



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

October 2, 2026

The Honorable Mehmet Oz  
Administrator  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, Maryland 21244

via Email only

Administrator Oz:

Minnesota and the Centers for Medicare & Medicaid Services (CMS) share a commitment to protecting both Medicaid funds and the millions of people who rely on a stable Medicaid system. Every dollar stolen from Medicaid harms children, families, people with disabilities, older adults, taxpayers, and countless others. At the same time, our program integrity work must protect legitimate providers and support continued access for the more than 1.2 million Minnesotans who rely on Medicaid-supported care.

Minnesota is doing this work, but we can't do it alone. Effective program integrity requires a strong federal-state partnership. Your leadership is needed to ensure CMS works with Minnesota productively and transparently toward resolution.

When you assumed leadership of CMS you said, "Great societies protect their most vulnerable."<sup>1</sup> As Minnesotans and communities across our nation face rising healthcare costs, affordability pressures, and declining trust in public institutions, confidence in Medicaid stewardship is especially critical.

Now more than ever, that confidence must transcend any administration, election, or political party. Fraud in Minnesota or any other state is not a Democrat or Republican issue. Regardless of political affiliation, fraud harms communities across the nation, erodes public trust and drains financial resources. Combating fraud is in the American interest and requires a unified effort.

The scale of this national challenge is demonstrated by the Administration's National Fraud Takedown Day. In June 2025, the Department of Justice charged defendants in schemes involving over \$14.6 billion in alleged Medicare and Medicaid fraud, none of which occurred in Minnesota.<sup>2</sup> In June 2026, the Department of Justice charged an additional 455 defendants in schemes involving over \$6.5 billion in alleged Medicare and Medicaid fraud, with \$700,000 allegedly occurring in Minnesota.

Beyond Medicare and Medicaid, a 2024 U.S. Government Accountability Office report estimated fraud cost the federal government between \$233 billion and \$521 billion annually, or roughly 3% to 7% of federal obligations.<sup>3</sup> At such a staggering scale, it is little surprise that Americans' confidence in U.S. Institutions remains near an all-time low.<sup>4</sup> In Minnesota, however, we have treated this national challenge as a call to action.

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<sup>1</sup> [Dr. Mehmet Oz Shares Vision for CMS | CMS](#), April 10, 2025.

<sup>2</sup> [Office of Public Affairs | 2025 National Health Care Fraud Takedown | United States Department of Justice](#), June 30, 2025.

<sup>3</sup> [GAO-24-105833](#), April 16, 2024.

<sup>4</sup> [Confidence in U.S. Institutions Remains Near All-Time Low](#), July 13, 2026.

Before your appointment as administrator of CMS, our Department of Human Services had already started expanding and accelerating program integrity efforts to fight fraud, while protecting continued access to care. Since January 2026, we have also been advancing the Corrective Action Plan (CAP) you approved. In total, over the past two years, our efforts have included:

- Identifying 14 high-risk services and establishing a public program integrity dashboard;
- Establishing enhanced pre-payment review for fee-for-service claims for high-risk services;
- Auditing autism service providers, including on-site visits;
- Discontinuing the Housing Stabilization Services benefit;
- Completing off-cycle revalidation of more than 5,000 providers across the remaining 13 high-risk services;
- Establishing a moratorium on adding new service providers in those 13 high-risk services; and
- Securing funding to expand the Department of Human Services program integrity workforce by more than 400 new positions over the next 24 months.

Since your approval of the CAP, we have continued transmitting required data on a weekly basis. We also maintain regular communication with career civil servants at CMS related to the revalidation process and working through each step of the deferral process for each of the three deferrals you have issued to date.

As we've continued this proactive fraud prevention and fraud fighting work, our Office of Inspector General has continued to identify credible allegations of fraud, issue payment withholds, and relay investigatory data to local and federal law enforcement, the US Attorney's Office, and the Minnesota Attorney General's Office.

We remain prepared to act on credible concerns, but we need CMS to join us by sharing critical information on identified fraud risks. We also need a clear path to resolution in order to remove the threatened \$2 billion cut, release deferrals that have frozen \$550 million in Medicaid funds, and to work with us to address outstanding issues with claims to mitigate potential funding clawbacks.

That's why I am urging you to engage with us directly and respond to the following outstanding issues:

**1. Basis and resolution for Q2 2026 deferral.**

In your letter dated July 21, 2026, you noted that CMS has identified \$3,328,872 in state expenditures associated with the 14 high-risk service provider types as being "particularly vulnerable to fraud or abuse." CMS has also deferred \$195,704,735 for claims "by specific providers that we have identified as high-risk for fraud or aberrant billing practices based on historical billing and CMS data analytics."

It is our understanding from our meeting on July 23, 2026, that \$153,170,947.42 in federal financial participation was identified for claims submitted by providers who were enrolled as of the date of service but who subsequently received a notice of termination with the ability to appeal within 60 days, and that \$42,533,787.17 was identified from 870 high-risk providers that CMS identified through analytics.

CMS, however, has not identified the specific concerns about the providers who received notices of disenrollment through revalidations or how it identified the 870 high-risk providers, the violations that necessitated the latest deferral or the expectations for the state to resolve CMS's questions regarding these claims.

We are seeking clarification on the following:

- 1.1 *What is CMS's justification for determining that a provider receiving a disenrollment notice due to incomplete revalidation documentation constitutes a fraud risk for claims submitted before the disenrollment notice, particularly now that more than half<sup>5</sup> of those providers have now been revalidated?*
- 1.2 *Does CMS contend that providers who received disenrollment notices following our revalidation initiative, which was completed by May 31, 2026, were not eligible to submit claims for Medicaid reimbursement for the quarter ending March 31, 2026?*

## **2. Criteria, methodology, use of machine learning, artificial intelligence (AI) and fraud detection analytics to identify high-risk providers.**

As noted above, CMS identified specific providers as high-risk for fraud or aberrant billing practices based on historical billing and CMS data analytics. In a July 21, 2026, U.S. Department of Health and Human Services (HHS) press briefing, you noted providers were flagged through "fraud detection analytics."<sup>6</sup>

Additionally, Deputy Director of the White House Task Force to Eliminate Fraud Jetson Leder-Luis indicated CMS was using "... machine learning. That's a form of AI that allows us to analyze the Medicaid claims..."<sup>7</sup> At that same briefing, you indicated claims were being deferred because they were "claims that smell like fraud."<sup>8</sup>

We are seeking clarification on the following:

- 2.1 *What criteria, methodology, and data analytics did CMS use to identify providers as high risk for fraud or aberrant billing?*
- 2.2 *What machine learning, AI tool(s) and/or fraud detections analytics did CMS use?*
- 2.3 *CMS staff has shared with our Minnesota Department of Human Services staff 870 providers that CMS considers high risk. What criteria, methodology, metrics and/or analytics were used, and did the analysis include the use of AI and/or advanced data analytics?*
- 2.4 *What are the criteria for claims being identified for "smell[ing] like fraud?" Is this consistent with CMS's analysis, and if so, what methodology did CMS use in making this determination?*

## **3. Information sharing necessary for state action.**

The Minnesota Department of Human Services has the sole authority to impose payment withholds on a provider's future claims while an investigation into allegations of fraud is pending. We stand ready to stop payments and routinely take this action when credible evidence supports it. To do so, however, Minnesota must receive the underlying information necessary to identify the provider, evaluate the concern, and act.

Minnesota has repeatedly asked CMS and federal law enforcement to provide evidence supporting public claims of fraud in Minnesota's Medicaid program so the Department of Human Services can stop payments where warranted. To date, no such evidence has been shared with the Department of Human Services. Nor has CMS requested that the Minnesota Department of Human Services impose a payment withhold on any provider.

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<sup>5</sup> [Revalidate 2026 | mn.gov/dhs](https://mn.gov/dhs), September 8, 2026.

<sup>6</sup> [U.S. Department of Health and Human Services Media Briefing, at 6:00](#), July 21, 2026.

<sup>7</sup> [U.S. Department of Health and Human Services Media Briefing, at 21:57](#), July 21, 2026.

<sup>8</sup> [U.S. Department of Health and Human Services Media Briefing, at 4:42](#), July 21, 2026.

Minnesota requests that CMS provide all evidence supporting allegations of fraud it has identified, including the criteria, methodology, use of machine learning, artificial intelligence, or fraud detection analytics of any kind used to identify suspected fraud, so the Department of Human Services can evaluate the evidence and take appropriate action.

- 3.1 *When will CMS provide the Department of Human Services with evidence supporting fraud allegations including the criteria, methodology, machine learning, artificial intelligence, or fraud detection analytics of any kind it used to identify suspected fraud so the Department of Human Services can take appropriate action?*

#### **4. Accuracy in public communications regarding fraud and administrative actions.**

Minnesota supports strong enforcement against fraud and defers to local, state, and federal law enforcement and justice system partners on criminal investigations, enforcement actions, charging decisions, prosecutions and related public communications.

CMS administrative actions including withholds, deferrals or potential disallowances are different and do not establish fraud. These administrative actions frequently involve unresolved claims, documentation questions, eligibility concerns or other issues that have not been and ultimately in most cases are never established as fraudulent.

Public communications surrounding the Q2 2026 deferral announced on July 21, 2026, illustrates why this distinction matters. HHS announced more than \$1 billion in deferrals to Minnesota and California under the headline of “Crackdown on Fraud,”<sup>9</sup> describing this action as advancing the “administration’s effort to combat fraud, waste and abuse.”

In that same announcement, you also stated that the action was focused on “stopping waste and fraud before the check clears,” while characterizing the identified claims as simply requiring “additional documentation.”

Prior to that on June 30, you posted on X, about the assessment all states are now required to conduct on their Medicaid providers at highest risk for waste, fraud, and abuse. Specifically, you stated that “Minnesota DISENROLLED more than 3,400, roughly 58%, for failures to maintain required documentation, pass site visits, and clear background checks. This staggering number underscores the urgent need for stronger oversight of high-risk providers in order to protect taxpayers — and most importantly, our Medicaid beneficiaries.”<sup>10</sup>

Revalidation is an enrollment and screening process, not a fraud determination. Providers may be disenrolled for administrative or enrollment issues that do not establish fraud, waste or abuse. And as noted above, more than half of providers who received a disenrollment notice have since met necessary requirements and have been revalidated. Just as amounts deferred, withheld, or potentially disallowed are not an amount of fraud identified, disenrollment of a provider does not establish fraud, waste or abuse.

Minnesota requests that future public communications clearly and accurately distinguish suspected or established fraud, waste or abuse from administrative or funding actions.

- 4.1 *How will CMS ensure its public communications clearly and accurately distinguish law enforcement actions and alleged or identified fraud from the dollar value of deferrals, withholds, disallowances and other administrative actions involving Minnesota Medicaid?*

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<sup>9</sup> [HHS Defers More Than \\$1 Billion in Medicaid Payments to California, Minnesota Pending Review of High-Risk Claims in Crackdown on Fraud | HHS.gov](https://www.hhs.gov/news/2026/07/21/crackdown-on-fraud), July 21, 2026.

<sup>10</sup> [Dr. Oz CMS on X | https://t.co/NYkd2zIVW6](https://t.co/NYkd2zIVW6), June 30, 2026.

Honorable Mehmet Oz

October 2, 2026

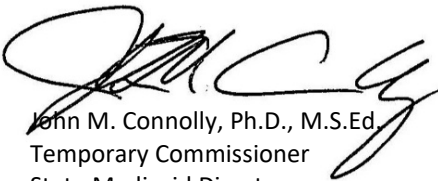
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Government requires continuous improvement, and Minnesota has fundamentally reoriented its program integrity work toward prevention, early intervention, and accountability. As Minnesota's Medicaid Director, my highest priority remains program integrity and fighting fraud while protecting continued access to care.

As we continue to balance this dual imperative in Minnesota, your leadership can help ensure that this work moves forward productively, transparently, rooted in facts and data, and in partnership toward resolution without causing further uncertainty and disruption to the more than 1.2 million Minnesotans who rely on Medicaid.

Your timely response to the questions above by October 15<sup>th</sup> is a vital step in this effort. I welcome the opportunity to meet with you in the coming weeks to fundamentally reshape this work.

Minnesota remains ready to be your partner in the work ahead.



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