2025 alone and disenrolling another roughly 4,300 managed care organization providers in January 2026 that were out-of-network and out-of-state.

DHS would have preferred to work as a partner with CMS to address the recent challenges that have been identified in Minnesota's Medicaid program. *See* 42 C.F.R. § 430.35(a) ("Hearings under Subpart D are generally not called until a reasonable effort has been made to resolve the issues through conferences and discussions."). Indeed, the State believed that CMS's recent visit to Minnesota was done in good faith to "participate and...provide appropriate [] assistance," as stated in CMS's December 5, 2025, letter, and in accord with our communications and partnership to date.

Consistent with our historical partnership, DHS engaged in good faith and in close communication with CMS staff throughout these efforts. You have made it clear now, however, that the purpose of CMS's recent visit was instead for CMS to "see firsthand [the State's alleged] deficiencies..." to attempt to

bolster your case for withholding.[1] *See* Notice, p. 3. These adversarial actions run contrary to the structure of the Medicaid program. As the United States Supreme Court has said, "Medicaid is a joint state-federal funding program for medical assistance in which the Federal Government approves a state plan for the funding of medical services for the needy and then subsidizes a significant portion of the financial obligations the State has agreed to assume." *Alexander v. Choate*, 469 U.S. 287, 289 n. 1 (1985). Instead of being a reliable partner to Minnesota in the joint Medicaid enterprise, it is regrettable that the federal administration has chosen to weaponize the Medicaid program against the State of Minnesota for political purposes.

Sincerely,

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

Cc: Ben Cohen, Designated Hearing Officer

[1] CMS is also engaging in political gamesmanship with respect to the Corrective Action Plan ("CAP") that it requested of DHS. As you are surely aware, DHS worked in close consultation with CMS on the CAP during December to ensure it would address all of CMS's concerns, only for you to proclaim the CAP "deficient" for not containing information never requested of, or discussed with, DHS.

EXHIBIT 1

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

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,

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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/

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 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.

Sincerely,

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

State of Minnesota, et al.
v.
Dr. Mehmet Oz, et al.
U.S. District Court No.
26-cv-1701

DECLARATION OF NATE BRENNAMAN

Exhibit 5

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:

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

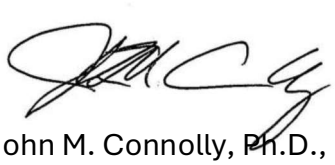
Additional proposed statutory changes would strengthen provider licensing and enrollment by establishing structured, data-driven risk and readiness assessments prior to enrollment, enhancing verification of business legitimacy, deterring false or misleading applications, and clarifying the Commissioner's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

State of Minnesota, et al.
v.
Dr. Mehmet Oz, et al.
U.S. District Court No.
26-cv-1701

DECLARATION OF NATE BRENNAMAN

Exhibit 6

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

Financial Management Group
Division of Financial Operations West

February 25, 2026

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

Deferral Numbers: MN/2025/4/E/04/ADM - MN/2025/4/E/05/MAP - MN/2025/4/E/06/MAP - MN/2025/4/E/07/MAP

Dear Director Connolly,

This letter constitutes a notice of four deferrals totaling $259,505,491 federal financial participation (FFP). This amount represents expenditures claimed on Form CMS-64 for the quarter ending September 30, 2025, certified on December 30, 2025. The state should provide the requested documentation for each deferral within the required timeframe of 42 C.F.R. § 430.40 for CMS to make a proper determination on the allowability of the claim or remove the claims by including a Line 10B decreasing adjustment on the next quarterly CMS-64 submission. During the handling of these deferred amounts, please reduce your draws in the Payment Management System (PMS) MAP25 - $255,139,149 and ADM25 - $4,366,342. A negative grant award was issued in the amount of $259,505,491 in federal share dated February 25, 2026.

CMS identified $4,366,342 FFP (MN/2025/4/E/04/ADM) due to the continuing review of documentation that demonstrates administrative costs are properly allocated that include state-only health programs, including those relating to individuals lacking a satisfactory immigration status. CMS's deferral is based on the percentage of claims volume related to state-only health programs from an Advanced Planning Document for the Medicaid Management Information System at five point two-nine (5.29%) percent and applied to specific Administrative Lines on Form CMS 64.10. We are requesting Minnesota provide additional supporting documentation that no allocation to the local-only programs was appropriate, provide a better allocation basis that is validated through Minnesota's current Public Assistance Cost Allocation Plan, or make a decreasing Line 10B adjustment on the next quarterly CMS-64 submission to reflect the deferred amounts.

CMS identified $11,025,548 FFP (MN/2025/4/E/05/MAP) related to an ongoing review of claims documentation for services furnished to individuals lacking satisfactory immigration status. The supporting documentation does not appear to satisfy Minnesota's policy for

emergency Medicaid services and does not appear to comply with section 1903(v) of the Social Security Act. We are requesting Minnesota either provide additional documentation to support the claims or make a decreasing Line 10B adjustment on the next quarterly CMS-64 submission.

CMS identified $243,790,260 FFP (MN/2025/4/E/06/MAP) attributable to CMS's ongoing review of state expenditures, with a focus on fourteen high-risk Medicaid service areas identified as particularly vulnerable to fraud or abuse. CMS has identified $164,198,916 FFP for other practitioner, personal care, and home and community-based services lines that have questionable variances and raise concerns about allowability of the claimed expenditures. Additionally, CMS has identified $79,591,344 FFP claimed by the state associated with reimbursement claims submitted to the state by specific providers that we have identified as high-risk for fraud or aberrant billing practices based on historical billing and CMS data analytics. We are requesting Minnesota either provide additional state and provider documentation to support the allowability of these claims, including through CMS sample-based reviews, or make decreasing Line 10B adjustments on the next quarterly CMS-64 submission.

Finally, CMS identified $323,341 FFP (MN/2025/4/E/07/MAP) due to returns of FFP for periods of 2020 through 2024 that were not returned at the same matching percentage of the original claim and that require additional documentation to demonstrate the allowability of the claims. We are requesting Minnesota provide additional supporting documentation that demonstrates the FFP was reported at the correct FMAP or make a Line 10B adjustment on the next quarterly CMS-64 submission to reflect the deferred amounts.

Per 42 C.F.R. §430.40, your office is requested to provide, within 60 days from receipt of this letter, all documents and materials that it believes support the allowability of the above claims that have not already been received by CMS. The requested information must be in readily reviewable form. If your office is unable to provide the required information within the 60 days, you may request an extension up to an additional 60 days as specified in 42 C.F.R. §430.40(c)(1). Your request for an extension should be submitted to our Financial Analyst, Audrey Mattison at audrey.mattison@cms.hhs.gov.

Should you require further details regarding this matter, please contact Jeoffrey Branch, Branch Chief, Branch A, Division of Financial Operations West, Financial Management Group, CMS at jeoffrey.branch@cms.hhs.gov or (214) 326-9038.

Sincerely,

Dorothy Ferguson

Digitally signed by Dorothy Ferguson
Date: 2026.02.25 15:05:48 -06'00'

Dorothy Ferguson, Director
Division of Financial Operations West

State of Minnesota, et al.
v.
Dr. Mehmet Oz, et al.
U.S. District Court No.
26-cv-1701

DECLARATION OF NATE BRENNAMAN

Exhibit 7

Minnesota Department of Human Services
Elmer L. Andersen Building
Temporary Commissioner Shireen Gandhi
Post Office Box 64998
St. Paul, Minnesota 55164-0998

December 31, 2025

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**

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.

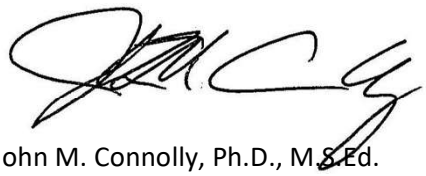
In 2026, DHS will also release a request for proposals (RFP) to secure a longer-term vendor to conduct an even more expansive and continuing prepayment review for all Medicaid services, based on capacity, after the initial one-year Optum contract term expires.

- **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,



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

UNITED STATES DISTRICT COURT

DISTRICT OF MINNESOTA

Case No.

State of Minnesota, by and through its Attorney General Keith Ellison, and Shireen Gandhi, in her official capacity as the Commissioner of the Minnesota Department of Human Services,

Plaintiffs,

vs.

Dr. Mehmet Oz, in his official capacity as Administrator for the Centers for Medicare and Medicaid Services; the Centers for Medicare and Medicaid Services; Robert F. Kennedy, Jr., in his official capacity as Secretary of the U.S. Department of Health and Human Services; U.S. Department of Health and Human Services,

Defendants.

DECLARATION OF JOHN CONNOLLY

I, John Connolly, hereby declare as follows:

1. I am Deputy Commissioner and State Medicaid Director at the Minnesota Department of Human Services ("Department"). I have personal knowledge of the facts in this Declaration.

2. The provision of Medicaid in Minnesota is a joint federal-state endeavor, which requires coordination and cooperation between the state and the federal agency that oversees Medicaid, the Centers for Medicare & Medicaid Services ("CMS"). Minnesota operates its Medicaid program, which it calls "Medical Assistance" under a State Plan and

waivers negotiated with and approved by CMS, who also monitors Minnesota's implementation and compliance with the Plan and waiver requirements.

3. The CMS-Minnesota relationship has historically been cooperative and collaborative. This is important and necessary, as the provision of Medicaid to approximately 1,160,000 Minnesota citizens requires near-constant communication and coordination between CMS and the state.

4. Minnesota has made massive efforts to identify and combat fraud in Minnesota in recent months. Until recently, CMS and Minnesota continued to work collaboratively on the issue and Minnesota sought, and CMS provided, help and guidance on what measures to adopt to fortify the states processes and systems to help protect against fraud. As just one example, during the process of ending the state's Housing Stabilization Services benefit in the fall of 2025, CMS encouraged, and the state implemented an action to disenroll providers that had not submitted billing for services within the previous 12 months.

5. The State also took its own measures, including, on September 17, 2025, Governor Walz's Executive Order EO 25-10, which directed the Minesota Department of Human Services, the Minnesota Department of Public Safety, Minnesota Management and Budget, and other state agencies to implement a wide range of anti-fraud directives:

- Establishing a proactive, data-driven post-payment review program for Medicaid providers and claims and deploying advanced analytics and risk-scoring models to identify high-risk providers, claims, and service patterns for targeted review.
- Identifying programs that present a high risk of fraud, waste, and abuse and recommending programmatic changes, including termination of the HSS program;
- Implementing a temporary licensing moratorium as authorized under state law and by requesting that CMS allow the Department to implement moratoria;

- Subjecting providers who present identified risk factors to prepayment review;
- Immediately disenrolling all Minnesota Health Care Program enrolled providers who have not billed Medicaid in the last 12 months;
- Submitting a request for funds from any available state accounts to modernize systems to better prevent and detect fraud, waste, and abuse;
- Requesting any and all assistance from CMS and other federal partners to ensure that the Department's program integrity measures are in line with national program integrity standards; and
- Hiring an external consultant to assess the Department and make recommendations on reorganization to more effectively serve as the State's Medicaid agency, with a focus on program integrity and anti-fraud efforts, including through suggested policies, procedures, systems changes, structural changes, staffing levels.

6. Minnesota also identified providers of 14 total service types as high-risk based on programmatic vulnerabilities, investigations, and analysis. The Department initiated enhanced prepayment review for all fee-for-service claims involving these services, a 24-month licensing moratorium for Home and Community Based Services providers, an additional moratorium for Adult Day Services, and ended enrollment of new autism service providers. In October 2025 alone, the Department also disenrolled over 800 inactive healthcare providers to further protect against fraudulent billing.

7. Given the massive effort and resources that Minnesota was already directing to identifying and addressing fraud vulnerabilities in its Medicaid systems and processes—most of which was known to, or even directed by CMS—I was surprised to receive, on December 5, 2025, a letter from CMS Administrator Dr. Mehmet Oz, in which he stated that Minnesota "was not taking fraud seriously," demanding that Minnesota take certain additional fraud prevention measures, and requiring a Corrective Action Plan.

8. Minnesota agreed to take all of the steps required in Dr. Oz's letter, including providing weekly updates to CMS, imposing a six-month enrollment moratorium on high-

risk providers, and enacting off-cycle revalidation[1] for all provider enrollments. On January 5, 2026, Minnesota disenrolled roughly 4,300 out-of-network and out-of-state managed care providers, pursuant to the direction it had received from CMS.

9. The next day, January 6, 2026, the parties had their first weekly standing meeting, at which the Department actively invited feedback on the CAP and requested any modifications CMS believed were necessary. CMS representatives offered no substantive comments at that time but expressed willingness to work with the State after reviewing the plan in detail. The parties also discussed the rollout of the provider enrollment moratorium, with CMS requesting operational details, giving advice on timing, and offering to assist where needed.

10. At no time did CMS staff suggest that the December 31 CAP submitted by the Department—which was drawn from previous statements by, and discussions with, CMS—was deficient or would form the basis for withholding federal financial participation absent any notice to the State of alleged deficiencies.

11. On January 6, 2026, CMS Administrator, Dr. Oz, provided notice to Minnesota that CMS considered Minnesota to be in noncompliance with SSA 1902a(64) and 42 CFR 455, Subpart A. The action targeted 14 Medicaid service areas that Minnesota had identified as "high-risk" for fraud in October of 2025, and which the state was already taking intensive action to remedy, as noted above. Despite the fact that Minnesota had

[1] Providers of Medicaid services are periodically reviewed and revalidated by the state to ensure that they continue to be eligible for receipt of Medicaid dollars. Off-cycle revalidation simply means that such review is happening now—not on the normal cycle.

already identified these areas as having vulnerabilities, and was taking action—in coordination with CMS—to address the vulnerabilities, CMS stated it would withhold more than $515M quarterly, which it stated was the entire quarterly "expenditures for the fourteen high risk services" by the federal government.

12. Despite Minnesota's substantial efforts to coordinate with CMS about the CAP to include all of the elements that CMS stated were necessary, Dr. Oz declared on January 6th that it was "deficient" for failing to include topics that were never requested of Minnesota by CMS.

13. Minnesota appealed the noncompliance decision on January 9, 2026.

14. Minnesota has not been told how it is noncompliant with federal statutes or regulations. Minnesota has asked CMS repeatedly for information and detail regarding the claimed noncompliance, but CMS has refused to provide any information regarding which specific statutes or regulations with which Minnesota is noncompliant or how it is noncompliant. There is no hearing yet scheduled in the noncompliance case.

15. The January 6, 2026, Notice required Minnesota to submit to CMS "a revised comprehensive corrective action plan" on January 30, 2026. During January, during its weekly meetings with CMS, Minnesota again attempted to coordinate with CMS about the CAP to ensure the revised CAP would address all of the issues of which CMS was concerned. In Administrator Oz's letter of January 6, 2026, he communicated that the state must address how claim editing will be applied to deny payment when appropriate, prior authorization, provider education and training, Department employee training and education, surveillance and utilization review, and managed care oversight.

16. Minnesota submitted a revised and more detailed CAP on January 30, 2026, and the state included in this version each of the elements that CMS identified in Administrator Oz's letter on January 6, 2026. Since that date, at each of the weekly meetings I have had with CMS, I have asked CMS for its reaction and comments to the revised CAP. Many of the CAP initiatives and milestones are time sensitive, or require an enormous outlay of time, effort, or resources by the Department. Minnesota has wanted to ensure, throughout the month of February, including on a meeting it had with CMS on the morning of February 25, 2026, that CMS was not going to have major problems or revisions to the CAP. At the February 25, 2026, meeting, I was told by CMS that they had no feedback, but that written feedback would be forthcoming at some point in the future.

17. Later that same day, Administrator Oz and Vice President Vance announced that CMS was deferring approximately $259M from the state. The Administrator's stated reason for the deferral was to pressure the state into enacting a corrective action plan, even though Minnesota has provided a comprehensive proposal that CMS has refused to comment on. Administrator Oz also commented at the February 25, 2026, press conference that CMS will defer every quarter throughout 2026. By the terms of the regulations, a deferral can only be made on a claim or a part of a claim that has been paid and that lacks supporting documentation. Threatening future deferral before claims have been paid and documentation has been provided makes no sense. Similarly, using deferral to "turn the screws" on Minnesota—as remarked by Vice President Vance—is not a recognized or legitimate use of that auditing tool.

18. To state the obvious, $259M is a lot of money for a State the size of Minnesota, and it is an amount of money that provides support to a large number of Minnesotans who rely on Medicaid. That number represents, for example, a complete quarterly federal defunding for Assertive Community Treatment Mental Health Services, Adult Rehabilitative Mental Health Services, Intensive Residential Treatment Services, and Nonemergency Medical Transportation Services. These programs provide services to 160,000 Minnesotans, many with significant needs. The withholding of federal funding would require—in particular if funding is delayed or denied for a protracted period, or if the withholdings occur quarterly, as has been threatened—the state to make cuts to Medicaid services.

I declare under penalty of perjury that everything I have stated in this document is true and correct.

Executed on: March 2, 2026
Ramsey County
State of Minnesota

John Connolly

UNITED STATES DISTRICT COURT

DISTRICT OF MINNESOTA

Case No.

State of Minnesota, by and through its Attorney General Keith Ellison, and Shireen Gandhi, in her official capacity as the Commissioner of the Minnesota Department of Human Services,

Plaintiffs,

vs.

Dr. Mehmet Oz, in his official capacity as Administrator for the Centers for Medicare and Medicaid Services; the Centers for Medicare and Medicaid Services; Robert F. Kennedy, Jr., in his official capacity as Secretary of the U.S. Department of Health and Human Services; U.S. Department of Health and Human Services,

Defendants.

DECLARATION OF PATRICK HULTMAN

I, Patrick Hultman, hereby declare as follows:

1. I am the Deputy Medicaid Director at the Minnesota Department of Human Services. I have personal knowledge of the facts in this Declaration.

2. On February 25, 2026, CMS served Minnesota with a sweeping Notice of Deferral (the "Deferral"), the effect of which immediately denies the state approximately $259M by reducing the State's federal funds account by that amount. Minnesota has received many deferral notices over the years, but this one is unlike any of those. Most

notably, the deferral is much larger than any past deferral—more than fifteen times the amount of any I can recall Minnesota has ever received in the past. The largest prior quarterly deferral Minnesota has seen is $10,966,609.

3. The Deferral[1] is remarkable in a number of additional ways. Medicaid records related to the 14 high-risk services were only recently requested and provided to CMS and they have told us that they have not yet had time to review and understand the information that has been provided. The Deferral states that more information is needed from the state, but CMS has told us that it has not been able to review what has been provided.

4. The Deferral lacks specificity. Typically, a "variance" or a suggestion of "aberrant" billing practices based on data analytics would be a cause for CMS to conduct a review or audit—not the basis for a sweeping and overbroad deferral.

5. Deferral is a narrow auditing tool that focuses on whether there is documentary support for claims or parts of claims. Deferrals are not meant to function as a means to withhold funding for entire program areas for which there are only generalized concerns. It would be more common for CMS to issue a narrower deferral based on a well-defined set of expenditures. In my experience, CMS has never jumped so quickly to a deferral, depriving Minnesota of Medicaid dollars while it reviews information already in

[1] The Department does not concede that any part of the Deferral Notice is appropriate or warranted, but my comments in this Declaration will focus on the approximately $243M that is being withheld for the fourteen service areas that Minnesota has determined are "high-risk."

its possession to see whether any claims are actually problematic, which it seems like CMS has not even done.

6. Historically, if CMS had concerns with claims documentation or a State's compliance with applicable Medicaid statutes or regulations, it would communicate with the state and work with it informally to cure any deficiencies—a collaborative process that may take months or even years.

7. Another problem is that Minnesota now has 60 days to provide information that CMS claims is missing to CMS, but because of the breadth of the Deferral, the lack of specificity about what claims are at issue, and the absence of detail about what problems exists with those claims, Minnesota is not certain of what information CMS needs to determine the allowability of the claims.[2] I am concerned about Minnesota's abuility to provide supporting documentation within 60 days, given these issues with the Notice.

8. I am also concerned that CMS will drag its feet in resolving this Deferral and reimbursing the state. CMS often takes a long time to evaluate information and resolve claims. Although, in theory, CMS has only 90 days to decide whether to pay a claim, CMS regularly evades the 90-day deadline by claiming that the state's submissions are insufficient or by demanding additional information so that the 90-day deadline never begins.

[2] Minnesota has not been told, for example, the identity of the "specific providers" whose billing is "aberrant," or what CMS's data analysis related to that billing showed.

9. Minnesota will not be able to effectively challenge these improper and arbitrary withholdings in federal court for many months, or even years. If federal financial participation is not available until the administrative process is complete, CMS would already have withheld—as it has already promised to do—several hundred million, or billions of dollars in quarterly deferrals.

I declare under penalty of perjury that everything I have stated in this document is true and correct.

Executed on: March 2, 2026
Ramsey County
State of Minnesota

Patrick Hultman

UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

State of Minnesota, by and through its Attorney General Keith Ellison, and Shireen Gandhi, in her official capacity as the Commissioner of the Minnesota Department of Human Services,

Plaintiffs,

vs.

Dr. Mehmet Oz, in his official capacity as Administrator for the Centers for Medicare and Medicaid Services; the Centers for Medicare and Medicaid Services; Robert F. Kennedy, Jr., in his official capacity as Secretary of the U.S. Department of Health and Human Services; U.S. Department of Health and Human Services,

Defendants.

Civil File No.

DECLARATION OF AHNA MINGE

I, Ahna Minge, hereby declare as follows:

1. I am the State Budget Director at Minnesota Management and Budget and am employed by the Minnesota Department of Management and Budget ("MMB"). I have held this position for four years seven months. I have been employed by MMB from September 2014 to February 2020 and then again from August 2021 through the present; between February 2020 and August 2021, I was the Chief Financial Officer at the Minnesota Department of Human Services ("DHS"). I have personal knowledge of the facts in this Declaration.

2. The Legislature appropriates a set amount of money for a fiscal year to Minnesota's Medical Assistance program ("MA"), which is how it refers to its Medicaid program, based on a forecast of projected expenditures, adjusted for any legislative changes. The MA appropriation for the current fiscal year, which ends June 30, 2026, was made in May 2025, based on the February 2025 budget forecast. The forecast assumes the State is fully reimbursed for those services as agreed upon between the federal government and DHS.

3. The State's loss of over $240 million in fourth quarter MA expenditures related to fourteen high-risk Medicaid service areas that it already made will have significant impacts on the State's budget and forecast. This amount represents 1.8% of projected federal funds for this year, which equates to 7.2% of estimated quarterly funds, assuming even distribution across quarters, and would require MMB and DHS to identify potential cuts to services absent a legislative appropriation that covers this shortfall.

4. I understand that Administrator Oz believes the State can use its "rainy day fund" to cover this loss in federal funds. Assuming Administrator Oz is referring to the budget reserve account found in Minnesota Statutes, section 16A.152, that is incorrect. Under subdivision 4, the MMB Commissioner may only reduce the budget reserve if she "determines that probable receipts for the general fund will bc lcss than anticipated." The loss of federal funds is not a receipt to the general fund, so the State may not use the budget reserve under that circumstance. In addition, under subdivision 3, the State may only use the budget reserve "when a negative budgetary balance is projected and when objective measures, such as reduced growth in total wages, retail sales, or employment reflect

downturns in the state's economy." None of these circumstances are presented by the Administrator's determination in CMS's February 25, 2026 letter to State Medicaid Director John Connolly.

I declare under penalty of perjury that everything I have stated in this document is true and correct.

Executed on March 2, 2026
Ramsey County
State of Minnesota

AHNA MINGE