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On behalf of Optum State Government Solutions (Optum), we are pleased to submit the enclosed Vulnerability Assessment to the Minnesota Department of Human Services (DHS) and Minnesota IT Services (MNIT) in accordance with the Phase 1 deliverables of the Program Integrity engagement.

This assessment represents a point-in-time evaluation conducted during the first ninety days of a one-year contract and is intended to identify potential vulnerabilities, policy gaps, and opportunities to strengthen program integrity and pre-payment safeguards within the fourteen (14) programs identified by the State as high-risk. Our Phase 2 work will continue to evaluate these 14 programs with a pre-payment focus in close consultation with DHS, MNIT and Office of Inspector General (OIG) staff.

The Vulnerability Assessment is based on analysis of fee-for-service Medicaid claims data provided by DHS and MNIT, review of Minnesota Medicaid policies and provider manuals supplied by the State, and discussions with DHS, MNIT, and Office of Inspector General (OIG) staff to understand existing processes and controls.

Observations reflect analytic indicators of potential program integrity risk and operational vulnerabilities; they are not determinations of fraud, waste, or abuse. Decisions regarding investigations, enforcement actions, payment determinations, and implementation of any recommendations remain solely with the State of Minnesota, DHS and the Office of Inspector General.

This report is intended to inform DHS's ongoing program integrity efforts and to support the State's broader, phased approach to strengthening Medicaid oversight over the remainder of the engagement.

Optum appreciates the opportunity to partner with the State of Minnesota on this important work and to support DHS in strengthening program integrity for services that are vital to Minnesota's children, older adults, and individuals with disabilities. By identifying opportunities to improve prevention, detection, and policy clarity, this assessment contributes to the State's broader efforts to safeguard public funds and help ensure quality care and support reach the people who depend on these programs.

Sincerely,

Diane Evenson
VP, Regional General Manager

Enclosures (Vulnerability Assessment)

Optum

Minnesota DHS/MNIT

Pre-payment solution roadmap and Rapid Response Team to improve detection of Fraud, Waste and Abuse in DHS health care programs

Vulnerability Assessment

January 31, 2026 - Final

This report contains not public data as classified by the Minnesota Government Data Practices Act, including security information, trade secret information, and auditing data. For ease of reference and protection, not public information is highlighted throughout the document. Improper disclosure of such information could jeopardize the State's ability to safeguard tax payer funds from fraudulent actors.

Executive Summary

The purpose of this Vulnerability Assessment deliverable is to present a formal summary of the fraud, waste, and abuse (FWA) evaluation undertaken during the initial ninety days of our engagement. This assessment encompasses a thorough review of fourteen high-risk service and program areas, including detailed analysis of a data set covering 46-month period of fee-for-service claims history. This deliverable provides quantified MMIS claim edits, delineates opportunities for cost avoidance and financial recovery, and offers evidence-based recommendations to inform pre-payment strategies that will optimize long-term savings and enhance operational efficiency.

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

Expected Outcomes:

- Identification of clear FWA patterns and vulnerabilities.
- Measurable estimates of cost avoidance and potential recoveries.
- Strategic recommendations for pre-payment prevention and operational improvements.
- Stand-up of necessary pre-prepayment infrastructure to support rapid implementation.

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Introduction

The Minnesota Department of Human Services (DHS) has identified 14 Medicaid services as high-risk and therefore high-priority areas for addressing fraud, waste, and abuse, with the goal of strengthening program integrity. These services are now under heightened scrutiny, including direct oversight from Governor Tim Walz.

To address these issues, DHS awarded a contract to Optum to deliver fraud, waste, and abuse services, including the deployment of a rapid response team (RRT) and other essential resources to swiftly review the 14 high-risk services identified by the State.

Focusing on Fee for Service (FFS) based payments being made on the 14 high-risk services, Optum's RRT Team conducted a comprehensive vulnerability assessment, performed in-depth analytics, and is providing recommendations to help prevent future misuse and improve program integrity. Optum participated in the RRT initiative by integrating pre-validated analytics designed to address several high-risk services identified by DHS. These areas include invalid transportation claims, billed but unprovided Personal Care Assistance (PCA) services, and phantom billing within Housing Stabilization Services—where Governor Walz had previously suspended 50 providers due to ongoing investigations and related concerns.

During the review of the 14 high-risk Medicaid services, Optum conducted a comprehensive vulnerability assessment across three key domains. This assessment took place concurrently with the payment pause, allowing for focused analysis of service delivery risks, billing anomalies, and provider practices, in the following areas:

1. **MMIS (Medicaid Management Information System) edits**
2. **Current policy and potential policy adjustments**
3. **Overall service vulnerability based on claims**

The vulnerability assessment framework concentrated on identifying potential fraudulent scenarios, summarizing high-risk services/billing areas, and enhancing transparency by providing detailed claim-level insights. These claims are being reviewed by Optum and validated by DHS to facilitate clarity and accountability.

Targeted analytics will be continuously monitored throughout the contract period to identify repeat offenders, uncover supplemental findings, and enable a more refined analysis of provider behavior and billing patterns.

In parallel, as the policy undergoes evaluation for concerns beyond billing, the Optum RRT is also examining policy-related issues that may contribute to improved provider understanding and billing accuracy.

This document presents a formal summary of the consensus recommendations developed by the Optum RRT and includes an overview of the supporting analytics. These data-driven insights highlight key findings and areas of concern identified in response to the contract's objectives.

Table 1 shows the universe of Fee for Service approved claims with first dates of service from January 2022 through October 2025 (46 months), identified using the payment claim criteria across the 14 programs defined by the Department of Human Services. These records are not analytics derived; rather, they represent all claims that meet the specified filtering guidelines.

Table 1 Universe of Claims Reviewed by Optum

HR Service	Count #claim lines	Distinct # claims lines	Distinct # pay to provs	Distinct #members	Total $ line paid
1. Housing Stabilization Services	458,032	179,248	837	11,099	$ 36,435,903.80
2. Peer Recovery	128,326	82,936	153	11,202	$ 10,157,141.28
3. Early Intensive Developmental and Behavioral Intervention	6,251,811	3,241,196	347	5,908	$ 743,904,931.26
4. Integrated Community Supports	1,626,831	288,665	446	3,214	$ 453,984,544.90
5. Non Emergency Medical Transportation	909,341	256,452	146	12,717	$ 29,748,459.73
6. Adult Rehabilitation Mental Health Services	510,527	430,177	338	24,133	$ 74,917,024.98
7. Personal Care Assistance/Community First Services and Supports	38,005,361	6,045,099	1,283	83,042	$ 4,313,558,433.34
8. Adult Day Services	1,492,523	226,928	205	3,399	$ 136,975,681.01
9. Recuperative Care	795	251	13	63	$ 383,012.77
10. Individualized Home Supports	5,126,995	1,825,975	1,494	25,471	$ 1,149,816,834.21
11. Adult Companion Care	7,613,109	1,588,888	1,422	15,979	$ 1,601,101,446.34
12. Night Supervision	2,970,123	419,739	955	4,842	$ 757,132,339.02
13. Assertive Community Treatment	231,178	192,894	35	1,384	$ 54,666,390.90
14. Intensive Residential Treatment Services	161,066	72,894	72	2,904	$ 83,622,507.18
Total	**65,486,018**	**14,851,342**	**7,746**	**205,357**	**$ 9,446,404,650.72**

Data used in this report reflects DHS supplied criteria.

Identification of Fraud, Waste and Abuse

Guided by the priorities set by the Minnesota Department of Human Services (DHS), the Rapid Response Team (RRT) conducted a thorough review of the policy manual, focusing on billing structures and guidelines. The findings from this review were categorized into two main analytic areas:

1. Policy Rules (Rule-based detection)
    - Duplicate billing, unbundling, invalid modifiers, service limits, frequency, and possible upcoding
2. Excessive Behaviors (Recurring behaviors, trends, or sequences observed in data).
    - A provider consistently billing for the same procedure across many members excessively.
    - A provider billing member daily under a certain program within the high-risk services.
    - Billing a member for multiple high-risk services at the same time exceeding hours in a day.

If a policy includes an age restriction, it is classified under Policy Analytics. If a policy lacks defined billing codes or does not specify when billing is appropriate allowing for excessive billing, it is categorized under Pattern Analytics.

A comprehensive list of all analytics is then compiled per each high-risk service using AI intervention and Special Subject Matter Expertise. Detailed specification documents are created to support data analysis on the MN Teradata platform, specifically targeting identified high-risk providers. These specification documents include key identifiers such as service types, program names, procedure codes, modifiers, and more.

Analytics are tagged with allegations and/or concerns (examples below):

- Timed services billed for more than 24 hours in a single day are tagged as Impossible Days.
- Travel services billed for over 2.5 hours, where 1 unit equals 1 minute is tagged as Questionable Travel.
- Authorization wasn't present during claim submission is tagged as Missing Authorization.

Optum's assessment and vulnerability review of the 14 high-risk areas was grounded in the most up-to-date DHS policy information available at the time of analysis.

Data developers and analysts then work closely to query the database and extract results.

The RRT Team also focused on reviewing policy for vulnerabilities. Vulnerabilities are weaknesses or gaps in systems, processes, or controls that can be exploited. They represent risk exposure and are often targeted by bad actors. A system that allows duplicate billing without alerts is a vulnerability. Identified Vulnerabilities within the initial 90-day assessment are discussed in the sections below. The universe from what the analytics were built on is shown below in the order of priority provided. Table 1 below shows the universe of claims review. The count of claim lines, unduplicated claim lines, unduplicated pay to providers, unduplicated number of members as well as the total dollars paid is displayed. The largest area of potential savings identified is in the PCA/CFSS program with approximately 90% of the payments reviewed by Optum.

Policy Rule Violations and Excessive Services Detected

Table 2 below outlines each high-risk service, by priority, and provides a count of the analytics executed within the first 90 days. The number of analytics focused on patterns and/or policy are separately broken down.

It should be noted that the analytics encompass 46 months of data of Fee for Service claims provided at the commencement of the contract, thereby facilitating a thorough examination of historical trends and billing practices. All claims are categorized as final paid claims, with an emphasis on historical data.

Table 2 Data Assessment of FWA patterns via analytics

High-Risk Service	Policy Rules # of analytics	Excessive Behaviors # of analytics
1. Housing Stabilization Services (HSS)	8	6
2. Peer Recovery Support Services (PRSS)	5	1
3. Early Intensive Developmental and Behavioral Intervention (EIDBI)	15	10
4. Integrated Community Supports (ICS)	12	0
5. Non-Emergency Medical Transportation (NEMT)	7	5
6. Adult Rehabilitation Mental Health Services (ARMHS)	16	8
7. Personal Care Assistance/Community First Services and Supports (PCA/CFSS)	4	9
8. Adult Day Services (ADS)	4	3
9. Recuperative Care (RS)	7	2
10. Individualized Home Supports (IHS)	11	2
11. Adult Companion Care (ACC)	8	5
12. Night Supervision (NS)	5	4
13. Assistive Community Treatment (ACT)	13	2
14. Intensive Residential Treatment Service (IRTS)	1	10
Total	**116**	**67**

Following the completion of analytics, the RRT team conducted a comprehensive review of the results to identify any additional scenarios that were not initially captured during the policy review and were only visible after data assessment. Each of the newly identified scenarios underwent a rigorous assessment to determine the need for further policy recommendations (as a second pass). This process supports the elimination of potential FWA vulnerabilities and, where implemented, enhances policy clarity for providers moving forward; this in turn helps outline any other vulnerabilities present.

Validated findings were then forwarded for assessment under the Pre-Pay Suspend process.

Vulnerabilities

Optum has identified recurring vulnerabilities across all high-risk services flagged by Minnesota DHS. These vulnerabilities stem from weaknesses in monitoring, auditing, and inter-agency communication, which undermine program integrity. Such gaps can result in beneficiary harm, improper payments, eligibility errors, or intentional fraud, waste, and abuse, for example, billing for services never provided or delivering unnecessary care that leads to inefficient resource use. These issues often arise from exploiting policy loopholes or inconsistent interpretations of policy.

As Optum continues to assess potential vulnerabilities, the team is still gaining an understanding of Minnesota's existing systems, such as the FWA Detection System used for Program Integrity. Gaining deeper insight into the tools currently in place—what data they capture and how they operate—will better equip Optum to develop informed recommendations and identify vulnerabilities that could help strengthen and improve current FWA processes.

General vulnerabilities include:

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

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

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

1. Housing Stabilization Services (HSS)

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

2. Peer Recovery Support Services (PRSS)

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

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

[redacted]

3. Early Intensive Developmental and Behavioral Intervention (EIDBI)

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

[redacted]

4. Integrated Community Supports (ICS)

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

[redacted]

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

5. Non-Emergency Medical Transportation (NEMT)

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

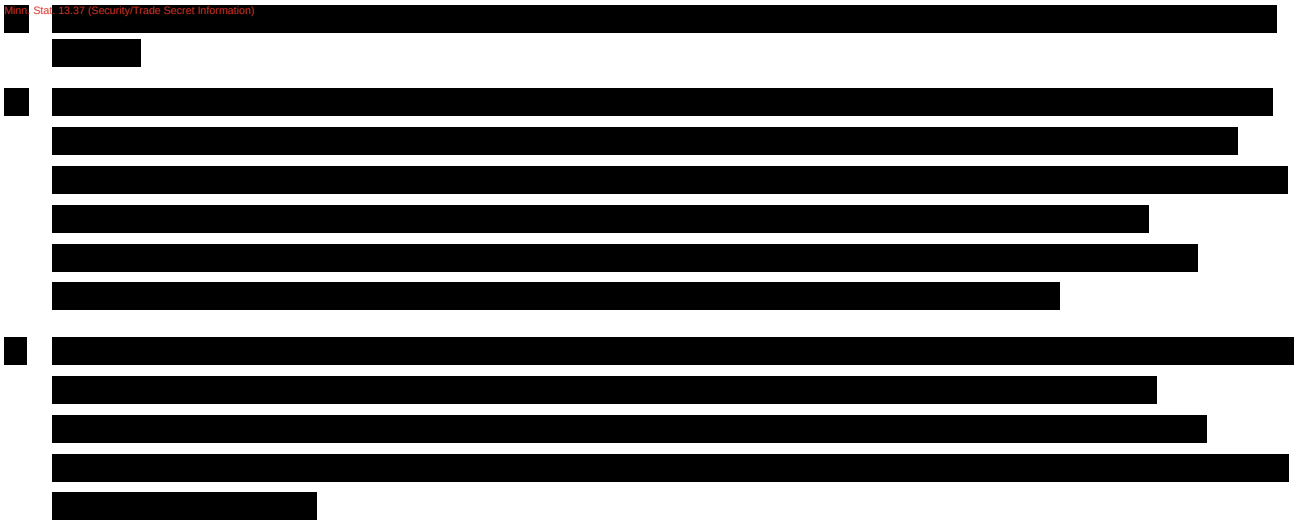
6. Adult Rehabilitative Mental Health Services (ARMHS)

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

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

7. Personal Care Assistance (PCA)/Community First Services and Supports (CFSS)

8. Adult Day Services (ADS)



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

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

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9. Recuperative Care (RC)

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

[redacted]

10. Individualized Home Supports (IHS)

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

[redacted]

11. Adult Companion Care

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

[redacted]

12. Night Supervision (NS)

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

[redacted]

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

13. Assertive Community Treatment (ACT)

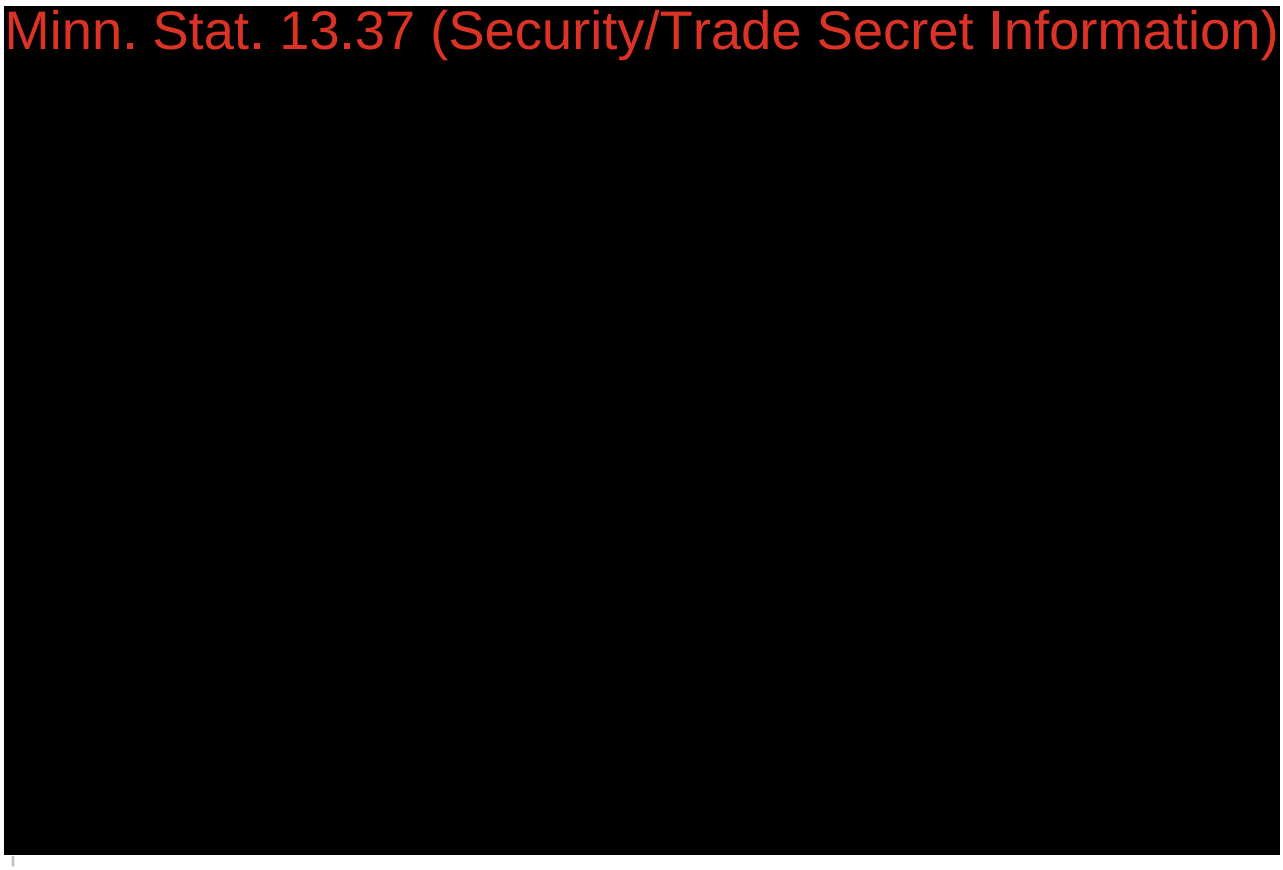
Minn. Stat. 13.37 (Security/Trade Secret Information)

14. Intensive Residential Treatment Services (IRTS)

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

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

IRTS Services



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

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

Measurable Outcomes

Measurable outcomes fall into two categories of recoveries:

- Some analytics lead to **direct recoveries**, where funds can be recouped based on identified issues (usually, directly against policy standards)
- Others represent **potential recoveries**, offering insights at a point in time that suggest opportunities for corrective action (usually, missing/vague policy found within vulnerabilities). May require a review of records for medical necessity.
- **Cost avoidance** refers to proactive measures that prevent future expenses rather than reducing current spending.

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

[redacted]

Direct Recoveries

These analytics are specifically addressing what is stated in the policy as “directive” for proper billing and instruction, including the claim criteria provided by Minesota DHS. These analytics are applied to FFS claims within the given 46 months of data.

Results of Policy Rule Analytics are focused on the 14 high-risk service areas only.

Identification of Direct Recoveries does *not* indicate a 100% recoupment, nor does it imply fraud, waste or abuse. Instead, it is intended to highlight areas where DHS may prioritize additional review based on policy interpretation and validation.

Please note, the data outlined in Table 4 below reflects a specific point in time and may change as Optum and the State of Minnesota collaborate on criteria, policy confirmation, and other factors such as data identification.

Table 4: Direct Recoveries which are a result of clearly stated policy violations.

High-Risk Services	Provider Count	Line claim count	$ paid
1. Housing Stabilization Services (HSS)	94	2,416	$437,997.65
2. Peer Recovery Support Services (PRSS)	222	48,619	$3,911,632,35
3. Early Intensive Developmental and Behavioral Intervention (EIDBI)	292	56,391	$8,631,542.94
4. Integrated Community Supports (ICS)	85	1,205	$451,917.13
5. Non-Emergency Medical Transportation (NEMT)	272	645,611	$23,964,871.86
6. Adult Rehabilitation Mental Health Services (ARMHS)	3	119	$14,003.87
7. Personal Care Assistance/Community First Services and Supports (PCA/CFSS)	3	6	$705.80
8. Adult Day Services (ADS)	6	83	$9,192.00
9. Recuperative Care (RS)	23	892	$377,682.79
10. Individualized Home Supports (IHS)	152	21,957	$5,175,117.80

High-Risk Services	Provider Count	Line claim count	$ paid
11. Adult Companion Care (ACC)	49	7,919	$655,069.04
12. Night Supervision (NS)	558	23,833	$11,527,248.06
13. Assistive Community Treatment (ACT)	10	4,941	$1,533,713.93
14. Intensive Residential Treatment Service (IRTS)	0	0	$0
Total	**1,769**	**813,992**	**$52,341,065.22**

Data used in this report reflects DHS supplied criteria. Counts may be duplicated.

Policy Refinements

These analytics target scenarios where, if policies were refined or updated, such cases would likely be captured by the edit system and either denied or adjusted for payment. Table 5 below shows potential savings that could be achieved if policies were updated to be made clearer based on the analysis of 46 months of paid claims.

Identification of Potential Savings does *not* indicate a 100% recoupment, nor does it imply fraud, waste or abuse. Instead, it is intended to highlight areas where DHS may prioritize additional review based on policy interpretation and validation.

Table 5: Potential savings achievable by revising and clarifying policy language to reduce ambiguity and improve compliance.

High-Risk Services	Provider Count	Line claim count	$ Paid
1. Housing Stabilization Services (HSS)	74	128	$17,529.45
2. Peer Recovery Support Services (PRSS)	0	0	0
3. Early Intensive Developmental and Behavioral Intervention (EIDBI)	901	7,856,008	$1,051,766,669.07
4. Integrated Community Supports (ICS)	0	0	0
5. Non-Emergency Medical Transportation (NEMT)	303	184,493	$17,384,185.24
6. Adult Rehabilitation Mental Health Services (ARMHS)	387	60,797	$10,523,693.67
7. Personal Care Assistance/Community First Services and Supports (PCA/CFSS)	28	6193	$761,085.89
8. Adult Day Services (ADS)	0	0	0
9. Recuperative Care (RC)	4	7	$5,668.11
10. Individualized Home Supports (IHS)	1,312	1,890,836	$429,634,732.73
11. Adult Companion Care (ACC)	15	903	$48,230.28
12. Night Supervision (NS)	1,375	697,814	$196,236,689.39
13. Assistive Community Treatment (ACT)	0	0	0
14. Intensive Residential Treatment Service (IRTS)	275	82,182	$42,664,789.00
Total	**4674**	**10,779,361**	**$1,749,043,272.83**

Data used in this report reflects DHS supplied criteria. Counts may be duplicated.

Cost Avoidance

Cost avoidance refers to preventing improper or unnecessary payments before they occur, rather than recovering funds after the fact. It's a proactive strategy aimed at reducing financial risk and safeguarding taxpayer dollars. This can be done by using pre-payment reviews to flag suspicious billing patterns.

Table 6 below are the dollar-value changes that became evident in the fourth quarter of 2025, as the 14 high-risk services gained national attention and the state strengthened its commitment to enhanced review. These actions resulted in measurable cost avoidance. As shown, there is a decline in dollars from the third to the fourth quarter, reflecting the avoided Medicaid expenditures driven by these ongoing efforts.

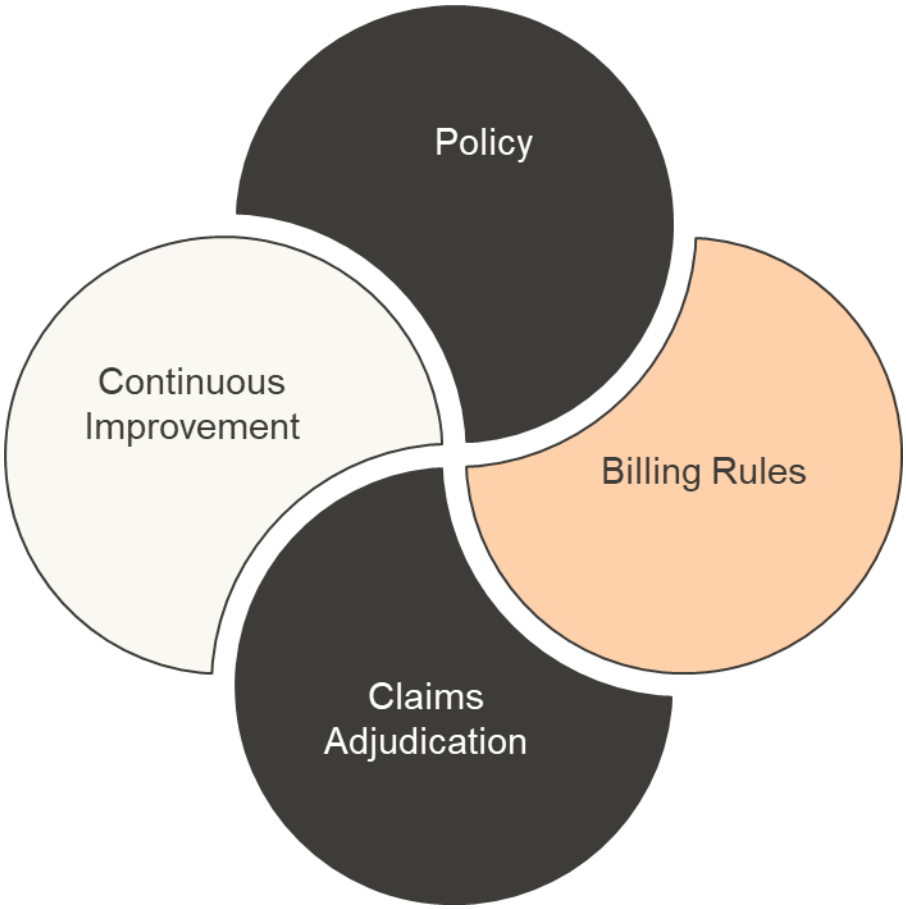
Table 6: Decrease in dollars paid and percentage from 3rd to 4th quarter 2025

Priority	HR Service	3rd Quarter	4th Quarter	Decrease in Paid $	Decrease in %
1	HSS	$ 1,515,352.93	$ 300,994.71	$ 1,214,358.22	-80%
2	PRSS	$ 751,009.04	$ 513,663.76	$ 237,345.28	-32%
3	EIDBI	$ 85,381,119.44	$ 59,545,292.02	$ 25,835,827.42	-30%
4	ICS	$ 49,073,411.82	$ 29,628,953.97	$ 19,444,457.85	-40%
5	NEMT	$ 1,786,960.64	$ 1,256,047.50	$ 530,913.14	-30%
6	ARMHS	$ 231,356.00	$ 157,266.00	$ 74,090.00	-32%
7	PCA/CFSS	$ 51,714,124.00	$ 36,217,495.00	$ 15,496,629.00	-30%
8	ADS	$ 378,259.00	$ 243,917.00	$ 134,342.00	-36%
9	RC	$ 129,885.27	$ 202,362.87	$ (72,477.60)	56%
10	IHS	$ 295,909,242.54	$ 213,285,075.76	$ 82,624,166.78	-28%
11	ACC	$ 18,271.00	$ 11,991.00	$ 6,280.00	-34%
12	NS	$ 79,594,454.97	$ 59,328,201.04	$ 20,266,253.93	-25%
13	ACT	$ 14,200.00	$ 8,849.00	$ 5,351.00	-38%
14	IRTS	$ 12,901.00	$ 9,233.00	$ 3,668.00	-28%
Grand Total		**$ 566,510,547.65**	**$ 400,709,342.63**	**$ 165,801,205.02**	**-29%**

Data used in this report reflects DHS supplied criteria.

Recommendations for Prevention

When potential Fraud, Waste and/or Abuse are identified, there are systemic changes that can be implemented that will allow the organization to begin to prevent overpayments and mitigate exploitation. Improving policy clarity, revising billing expectations to remove impediments, clarity in claims adjudication and refining editing, reducing the reliance of information in multiple systems to adjudicate claims, and implementing a continuous improvement program are all vital measures to reduce fraud, waste, and abuse.



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

Recommendation: Policy

Policies should be published to ensure that providers and other stakeholders are able to easily identify how claims will be adjudicated. This includes several tactical issues (noted below) to facilitate ease of use. Minn. Stat. 13.37 (Securi

[redacted]

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

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  - [redacted]

Internal and Operational Policies

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

Furthermore, we encourage policies that seek to drive each recipient's providers to coordinate services. Internal policies supporting the use of tools that allow access to the patient's treatment history may assist in driving coordination of care to reduce redundant treatments, making exploitation easier to detect.

Recommendation: Claims Coding (Billing) Rules to Align to Best Practice

Claims coding guidelines given to providers and used in claims adjudication should facilitate a clear and accurate understanding of the services that were received, how many, by whom, when, and who delivered the services. Minn. Stat. 13.37 (Security/Trade Secret Information) [redacted]

- [redacted]

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

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

[redacted]

Recommendation: Revise Claims Adjudication

Refine Exceptions / Claims Editing

A review of exceptions code descriptions contained in the MMIS exception code text document suggests that there are a large number of edits that may create opportunities for exploitation. Minn. Stat. 13.37 (Security/Trade Secret Information)

[redacted]

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

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

Pre-Pay Investigation Hold

Currently, there is no status in place to be used for pre-payment investigations of claims. It is understood to develop this will take a significant amount of time, up to several months of work. Best practice is to easily and expeditiously segregate claims that are for providers being investigated. This includes being able to use any point of data on the claim to be able to identify the impacted claims inventory quickly and ideally using automated processes to avoid error. Furthermore, it should be possible to segregate this work from the normal workflow for pended claims so that claims under investigation are not served to staff for manual intervention.

- **Recommendation**: Ability to hold and release claims from hold for investigation quickly, using automation, and using any combination of data points on the claim. The ability to add to and release from hold should be restricted so that claims are not allowed to pay inadvertently.

Data not in claims adjudication system

There are instances in which data that is not in the claims system impacts claim reimbursement. A few examples are below:

- In Housing Stabilization Services, Minn. Stat. 13.37 (Security/Trade Secret Information)
- In Non-Emergency Medical Transport, Minn. Stat. 13.37 (Security/Trade Secret Information) [redacted]
- In Individualized Home Support services, Minn. Stat. 13.37 (Security/Trade Secret Information) [redacted]
- In Adult Companion Care (ACC), Minn. Stat. 13.37 (Security/Trade Secret Information) [redacted]

Whenever all data that is relevant to a claim's adjudication is not in the same system that adjudicates the claim, there is an opportunity for claims to be reimbursed incorrectly. Any time a claims adjudication system relies on outside information, the opportunity exists for data to be compromised and drive incorrect adjudication. Furthermore, having to validate information in various systems manually will increase the opportunity for error during quality assurance. Individuals who are intent on conducting fraudulent activities may be able to exploit this weakness.

- **Recommendation**: Ensure information that impacts claim adjudication is housed within the claims adjudication system and can facilitate auto adjudication where possible.

Pre-payment Infrastructure Supporting Rapid Implementation

We recommend an approach of stabilizing and planning in the short term to enable quick wins and support execution of longer-term projects.

Short Term — 0-3 months

Pre-Pay Investigation Hold: Segregate Claims to Prevent Inappropriate Payments

Upon recognizing opportunities to improve payment accuracy, including the identification of potential fraud, waste, and abuse, the best practice is to hold claims during investigation. Implement automated or batch processes to suspend claims based on any combination of claim attributes while avoiding manual intervention.

Key considerations:

- Segregate pended claims from the standard inventory to prevent distribution to staff.
- Use automation or batch processing to apply pre-pay investigation pends to claims to promote accuracy and efficiency in the process.
- Identify the segregated pre-pay investigation-pended claims in operational reporting to maintain clarity between workable claims and pre-pay investigation-pended volumes.
- Restrict pend release authority to a limited group of staff to prevent accidental release.
- Maintain records to be able to identify the reason for each claim to be in pre-pay investigation hold.

Evaluate level of effort needed to resolve identified issues

A variety of vulnerabilities and recommendations have been identified above that include technical and process impacts. A cross functional team should evaluate what is needed to implement a fix for each one of these. Considerations should include:

- Staffing needs
- Changes to technology configuration or claim edits
- Process changes
- Training needs

If current technology cannot accommodate the necessary changes, consider acquiring new tools.

Once this is completed, identify if there are any risks that cannot be addressed and seek assistance until a plan is in place for each risk identified.

Rank each solution to identify which can be implemented quickly within 3 months, and which will take longer. Of the items that may take longer, categorize them into mid-range (3-12 months) and those that will require long-term planning and activity to implement (12+ months). Ensure all planning, funding, and staffing is obtained.

As claims mitigations are being identified, develop a prioritization matrix of impact of each issue (considering factors including number of members and/or providers impacted, severity of impact to members and severity of impact to providers and the state). Also capture the level of effort to repair each.

Once items for which there is a low-effort fix identified, begin working on these in order of highest impact first to lowest impact and begin to plan for mid- and long-term fixes.

Claims / Member Impact	Level of Effort	Roadmap
High	Low	Near Term 0-3 months – First
Medium		Near Term 0-3 months – Second
Low		Near Term 0-3 months – Third
High	Medium	Mid Term 3-12 months
Medium		
Low		
High	High	Long Term 12+ months
Medium		
Low		

Revised Policy Template Minn. Stat. 13.37 (Security/Trade Secret Information)

Develop a revised policy template that can be used across all policies to facilitate consistent format and ease of finding information. Minn. Stat. 13.37 (Security/Trade Secret Information) [redacted]

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

Mid-Range — 3-12 months

Staffing

Begin to hire, onboard, and train any staff identified as needed to implement mid and long-term fixes.

Implement Monitoring

Develop internal organizational structure to support program integrity office, internal detection algorithms, and FWA detection. Begin implementation of case monitoring tool. Begin implementing these capabilities by developing/acquiring technology or engaging vendors.

Revise Policy

Begin revision of all policies in the provider manual using the revised template.

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

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

Policy changes should be socialized to providers in advance of being put into effect.

Long Term 12+ Months

Continue Claims Mitigation Implementation

Begin implementation of items that will require 12+ month fixes.

Ongoing Monitoring

If implementation of Program Integrity Office, internal detection algorithms, and FWA detection capabilities is not complete, finalize this. Once in place, monitoring, detection, and resolution/mitigation activities should be ongoing.

Perform root cause analysis to identify underlying issues. This will help you to understand the nature of the issue and what may be needed to remediate issues. Operational remediation of issues, even if referred for investigation, should be evaluated. This may include actions such as policy updates or system configuration changes. Provider education should also continue on an ongoing basis as issues are identified.

Closing Remarks

The results of this Vulnerability Assessment demonstrate both the magnitude of program integrity risks within Minnesota's Medicaid system and the significant financial opportunity associated with strengthening oversight, modernizing policy, and enhancing claims adjudication. Over the course of the initial ninety-day Rapid Response Team engagement, we evaluated 46 months of Fee for Service claims across 14 high-risk services and identified patterns, vulnerabilities, and operational gaps that—if addressed—can meaningfully improve program accuracy and safeguard taxpayer dollars.

Identification of FWA Patterns and Vulnerabilities

In total, 116 policy-rule analytics and 67 excessive-behavior analytics were executed, demonstrating both the breadth and depth of evaluation conducted during the initial assessment.

Recurring vulnerabilities appeared across nearly all services, including:

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

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

[redacted]

Measurable Estimates of Cost Avoidance and Potential Recoveries

During the fourth quarter of 2025 payment pause and heightened national attention to the 14 high-risk services, Minnesota saw a measurable drop in Fee for Service spending. Across the fourteen programs, more than $165 million in cost avoidance was realized quarter over quarter as inappropriate billing declined.

The team identified over $52.3 million in direct recoveries attributable to clearly defined policy violations across the 14 high-risk service areas in 46 months of paid claim data. These represent dollars that are recoverable based on existing, published rules and claim criteria.

The largest contributors include:

- Non-Emergency Medical Transportation (NEMT): $23.96M
- Night Supervision (NS): $11.53M
- Early Intensive Developmental and Behavioral Intervention (EIDBI): $8.63M
- Individualized Home Supports (IHS): $5.18M

These findings demonstrate the importance of foundational controls, such as Minn. Stat. 13.37 (Security/Trade Secret Information) [redacted]

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

Beyond direct noncompliance, the assessment revealed vulnerabilities Minn. Stat. 13.37 (Security/Trade Secret Information) [redacted]

If policies were modernized and aligned to best practices, potential recoveries based on analysis of 46 months of paid claim data total more than $1.7 billion, including:

- EIDBI: $1.05B
- IHS: $429.6M
- Night Supervision: $196.2M
- IRTS: $42.7M
- NEMT: $17.3M

These figures reflect systemic exposure resulting from Minn. Stat. 13.37 (Security/Trade Secret Information) [redacted]

This reinforces the value of proactive controls—particularly pre-payment edits, monitoring tools, and policy clarification—to prevent improper payments before they occur.

Strategic Recommendations for Pre-Payment Prevention and operational Improvements.

Strengthening fraud, waste, and abuse prevention requires more than isolated fixes—it demands a coordinated, system-wide commitment to clearer policies, Minn. Stat. 13.37 (Security/Trade Secret Information) [redacted] By advancing these recommendations, Minnesota can build a more transparent, consistent, and resilient program integrity framework that protects beneficiaries, supports providers, and ensures Medicaid dollars are used appropriately. The outlined short-, mid-, and long-term actions create a clear roadmap for sustainable improvement and position the State to proactively prevent overpayments while enhancing overall operational effectiveness.

Optum remains committed to supporting DHS and MNIT through the next phases of implementation, to support translating these findings into long-term, systemic impact.