

Publications

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Issue Brief: State-Level Medicaid Fraud in Focus

Comprehensive Analysis of Current Developments, Anticipated National Implications and Recommendations for Clients

Spurred by ongoing allegations of fraud in the State of Minnesota, where federal investigators have alleged upwards of \$9 billion¹ in Medicaid-related fraud, waste and abuse, oversight of Medicaid spending is becoming an area of clear focus for state and federal authorities. In Minnesota, coordinated state and federal investigations suggest the existence of sophisticated criminal schemes involving false and inflated billing, provision of medically unnecessary services, kickback arrangements, and intentional misrepresentation of patient information and services rendered. The findings in Minnesota have ignited nationwide interest in how state agencies conduct oversight of Medicaid providers and services, with significant potential impacts for providers across the country.

On the Ground in Minnesota

The Minnesota fraud allegations focus primarily on 14 Medicaid services the State has now deemed at “high risk” for fraud: Early Intensive Developmental and Behavioral Intervention services for autism, Integrated Community Supports, Nonemergency Medical Transportation, Peer Recovery Services, Adult Rehabilitative Mental Health Services, Adult Day Services, Personal Care Assistance/Community First Services and Supports, Recuperative Care, Individualized Home Supports, Adult Companion Services, Night Supervision, Assertive Community Treatment, Intensive Residential Treatment Services and Housing Stabilization Services.² Minnesota has engaged Optum to conduct a third-party analysis of claims for these services and has already terminated its housing stabilization service program.^{3, 4}

It is worth noting that the “high risk” services identified by Minnesota largely fall outside the realm of traditional health care covered by Medicare or traditional insurance (brick and mortar physician offices, skilled nursing facilities, hospitals, etc.) and instead center on community-based support services and waiver programs covered by Medicaid. While not as well known, these services represent an important component of Medicaid-covered services that permit individuals to receive services in the least restrictive setting possible, and avoid institutionalization, which can help to reduce overall Medicaid program costs. Because these services are not as well-known or well-understood, however, licensure, certification, and other oversight mechanisms lag behind those that more

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traditional health care providers are familiar with.

Over the past several years, we have seen an increased shift from community-based providers of these services to large centralized, corporate-owned and operated providers, with significant investments in many of these service categories – particularly personal care and other home-based attendant care services, autism therapy providers and behavioral health support services. Despite a trend toward consolidation and increased investment, community-based services are still furnished by a wide range of providers and provider types, from small, mom-and-pop organizations with one or two providers to national, private equity-backed providers with immense reach.

National Attention to State Enforcement

The allegations in Minnesota continue to generate intense national scrutiny, compelling legislators, regulators and providers alike to revisit protocols and internal controls designed to safeguard public funds and promote Medicaid program integrity. We have already seen that this focus is likely to extend well beyond Minnesota.⁵ As a result, health care providers who furnish Medicaid services should anticipate the very real possibility of increased government audits, investigations and enforcement actions.

Recent credible reports and media coverage indicate the federal government is already conducting parallel investigations into Medicaid fraud in several states, consistent with an overall focus on Medicaid enforcement across the country.⁶ In these jurisdictions, the common investigative themes include attacks on medical necessity of pharmaceutical products and therapeutic services, improper billing for durable medical equipment, home health service irregularities, as well as unlawful referral and kickback arrangements. The heightened activity in these states suggests a coordinated and sustained federal response to systemic vulnerabilities in the administration of publicly funded healthcare programs.

Prepare Now for the Coming Storm

Given the gravity of these developments and the likelihood of further enforcement actions, we strongly advise our clients to undertake proactive measures to prepare for future audits and investigations. While intended to target the type of eye-catching fraud that has made headlines in Minnesota, the investigative and enforcement tools and pathways available to state and federal authorities will cause operational disruption and difficulty for ensnared Medicaid providers, the vast majority of which have done nothing wrong. And, although the Minnesota allegations focus on non-traditional types of health care providers and services, enforcement efforts impact all types of Medicaid providers, particularly where services and costs have increased.

To help mitigate the potential harmful impact of this scrutiny, Medicaid providers should take the following steps:

1. Evaluate internal compliance program policies, procedures and processes to promote alignment with HHS-OIG guidance for effective compliance programs.⁷ Effective compliance programs are the first line of defense against the types of issues identified in Minnesota.
2. Train staff to promote compliance and identify risk areas.
3. Train staff for interactions with government auditors, investigators and (potentially) law enforcement. Include applicable agency identification, responding to audit letters, document requests, and other investigative steps and familiarity with internal processes for handling audits and investigations
4. Ensure third party vendor and other relationships (e.g. billing and management duties) are structured to comply with applicable federal and state laws and require vendors to follow applicable compliance requirements.

5. Engage internal and external resources to evaluate current credentialing, billing and documentation practices, identify areas of weakness, and take corrective actions (if needed) to promote compliance and change improper practices.
6. Prepare for revenue cycle disruption. One of the tools the government may use to combat perceived fraud is the implementation of payment holds or pre-payment review. In fact, on January 6, 2026, the Trump Administration ordered a funding freeze for the Child Care and Development Fund, Temporary Assistance for Needy Families (TANF) and the Social Services Block Grant program for California, Colorado, Illinois, Minnesota, and New York.⁸ These measures can lead to months of revenue cycle delays for providers and have devastating operational impacts. Providers should plan now for the possibility that revenue cycle disruptions may occur.
7. Engage with the community. The time to speak to state legislators, enforcement agencies and Medicaid programs is now. Proactive and prophylactic measures, driven by the provider community rather than reactive responses to auditors paid on a contingent basis, or policy makers facing budget pressures, are an investment for smoother operations in the future.
8. Continue to care for your patients. Medicaid providers furnish critical health care services to some of the most vulnerable patients in the United States. By taking the proactive steps outlined above, providers can be prepared to weather the coming storm and continue to fulfill their primary mission of delivering high-quality patient care.

Polsinelli has deep experience and proven capability in health care law, particularly in navigating complex regulatory, enforcement and compliance matters such as those implicated by the current Medicaid fraud investigations. The firm's Health Care Practice is comprised of seasoned attorneys who regularly counsel clients on federal and state health care regulations, fraud and abuse laws, and the intricacies of government investigations. With a robust team adept at conducting internal audits, responding to government inquiries and implementing effective compliance programs, Polsinelli stands as a trusted advisor for health care providers facing heightened scrutiny and enforcement risk.

In addition to its legal acumen, Polsinelli's Public Policy group offers clients strategic guidance and advocacy services to engage effectively with federal representatives, regulators and key political appointees within the Administration. The group leverages its deep relationships on Capitol Hill and across federal agencies to help clients communicate their positions, shape policy outcomes and navigate legislative and regulatory challenges arising from increased enforcement activities. Whether clients seek to clarify the impact of new regulations, advocate for policy changes, or address enforcement priorities, Polsinelli's government relations professionals work seamlessly alongside the firm's legal team to deliver comprehensive solutions tailored to each client's needs.

By combining focused experience with proactive public policy engagement, Polsinelli empowers health care providers to both address immediate legal risks and influence the broader regulatory landscape. Clients benefit from a coordinated approach that anticipates government actions, facilitates constructive dialogue with policymakers and ensures their voices are heard during this pivotal era of increased oversight and enforcement in the health care sector.

[1] CBS News, *At least \$9B billed across 14 Medicaid services in Minnesota may be fraudulent, top prosecutor says* (Dec. 18, 2025) <https://www.cbsnews.com/minnesota/news/billions-paid-out-by-medicaid-in-minnesota-may-be-fraudulent-us-attorney/>.

[2] State of Minnesota, Office of the Governor, *Governor Walz Orders Third-Party Audit of Medicaid Billing at DHS* (Oct. 29, 2025) <https://mn.gov/governor/newsroom/press-releases/?id=1055-711001>.

[3] *Id.*

[4] MN Dep't of Human Services, *Housing Stabilization Services program termination FAQ for providers and clients* (Nov. 1, 2025) <https://mn.gov/dhs/housing-stabilization-services-termination/>.

[5] Downs, Garrett, CNBC, *Khanna calls for nationwide fraud investigation after wealth tax proposal caused firestorm* (Dec. 30, 2025) <https://www.cnbc.com/2025/12/30/ro-khanna-calls-for-fraud-probe-after-california-wealth-tax-firestorm.html>.

[6] See, e.g., U.S. Dep't of Justice, *National Health Care Fraud Takedown Results in 324 Defendants Charged in Connection with Over \$14.6 Billion in Alleged Fraud* (June 30, 2025) <https://www.justice.gov/opa/pr/national-health-care-fraud-takedown-results-324-defendants-charged-connection-over-146>; Mich. Dep't of Atty. Gen. *Three Charged with Medicaid Fraud in Alleged Transportation Scheme* (Oct. 9, 2025) <https://www.michigan.gov/ag/news/press-releases/2025/10/09/three-charged-with-medicaid-fraud-in-alleged-transportation-scheme>; Mo. Atty. Gen. *Attorney General Hanaway Secures Felony Indictments in Four Major Medicaid Fraud Cases in St. Louis* (Oct. 3, 2025) <https://ago.mo.gov/attorney-general-hanaway-secures-felony-indictments-in-four-major-medicaid-fraud-cases-in-st-louis/>.

[7] See, e.g., HHS-OIG, *General Compliance Program Guidance* (Nov. 2023) <https://oig.hhs.gov/compliance/general-compliance-program-guidance/>.

[8] U.S. Dep't of Health and Human Svcs., *HHS Freezes Child Care and Family Assistance Grants in Five States for Fraud Concerns* (Jan. 6, 2026) <https://www.hhs.gov/press-room/hhs-freezes-child-care-family-assistance-grants-five-states-fraud-concerns.html>.