DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

March 17, 2026

The Honorable Ron DeSantis
Governor of Florida
Office of the Governor
The Capitol
200 South Monroe Street
Tallahassee, FL 32399

James Uthmeier
Attorney General of Florida
Office of the Attorney General
The Capitol
Tallahassee, FL 32399

Shevaun L. Harris
Secretary
Florida Agency for Health Care Administration
2727 Mahan Drive
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Brian Meyer
Deputy Secretary for Medicaid
Florida Agency for Health Care Administration
2727 Mahan Drive
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Tim Helms
Bureau Chief
Office of Medicaid Program Integrity
Florida Agency for Health Care Administration
2727 Mahan Drive
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Dear Governor DeSantis, Attorney General Uthmeier, Secretary Harris, Deputy Secretary Meyer, and Bureau Chief Helms:

The Centers for Medicare & Medicaid Services (CMS), through the Center for Program Integrity (CPI), is responsible for protecting the integrity of the Medicare and Medicaid programs. This duty involves ensuring that taxpayer funds are used appropriately for items and services rendered to eligible individuals by qualified providers. In line with CMS and state Medicaid program integrity oversight responsibilities under sections 1902(a)(4), 1902(a)(6), 1902(a)(27),

1902(a)(42), 1902(a)(64), 1902(a)(75), 1902(a)(77), 1903(i)(2), and 1936 of the Social Security Act and implementing regulations at 42 CFR Parts 430.32, 431.16, 433.32, 455.12, and 456, CMS routinely evaluates state Medicaid program integrity efforts and may request additional information when program vulnerabilities are identified. These evaluations are necessary to ensure public confidence and protect beneficiaries in your state's Medicaid program.

CMS is currently reviewing Florida's program integrity activities due to the state's well-documented history of health care fraud affecting both Medicare and the Florida Medicaid program. Recent enforcement actions by the Department of Justice (DOJ) and other federal and state agencies highlight the significant and ongoing challenges of fraud, waste, and abuse (FWA) within Florida's health care system. These cases reveal sophisticated schemes that result in substantial federal and state financial losses and can compromise beneficiary care.

A clear indicator of the scale of fraud in Florida was the June 2025 National Health Care Fraud Takedown. That coordinated effort resulted in criminal charges against 56 individuals across Florida and constituted a significant component of that nationwide enforcement action that targeted schemes responsible for over $14.6 billion in alleged fraud. Investigations into individual matters involved in this national case vividly reveal alleged fraudsters' tactics, including a $46 million scheme by the owner of several telemedicine and durable medical equipment (DME) companies who allegedly targeted Medicare beneficiaries through deceptive telemarketing, leading to allegedly fraudulent claims for DME and genetic tests.[1]

Criminal schemes prosecuted and occurring in south Florida have been proven to involve staggering sums and elaborate conspiracies. For example, in June 2025, a healthcare software company CEO was convicted for playing the central role in a nationwide conspiracy that generated fraudulent physician orders yielding over $1 billion in false claims to Medicare.[2] In another case, two health care executives were convicted in January 2026 for orchestrating a $34 million Medicare Advantage fraud scheme using deceptive telemarketing to coerce elderly beneficiaries into accepting unneeded medical equipment.[3] A laboratory owner also pleaded guilty in January 2026 to a $52 million Medicare fraud scheme involving unnecessary genetic testing procured through illegal kickbacks.[4]

This environment of pervasive fraud is not confined to Medicare and has inevitably led to schemes directly targeting the Florida Medicaid program.

In March 2025, the owner of a Florida home services provider was arrested for allegedly defrauding the state's Medicaid program of more than $50,000 by billing for home and community-based services that were never rendered.[5] More recently, in January 2026, two individuals were arrested in a Central Florida scheme that defrauded the Medicaid program of

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[1] https://www.justice.gov/usao-sdfl/pr/national-health-care-fraud-takedown-results-324-defendants-charged-connection-over-146
[2] https://www.justice.gov/usao-sdfl/pr/ceo-health-care-software-company-convicted-1b-fraud-conspiracy
[3] https://www.justice.gov/usao-sdfl/pr/two-healthcare-executives-convicted-exploiting-elderly-medicare-advantage
[4] https://www.justice.gov/opa/pr/florida-laboratory-owner-pleads-guilty-52m-medicare-fraud-scheme-involving-genetic-tests
[5] https://www.myfloridalegal.com/newsrelease/attorney-general-james-uthmeier-announces-arrest-home-services-provider-defrauding

over $65,000 by billing for thousands of non-emergency medical transportation trips that never happened.[6] A separate criminal conspiracy involving another nonemergency medical transportation service was also shut down after it was found to have defrauded Florida's Medicaid program of more than $5 million by systematically billing for thousands of trips that never occurred.[7] Florida continues to see fraud related to Applied Behavior Analysis (ABA), including a registered behavior technician who defrauded the state of $119,000.[8]

Given the widespread scale and nature of such schemes, CMS is seeking additional information regarding Florida Medicaid's program integrity infrastructure and the state's current efforts to identify, prevent, and address fraud risks in high-risk provider categories.

CMS requests that Florida provide written responses and supporting documentation addressing the following areas:

1. **State Program Integrity Infrastructure and Accountability**
    a. Describe the organizational structure of the Florida Medicaid program integrity unit. Please include a description of how program integrity responsibilities are divided among the Agency for Health Care Administration (AHCA) including its Office of Medicaid Program Integrity, the Medicaid Fraud Control Unit (MFCU), other state agencies, managed care plans, and contractors.
    b. Provide an organizational chart and data on staffing levels (full-time equivalents) and budget allocations for all state entities responsible for Medicaid program integrity for FFYs 2020–2025.
    c. Describe the metrics that AHCA uses to assess the effectiveness of its program integrity initiatives over time. How are trends in payment error rates, recoveries, and enforcement outcomes evaluated and reported to the public?
    d. Provide all guidance, policies, or training materials related to state staff and managed care plan (MCP) responsibilities for fraud detection, prevention, and reporting.
    e. Provide information about Florida's payment suspension processes pursuant to 42 CFR § 455.23 and/or any state-based payment suspension authority, including how the state oversees its Medicaid MCP implementation of payment suspensions under 42 CFR § 438.608(a)(8). Include the number of payment suspensions implemented by the state and MCPs during Federal Fiscal Years (FFYs) 2023 – 2025.
    f. Provide any Memorandum of Understanding (MOU), standard operating procedures, and other relevant information about the process by which the MFCU receives referrals of potential fraud from the state and MCPs, as required by 42 CFR § 455.21.
    g. Describe Florida's oversight of its MCP program integrity operations, including relevant contract language provisions, data/information reporting requirements from the MCPs to AHCA, and audits/recoveries of MCP overpayments.

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[6] https://www.myfloridalegal.com/newsrelease/attorney-general-james-uthmeier-announces-arrests-central-florida-medicaid-fraud-scheme

[7] https://www.myfloridalegal.com/newsrelease/attorney-general-james-uthmeier-announces-final-arrest-massive-medicaid-fraud-case

[8] https://www.myfloridalegal.com/newsrelease/behavior-technician-defrauded-medicaid-119000

2. **Provider Screening, Enrollment, and Revalidation**
    a. Describe the state's criteria for determining provider risk levels (limited, moderate, high) pursuant to 42 CFR § 455.450, particularly for high-risk provider types such as DME providers, pharmacies, and telemedicine providers.
    b. Describe how the state identifies and monitors related entities, common ownership, or shared management across multiple enrolled providers to detect and prevent collusive fraud schemes.
    c. Report how many providers have been suspended and/or terminated in the past 5 years. Include data on provider application denials, terminations, and re-enrollment denials associated with program integrity concerns for FFYs 2020–2025.
    d. Describe the circumstances, beyond the federal reasons outlined in 42 CFR § 455.416, if any, under which AHCA suspends or terminates a Florida Medicaid provider's enrollment.

3. **Targeted Oversight of High-Risk Services**
    a. DME Oversight:
        i. Describe all prior authorization, utilization review, and pre-payment review mechanisms applied to DME claims.
        ii. Describe what data analytics or automated tools are used to identify aberrant DME billing patterns (e.g., geographic hotspots, unusual provider/beneficiary claim volumes).
        iii. Provide data for FFYs 2020–2025 on audits, investigations, payment suspensions, and overpayment recoveries involving DME providers.
    b. ABA, Adult Day Centers, and Personal Care Services:
        i. Describe all utilization management tools including, but not limited to, prior authorization and limitations applied to these high-risk service categories. For any services where management is delegated to MCPs, please provide the relevant contract sections and any state-issued guidance or policy documents that outline how MCPs must manage and monitor these services.
        ii. Describe what data analytics or automated tools are used to identify aberrant billing patterns for these high-risk services and how the state addresses any identified aberrancies.
        iii. Describe how Electronic Visit Verification (EVV) data is used to identify suspected FWA for personal care services.
        iv. Provide data for FFYs 2020–2025 on audits, investigations, payment suspensions, and overpayment recoveries involving these three high-risk
        v. service categories.
        vi. What programs or policies have been implemented to address these aberrancies?
    c. Data Analytics and Fraud Detection:
        i. Describe the analytic tools, predictive models, and/or algorithms the state uses to identify aberrant billing trends across all service categories.
        ii. Describe the state's process for referring suspected fraud and abuse to federal authorities when a scheme appears to impact both Medicare and Medicaid, particularly those involving telemedicine, genetic testing, and pharmacies.

iii. Describe the state's protocols and procedures for exchanging case information and investigative leads with federal partners and other state law enforcement. Specifically, detail how AHCA coordinates with the Florida MFCU to make referrals and share data with CMS, the HHS Office of Inspector General (OIG), and other relevant agencies.
iv. Report what the state has identified as the top five high-risk Medicaid services areas on which Florida is currently focusing its program integrity efforts, and how those services areas were identified.

d. Corrective Actions and Future Initiatives:
   i. Describe any additional measures the state is planning or implementing to strengthen program integrity oversight in high-risk service categories, including DME, pharmacy billing, and telehealth-related services.

CMS requests that Florida submit its written responses and supporting documentation within 30 days of the date of this letter. CMS may request additional documentation or technical discussions following its review of the state's responses.

Protecting the integrity of the Medicaid program is a shared federal and state responsibility. CMS appreciates Florida's continued cooperation in safeguarding beneficiary access to services while ensuring that taxpayer funds are protected from FWA.

We look forward to your timely response.

Sincerely,

Dr. Mehmet Oz

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