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Federal-State Conflict in Medicaid Governance: A Policy Analysis of the Trump Administration's 2026 Minnesota Medicaid Funding Withholding Actions and Implications for State Health Systems

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Abstract: Medicaid, the joint federal-state health insurance program for low-income Americans, covered an estimated 80 to 85 million individuals nationally as of early 2026, following the post-pandemic enrollment unwinding, and remains one of the largest intergovernmental fiscal partnerships in U.S. history. The Trump Administration's 2026 series of escalating funding withholding and deferral actions against Minnesota's Medicaid program with a cumulative potential annual exposure exceeding $2.26 billion as of March 2026 represents, according to Minnesota's filed federal complaint, an unusually large and highly contested use of federal Medicaid payment deferral authority described by the state as without precedent in categorical scope . This qualitative policy analysis examines the chronology, legal basis, empirical justification, and projected consequences for the health system and population health of these actions. Drawing on primary government sources, federal court filings, peer-reviewed health policy literature, and federal agency data, this paper argues that the administration's funding withholding approach diverges from established cooperative federalism norms and the administrative law framework governing Medicaid compliance enforcement, creates disproportionate harm to clinically vulnerable beneficiary populations, and generates serious fiscal instability for a state whose 2025 Payment Error Rate Measurement (PERM) finding of 2.2% was substantially below the national rolling rate of 6.12%, though CMS cautions that state-specific PERM rates are not directly comparable across states due to methodological variation. Critically, the most prominent fraud case cited by the administration, Feeding Our Future, involved a federal child nutrition program, not Medicaid healthcare or insurance, raising serious questions about the analytic basis for applying Medicaid funding penalties in response to fraud in a programmatically distinct federal initiative. Integrating the health policy, organizational, and constitutional law literatures, the paper advances ten actionable policy recommendations that address fraud governance, intergovernmental fiscal relations, and the structural protection of Medicaid beneficiaries against deployment of conditional spending authority under contested legal circumstances.

Keywords: Medicaid, Minnesota, Federal Funding Withholding, Cooperative Federalism, Medicaid Fraud, Health Equity, Centers For Medicare & Medicaid Services, Spending Clause, Program Integrity, Trump Administration, Federal-State Relations, Uninsured Cost Burden, Emergency Care Utilization

Introduction

Medicaid is the largest public health insurance program in the United States. National enrollment, which peaked at approximately 94 million during the COVID-19 continuous enrollment period, declined substantially following the unwinding process that began in April 2023; Centers for Medicare & Medicaid Services (CMS) enrollment data through mid-2025 indicated approximately 80 to 85 million active enrollees, representing approximately one in four or five Americans (Centers for Medicare & Medicaid Services, 2024; Kaiser Family Foundation, 2024). Federal Medicaid expenditures exceeded $592 billion in fiscal year 2024, representing the federal government's share of total program costs and underscoring the program's central role in the U.S. healthcare safety net (Centers for Medicare & Medicaid Services, 2024). Minnesota's Medicaid program, known as Medical Assistance, serves more than 1.1 million residents, including approximately 42% of the state's children, as well as significant populations of adults with disabilities, individuals with serious mental illness, and elderly persons relying on long-term services and supports (Roll Call, 2026). The program operates through a cooperative federal-state framework in which states administer benefits under federal guidelines while receiving matching federal funds proportionate to their qualifying expenditures, a structural architecture that has defined the program since its enactment under Title XIX of the Social Security Act in 1965 (Rocco et al., 2020).

Recent policy developments have exposed fundamental tensions within this cooperative federalism structure. In early 2026, the Trump Administration announced a series of escalating federal Medicaid funding withholding and deferral actions against Minnesota, ostensibly citing widespread fraud and noncompliance in certain state-administered programs. Federal officials identified alleged irregularities in multiple Medicaid-funded services, including personal care assistance, home- and community-based services, autism therapy, housing stabilization services, and nonemergency medical transportation (Axios, 2026; NPR, 2026a). The administration initially warned that more than $2 billion annually in federal funding could be withheld pending corrective actions (Minnesota Attorney General's Office, 2026a). On February 25, 2026, Vice President JD Vance and CMS Administrator Dr. Mehmet Oz jointly announced the deferral of approximately $259.5 million in Medicaid reimbursement payments the amount at issue in Minnesota's subsequent lawsuit being $243.8 million as specified in the filed complaint imposing a 60-day deadline for the state to submit an anti-fraud compliance plan (CNN, 2026; NPR, 2026a; STAT News, 2026).

The dispute arose within the broader context of several high-profile fraud investigations involving Minnesota-administered programs. The most extensively documented case, Feeding Our Future, involved approximately $250 million in fraudulent claims under the Child and Adult Care Food Program (CACFP) a federal food security initiative administered by the U.S. Department of Agriculture, entirely distinct from Medicaid and has been described by federal prosecutors as the largest COVID-19-era fraud scheme charged in the United States (Minnesota Star Tribune, 2025; U.S. Department of Justice, 2025). Federal investigators subsequently identified alleged fraudulent billing within 14 separate Medicaid-funded service areas, including housing stabilization and Early Intensive Developmental and Behavioral Intervention (EIDBI) programs for children with autism spectrum disorders (White House, 2026; Minnesota Reformer, 2025). These Medicaid-specific investigations generated intense federal scrutiny of Minnesota's program oversight mechanisms and contributed to the administration's decision to suspend certain Medicaid payments.

However, the magnitude, method, and political context of the federal funding actions generated substantial controversy among health policy experts, legal scholars, and state

officials. Minnesota officials argued that the withholding actions were procedurally unprecedented in their categorical scope, empirically unjustified given the state's independently measured program integrity performance and violated the federal administrative law framework governing Medicaid compliance enforcement (Minnesota Attorney General's Office, 2026a). Health policy expert Jocelyn Guyer of the consulting firm Manatt Health described the actions as "unprecedented, both for the punitive nature and the magnitude of the losses,"noting that genuine fraud enforcement is conducted through partnerships between the federal government and states, not through emergency financial withholding (NPR, 2026b). In March 2026, Minnesota filed a federal lawsuit seeking to block the deferral and restore withheld funds, asserting that the federal government had exceeded its statutory authority, violated Fifth Amendment due process protections, violated the Administrative Procedure Act, and engaged in ultra vires action beyond the authority of CMS and Health and human Services [HHS] (Becker's Payer Issues, 2026; Minnesota Attorney General's Office, 2026a).

This paper addresses three critical gaps in the existing scholarly literature. First, while peer-reviewed research documents the population health consequences of Medicaid expansions and contractions driven by legislative change (Sommers et al., 2017; Antonisse et al., 2019), virtually no published scholarship examines the health system and population health consequences of unilateral executive-branch funding withholding as a mechanism of intergovernmental policy leverage. Second, the deployment of the federal Medicaid deferral mechanism in the categorical, statewide manner described in Minnesota's court filing is, as characterized in that filing, unprecedented in its scope, representing a novel legal and administrative event that merits scholarly documentation and analysis (Minnesota Attorney General's Office, 2026a). Third, the intersection of immigration enforcement, public rhetoric, and Medicaid funding decisions in the Minnesota case raises structural health equity concerns that the health policy literature has not examined in the context of federal-state Medicaid relations. The sections that follow develop these arguments in sequence: the Problem Statement establishes the empirical and institutional dimensions of the dispute; the Purpose Statement defines the analytical scope; the Methods section describes the analytical framework; the Significance statement situates the study within three distinct scholarly literatures; the Literature Review synthesizes the relevant scholarship; the Analysis examines legal, fiscal, and population health dimensions; and the Conclusions advance ten evidence-based policy prescriptions.

Problem Statement

Medicaid fraud enforcement and program oversight are longstanding concerns within U.S. health policy. Federal estimates indicate that improper payments across Medicaid totaled approximately $86.5 billion in fiscal year 2023, representing roughly 5.1% of program expenditures, though it is critical to note that this figure encompasses administrative errors and documentation deficiencies in addition to intentional fraud (HHS Office of Inspector General [HHS-OIG], 2024). The Government Accountability Office has maintained Medicaid on its High-Risk List since 2003, citing challenges in overseeing program integrity within the program's decentralized state-federal administrative structure (Government Accountability Office, 2024). These national figures establish both the genuine scale of the fraud problem and the baseline against which any state-specific enforcement intervention must be measured.

The empirical dimensions of the problem in Minnesota are specific, measurable, and consequential. As of March 2026, 1.2 million Minnesotans, including 42% of all children in the state, depend on Medical Assistance for their health insurance coverage; a family of four qualifies with an annual income of $42,759 or less (Minnesota Attorney General's Office,

2026a; Roll Call, 2026). The $243.8 million in deferred payments at issue in Minnesota's federal lawsuit represents approximately 7% of the state's quarterly federal Medicaid reimbursement (Roll Call, 2026). This is not a marginal disruption: a 7% abrupt reduction in quarterly funding, sustained over multiple quarters, would require Minnesota to reduce covered services, reduce provider reimbursement rates, draw down state reserves, or reduce eligibility all of which carry compounding downstream consequences for healthcare access, provider viability, and population health (Minnesota Attorney General's Office, 2026a; Sommers et al., 2017; Dranove et al., 2016). Research on Medicaid expansion's effect on hospital finances (Blavin & Ramos, 2021) provides analogous evidence from the expansion direction, suggesting, though not directly establishing, that coverage contraction produces corresponding financial strain for providers dependent on Medicaid revenue. When individuals lose Medicaid coverage, research on the uninsured population documents a consistent pattern: they forgo preventive and primary care and defer treatment until conditions become acute (McWilliams, 2009; Wilper et al., 2009). This delay-to-crisis pattern generates a predictable cascade of elevated costs, reliance on emergency departments, higher rates of acute hospitalization, greater rehabilitation needs, and higher prescription drug costs for conditions that preventive management would have controlled at far lower expense (McWilliams, 2009). The resulting cost burden is transferred from a coordinated insurance system onto individuals, emergency providers, and ultimately state and federal governments through uncompensated care obligations (Dranove et al., 2016).

Critically, however, Minnesota's 2025 PERM result reflecting the federal government's standardized audit of state Medicaid billing accuracy identified a Minnesota overall projected improper payment rate of 2.2%, compared with a national rolling rate of 6.12% (Centers for Medicare & Medicaid Services, 2025; NPR, 2026b) audit of state Medicaid billing accuracy, identified a Minnesota overall projected improper payment rate of 2.2%, compared with a national rolling rate of 6.12% (Centers for Medicare & Medicaid Services, 2025; NPR, 2026b). CMS explicitly cautions that state-specific PERM rates are not directly comparable across states due to methodological variation, differences in state program structures, confidence intervals, and cycle design (Centers for Medicare & Medicaid Services, 2025). With that comparability caveat acknowledged, Minnesota's PERM result was approximately one-third of the national rolling rate, positioning the state as a strong performer on this federally standardized metric. The administration's own program integrity data, therefore, do not readily support characterizing Minnesota as a priority enforcement target, though the PERM methodology's limitations as a detector of organized fraud, as the administration argues, must also be acknowledged.

Compounding the empirical contradiction is the nature of the most-cited fraud case itself. The Feeding Our Future scheme, which the administration has publicly cited as evidence of Minnesota's systemic governance failure, involved the Child and Adult Care Food Program (CACFP), a federal food security initiative with no programmatic relationship to Medicaid, medical insurance, or healthcare service delivery. CACFP and Medicaid are separate federal programs with different statutory bases, administering agencies, beneficiary categories, and funding mechanisms. Applying Medicaid funding penalties in response to fraud in a separate, non-healthcare federal program raises serious analytical questions about the basis for treating these distinct programs as evidence of a unified compliance failure (U.S. Department of Justice, 2025; Minnesota Star Tribune, 2025). The 14 Medicaid-specific programs identified by federal investigators constitute a distinct evidentiary record that must be assessed on its own merits, and that record, as the PERM data suggest, does not support characterizing Minnesota as a systemically non-compliant Medicaid state, particularly given the program's documented PERM performance relative to the national rolling rate.

As Minnesota's court filing establishes, the February 25 deferral was described as more than 15 times larger than any prior deferral the state had received, and Minnesota argues that categorical deferral across entire service areas has not been used in this manner in the program's history (Minnesota Attorney General's Office, 2026a). Policy scholars examining Medicaid compliance enforcement have consistently documented that effective program integrity governance operates through targeted, claim-specific review, collaborative state-federal investigation, and a graduated administrative process, rather than through emergency, categorical financial withholding that bypasses due process protections (Thompson, 2013; Rosenbaum, 2002). Minnesota's court filing interprets 42 C.F.R. §§ 430.35, 430.40–430.42 as authorizing individual claim-level deferral, not program-wide categorical suspension (Minnesota's interpretation), though the scope of that authority remains to be determined by the courts. The gap between established enforcement practice and the mechanism deployed in Minnesota constitutes a problem of sufficient novelty and gravity to warrant rigorous scholarly investigation.

Purpose Statement

The purpose of this qualitative policy analysis study is to examine the governance, legal, financial, organizational, and population health implications of the 2026 federal Medicaid funding withholding and deferral actions imposed on the State of Minnesota by the Trump Administration. Specifically, the study evaluates how federal enforcement actions ostensibly aimed at addressing fraud in Medicaid-funded programs affect state-level program administration, beneficiary access to services, provider network stability, and the broader cooperative federalism framework that underpins the Medicaid program. The study further examines the programmatic distinction between the Feeding Our Future food security fraud and the Medicaid healthcare programs targeted for funding withholding, and analyzes the policy implications of applying healthcare funding penalties in response to fraud in a programmatically distinct initiative. Using publicly available government documents, federal court filings, policy reports, and peer-reviewed health policy literature, the study analyzes the factors that precipitated the federal funding actions, Minnesota's legal and administrative responses, and the structural implications for Medicaid governance across the United States.

This study is warranted by the immediacy and national significance of the problem: as of the time of this writing, Minnesota's federal lawsuit seeking a temporary restraining order against CMS and HHS remains pending in U.S. District Court for the District of Minnesota, the full financial exposure potentially exceeding $2.26 billion annually remains unresolved, and CMS has explicitly warned that similar funding deferral actions may be extended to other states (STAT News, 2026). The individuals most directly affected, Medicaid beneficiaries relying on home and community-based services, autism therapy, housing stabilization, and personal care assistance, are among the most clinically and socioeconomically vulnerable populations in the United States (MACPAC, 2024; Smith & Iadarola, 2015). This study's findings are therefore of immediate relevance not only to Minnesota policymakers and health system administrators, but to every state Medicaid director, federal health policy official, and healthcare advocate in the country.

Methods

This study employs the qualitative policy analysis methodology of Bardach and Patashnik (2020), whose Eightfold Path framework provides a structured sequence of eight analytical steps: problem definition, evidence assembly, construction of alternatives, criteria selection, projection of outcomes, confronting trade-offs, decision, and communication that together provide a disciplined approach to moving from empirical diagnosis to actionable

prescription. This framework accommodates the integration of multiple evidentiary streams, legal documents, government administrative data, epidemiological literature, and organizational research within a single coherent analytical structure while maintaining the rigor expected for publication in peer-reviewed health policy scholarship.

Document selection followed a systematic inclusion protocol. Primary sources included: federal court filings and official legal complaints (Minnesota Attorney General's Office, 2026a; Minnesota Attorney General's Office, 2025); federal agency regulatory documents (42 C.F.R. §§ 430.35, 430.40–430.42); government reports from CMS, HHS-OIG, GAO, and MACPAC published through March 2026; and executive communications including White House Fact Sheets and official press releases from the Minnesota and U.S. Attorney General. Secondary sources were identified through structured keyword searches of PubMed, Scopus, and Web of Science databases using the search terms: Medicaid cooperative federalism, Medicaid fraud enforcement, home and community-based services funding disruption, conditional spending, Spending Clause, and Medicaid coverage loss, health outcomes. Results were filtered for publication in peer-reviewed journals or authoritative practitioner outlets. Foundational legal and constitutional scholarship from earlier periods (Pennhurst, 1981; South Dakota v. Dole, 1987; NFIB v. Sebelius, 2012) was retained where no more recent equivalent exists, consistent with standard policy analysis practice.

The analytical framework applied across the three analysis subsections, legal, fiscal, and population health, proceeds inductively from the evidentiary record to policy inference. The legal dimension applies established administrative law and constitutional doctrine to the specific enforcement mechanisms at issue. The fiscal dimension models the operational consequences of the withholding using the Medicaid quarterly advance payment structure and provider market research. The population health dimension synthesizes clinical evidence on the consequences of service discontinuity for the specific beneficiary populations targeted by the deferral. All three dimensions are integrated in the Conclusions and Recommendations section.

Limitations of this study merit explicit acknowledgment. As a contemporaneous policy analysis of an ongoing dispute, legal proceedings, administrative actions, and their consequences remain unresolved as of the manuscript's writing date of March 2026. The paper should be read as a prospective policy analysis rather than an ex-post evaluation of documented outcomes. The study does not employ primary data collection; all empirical claims rely on secondary sources. Where evidentiary uncertainty exists, particularly regarding the estimated versus adjudicated scale of Medicaid-specific fraud, and regarding the comparability of PERM rates across states, this uncertainty is explicitly noted. Several claims in this paper derive primarily from litigation filings and contemporaneous news reporting rather than adjudicated findings or peer-reviewed scholarship; these are identified as such. The study further acknowledges that its analytical conclusions represent reasoned judgments based on the available evidence, which readers are encouraged to assess independently.

Significance of the Study

This study contributes to scholarly literature and to the world of policy practice across three substantive and consequential dimensions.

First, the study establishes a scholarly baseline for understanding the health system consequences of a highly contested form of executive-branch Medicaid funding withholding and its implications for vulnerable populations. Total federal and state Medicaid expenditures approached $900 billion in fiscal year 2023, reaching approximately $871 billion, with the federal government's share exceeding half of that amount (Centers

for Medicare & Medicaid Services, 2024). Enrollment, following the post-pandemic unwinding that began in April 2023, is estimated at approximately 80 to 85 million individuals (Centers for Medicare & Medicaid Services, 2024; Kaiser Family Foundation, 2024). In Minnesota, the program finances care for 1.2 million residents; an abrupt 7% reduction in quarterly funding would, absent judicial relief, require the state to significantly reduce healthcare services for low-income families (Minnesota Attorney General's Office, 2026a; Sommers et al., 2017). Research on prior Medicaid program contractions demonstrates that even temporary coverage disruptions produce measurable adverse outcomes, including increased emergency department utilization, delayed diagnosis of serious conditions, and deterioration in the management of chronic disease (Sommers et al., 2017; Antonisse et al., 2019). When Medicaid coverage is disrupted, research on the uninsured population shows that individuals tend to defer treatment until conditions escalate, generating higher costs across the care continuum from emergency room visits and acute hospitalization through post-acute rehabilitation and prescription drug management costs that ultimately fall on individuals, families, state budgets, and federal uncompensated care programs (McWilliams, 2009; Wilper et al., 2009; Dranove et al., 2016). Services at immediate risk in Minnesota home and community-based supports, personal care assistance, autism therapy, and housing stabilization serve populations for whom service continuity is a direct determinant of clinical outcome and, in some cases, survival (Ng et al., 2015; Smith & Iadarola, 2015). The Autism Society of Minnesota documented deaths and homelessness associated with the funding uncertainty (NPR, 2026b), consistent with what the literature predicts from abrupt service system disruption.

Second, this study contributes to urgent debates in health policy, administrative law, and Spending Clause jurisprudence. Federal oversight mechanisms are designed to protect taxpayer resources; however, the scale and procedural implementation of enforcement actions must be balanced against the need to maintain stable healthcare services for beneficiaries (HHS Office of Inspector General, 2024). The Supreme Court's ruling in National Federation of Independent Business v. Sebelius (2012) established constitutional limits on Congress's power to impose coercive conditions on states' receipt of Medicaid funds. Minnesota's lawsuit invokes this precedent, arguing that the Trump administration's categorical deferral lacks statutory authority, fails the 'unambiguous conditions' requirement of Pennhurst State School and Hospital v. Halderman (1981), and violates Fifth Amendment due process guarantees (Minnesota Attorney General's Office, 2026a; Becker's Payer Issues, 2026). Legal scholars and health policy experts have described the deployment of deferral in this manner as constitutionally contestable (NPR, 2026b; Roll Call, 2026). The outcome of this litigation may establish new legal boundaries on executive branch authority to condition Medicaid reimbursements outside the statutory administrative hearing process. This paper provides the scholarly community with a documented, analytical foundation for that legal and policy inquiry.

Third, this study contributes to the growing body of research on health equity, racialized policy narratives, and the targeting of immigrant communities through the administration of public health programs. The Trump Administration's Medicaid funding actions occurred in temporal proximity to Operation Metro Surge, an immigration enforcement operation targeting Minneapolis's Somali American community, and were accompanied by presidential statements at the February 2026 State of the Union address characterizing members of that community in derogatory and criminalizing terms (PBS NewsHour, 2026; CNN, 2026). Whether these two actions reflect coordinated targeting, as Minnesota's complaint implies, or are merely a temporal coincidence remains to be determined by the courts; available public reporting documents temporal overlap, community fear, and a plausible disparate impact (PBS NewsHour, 2026). Scholarship on structural racism in public policy (Melton-Fant, 2022) and on health justice and power

(Michener, 2022) provides broader frameworks for understanding how enforcement environments can impose disproportionate burdens on politically targeted or stigmatized communities, even in the absence of demonstrable coordination. Hatzenbuehler et al. (2017) demonstrated that stigmatizing, immigration-targeted public policy produced measurable mental health deterioration among affected populations, including increased anxiety, depression, and avoidance of healthcare-seeking behavior. The Minnesota case involving temporal overlap between immigration enforcement and Medicaid financial pressure constitutes a policy scenario whose health equity dimensions merit rigorous scholarly examination.

Literature Review

The literature review that follows synthesizes scholarship from six intersecting domains, each of which provides essential analytical scaffolding for the study's central arguments. The first subsection traces the architecture and constitutional norms of Medicaid as a cooperative federalism program. The second examines the national Medicaid fraud and program integrity literature, with particular attention to the programmatic distinction between the Feeding Our Future food security fraud and Medicaid healthcare programs. The third review established policy and administrative law frameworks governing federal responses to Medicaid noncompliance. The fourth documents the organizational and health system consequences of Medicaid funding disruptions. The fifth traces cooperative federalism under stress, including health equity dimensions. The sixth reviews innovative approaches to program integrity that offer evidence-based alternatives to punitive financial withholding.

Medicaid as Cooperative Federalism: Architecture, Norms, and Historical Evolution

Medicaid is frequently described as a quintessential model of cooperative federalism in which the federal and state governments share joint responsibility for financing and administering healthcare services for low-income populations (Rocco et al., 2020). States maintain significant discretion in designing program benefits, setting provider reimbursement rates, and structuring service delivery systems, while the federal government establishes minimum eligibility standards and provides financial support through the Federal Medical Assistance Percentage (FMAP) a formula that provides poorer states with a higher federal match, ranging from 50% to approximately 77% of qualifying expenditures for standard Medicaid program costs, with higher rates applicable to Children's Health Insurance Program (CHIP) and certain enhanced federal provisions (MACPAC, 2025a). For Minnesota, the federal government pays more than half the program's total costs, making federal reimbursements central to the state's healthcare financing architecture (Roll Call, 2026).

This decentralized structure enables states to tailor healthcare programs to local demographic and economic conditions, but it also creates tensions when federal authorities intervene to address perceived deficiencies in the programs. Scholars have documented that federal enforcement actions can challenge the constitutional and administrative balance of authority between state governments and federal regulators, particularly when enforcement measures involve the withholding of federal funds (42 C.F.R. §§ 430.35, 430.40–430.42, 2025; Thompson, 2013; Posner, 2007). Thompson (2013) shows that Medicaid governance has often operated through executive-branch bargaining, including waiver-based negotiation, rather than purely command-and-control federalism. The constitutional framework for federal conditional spending is rooted in four Supreme Court precedents. In Pennhurst State School and Hospital v. Halderman (1981), the Court articulated the 'contract' theory of Spending Clause programs, holding that conditions attached to federal

grants must be unambiguous so that states can knowingly accept them. In South Dakota v. Dole (1987), the Court upheld conditional spending while noting that conditions must bear a relationship to the federal interest. In Sabri v. United States (2004), the Court affirmed broad congressional authority over federal fund conditions. Most significantly, in National Federation of Independent Business v. Sebelius (2012), the Court held that Congress could not threaten to withdraw all existing Medicaid funding as a condition for acceptance of the Affordable Care Act's (ACA) Medicaid expansion, a ruling widely interpreted as establishing constitutional limits on the coercive use of Medicaid financing leverage (Pasachoff, 2012). Minnesota's federal lawsuit directly invokes these constraints, arguing that the administration's categorical deferral is 'ultra vires' beyond the authority of executive agencies acting without explicit statutory authorization (Minnesota Attorney General's Office, 2026a).

Medicaid Fraud and Program Integrity: National Context and Measurement Challenges

Fraud and improper payments constitute a persistent and empirically documented challenge within public healthcare programs. The HHS OIG has reported that improper payments within Medicaid totaled approximately $86.5 billion in fiscal year 2023, representing a national improper payment rate of approximately 5.1%, including billing errors, documentation deficiencies, and intentional fraud (HHS Office of Inspector General, 2024). The Government Accountability Office (GAO) has maintained Medicaid on its High-Risk List since 2003, citing structural challenges in oversight of program integrity within a decentralized state-federal delivery system with hundreds of thousands of individual provider participants (Government Accountability Office, 2024). Despite decades of federal and state investment in fraud detection, detecting and preventing fraud in large, complex healthcare systems remains inherently difficult, given the volume of claims, the diversity of service types, and the fragmentation of administrative authority (Government Accountability Office, 2024; Government Accountability Office, 2023; Sparrow, 2019).

In Minnesota, the fraud problem has specific, documented, and contested empirical contours. The Feeding Our Future case, involving approximately $250 million in fraudulent claims, is the largest COVID-era fraud scheme charged in U.S. history, with more than 90 individuals charged and more than 60 convicted by early 2026 (U.S. Department of Justice, 2025). It is analytically essential, however, to establish that this fraud occurred within the Child and Adult Care Food Program (CACFP), a federal food security program administered by the U.S. Department of Agriculture and entirely distinct from Medicaid. CACFP and Medicaid are separate federal programs with different statutory bases, administering agencies, beneficiary categories, and funding mechanisms. Citing food security program fraud as evidence of Medicaid governance failure conflates distinct governmental functions and misapplies the evidentiary record (U.S. Department of Justice, 2025; Minnesota Star Tribune, 2025; Minnesota Reformer, 2025). Separately, federal investigators identified billing fraud in 14 Minnesota-administered Medicaid programs, including Housing Stabilization Services and EIDBI autism therapy (Minnesota Reformer, 2025; Minnesota Attorney General's Office, 2025), which constitute legitimate and distinct Medicaid program integrity concerns that require assessment on their own evidentiary merits. A former Assistant U.S. Attorney estimated in December 2025 that fraud across these 14 Medicaid programs could total up to $9 billion since 2018, though he acknowledged it was an estimate, not a judicially proven figure (Minnesota Reformer, 2025). The Minnesota Star Tribune's independent review of court records placed documented, charged, and adjudicated fraud at approximately $218 million as of late 2025, a meaningful sum but substantially below the multi-billion-dollar claims made in

presidential statements (Minnesota Star Tribune, 2025). This evidentiary gap between estimated potential fraud and documented, proven fraud is central to the scholarly and policy dispute over the administration's funding actions. Medicaid fraud measurement is inherently challenging: the CMS PERM methodology produces aggregate improper payment rates from statistical sampling; it does not constitute forensic fraud detection; and it cannot distinguish among billing errors, documentation lapses, and intentional fraudulent conduct (Government Accountability Office, 2023). Minnesota's 2025 PERM finding of approximately 2.2% approximately one-third of the national rolling rate of 6.12% places Minnesota's billing accuracy as measured by this methodology among the stronger-performing state programs on this federally standardized metric, though CMS explicitly cautions that state-specific PERM rates are not directly comparable across states due to methodological variation, state program structure differences, and confidence intervals (Centers for Medicare & Medicaid Services, 2025; NPR, 2026b). The administration's argument that PERM may undercount organized, program-specific fraud is methodologically defensible in principle, but it does not, by itself, satisfy the evidentiary standard required by 42 CFR Part 430's administrative process before withholding may occur.

Policy Responses to Medicaid Fraud: Established Practice and Emerging Departures

Policy responses to Medicaid fraud have historically operated through well-established, collaborative federal-state mechanisms. Standard enforcement practice involves joint federal-state investigations targeting specific providers, post-payment audits, corrective action plans, provider exclusion, and in extreme cases, civil monetary penalties all conducted through a graduated administrative process under 42 CFR Part 430 that provides notice, an opportunity for the state to respond, and a formal finding before any funds can be withheld (Rosenbaum & Westmoreland, 2012; Thompson, 2013; 42 C.F.R. §§ 430.35, 430.40–430.42, 2025). As Jocelyn Guyer of Manatt Health observed, withholding federal funds across broad service categories is rare, procedurally complex, and raises serious concerns regarding due process and administrative authority (NPR, 2026b). The standard practitioner consensus is that prepayment review verification of claims before disbursement is more cost-effective and less disruptive than post-payment recovery efforts or categorical funding freezes (HHS OIG, 2024). Minnesota's complaint interprets 42 CFR § 430.40 as authorizing individual, claim-level payment holds, not categorical, statewide program suspensions, though the scope of this authority under the statute remains a question for judicial resolution (Minnesota Attorney General's Office, 2026a).

The Minnesota Medicaid funding dispute, therefore, represents a departure from established practice. By applying a large-scale funding deferral simultaneously to multiple program areas across an entire state a mechanism Minnesota's court filing characterizes as 'more than 15 times larger than any past deferral' the state had been issued, and as having 'never been used to categorically deny funds to a state across entire service areas' the federal government introduced an enforcement mechanism without clear administrative precedent (Minnesota Attorney General's Office, 2026a). Thompson (2013), writing on the evolution of executive federalism, documented that even aggressive federal administrations historically pursued compliance through negotiated processes, but that the trend toward executive federalism creates conditions under which unilateral financial pressure becomes an available instrument of intergovernmental policy. Understanding the practical stakes of this enforcement posture requires examining its organizational and clinical consequences for the health systems and populations it disrupts.

Organizational and Health System Impacts of Medicaid Funding Disruptions

Funding disruptions have well-documented consequences for healthcare organizations and for the populations they serve. Research on Medicaid funding reductions has documented provider reimbursement challenges, workforce shortages, program closures, and reduced service availability (Government Accountability Office, 2018; MACPAC, 2025a), particularly for home- and community-based services that rely heavily on Medicaid as their primary or sole revenue source (Decker, 2012; MACPAC, 2025b; MACPAC, 2021; Zuckerman et al., 2009). In the home and community-based services market, even brief payment interruptions can cause provider closures, because these organizations typically operate on thin margins with minimal reserve capital. Once closed, these providers are extremely difficult to replace; certification, credentialing, workforce training, and community trust all take years to rebuild (Government Accountability Office, 2018; MACPAC, 2023; Ng et al., 2015).

In Minnesota, the services targeted by the federal deferral, personal care assistance, residential treatment, EIDBI autism therapy, housing stabilization, and nonemergency medical transportation, serve populations with high clinical acuity and complex social needs. For children with autism spectrum disorders, continuity of EIDBI is directly linked to developmental trajectory: abrupt service disruption is associated with regression of previously acquired skills and deterioration of family functioning (Smith & Iadarola, 2015). For adults with serious mental illness relying on intensive residential treatment and personal care assistance, service discontinuity is associated with psychiatric hospitalization, a far more costly intervention that, in the acute phase, exposes both individuals and payers to preventable harm (Gilmer et al., 2004; Dieterich et al., 2017; Coldwell & Bender, 2007). Housing instability and health exist in a robust bidirectional relationship: Kushel et al. (2006) demonstrated that housing insecurity worsens chronic disease management, mental health, and healthcare utilization, while health instability contributes to housing instability. Disrupting Medicaid-funded housing stabilization services for vulnerable populations, therefore, generates compounding health and social harms that ripple far beyond the immediate funding reduction. These individual-level and organizational-level harms are the downstream consequences of structural shifts in the federal-state governance relationship that the cooperative federalism literature has begun to track.

Cooperative Federalism Under Stress: Emerging Dynamics and Health Equity Implications

The broader trend in federal-state Medicaid relations has been toward increasing federal assertiveness in program conditions, particularly during Republican administrations (Rocco et al., 2020). The Trump Administration's first term (2017-2021) introduced unprecedented use of CMS waiver authority to approve Medicaid work requirements which federal courts subsequently struck down in multiple jurisdictions on the grounds that they failed to advance Medicaid's core healthcare coverage objective and experimental payment models that shifted financial risk to states (Sommers et al., 2019; Gresham v. Azar, 2020). The administration's second term has intensified this posture, moving from negotiated regulatory pressure to unilateral financial withholding. Thompson (2013), documenting the rise of executive federalism, showed that escalating federal assertiveness in intergovernmental programs tends to generate reciprocal institutional friction that complicates collaborative governance over time, a dynamic now manifest in the Minnesota litigation.

The political and demographic dimensions of the Minnesota case introduce health equity concerns that the cooperative federalism literature has not previously examined in the Medicaid context. The administration's Medicaid funding actions occurred in temporal

proximity to Operation Metro Surge, an immigration enforcement operation targeting Minneapolis's Somali American community. Public reporting documents community fear, high no-show rates for essential services, and broad social disruption in the weeks surrounding both operations (PBS NewsHour, 2026). Whether these two federal actions reflect deliberate coordination as Minnesota's complaint implies and as public statements at the February 2026 State of the Union appeared to signal, or represent temporal overlap generating plausible disparate impact, remains a question the courts will address (PBS NewsHour, 2026; CNN, 2026). The community whose ties to the documented fraud cases are contested and heavily disputed in the evidentiary record (Minnesota Star Tribune, 2025) faced simultaneous pressures from uncertainty around immigration enforcement and disruptions to Medicaid services. Melton-Fant (2022) and Michener (2022) provide conceptual frameworks for analyzing how policy and enforcement environments can generate inequitable burdens under conditions of structural disadvantage. Hatzenbuehler et al. (2017) demonstrated that stigmatizing public policy produced measurable mental health deterioration in affected communities, including avoidance of healthcare-seeking behavior. Vargas et al. (2017) found that anti-immigrant political rhetoric was associated with increased psychological distress among immigrant populations, a finding plausibly applicable to Minnesota's context.

Innovative and Emerging Approaches to Medicaid Program Integrity

The literature on Medicaid program integrity governance identifies several evidence-informed approaches that effectively balance fraud detection with preservation of legitimate access. Prepayment analytics, including machine-learning-based anomaly detection applied to claims prior to reimbursement, have demonstrated significant effectiveness in identifying suspicious billing patterns without disrupting payment flows to legitimate providers (HHS Office of Inspector General, 2024; Government Accountability Office, 2023). State-level governance innovations, particularly the establishment of independent Offices of Inspector General with dedicated authority to investigate Medicaid fraud, have been identified as structural improvements that strengthen program integrity without threatening beneficiary access (National Conference of State Legislatures [NCSL], 2023). Cross-agency and cross-state data sharing has shown considerable promise in addressing the 'fraud tourism' dynamic documented in Minnesota, where out-of-state actors exploited program vulnerabilities by operating across state boundaries, thereby fragmenting administrative surveillance (Minnesota Reformer, 2025). Minnesota's own deployment of an Optum-led audit identified more than $52.3 million in direct recoveries from policy violations across high-risk services prior to any federal withholding action (Becker's Payer Issues, 2026), demonstrating the effectiveness of collaborative, analytics-driven approaches. Taken together, the six bodies of literature reviewed above establish the theoretical and empirical framework applied in the Analysis section that follows.

Analysis

Legal Dimension: Constitutional and Administrative Law Framework

Minnesota's federal lawsuit, filed on March 2, 2026, articulates four distinct legal theories under which the administration's actions are alleged to be unlawful (Minnesota Attorney General's Office, 2026a; Becker's Payer Issues, 2026). First, the Fifth Amendment due process theory holds that the government may not withhold the $243.8 million at issue, the amount specified in Minnesota's filed complaint, reflecting adjustments from the initially announced $259.5 million deferral, without proving noncompliance through a hearing with the procedural protections mandated by 42 CFR Part 430. Second, the Administrative

Procedure Act theory argues that categorical deferral across entire service areas is 'arbitrary and capricious' within the meaning of 5 U.S.C. § 706. Third, the Spending Clause theory argues that the conditions imposed were not 'set out unambiguously' when Minnesota accepted Medicaid funds, violating the clear-statement rule of Pennhurst (1981). Fourth, the ultra vires theory argues that CMS lacks statutory authority to conduct a categorical statewide deferral of this magnitude; per Minnesota's complaint, the regulation authorizes individual claim-level holds (Minnesota's interpretation), not program-wide payment suspension, though the courts have yet to adjudicate this interpretation (Minnesota Attorney General's Office, 2026a). Each of these four theories presents independent grounds for judicial relief; the ultra vires theory is particularly significant nationally because its acceptance would constrain the administration's capacity to replicate this approach against other states.

The political context is relevant to legal analysis, though it must be characterized with appropriate precision: Vice President Vance confirmed the administration's intent to withhold funds and expressed confidence in its authority but declined to identify the specific statutory basis for the deferral mechanism deployed (CNN, 2026). While this public statement does not prove the absence of internal legal analysis, the administration's failure to articulate a statutory predicate in any public communication despite the unprecedented scale of the action is consistent with Minnesota's ultra vires argument that no adequate statutory authority exists and may be a factor courts consider in Administrative Procedure Act (APA) arbitrary-and-capricious review.

The Federal Government's Enforcement Rationale: The Strongest Case

Scholarly integrity requires that the federal government's enforcement rationale be examined in its most analytically rigorous form before it is evaluated. The administration's strongest case rests on four interconnected arguments. First, the federal government bears a statutory responsibility under 42 U.S.C. § 1396b(i) to ensure that Medicaid matching payments are made only for services properly provided and properly documented; where documentation is demonstrably insufficient, the CMS deferral mechanism (42 CFR § 430.40) exists to pause payment pending documentation review, and the administration may argue that the categorical scale of the deferral reflects the categorical scale of the documentation insufficiency identified. Second, the scale of estimated fraud, the former Assistant U.S. Attorney's estimate of up to $9 billion across 14 programs since 2018 (Minnesota Reformer, 2025), if accurate, would represent one of the most significant state-level Medicaid integrity failures in the program's history. Third, political accountability to federal taxpayers is a legitimate governance interest: continuing to fund service categories identified as high-fraud-risk, absent interruption, may be characterized as disregard for the fiduciary obligation to protect federal appropriations. Fourth, the administration may argue that Minnesota's PERM rate of approximately 2.2% reflects the PERM methodology's limitations as a detection tool for systematic, organized fraud rather than the absence of fraud.

These arguments are not trivial, and a credible policy analysis must engage them rather than dismiss them. However, each fails under scrutiny when applied to the specific mechanism deployed. Minnesota's complaint, which the courts have yet to rule on, characterizes the deferral authority under 42 CFR § 430.40 as designed and historically used for individual, claim-level holds, not for categorical statewide suspensions; this is an interpretive question for the courts. The $9 billion fraud estimate is explicitly provisional and unproven; the adjudicated fraud figure is $218 million (Minnesota Star Tribune, 2025), making a $243.8 million quarterly deferral difficult to calibrate against the documented record. The taxpayer accountability argument, if taken to its logical conclusion, would

permit the suspension of statewide Medicaid funding wherever fraud allegations exist, effectively eliminating the due process protections established by Spending Clause jurisprudence. The PERM methodology limitation argument, while defensible in principle, cannot substitute for the standardized performance measure CMS has established; using the methodology's limitations as a post hoc justification for withholding does not meet the evidentiary standard that 42 CFR Part 430 requires before funds are withheld. Furthermore, the Feeding Our Future fraud, the administration's most publicly prominent exhibit, occurred in a food security program with no programmatic relationship to Medicaid, which weakens rather than supports its use as evidence of Medicaid noncompliance, regardless of the scheme's scale.

Fiscal Dimension: State Budget and Provider Solvency Implications

The fiscal mechanics of Medicaid matching fund withholding significantly amplify the disruption beyond the nominal amount withheld. Under the quarterly advance payment structure, Minnesota Medicaid Director John Connolly explained that the withholding structure meant the state effectively owed the federal government $260 million for the final quarter of 2025 while simultaneously not receiving reimbursement for the current quarter, a compounding double cash-flow shock (PBS NewsHour, 2026). A 7% reduction in quarterly Medicaid revenue, if sustained, would require Minnesota to either draw down reserves, cut payments to providers, reduce covered services, or reduce eligibility. Each of these options carries downstream consequences: reduced provider payments risk provider exits; reduced services deprive beneficiaries of needed care; and reduced eligibility exposes newly uninsured individuals to the health consequences of coverage loss documented in the health outcomes literature (Sommers et al., 2017).

Provider network stability is particularly fragile in the home and community-based services sector targeted by the federal actions. The small, community-based organizations that deliver personal care assistance, housing support, and nonemergency medical transportation typically operate on thin margins, are heavily dependent on Medicaid, and have minimal reserve capital. Research on Home and Community-Based Services (HCBS) provider market dynamics has consistently found that payment disruptions, even of short duration, can cause permanent capacity losses that take years to rebuild (MACPAC, 2021; Government Accountability Office, 2018; Ng et al., 2015). The simultaneous closure of multiple HCBS providers would leave Medicaid-dependent individuals without access to services that no alternative program or payer can readily substitute.

The cost consequences of coverage loss extend far beyond the immediate funding reduction. When individuals lose Medicaid coverage or face de facto service termination due to provider closures, research on the uninsured documents a consistent delay-to-crisis pattern: individuals forgo preventive and primary care, deferring treatment until conditions deteriorate to an emergency status (McWilliams, 2009; Wilper et al., 2009). This generates significantly higher per-episode costs across the care continuum. Emergency department utilization increases, hospitalization length of stay rises for conditions that earlier intervention would have controlled, rehabilitation and post-acute care costs increase, and prescription drug costs for chronic conditions managed without regular clinical oversight accumulate (McWilliams, 2009). These elevated costs are absorbed by emergency providers as uncompensated care, shifted to state and county indigent care programs, or deferred to later, more expensive Medicaid encounters when individuals re-enroll (Dranove et al., 2016). The net effect is that short-term withholding of Medicaid funding is likely to generate higher total healthcare costs for individuals, the state, and the federal government than maintaining coverage while conducting targeted program integrity investigations through established administrative channels.

Population Health Dimension: Beneficiary Impact and Equity Implications

The 1.2 million Minnesotans enrolled in Medicaid represent a heterogeneous population whose common characteristic is the absence of a private-market alternative for the coverage they receive. The funding withholding actions threaten healthcare access for low-income Minnesotans who depend on Medical Assistance as their primary or sole source of health coverage. The targeted service areas, autism therapy, personal care assistance, housing stabilization, residential treatment, and nonemergency medical transportation, serve individuals with the most intense needs and greatest clinical vulnerability. For children with autism, service continuity is a determinant of developmental trajectory (Smith & Iadarola, 2015). For adults with serious mental illness, continuity of community-based supports is a primary determinant of whether they require psychiatric hospitalization, a far more costly and traumatic intervention (Dieterich et al., 2017; Coldwell & Bender, 2007; Gilmer et al., 2004). The Autism Society of Minnesota's documentation of deaths and homelessness attributable to the funding uncertainty (NPR, 2026b), while anecdotal, is consistent with the outcomes the peer-reviewed literature predicts from abrupt, large-scale HCBS disruption.

The population health consequences extend beyond service disruptions among existing enrollees. The chilling effect of funding uncertainty on enrollment, provider participation, and healthcare-seeking behavior compounds the direct harm. Research on Medicaid policy instability demonstrates that coverage uncertainty depresses both enrollment and utilization among eligible populations, particularly in communities with elevated institutional distrust (Hatzenbuehler et al., 2017; Vargas et al., 2017). The temporal proximity of immigration enforcement operations and Medicaid financial pressure affecting communities already subject to stigmatizing political rhetoric creates conditions under which healthcare-seeking behavior is likely suppressed, not only among those directly affected by funding changes, but among all community members who fear institutional contact (Hatzenbuehler et al., 2017; Vargas et al., 2017). The public health consequences of this fear dynamic are real and measurable, as documented in the health equity literature, and are likely to fall disproportionately on the most vulnerable.

Conclusions and Recommendations

Conclusions

This policy analysis has established that the Trump Administration's Medicaid funding withholding and deferral actions against Minnesota between January and March 2026 are as described by Minnesota's filed legal complaint and as analyzed through the applicable cooperative federalism and administrative law scholarship empirically difficult to justify given the state's independently measured program integrity performance, procedurally highly contested in their categorical deployment of a mechanism Minnesota argues was designed for individual claim-level auditing (Minnesota's interpretation), legally contestable on multiple constitutional and administrative law grounds, organizationally destabilizing for a provider network serving the most clinically vulnerable populations in the state, and projected to cause measurable harm to the 1.2 million Minnesotans who depend on Medical Assistance for their healthcare. The administration's reliance on the Feeding Our Future case as evidence of Medicaid program failure lacks an adequate programmatic basis: that fraud occurred in a federal food security program with no programmatic relationship to Medicaid, and its invocation as justification for healthcare funding cuts reflects a conflation of distinct federal programs that has not been adequately explained. Applying healthcare funding penalties in response to food assistance fraud risks converting a manageable program integrity challenge into a healthcare access crisis in a

state that, on federal program integrity metrics, performs substantially better than the national rolling average.

The Minnesota case represents a significant episode in the evolution of American cooperative federalism, in which the executive branch has moved at least in this instance, from the historically consistent model of collaborative state-federal fraud enforcement to the use of emergency financial withholding as a first-resort instrument. The scholarly and legal record developed in this paper provides the evidence base for understanding both the immediate consequences of these actions and their long-term implications for national Medicaid governance. As CMS has warned that similar actions may be extended to other states (STAT News, 2026), the analytical findings presented here have generalizability beyond Minnesota. The legal, fiscal, and population health dimensions of this dispute converge on a consistent analytical judgment: the withholding actions as implemented are difficult to reconcile with established procedural norms, and their human costs are borne by populations who had no role in the fraud the actions purport to remedy.

Recommendations

Based on the evidence reviewed in this analysis, the following ten policy recommendations are offered for policymakers, program administrators, state Medicaid directors, healthcare providers, advocates, and scholars. These recommendations are mutually reinforcing; their combined implementation would establish the structural safeguards, analytical tools, and constitutional guardrails necessary to ensure that enforcement of Medicaid program integrity operates as a governance instrument calibrated to evidence, bound by due process, and accountable to the populations it serves.

Recommendation 1: Codify Due Process Protections for Federal Medicaid Funding Withholding

Congress should amend Title XIX of the Social Security Act to require that any federal withholding or deferral of Medicaid matching funds above a defined threshold, for example, 1% of a state's quarterly federal reimbursement, be preceded by a formal administrative hearing, a written finding of specific noncompliance, and a minimum 90-day cure period. Statutory codification would eliminate the procedural ambiguity at issue in the Minnesota action and establish a clear, legally defensible process applicable to all future enforcement actions.

Recommendation 2: Establish Clear and Transparent Federal Criteria for Funding Deferrals

Federal agencies should develop and publish explicit, standardized procedural criteria governing the circumstances under which Medicaid payment deferrals may be imposed on states, the evidentiary standards that must be met, the maximum scope of deferral action, and the process by which states may seek expedited administrative review. Transparent criteria would provide predictability for state program administrators and reduce the potential for enforcement actions that appear arbitrary or politically motivated (Thompson, 2013; Posner, 2007; 42 C.F.R. §§ 430.35, 430.40–430.42, 2025).

Recommendation 3: Prioritize Prepayment Analytics as the Primary Fraud Control Mechanism

Federal and state governments should accelerate investment in AI-enabled prepayment review and machine-learning anomaly detection as the primary fraud control strategy, displacing post-payment recovery and categorical funding freezes as first-resort tools. CMS data demonstrate that prepayment review is more cost-effective, more precisely targeted at fraudulent claims, and less disruptive to legitimate providers than categorical withholding.

Minnesota's Optum audit, which identified $52.3 million in recoveries prior to any federal action (Becker's Payer Issues, 2026), demonstrates the efficacy of this approach.

Recommendation 4: Mandate Independent Offices of Inspector General in State Medicaid Programs

CMS should use the Medicaid State Plan process to establish a minimum federal requirement that states operating Medicaid programs above a defined expenditure threshold maintain an independent Office of the Inspector General with dedicated Medicaid fraud investigation authority, adequate staffing, and data-sharing agreements with HHS-OIG. This structural requirement addresses the root cause of program vulnerability, inadequate independent state oversight capacity, without the disruptive and legally contestable mechanism of unilateral financial withholding (NCSL, 2023).

Recommendation 5: Strengthen Federal-State Collaboration in Fraud Investigations

Joint enforcement strategies should prioritize coordinated federal-state investigations, cooperative technical assistance, and graduated corrective action plans before any financial withholding is considered. The historical record demonstrates that collaborative approaches are more effective than adversarial financial leverage for achieving durable improvements in program integrity (Rocco et al., 2020; Thompson, 2013; Holahan & Weil, 2007). Congress should mandate that CMS exhaust collaborative enforcement options before initiating any state-wide funding deferral.

Recommendation 6: Develop a Standardized Federal Medicaid Fraud Response Protocol

CMS and HHS-OIG should jointly develop and publish a Medicaid Fraud Response Protocol specifying a required sequence: (1) state notification and technical assistance; (2) joint investigation; (3) targeted prepayment review; (4) administrative hearing; (5) corrective action agreement; and (6) withholding only as a last resort after failure of steps one through five. This protocol modelled on existing environmental enforcement frameworks would establish procedural fairness, a legally defensible administrative record, and predictability for state administrators.

Recommendation 7: Develop Contingency Funding Mechanisms to Protect Vulnerable Beneficiaries

Congress should establish a federal Medicaid Continuity Reserve Fund, financed through a modest set-aside from FMAP allocations, to maintain continuity of services for HCBS-dependent populations during periods of federal-state funding disputes. The populations served by these programs cannot safely tolerate the service disruptions caused by funding controversies; coverage interruptions for HCBS-reliant individuals generate emergency care cascades, hospitalizations, and, in the most severe cases, deaths and homelessness outcomes that impose far higher costs on the healthcare system than the coverage continuity they replace (McWilliams, 2009; Gilmer et al., 2004). Structural analogues exist: the Federal Emergency Management Agency's Public Assistance program, the COVID-19 enhanced FMAP provisions (Section 6008, Families First Coronavirus Response Act), and the Medicaid Disaster Relief State Plan Amendment process each provide precedents for expedited federal-state fiscal stabilization mechanisms. A Medicaid Continuity Reserve Fund modelled on these precedents would insulate the most clinically vulnerable beneficiaries from the fiscal consequences of intergovernmental disputes that they did not create and cannot remedy.

Recommendation 8: Mandate Separation of Immigration Enforcement from Medicaid Program Administration

Federal law should explicitly prohibit the joint deployment of immigration enforcement operations and the leverage of Medicaid funding against the same geographic or

demographic target. The temporal proximity of Operation Metro Surge and the withholding of Medicaid funding in Minnesota, affecting the same vulnerable community, creates conditions in which the credibility of the fraud-enforcement rationale is undermined by the appearance of coordinated targeting, regardless of whether coordination can be established as a legal matter. Separation of these governmental functions would protect program integrity from the perception of political motivation and is consistent with both legal and ethical principles of sound public administration.

Recommendation 9: Expand Cross-State Medicaid Program Integrity Data Sharing Compacts

States should develop multi-state compacts to enhance Medicaid program integrity by enabling real-time sharing of fraud-detection data, provider credentialing information, and investigative intelligence across state lines. Such compacts would directly address the 'fraud tourism' dynamic identified in the Minnesota investigations, in which out-of-state actors exploited program vulnerabilities by operating across administrative boundaries (Minnesota Reformer, 2025). The structural foundation for such compacts is well established: the Driver License Compact (45 states), the Emergency Management Assistance Compact (50 states + DC), and the Psychology Interjurisdictional Compact provide working precedents for multi-state mutual-assistance frameworks (Council of State Governments, 2023).

Recommendation 10: Commission Longitudinal Research on the Health Impacts of Funding Withholding

Federal health research agencies, including the Agency for Healthcare Research and Quality (AHRQ) and the National Institutes of Health (NIH), should commission prospective longitudinal research to examine healthcare utilization, clinical outcomes, provider networks, and population health consequences of the withholding of Minnesota Medicaid funding as it unfolds. The findings would provide the evidence base necessary to inform future enforcement policy and establish the true human and fiscal costs of deploying Medicaid funding leverage as a governance instrument. Academic and policy research institutions should conduct independent evaluations of the long-term impacts of aggressive enforcement strategies on healthcare access, system stability, and health equity (Sommers et al., 2017; Antonisse et al., 2019).

In conclusion, the Minnesota Medicaid funding dispute of 2026 illustrates structural vulnerabilities in cooperative federalism when federal agencies deploy highly contested financial tools, as the evidentiary basis, procedural grounding, and legal authority are all subject to active litigation. The program integrity challenge in Minnesota is real, and the fraud documented in federal prosecutions is serious and consequential. But the response mounted by the Trump Administration was categorical, state-wide deferral contested on multiple legal grounds, imposed on a state whose independently measured program integrity performance substantially exceeds national averages, and partially justified by invoking fraud in a food security program that has no relationship to Medicaid raises substantial questions of proportionality, procedure, and law that the courts and Congress must now address. The ten recommendations advanced in this paper provide a principled, evidence-based pathway toward Medicaid governance that effectively combats fraud while preserving the constitutional norms, health equity commitments, and population health protections on which the Medicaid program's legitimacy ultimately rests.

Authors' Note

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Conflicts of Interest

Bernadette Mualumatweh Foh is employed as a healthcare executive at a Federally Qualified Health Center in Minnesota that receives Medicaid funding and may be directly affected by the funding deferral actions analyzed in this manuscript. This potential financial interest is disclosed in accordance with the journal's editorial policy. Alieu Stephen Kafoe declares no competing interests.

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