



Program Integrity
Preventing Improper Medicaid Payments

The Evolving Threat

Criminals and the various schemes they've concocted to defraud our Medicaid program have become more sophisticated – it's time for Minnesota to catch up. While single actors and individuals used to be the norm, now we are seeing organized bands of providers gaming the system in concert.

To get ahead, we must:

- Modernize data analytics and detection tools.
- Strengthen data integrity and oversight.
- Build a DHS culture of continuous learning and collaboration.

Limitations of the Current Approach

Fraud prevention at DHS has historically been strong—but the threat is evolving.

- We're seeing a sharp increase in sophisticated fraud schemes targeting Medicaid, driven by a growing number of bad actors **exploiting gaps in benefit design, data integrity, and system limitations.**
- Improper payments—those not caught by our current MMIS claims edits—are likely slipping through due to these evolving tactics. While our edit process is thorough and collaborative, it's not agile. We can't detect emerging patterns without the right tools—not due to a lack of understanding, but due to **system limitations.**
- To stay ahead, we must evolve—**modernizing our analytics, accelerating our response, and strengthening our systems to meet today's threats head-on.**

- Governor Walz issued Executive Order 25-10 directing all state agencies to strengthen fraud prevention and transparency. Specifically, EO 25-10 directs DHS to take new and expanded activities to prevent, detect and stop fraud.
- Further, the Governor's October 29 [announcement](#) ordered a third-party audit of Medicaid billing at DHS and to “pump the brakes” on risky payments to providers, verifying claims before payment is made in 14 high-risk services.
- DHS designation of the high-risk services was [communicated](#) to the federal Center for Medicaid and CHIP Services on October 27. The goal of this action is to detect and stop fraud before it happens.
- DHS, under this order, initiated a third-party audit and contracted Optum to analyze Medicaid billing patterns. **The goal: stop fraudulent or improper payments on claims before public dollars are spent. So, we can help people who are eligible and in need!**

THE EXECUTIVE ORDER

Executive Order 25-10: Empowering State Agencies to Continue Combatting Fraud

Mission: Ensure Medicaid dollars go to eligible Minnesotans and restore public trust through stronger oversight and faster action. Root out those bad actors who use the most vulnerable as a shield to enrich themselves. You are on the team driving that change.

Full text of the Executive Order. Read, learn, and get familiar with it.

[Executive Order 25-10](#)



“We’re taking a systematic approach to finding and stopping fraud. Adding outside review before payments go out and increasing safeguards for these high-risk services will preserve resources necessary to serve Minnesota’s children, people with disabilities and older adults.”

*Temporary Human Services Commissioner Shireen Gandhi
October 29 Announcement by Gov. Walz*

Immediate & Urgent Actions

Potential Actions Across Remaining Riskiest Services

Prepayment Claims Review



Enhance prepayment review across remaining services identified as riskiest



Claims submitted by providers in the riskiest service categories may be delayed for payment for review (goal of 30 days, could result in delay up to 90 days)



Pivot DHS staff to conduct prepayment review of riskiest providers w/ prepayment vendor

Investigations/Post Payment



Pursue a “*High Risk*” designation for riskiest services



Contact recipients to verify that services were received



Emergency contract for increased audits of paid claims

14 Medicaid services prioritized for prepayment review based on potential risk exposure

Priority	Service Type
1	Housing Stabilization Services
2	Home and Community Based Service - Integrated Community Supports (HCBS-ICS)
3	Early Intensive Developmental and Behavioral Intervention (EIDBI)
4	Non-Emergency Medical Transportation (NEMT)
5	Peer Recovery
6	Adult Rehabilitative Mental Health Services (ARMHS)
7	Adult Day
8	Personal Care Assistance (PCA) / Community First Services and Supports (CFSS)
9	Recuperative Care
10	Individualized Home Supports (without training, with training, with family training)
11	Adult Companion Care
12	Night Supervision
13	Assertive Community Treatment (ACT)
14	Intensive Residential Treatment Service (IRTS)

Third-Party Audit of Medicaid Billing at DHS: Pre-Payment Review

Prepayment Review

- At the governor's direction, DHS has signed a contract with a third-party vendor to scrutinize billing information and data for 14 high-risk Medicaid benefits before we make payments.
- Claim payments to providers for these 14 high-risk services may be paused for up to 90 days in order to detect suspicious billing activity and protect the use of public funds.
- The advanced technology Optum brings allows DHS to move upstream – applying advanced analytics to identify risks before we make payments. Optum brings expertise in claims analysis, supported by advanced analytical tools to detect anomalies and to support program integrity.

Pre-Payment Review Workflow



1 DHS identifies claims for 14 *high-risk* services and sends to Optum



2 Optum performs pre-payment analysis on claims and shares findings with DHS



3 DHS reviews Optum's findings and may conduct recipient and/or provider outreach to validate documentation and service delivery



4 Payment issued or claim referred to OIG for further investigation

How the Process Works for Fee-for-Service Payments

- DHS will continue its existing pre-payment claims process, which includes a system review of more than 700 automated claims checks based on requirements such as prior authorization, TPL, service limits, and provider and member eligibility, etc. DHS shares claims data for 14 identified high-risk Medicaid benefits with Optum.
- Every two weeks, Optum will review and analyze claims, and flag claims and/or providers they identify as needing further review. DHS will make final decisions about payment.
- If a claim or provider is flagged, we may need additional information and documents from the provider before payments are made. Our intention is to continue to pay most claims within 30 days; but additional review may result in longer wait times, which is why we want providers to understand their payment may be paused up to 90 days.
- We will still meet federal requirements to pay legitimate claims within 90 days.
- If signs of fraud are detected, DHS will not pay the claim, and providers will be referred to our Office of Inspector General (OIG) for investigation.

DHS will make final decisions about payment

- DHS will make final decisions about payment. Optum is not in a position to deny any claims.
- If a claim or provider is flagged, providers may need to share documentation with DHS before payments are made.
- If signs of fraud are detected, DHS will not pay the claim and providers will be referred to OIG for investigation.
- Currently, the state pays clean claims within 30 days. Additional review may result in longer wait times before providers are paid. The state will still meet federal rules requiring timely payment within a maximum of 90 days.

Message Sent to Providers October 29



"There may be payment processing delays as we roll out this new prepayment review process. We are working with Optum on a regular interval to review any suspended claims for these 14 Medicaid services and will continue to adjudicate claims timely and efficiently without compromising needed review. **DHS is not holding all submitted claims for these 14 Medicaid services for 90 days. Some submitted claims could be suspended for up to 90 days and, of course, some of these claims may be denied.**

DHS recognizes that payment delays have impacts on providers, and we are committed to processing claims as quickly as possible and within the mandated timelines."

[FAQs on prepayment review:](#)

Our Goals Moving Forward

- **Integrate Payment Integrity into Benefit Design** - Embeds fraud prevention and payment accuracy considerations early in the design and implementation of Medicaid benefits.
- **Foster Cross-Functional Collaboration** - Promotes closer alignment between benefit designers, implementers, and integrity teams to ensure shared goals and consistent execution.
- **Balance Access and Accountability** - Encourages thoughtful dialogue on how to ensure broad access to Medicaid services while maintaining strong payment integrity.
- **Cultivate a Culture of Continuous Learning** - Builds feedback loops to better understand how providers interpret, deliver, and bill for services—compared to DHS’s intent—enabling ongoing refinement of policies and systems.

Thank you!