Feds' Mixed Cues On Medicaid Fraud Signal States To Step Up

By **Kenneth Levine** (August 4, 2026)


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Over about six weeks this spring and summer, the federal government delivered four distinct and mutually inconsistent messages regarding Medicaid fraud enforcement.

Whatever the messages reveal about federal policy, their practical import for state attorneys general is the same: States, which co-fund Medicaid with the federal government but administer it themselves, should expand their own capacity to investigate and prosecute Medicaid fraud.

Four Contradictory Signals

On May 21, the U.S. Department of Justice announced the Minnesota Health Care Fraud Takedown: criminal charges against 15 defendants for more than $90 million in alleged fraud, developed by federal strike force prosecutors and the Health Care Fraud Unit's data analytics team.

The DOJ simultaneously funded 15 new trial attorney positions dedicated to Medicaid fraud nationwide. The charged cases were purely Medicaid matters, arising from two benefits that Minnesota itself designed and administers, Housing Stabilization Services and the Early Intensive Developmental and Behavioral Intervention autism services program, in which billing ballooned into the hundreds of millions of dollars.

The takedown landed amid sustained criticism of Minnesota's program oversight. The state's legislative auditor had found that inadequate oversight of the related $250 million Feeding Our Future scheme created opportunities for fraud, and the state had already suspended the housing benefit over credible fraud allegations. The accompanying release declared that the Minnesota experience "illustrates the insufficient nature of state enforcement alone."

Message 1: States cannot handle this, so the federal government is stepping in.

The federal government's second signal came through its funding authority. American taxpayers provide nearly half a billion dollars every year to fund the state Medicaid fraud control units, or MFCUs, and each unit must be recertified annually by the U.S. Department

of Health and Human Services' Office of Inspector General as a condition of that federal funding.

On June 4, the HHS inspector general denied recertification of Hawaii's unit and **terminated** its federal funding, citing the unit's own reported statistics: no fraud convictions or indictments at all from 2022 through 2025.

On June 30, it did the same to New York, the largest and best-funded unit in the country, suspending roughly $60 million per year in grant money and demanded, among other corrective actions, a written strategy to increase indictments.

The funding pressure soon extended beyond the units' grants. On July 21, HHS and the Centers for Medicare & Medicaid Services deferred more than $1 billion in federal Medicaid payments to California ($867.5 million) and Minnesota ($199 million) pending review of high-risk claims, while characterizing the actions as deferrals rather than permanent cuts.

Message 2: States must undertake more criminal enforcement, and, to encourage that, the federal government is withholding the money that pays for it.

The third signal pushed in the opposite direction. A few days after the Minnesota takedown, the head of the DOJ's Civil Division **issued** a memorandum addressing False Claims Act qui tam complaints that allege fraud on state-administered benefits programs, Medicaid above all.

The DOJ committed to completing its reviews of new benefits fraud qui tam actions within 60 to 120 days, and thereafter to either intervening, continuing a time-limited investigation, or declining and permitting the relator to proceed.

The memorandum acknowledges that the protocol will increase the number of benefits fraud matters litigated primarily by relators and their counsel rather than by government attorneys, even as it states that DOJ attorneys will continue to handle the majority of incoming matters.

The memorandum also describes the matters best suited to relator-led litigation: data-corroborated schemes, established legal theories and comparatively modest expected damages, much of the midsized provider fraud that historically fills Medicaid enforcement dockets.

Message 3: The federal government is stepping back from a meaningful share of the civil fraud docket, leaving room for others to assume a greater role.

A fourth message has been delivered through the pardon power. The president has issued second-term pardons to at least 15 owners, executives, pharmacists and physicians convicted in healthcare fraud cases collectively involving more than $3 billion.

Among the recipients was **Joseph Schwartz**, operator of a New Jersey-headquartered nursing home chain, who was sentenced in the U.S. District Court for the District of New Jersey to 36 months of imprisonment for withholding $38 million in employee payroll taxes while his facilities deteriorated around their residents, and who was pardoned while owing nearly $19 million on an unpaid wrongful death judgment to the family of a patient.

The White House described the case as an example of overprosecution, and each grant of clemency carries its own stated rationale. A pardon does not disturb civil liability, and the judgment against Schwartz remains outstanding.

Message 4: Federal healthcare fraud convictions, once obtained, are revocable.

Considered together, the four messages appear to defy reconciliation. The federal government is shedding much of its civil enforcement workload onto private relators while intervening directly in selected criminal matters, as in Minnesota.

The states, although their enforcement was just pronounced insufficient, are being directed to produce more of it, under threat of losing the federal grants that fund the majority of their budgets. And the criminal convictions all enforcers are being urged to produce have, at the highest levels of the industry, proven subject to unwinding.

An Uneven Record and a Selective Test

To be sure, state enforcement of Medicaid fraud has never been uniform, and many states have ample room for improvement. States have traditionally let the federal government lead.

The DOJ announced $6.8 billion in False Claims Act recoveries for fiscal year 2025, more than $5.7 billion of it from healthcare, while the 53 state units combined recovered $706 million in civil cases, many of them through global settlements developed by the DOJ and

relators' counsel that the states merely joined to collect their share. If federal pressure prods those states toward genuine enforcement capacity, so much the better.

New York, however, was not an obvious laggard. The New York unit recovered $110.5 million in 2025, second among the five largest units, and more than $627 million for Medicaid during the current attorney general's tenure, the product of a deliberate strategy of pursuing large, systemic cases that, by the inspector general's own account, yielded novel settlements holding nursing home operators accountable for neglect and fraud.

The recertification case against the unit rests instead on the number of convictions and indictments against a hand-selected peer group, a measure on which a guilty plea from a single personal care attendant weighs the same as a nine-figure corporate resolution. By combined recoveries, New York ranks midpack among those same peers over the last six fiscal years and second for 2025. A different yardstick would have produced a different verdict.

The politics of the efforts are also apparent. Every state singled out so far — Hawaii, New York, Minnesota and California — is Democratic-led; the July 21 deferrals struck two of them a second time; and no comparably situated unit in a Republican-led state has received a similar letter.

In New York, the OIG conditionally recertified the unit on May 1, the DOJ credited it as a partner in the national takedown announced June 23, and the denial and suspension followed within days. Whatever the motive, a favorable federal assessment cannot be counted on, and the only durable protection is an enforcement record that speaks for itself.

A Common Conclusion: States Should Step Up

For a state attorney general deciding what to do next, the mixed messaging nonetheless yields a single conclusion: Improve fraud enforcement. Whichever reading of the federal posture proves correct, the indicated response is the same.

Suppose the federal moves amount to a genuine reallocation, with blockbuster criminal cases going to federal strike forces, routine civil qui tams to the private bar and everything in between to the states.

Then states need investigative and prosecutorial capacity, because the recertification standard is now being enforced, the expectations are published and the funding depends

on meeting them.

The midtier matters, provider schemes too small to attract a federal strike force yet too fact-intensive or too modest in damages to sustain relator-financed litigation, do not disappear in a reallocation. They simply go unaddressed unless a state pursues them.

Suppose, instead, that the federal government intends to federalize the significant cases over the states' heads. Then states need capacity even more urgently, because the alternative is what happened in Minnesota: federal prosecutors announcing the two largest Medicaid fraud cases in the district's history while attributing the fraud's growth to inadequate state oversight.

Minnesota is unlikely to remain unique; the strike force expansion and new Medicaid-dedicated prosecutor positions exist precisely so that the model can be replicated. A state that cedes the field does not merely lose recoveries, restitution and charging control over its own program; it accepts having that program policed by another sovereign, on another sovereign's timetable.

And suppose the conclusion is that target selection is driven principally by politics. Then unimpeachable numbers are a durable defense. When the referee selects the metrics, a state has two options: Litigate the metrics, or compile a record no metric can impugn.

New York is attempting the first, and may well succeed on process grounds; the regulations provide for reconsideration, and the suspension runs only through the current grant period. The second is the only strategy a state fully controls.

Federal pressure on states to stay active is not new. Congress created the Medicaid fraud units in the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977, responding to that era's nursing home fraud scandals, with an enhanced 90% federal match as inducement.

In 1993, Congress made operation of an effective unit a state plan requirement, rendering the units effectively mandatory. And OIG has long pressed underperforming units through onsite reviews and corrective action plans; Hawaii's unit alone has had three since 2014.

As for what expanded capacity requires now, the corrective action conditions attached to the New York denial can serve as a checklist any state can audit itself against:

- A staffing plan weighted toward experienced fraud investigators;
- A root-cause analysis of referral volume, particularly from managed care organizations, which administer coverage for most Medicaid enrollees yet consistently generate few viable fraud referrals;
- Documented case progression with supervisory review at defined intervals;
- Investigator caseloads averaging roughly 10 open matters; and
- Tracking of referred cases through conviction and provider exclusion.

A state need not accept the metrics that produced the New York letter to see the value of conducting that audit before Washington conducts it for them. And a state need not wait for referrals: Where managed care organizations do not report fraud, states can investigate the organizations themselves.

Massachusetts shows what that looks like in practice. In May, its attorney general **sued** UnitedHealthcare under the state False Claims Act in the Suffolk County Superior Court of the Commonwealth of Massachusetts, alleging more than $100 million in inflated Medicaid payments from overstated patient health assessments, and built the case, through the civil investigative demands its statute authorizes, on internal records and executive testimony rather than on a federal referral or a global settlement.

It is the posture the moment rewards: a state acting on its own civil track, which Congress has long incentivized by granting qualifying state false claims acts an additional share of any Medicaid recovery.

Kansas brought a comparable action, Kansas v. Aenta Health Inc., against a managed care insurer weeks later in Shawnee County District Court, and as the DOJ offloads routine civil qui tams to the private bar, relators will increasingly bring these cases to the states equipped to pursue them.

The clemency record supplies one further reason, because the presidential pardon power reaches only federal convictions. When Schwartz received his pardon, he still owed Arkansas prison time on a separate state conviction for defrauding its Medicaid program, a sentence no federal pardon could disturb.

In a period when federal healthcare fraud convictions have proven revocable, a state

prosecution is the one enforcement outcome fully insulated from federal clemency. That argument for state capacity holds regardless of who occupies the White House, and it will hold under the next administration as well.

The federal signals conflict and disputes over their motivation will continue through the midterm elections and likely into the courts. But the assignment those signals collectively deliver to the states does not depend on how the disputes resolve. On every reading, whether reallocation, federalization or politics, the states that build enforcement capacity will control their own programs and share in the recoveries.

Correction: Due to an editing error, a prior version of this article's headline incorrectly identified a government health insurance program. The error has been corrected.

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[1] Press Release, U.S. Dep't of Justice, Minnesota Health Care Fraud Takedown Results in Charges Against 15 Defendants for Over $90M in Fraud (May 21, 2026), https://www.justice.gov/opa/pr/minnesota-health-care-fraud-takedown-results-charges-against-15-defendants-over-90m-fraud.

[2] Id. Minnesota's own MFCU partnered in several of the underlying investigations. See Press Release, Minn. Office of the Att'y Gen., Attorney General Ellison Partners with Federal Law Enforcement on Indictments of Housing Stabilization Services and Early Intensive Developmental and Behavioral Intervention Providers (Dec. 18, 2025), https://www.ag.state.mn.us/Office/Communications/2025/12/18_HSS.asp.

[3] See Feeding Our Future Audit Finds Minnesota Dept. of Education's Oversight "Created Opportunities for Fraud," CBS News (June

2024), https://www.cbsnews.com/amp/minnesota/news/feeding-our-future-legislative-auditor-report-minnesota-department-of-education (describing the Office of the Legislative Auditor's special review).

[4] U.S. Attorney: Fraud Likely Exceeds $9 Billion in Minnesota-Run Medicaid Services, Minn. Reformer (Dec. 18, 2025), https://minnesotareformer.com/2025/12/18/u-s-attorney-fraud-likely-exceeds-9-billion-in-minnesota-run-medicaid-services/ (reporting that the state Department of Human Services suspended Housing Stabilization Services in August 2025, citing credible allegations of fraud).

[5] Press Release, supra note 1.

[6] See Social Security Act § 1903(q), 42 U.S.C. § 1396b(q); 42 C.F.R. §§ 1007.17, 1007.19(d)(1); Letter from T. March Bell, Inspector Gen., U.S. Dep't of Health & Human Servs., to Letitia A. James, Att'y Gen. of New York, and Amy Held, Dir., New York MFCU (June 30, 2026) [hereinafter New York Letter]; Letter from T. March Bell, Inspector Gen., to Anne E. Lopez, Att'y Gen. of Hawaii, and Landon M.M. Murata, Dir., Hawaii MFCU (June 4, 2026) [hereinafter Hawaii Letter].

[7] Hawaii Letter, supra note 6.

[8] New York Letter, supra note 6; Associated Press, Trump Administration Suspends Funding for New York's Medicaid Fraud Unit Over Low Performance, PBS NewsHour (June 30, 2026), https://www.pbs.org/newshour/politics/trump-administration-suspends-funding-for-new-yorks-medicaid-fraud-unit-over-low-performance.

[9] New York Letter, supra note 6, at Enclosure A.

[10] Press Release, U.S. Dep't of Health & Human Servs., HHS Defers More Than $1 Billion in Medicaid Payments to California, Minnesota Pending Review of High-Risk Claims in Crackdown on Fraud (July 21, 2026), https://www.hhs.gov/press-room/hhs-defers-medicaid-payments-california-minnesota-fraud-review.html; see also Mark Payne, CMS Withholds $1B in Medicaid From Calif., Minn., Citing Fraud, Law360 (July 21, 2026).

[11] See 31 U.S.C. § 3730(b)(2)–(3) (providing that qui tam complaints are filed under seal while the government investigates and elects whether to intervene).

[12] Memorandum from the Assistant Att'y Gen., Civil Div., U.S. Dep't of Justice, regarding

expedited review of qui tam actions alleging benefits fraud (May 27, 2026), https://www.justice.gov/opa/media/1442566/dl; see also Press Release, U.S. Dep't of Justice, Civil Division Moves to Fast-Track Benefits Fraud Enforcement (May 27, 2026), https://www.justice.gov/opa/pr/civil-division-moves-fast-track-benefits-fraud-enforcement.

[13] Memorandum, supra note 12.

[14] Id.

[15] Trump Showers Health Care Crooks With Love, Am. Prospect (Apr. 21, 2026), https://prospect.org/2026/04/21/trump-showers-health-care-crooks-with-love/ (discussing a Protect Our Care analysis of second-term clemency grants in health care fraud cases).

[16] Press Release, U.S. Att'y's Office, Dist. of N.J., Former Owner of Collapsed Nursing Home Empire Sentenced to 36 Months' Imprisonment for $38 Million Employment Tax Fraud (Apr. 2025), https://www.justice.gov/usao-nj/pr/former-owner-collapsed-nursing-home-empire-sentenced-36-months-imprisonment-38-million.

[17] ProPublica (Apr. 2026) (reporting on the Schwartz pardon and the unpaid wrongful death judgment), https://www.propublica.org/article/trump-joseph-schwartz-pardon-lawsuit.

[18] See U.S. Dep't of Health & Human Servs., Office of Inspector Gen., Medicaid Fraud Control Units (MFCUs), https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/ (federal grant funds 75% of each unit's expenditures).

[19] Output varies enormously from state to state. See U.S. Dep't of Health & Human Servs., Office of Inspector Gen., Medicaid Fraud Control Units Annual Report: Fiscal Year 2025, OEI-09-26-00140 (Mar. 2026) [hereinafter MFCU FY 2025 Annual Report] (attributing $650 million, or 52% of FY 2025 criminal recoveries reported by all 53 units, to a single Virginia MFCU case), https://oig.hhs.gov/reports/all/2026/medicaid-fraud-control-units-annual-report-fiscal-year-2025; see also Hawaii Letter, supra note 6 (unit reported no fraud convictions or indictments from 2022 through 2025).

[20] Compare Press Release, U.S. Dep't of Justice, False Claims Act Settlements and Judgments Exceed $6.8 Billion in Fiscal Year 2025 (Jan. 16, 2026), with MFCU FY 2025

Annual Report, supra note 19 (reporting $706 million in civil recoveries and $1.3 billion in criminal recoveries by the 53 units for FY 2025).

[21] Hawaii Letter, supra note 6 (reporting that 23 of the unit's 30 civil judgments and settlements from 2021 through 2025 were global settlements investigated and developed by other entities).

[22] New York Letter, supra note 6; Associated Press, supra note 8.

[23] New York Letter, supra note 6 (describing the unit's strategic plan and acknowledging civil settlements involving "novel settlement arrangements" holding nursing homes accountable).

[24] New York Letter, supra note 6 (comparing New York's conviction and indictment counts with those of the California, Texas, Florida and Ohio units).

[25] Id. (reporting combined criminal and civil recoveries for the five units for fiscal years 2020 through 2025, with New York ranked third of five overall and second for 2025).

[26] New York Letter, supra note 6 (describing the May 1, 2026, conditional recertification and the targeted onsite review conducted during the week of June 8, 2026); NY Medicaid Fraud Unit Defunded After DOJ Credited It in National Takedown, Fortune (July 2, 2026), https://fortune.com/2026/07/02/ny-medicaid-fraud-unit-defunded-doj-credit/; see also Press Release, U.S. Dep't of Justice, National Health Care Fraud Takedown Results in 455 Defendants Charged in Connection With Over $6.5 Billion in Alleged Fraud (June 23, 2026), https://www.justice.gov/opa/pr/national-health-care-fraud-takedown-results-455-defendants-charged-connection-over-65.

[27] Associated Press, supra note 8 (quoting Joan Alker, Georgetown University Center for Children and Families).

[28] Press Release, U.S. Att'y's Office, Dist. of Ariz., District of Arizona Charges 7 Defendants as Part of National Health Care Fraud Takedown, https://www.justice.gov/usao-az/pr/district-arizona-charges-7-defendants-part-national-health-care-fraud-takedown.

[29] Press Release, supra note 1 (announcing the expansion of the Midwest Strike Force and 15 new Medicaid-dedicated trial attorney positions).

[30] See 42 C.F.R. § 1007.17(e) (providing for reconsideration of a recertification denial upon written submission contesting the findings); New York Letter, supra note 6 (suspension effective July 1, 2026, through the September 30, 2026, expiration of the current grant period).

[31] Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977, Pub. L. No. 95-142, 91 Stat. 1175 (adding Social Security Act § 1903(a)(6) and authorizing a 90% federal match for the establishment and operation of state units); see also Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499 (extending the 90% match for a unit's first 3 years of operation and 75% thereafter).

[32] Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66 (adding Social Security Act § 1902(a)(61), 42 U.S.C. § 1396a(a)(61), requiring each state plan to provide for an effective Medicaid fraud control unit unless waived).

[33] Hawaii Letter, supra note 6 (describing onsite reviews of the Hawaii unit in 2014, 2019 and 2026, together with corrective action plans and implemented recommendations).

[34] New York Letter, supra note 6, at Enclosure A.

[35] Complaint, Commonwealth v. UnitedHealthcare Ins. Co., No. 2684CV01570 (Mass. Super. Ct. filed May 29, 2026), removed, No. 26-cv-12853 (D. Mass. June 23, 2026) [hereinafter Mass. Complaint] (alleging that United retained more than $100 million in inflated capitated payments by submitting assessments that overstated enrollees' health status in the MassHealth Senior Care Options program); see Mass. G.L. c. 12, § 5O (authorizing the attorney general to compel documents and testimony by civil investigative demand).

[36] Social Security Act § 1909, 42 U.S.C. § 1396h (providing a 10-percentage-point increase in the state share of amounts recovered under a state false claims act that the HHS inspector general, in consultation with DOJ, determines meets the enumerated requirements); see Mass. Complaint, supra note 35 (brought under the Massachusetts False Claims Act, Mass. G.L. c. 12, §§ 5A–5O).

[37] State of Kansas v. Aetna Health Inc., No. SN-2066-CV-00599 (Kan. Dist. Ct. filed June 24, 2026) (state False Claims Act action against a managed care insurer). On the offloading of civil qui tams to the private bar, see Memorandum, supra note 12.

[38] ProPublica (Mar. 2026) (reporting on the Skyline nursing home collapse and Schwartz's Arkansas Medicaid fraud conviction), https://www.propublica.org/article/joseph-schwartz-trump-pardon-skyline-nursing-home-patients.