Biennial Review of AHCA's Oversight of Fraud and Abuse in Florida's Medicaid Program: 2026

Report 26-02

January 2026

OPPAGA

Office of Program Policy Analysis and Government Accountability

January 2026 Report 26-02

Biennial Review of AHCA's Oversight of Fraud and Abuse in Florida's Medicaid Program: 2026

EXECUTIVE SUMMARY

The Florida Agency for Health Care Administration (AHCA) administers and oversees Florida's Medicaid program. Medicaid enrollees receive services through either the Statewide Medicaid Managed Care (SMMC) program or the fee-for-service delivery system. The state contracts with eight managed care organizations (MCOs) to provide health care coverage under the SMMC program. Most enrollees receive health care under the SMMC program.

REPORT SCOPE

Section 409.913(35), *Florida Statutes*, directs OPPAGA to biennially review AHCA's efforts to prevent, detect, deter, and recover funds lost to fraud and abuse in the Medicaid program.

AHCA's Office of Medicaid Program Integrity (MPI) is responsible for fraud and abuse monitoring and collaborates with federal and state entities to support prevention, detection, and deterrence activities. MCOs support these efforts and are contractually required by AHCA to report suspected or confirmed provider fraud to MPI and Florida Office of Attorney General's Medicaid Fraud Control Unit (MFCU) and suspected or confirmed abuse to MPI. MPI also refers cases of suspected fraud to MFCU for investigation and prosecution.

There are several ways to assess program integrity efforts by state agencies and MCOs. Measuring prevention activities is considered a best practice, as prevention-based efforts have been emphasized as a more effective method for addressing Medicaid fraud than detection and recovery efforts. Despite this emphasis, AHCA primarily uses detection-based performance measures to evaluate MPI and MCO performance. AHCA uses one prevention-based measure and one detection-based measure to evaluate MPI performance. AHCA uses one detection-based performance measure to evaluate MCO program integrity performance.

During OPPAGA's review period (Fiscal Years 2022-23 and 2023-24), MPI and MCOs had mixed results in meeting fraud detection and prevention performance targets. MPI did not meet the detection-based performance target for overpayments identified but exceeded prevention-based performance targets for overpayments prevented. MCOs have not consistently met the detection-based performance target for fraud referrals.

OPPAGA identified issues related to measuring efforts to prevent, detect, and deter fraud and abuse and identified opportunities for AHCA, MFCU, and MCOs to improve communication and collaboration. To address these issues, OPPAGA recommends that AHCA consider taking steps that could improve the utility and comprehensiveness of its performance measures related to program integrity and collaborate with MFCU to specify the elements that define a quality referral.

BACKGROUND

The Florida Agency for Health Care Administration (AHCA) administers and oversees Florida's Medicaid program (Florida Medicaid). AHCA's Office of Medicaid Program Integrity (MPI) is responsible for fraud and abuse monitoring and collaborates with federal and state entities to support prevention, detection, and deterrence activities.[1,2] Medicaid enrollees receive services through either the Statewide Medicaid Managed Care (SMMC) program or the fee-for-service (FFS) delivery system; most enrollees receive health care under the SMMC program. The state contracts with eight managed care organizations (MCOs) to provide health care coverage under the SMMC program.

AHCA is Florida's health care policy and planning entity that administers and oversees the state Medicaid program

AHCA is the state's health policy and planning entity. The agency's divisions each have responsibilities pertaining to health care, several of which administer and oversee aspects of Florida Medicaid. Medicaid is a medical assistance program that provides access to health care for low-income adults, children, pregnant women, elderly adults, and people with disabilities. For Fiscal Year 2025-26, AHCA had 1,550 approved full-time employee positions and an operating budget of $40.6 billion.

AHCA facilitates health care services to Medicaid enrollees through the SMMC program and FFS delivery system. In the SMMC program, AHCA contracts with MCOs for the coordination and payment of a variety of medical and behavioral health services for Medicaid recipients. The SMMC program has three components—the managed medical assistance program, the long-term care program, and the dental program. Each MCO provides several health plans to enrollees, including comprehensive long-term care plus plans, medical assistance plus plans, specialty plans, and select comprehensive plans. For recipients not enrolled with an MCO, the FFS system reimburses Medicaid providers for services covered under Florida Medicaid. As of November 2025, there were approximately 4.0 million persons enrolled in Florida Medicaid. Seventy-three percent of enrollees received services through the SMMC program, while 27% received services through the FFS system. As of November 2025, there were 347,530 active providers across the eight MCOs operating within the SMMC program.[3]

To create larger provider networks, thereby increasing access for persons enrolled in Florida Medicaid, the 2022 Legislature reduced the number of service regions from 11 to 9, effective February 2025. Since February 2025, eight MCOs within the SMMC program coordinate and pay for services within a specified region, as well as two statewide dental plans.[4,5] Four of the eight MCOs operate statewide. These organizations may provide coverage for a wide range of services and conditions in multiple regions across the state. This includes required managed medical assistance services (e.g., physician and hospital services), as well as required long-term care services (e.g., adult day health care and assisted living services). (See Exhibit 1.)

---

[1] Section 409.913(1)(c), *F.S.,* defines fraud as "an intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to themselves or another person. The term includes any act that constitutes fraud under applicable federal or state law."

[2] Section 409.913(1)(a), *F.S.,* defines abuse as "provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care; or recipient practices that result in unnecessary cost to the Medicaid program."

[3] Active Medicaid providers are providers that are currently enrolled in the Florida Medicaid program and authorized to submit claims for reimbursement.

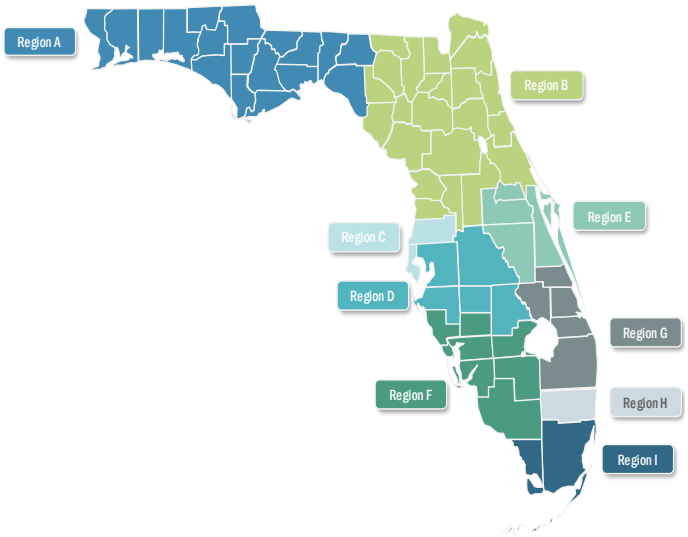
[4] Chapter 2022-42, *Laws of Florida*.

[5] As in prior reports, OPPAGA focused on the following MCOs within the SMMC program: Aetna Better Health, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine Health, and United Healthcare.

Exhibit 1

Medicaid Managed Care Organizations Vary in Number of Enrollees and Providers; Most Serve Multiple Regions

Managed Care Organization	Enrollment	Number of Providers	Region(s) Served
Aetna Better Health	138,453	63,599	D, E, I
Community Care Plan	67,787	11,768	E–I
Florida Community Care	35,007	49,513	Statewide
Humana Medical Plan	540,817	55,814	Statewide
Molina Healthcare	61,451	26,307	I
Simply Healthcare Plan	551,891	68,872	Statewide
Sunshine Health Plan	1,219,485	109,187	Statewide
United Healthcare	245,389	31,342	B, D, I



Note: Enrollment and provider data are as of November 2025.

Source: OPPAGA analysis of Florida Agency for Health Care Administration and managed care organization data.

Several federal, national, and state entities collaborate to prevent, detect, and deter Medicaid fraud and abuse

Several federal agencies, such as the U.S. Centers for Medicare & Medicaid Services (CMS), the U.S. Department of Health and Human Services Office of the Inspector General (HHS-OIG), and the U.S. Department of Justice, conduct Medicaid fraud and abuse prevention and detection activities. (See Appendix A for a description of different types of Medicaid fraud committed by health care providers.) These offices often collaborate with state-level agencies and MCOs. CMS provides direction, guidance, and oversight to state-operated Medicaid programs, while HHS-OIG provides oversight of state-level Medicaid Fraud Control Units (MFCUs) and operates a hotline that accepts tips and complaints about potential fraud and abuse. The U.S. Department of Justice Criminal Division's Health Care Fraud Unit and the Federal Bureau of Investigation investigate cases of health care fraud and prosecute individuals involved in fraudulent activity. In addition, national organizations, such as the National Health Care Anti-Fraud Association and Healthcare Fraud Prevention Partnership, support public and private stakeholders' program integrity efforts by providing anti-fraud information and data sharing. (See Exhibit 2.)

Exhibit 2
Multiple Federal and National Entities Engage in Medicaid Program Integrity Efforts

Entities	Entity Prevention and Detection Activities
Federal	
U.S. Centers for Medicare & Medicaid Services	• Oversees medical reviews and audits • Facilitates collaboration between states to share anti-fraud best practices • Manages provider enrollments for the Medicaid program • Provides guidance and resources on various topics, such as safeguards for Medicaid services, federal Medicaid enrollment standards, and the latest fraud schemes and detection • Provides program integrity training on fraud investigation, data mining and analysis, case development, provider enrollment, and medical billing and coding
U.S. Department of Health and Human Services Office of the Inspector General	• Conducts criminal, civil, and administrative investigations and enforcement actions to address fraud and other violations of law in U.S. Department of Health and Human Services programs • Recertifies each state's Medicaid Fraud Control Unit annually • Operates the federal fraud hotline that accepts tips and complaints from various sources about potential fraud and abuse
U.S. Department of Justice	• Investigates cases of health care fraud and prosecutes individuals involved in fraudulent activity • Engages in advanced data analytics and algorithmic methods to identify newly emerging health care fraud schemes
National	
National Health Care Anti-Fraud Association	• Grants accreditation based, in part, on demonstrated knowledge in fraud detection, investigation, and prosecution to health care anti-fraud professionals through the Accredited Health Care Fraud Investigator Program • Offers a range of education and training programs on various topics, such as fraud investigations, data analytics, and emerging schemes
Healthcare Fraud Prevention Partnership	• Conducts research studies of health care data across various Medicaid stakeholders • Facilitates collaboration among partners • Enables data and information sharing among key stakeholders

Source: U.S. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services Office of the Inspector General, U.S. Department of Justice, National Health Care Anti-Fraud Association, and Healthcare Fraud Prevention Partnership websites.

In Florida, AHCA's MPI has primary responsibility for administering and overseeing fraud and abuse prevention and detection efforts for the Medicaid program. MPI and MCOs conduct fraud and abuse prevention activities and collaborate with the Florida Attorney General's Medicaid Fraud Control Unit (MFCU) when fraud is suspected. MPI also collaborates with federal agencies and organizations on prevention and detection activities, including identifying and recouping overpayments, referring suspected provider fraud and abuse to federal agencies, and serving as a liaison between federal entities and MFCU on Medicaid fraud law enforcement activities. Additionally, federal law requires AHCA to facilitate prevention efforts nationally by submitting identification and employment information to the CMS Data Exchange System (DEX) about providers terminated from Florida Medicaid.[6] CMS reviews information submitted to DEX and makes it available to all state Medicaid agencies so the agencies can identify and terminate providers terminated in another state.[7]

[6] State agencies are required by federal law to notify CMS within 30 days of a provider's termination.
[7] 42 C.F.R. s. 438.214(d) (2025) prohibits MCOs from employing or contracting with providers excluded from participation in federal health care programs.

FINDINGS

The Florida Agency for Health Care Administration conducts and oversees program integrity efforts in coordination with managed care organizations and the Florida Medicaid Fraud Control Unit

AHCA's Office of Medicaid Program Integrity conducts and oversees fraud and abuse prevention and detection activities across Florida's Medicaid program. In this role, MPI oversees the prevention and detection efforts of MCOs within the Statewide Medicaid Managed Care program and collaborates with federal and state agencies and entities to support activities in these areas. This includes conducting audits to identify potentially fraudulent or abusive activities, monitoring overutilization of Medicaid services, and analyzing abnormal billing patterns.

MPI's activities are funded through state general revenue appropriated by the Legislature. MPI's Fiscal Year 2025-26 operating budget is $7.8 million. As of July 2025, there were 74.5 total MPI full-time equivalent positions. These positions include health care program analysts, registered nursing consultants, system project consultants, inspector specialists, and senior pharmacists. Individuals in these positions conduct investigations and audits, provide medical consultation and technical assistance to investigators, conduct data analysis, and make recommendations for referrals of fraud and abuse to other entities.

MPI continues to identify and investigate Florida Medicaid providers while supporting and assisting MCO efforts to identify fraud and abuse. In cases where an overpayment due to fraudulent billing practices has been identified, MPI staff recover these funds through three overpayment teams: practitioner care, pharmacy and durable medical equipment, and institutional.[8] These teams conduct audits according to provider type and recover overpayment funds. MPI uses various methods to identify potential cases of fraud, abuse, or overpayment.[9] These include auditing providers, analyzing Medicaid claims data, reviewing complaints about providers, and investigating referrals made from other providers or state agencies.[10] To support program integrity efforts, MPI conducts virtual and in-person quarterly meetings with MCOs; the meetings serve as open forums to communicate and educate on antifraud activities amongst the organizations. At these meetings, MPI and MCO staff share information (e.g., discuss how MPI reviews complaints, analyze and review recent cases) and discuss emerging trends and fraud schemes within the health care field (e.g., fraudulent practices in pharmacy settings). During these meetings, MPI may solicit feedback from MCOs related to policy changes and deadlines for submitting required reports (e.g., quarterly and annual fraud and abuse reports). Outside of these meetings, MPI periodically sends MCOs investigative alerts, which are prompts for an MCO to investigate the service or billing practices of a provider.

[8] The practitioner care team audits providers in non-institutional settings. The pharmacy and durable medical equipment team audits Medicaid drug service providers as well as providers of durable medical equipment and supplies. The institutional team audits hospitals, nursing homes, assisted living facilities, and hospice providers, among others.
[9] Overpayments include any amount that is not authorized to be paid by the Medicaid program whether paid due to inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or error.
[10] Section 409.913(2)(b), *F.S.*, defines a complaint as "an allegation that fraud, abuse, or an overpayment has occurred." Once a complaint has been reviewed by MPI staff for viability, determination of jurisdiction, and other factors, a case may be opened and referred for formal criminal investigation or a civil case may be initiated.

In addition to identifying potential fraud, abuse, and overpayments, MPI ensures MCO compliance with all state and federal requirements to prevent, detect, and deter abusive and fraudulent practices within the Medicaid program and monitors all contractual obligations related to program integrity.[11] Each of the eight MCOs is contractually required to have a special investigations unit (SIU). SIUs typically comprise individuals with knowledge or expertise in the field of health care fraud and program integrity (e.g., fraud and abuse specialists, medical coding auditors, data analysts).

MCO SIUs engage in various activities to prevent and detect potential incidents of fraud and abuse. SIU staff engage in prevention, detection, and recovery activities to identify and address fraudulent and abusive practices (e.g., billing for unnecessary services or services that were not provided).[12] (See Appendix B for an example of one MCO's SIU prevention, detection, and recovery activities.)

Prevention activities may include examining claims and supporting documents to identify improper billing practices prior to making a payment, mining data to detect fraud and abuse trends in claims data, and evaluating treatments or services and providing prior authorization before the treatment or service is rendered. For example, one MCO assesses treatments and services against established clinical guidelines to prevent unnecessary procedures or misuse and utilizes anti-fraud software to identify anomalies in billing patterns.

To detect potential fraud and abuse, SIU staff use automated claims edits to identify possible areas of concern, including to review medical records to verify claim validity and service necessity and to use fraud detection software to assess provider risk.[13] For example, one MCO evaluates duplicate or incorrect claims, examines variances between medical records and claims to assess a claim's validity, and uses fraud detection software—Healthcare Fraud Shield—to identify providers with potential fraudulent and abusive behaviors and assign providers a risk score.[14]

In addition, SIU staff conduct recovery activities, including recovering funds from a Medicaid provider if the SIU has determined that an improper payment or overpayment has occurred. For example, one SIU conducts audits and requests repayment from providers of overpayments identified during the reviews.

AHCA contracts require MCOs to report suspected or confirmed provider fraud to both MPI and MFCU and suspected or confirmed abuse to MPI. MPI and MCOs refer cases of suspected fraud to MFCU for investigation and prosecution. As required by federal law, MCOs refer cases of suspected abuse to MPI.[15] MCOs are required to notify MPI of the detection of suspected or confirmed provider fraud within five days of the discovery. This initial notice includes details about the suspected provider (e.g., name, Medicaid ID number, and entity type), information about the allegation (e.g., type of allegation, detection date), details about the potential fraud scheme, and the estimated dollar amount potentially lost.

---

[11] MPI uses contract management, auditing, encounter data, and a performance target to oversee and support MCOs' fraud and abuse detection activities.

[12] Section 409.913(1)(d), *F.S.,* defines medically necessary as "any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice." AHCA is the final arbiter of what goods and services are medically necessary.

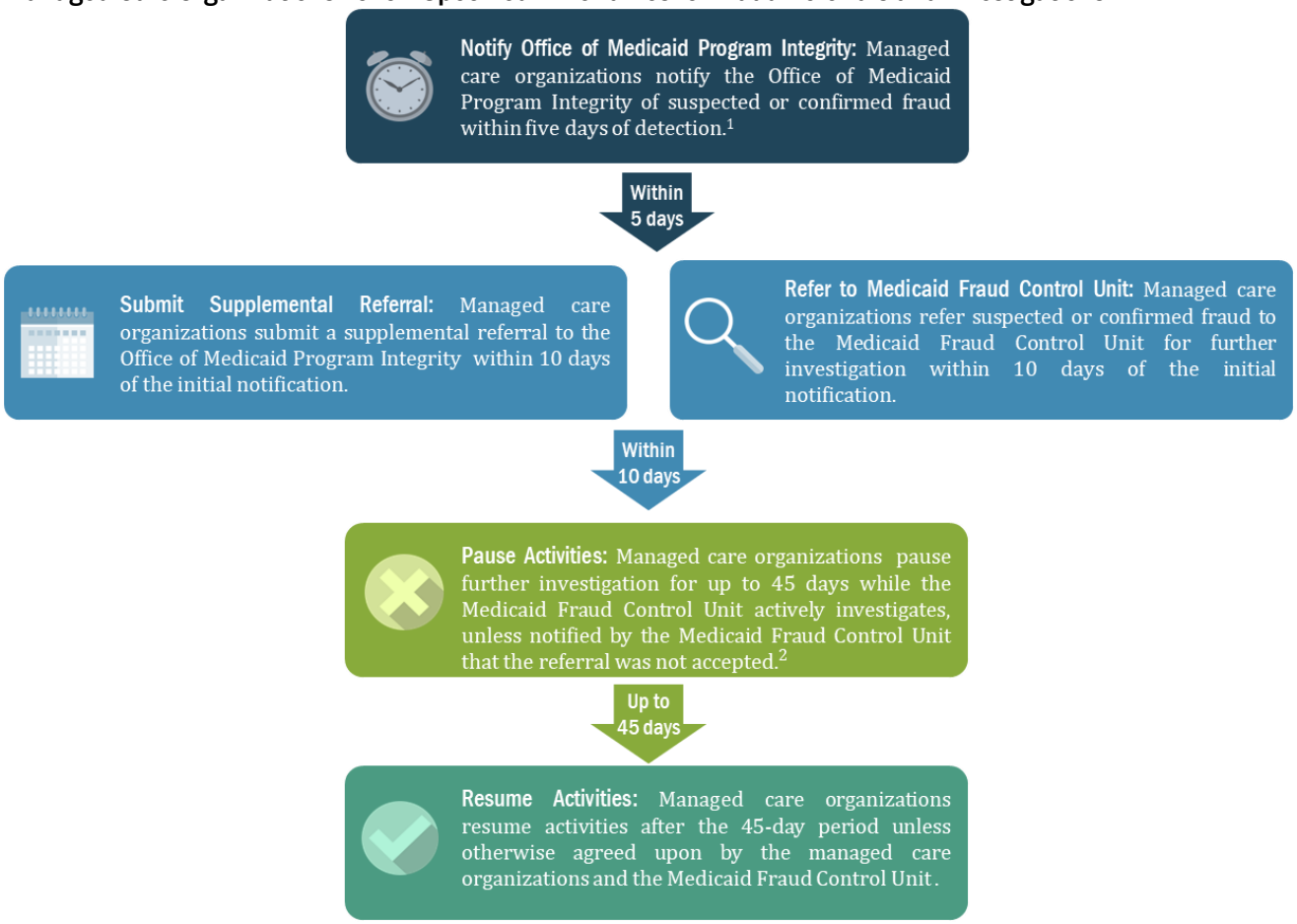
[13] Claims edits flag high-risk claims, providers, and members before a payment and may use advanced artificial intelligence, rules, and anomaly detection.

[14] Healthcare Fraud Shield is a platform with over 800 business rules and algorithms that identify providers with potential fraudulent and abusive behaviors and assigns a risk score. The platform is maintained and updated quarterly and can be customized to each state Medicaid plan.

[15] 42 C.F.R. s. 438.608 (2025) specifies that MCOs refer any potential cases of fraud and abuse to the respective state MPI unit and any potential cases of fraud to the state's respective MFCU. According to the U.S. Centers for Medicare & Medicaid Services, abuse is when health care providers or suppliers perform actions that directly or indirectly result in unnecessary costs to any health care benefit program.

After initial notification to MPI, MCOs are required to submit a supplemental referral with supporting documents (e.g., a factual explanation of the allegation, including specific Medicaid statutes, rules, and policies violated, communication between the MCO and provider, including emails, letters, and any attempts at provider education) to MPI within 10 days of the initial notice. Following the referral to MPI, MCOs refer incidents of suspected or confirmed fraud to MFCU within 10 days for further investigation. These referrals typically include a summary of MCO preliminary investigation efforts, supplemental documents such as interviews and audit report findings, and estimated exposed amount. MCOs temporarily pause any investigative and recovery efforts for up to 45 days (unless otherwise notified by MFCU) while MFCU actively investigates the referral, so it does not interfere with the investigation.[16] These activities include recovering payments from providers and witness interviews. If MCOs determine that the provider's actions warrant further scrutiny after 45 days from referral or notification by MFCU, the MCO may resume investigatory activities. (See Exhibit 3.)

Exhibit 3
Managed Care Organizations Follow Specified Timeframes for Fraud Referrals and Investigations



[1] The initial notice must include provider information, details about the allegation and potential fraud scheme, and the estimated dollar amount potentially lost.
[2] For up to 45 days after submitting a referral to MFCU, MCOs must pause investigatory and recovery actions, such as payment recovery and witness interviews.

Source: OPPAGA review of a Florida Agency for Health Care Administration Medicaid standard contract with a managed care organization.

[16] Payments to providers may be suspended while MFCU investigates the allegations of Medicaid fraud and abuse.

State Medicaid program integrity efforts can be assessed in several ways; measuring prevention activities is considered a best practice

Fraud and abuse can be identified through prevention- and detection-based activities. CMS has placed increased emphasis on prevention activities, which are generally more effective at addressing health care fraud than detection-based activities. States, MCOs, and related entities use a range of outcomes to assess these activities. Outcomes generally fall into two broad categories: prevention and detection. Although AHCA relies on a variety of detection-based outcomes to monitor program integrity, the agency only uses three formal performance targets, which are predominantly detection-based.

Program integrity and anti-fraud activities are measured in many ways; federal and national entities have emphasized the importance of prevention-based measures

State entities, MCOs, and related entities use various outcomes to measure Medicaid fraud and abuse prevention and detection efforts. There are two broad categories of these outcomes: prevention- and detection-based outcomes.[17,18] (See Exhibit 4.)

Exhibit 4
In Health Care, Program Integrity and Anti-Fraud Activities Are Measured Using a Variety of Outcomes

Outcome Type	Examples of Outcomes
Prevention-Based Outcomes	• Revocation of provider billing privileges • Payment denial from claims edits • Provider education activities (e.g., letters) conducted by a managed care organization • Number of provider terminations made by a managed care organization
Detection-Based Outcomes	• Number of referrals made to government agencies (e.g., Medicaid Fraud Control Unit, Florida Agency for Health Care Administration) when fraud or abuse is suspected • Percentage of acceptable suspected fraud and abuse referrals submitted • Total number of dollars recovered • Total number of fines levied against providers • Number of paid claims reversals made when fraud or abuse is detected

Source: OPPAGA analysis.

Although detection activities have historically been the focus of government entities, these efforts have limitations. CMS reported that, in comparison to prevention efforts, detection and recovery efforts can be time-consuming and expensive. Over time, CMS shifted from a recovery-based model, which attempts to recover dollars lost to fraud after the loss has occurred, to an integrated prevention and detection model because such an approach is typically more cost effective. Moreover, CMS reported that fraud prevention efforts are important because such activities address potential harm to beneficiaries, like receiving unnecessary services, before it occurs. The National Health Care Anti-Fraud Association (NHCAA) similarly reported that while the federal government still utilizes recovery, there has been a focus on prevention, especially over the past 10 years.

NHCAA convened a workgroup in 2019 to discuss the challenges of Medicaid fraud and abuse and recommend practices that promote effective coordination and communication among anti-fraud

[17] For this report, OPPAGA is categorizing outcomes related to detection- and recovery-based activities as detection-based outcomes. Some outcomes, however, do not cleanly fit in any one category. For example, return on investment is generally calculated by comparing operating costs of an agency or organization with the amount of dollars saved and recovered through prevention and detection activities.
[18] For example, in 2008, CMS published a performance standard for referrals of suspected fraud from state agencies to state MFCUs. U.S. Centers for Medicare & Medicaid Services. "CMS-MIG Performance Standard for Referrals of Suspected Fraud From a Single State Agency to a Medicaid Fraud Control Unit." Accessed December 8, 2025. https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/downloads/fraudreferralperformancestandardsstateagencytomfcu.pdf.

partners. The workgroup recommended that states recognize and account for the impact of MCO fraud prevention measures to evaluate the effectiveness of state anti-fraud efforts. Measures may include pre-payment authorizations and reviews, provider screening to prevent potentially fraudulent providers from network participation, advanced data analytics to identify providers exhibiting a pattern of behavior that indicates potential fraud, and the quality of referrals made to state MFCUs and Medicaid program integrity offices.[19]

AHCA uses several outcomes to monitor program integrity efforts; outcomes and formal performance targets are largely detection-based

AHCA and MFCU are statutorily required to annually report detection-based outcome measures to the Legislature related to efforts to control Medicaid fraud and abuse and to recover Medicaid overpayments during the previous fiscal year.[20] In addition, AHCA contractually requires MCOs to submit quarterly and annual reports on fraud and abuse activities conducted by the MCO.[21] Similar to AHCA and MFCU outcomes, the outcomes used in these reports are primarily detection-based. (See Exhibit 5.)

Exhibit 5
The Florida Agency for Health Care Administration and Managed Care Organizations Routinely Report on a Range of Medicaid Program Integrity Outcomes, Most of Which Are Detection-Based

Report	Entity	Examples of Required Outcomes
Fraud and Abuse Report (Annually)	Florida Agency for Health Care Administration; Medicaid Fraud Control Unit	Fraud, Abuse, and Overpayment Cases • Number of cases opened • Number of cases investigated • Sources of the cases opened • Disposition of the cases closed • Number and amount of fines or penalties imposed • Amount of overpayments alleged in preliminary and final audit letters • Amount of overpayments recovered Provider-Level • Number of providers, by type, that are terminated from participation in the Medicaid program as a result of fraud and abuse • Number of providers prevented from enrolling or reenrolling in the Medicaid program as a result of documented Medicaid fraud and abuse Overall Performance • All costs associated with discovering and prosecuting cases of Medicaid overpayments and making recoveries in such cases
Fraud and Abuse Activity Report (Annually, Quarterly)	Managed Care Organizations	Fraud and Abuse Cases • Number of fraud and abuse cases opened • Number of cases investigated • Number of cases closed • Total dollar amount lost to fraud and abuse identified • Total dollar amount lost to fraud and abuse recovered Overpayment Cases • Number of fraud and abuse overpayments alleged • Number of fraud and abuse cases with overpayments recovered • Total dollar amount of overpayments identified for recovery • Total dollar amount of overpayments recovered Overall Performance • Program integrity and/or special investigation unit return on investment

Source: OPPAGA analysis of Office of Medicaid Program Integrity documentation.

[19] While NHCAA recommends a measure related to referral quality, it does not define the elements of a quality referral.
[20] Section 409.913, *F.S.,* specifies that AHCA and MFCU must submit an annual report to the Legislature that summarizes case activity, including the number, sources, and dispositions of cases opened and investigated, the dollar amount in overpayments identified and recovered and fines imposed, the number of providers terminated or suspended for fraud and abuse, and the costs associated with investigating, prosecuting, and recovering Medicaid overpayments, for the previous fiscal year.
[21] The quarterly and annual fraud and abuse reports describe results for a number of SIU activities, including the number of cases opened, investigated, and closed during the reporting period; the number of overpayments identified and recovered; the total number of fines and penalties imposed; the dollar amount in fines and penalties imposed; the total number of referrals made to MPI and MFCU; and the SIU's estimated return on investment, among other things. Unlike MPI, MCOs are not required to report on the dollar amount in overpayments prevented.

Although AHCA uses a number of detection-based outcomes to monitor program integrity efforts, it relies on only three formal performance targets to compare and assess MPI and MCO performance each year. (See Exhibit 6.) Specifically, the agency uses one prevention-based target and one detection-based target to evaluate MPI program integrity performance and one detection-based target to evaluate MCO program integrity performance. For MPI, AHCA assesses the annual dollar amount for overpayments identified and overpayments prevented. These targets are published annually in the agency's long-range performance plan (LRPP).[22] For Fiscal Year 2023-24, the performance target for overpayments identified was $34.3 million and the target for overpayments prevented was $16.4 million.

Subsequent to OPPAGA's prior recommendation, AHCA developed one detection-based annual fraud referral performance target to evaluate MCO program integrity efforts.[23] Specifically, in Fiscal Year 2020-21, AHCA developed an annual performance target for the number of referrals of suspected fraud and abuse that MCOs submit to MFCU and implemented the performance target in Fiscal Year 2021-22. MCOs are contractually required to submit a specific number of fraud referrals to AHCA and MFCU each year. AHCA determines the annual performance target for each MCO using a formula that accounts for the organization's size (i.e., ratio of enrollees to providers) and the monthly capitation payment amount paid to the MCO. AHCA updates each MCO's performance target annually. For Fiscal Year 2023-24, performance targets ranged from 3 to 90 referrals across the eight MCOs. Currently, there are no other program integrity-related performance outcomes that MCOs are contractually required to report.

Exhibit 6
The Florida Agency for Health Care Administration Uses Three Performance Measures to Evaluate Medicaid Program Integrity Efforts

Performance Measure	Accountable Entity	Description	Type	Fiscal Year 2022-23 Performance Target	Fiscal Year 2023-24 Performance Target
Overpayments identified	Office of Medicaid Program Integrity	Dollar amount in overpayments to Medicaid providers identified due to Medicaid Program Integrity oversight[1]	Detection-based	$34.3 million	$34.3 million
Overpayments prevented	Office of Medicaid Program Integrity	Dollar amount in overpayments prevented due to Medicaid Program Integrity oversight[2]	Prevention-based	$16.4 million	$16.4 million
Fraud referrals sent to Medicaid Fraud Control Unit	Managed Care Organizations	Number of referrals for suspected or confirmed fraud sent to Medicaid Fraud Control Unit by managed care organizations	Detection-based	Range: 3 to 80 referrals	Range: 3 to 90 referrals

[1] The overpayment identification performance target is the total annual dollars lost to inaccurate or improper cost reporting, claims, fraud, abuse, or error.
[2] The overpayment prevention performance target (i.e., cost avoidance) is the total annual dollars saved through activities such as claims and reimbursement denial, site visits, and provider audits, sanctions, and terminations.

Source: OPPAGA analysis of Florida Agency for Health Care Administration documentation.

[22] OPPAGA categorizes overpayments identified as a detection-based outcome and overpayments prevented as a prevention-based outcome.
[23] OPPAGA's 2020 report noted that MCOs lacked plan-specific benchmarks to assess antifraud performance. OPPAGA recommended that AHCA develop reports that provide context for plan antifraud activities. Although AHCA did not develop summary reports of plans' program integrity efforts, it did create a performance target for plans' fraud referral activities, which was noted in OPPAGA's 2022 report. See *AHCA Continues to Improve Medicaid Program Data Quality and Oversight; Additional Improvements Needed in Use of Data*, OPPAGA Report 20-04, January 2020 and *Biennial Review of AHCA's Oversight of Fraud, Waste, and Abuse in Florida's Medicaid Program*, OPPAGA Report 22-03, January 2022.

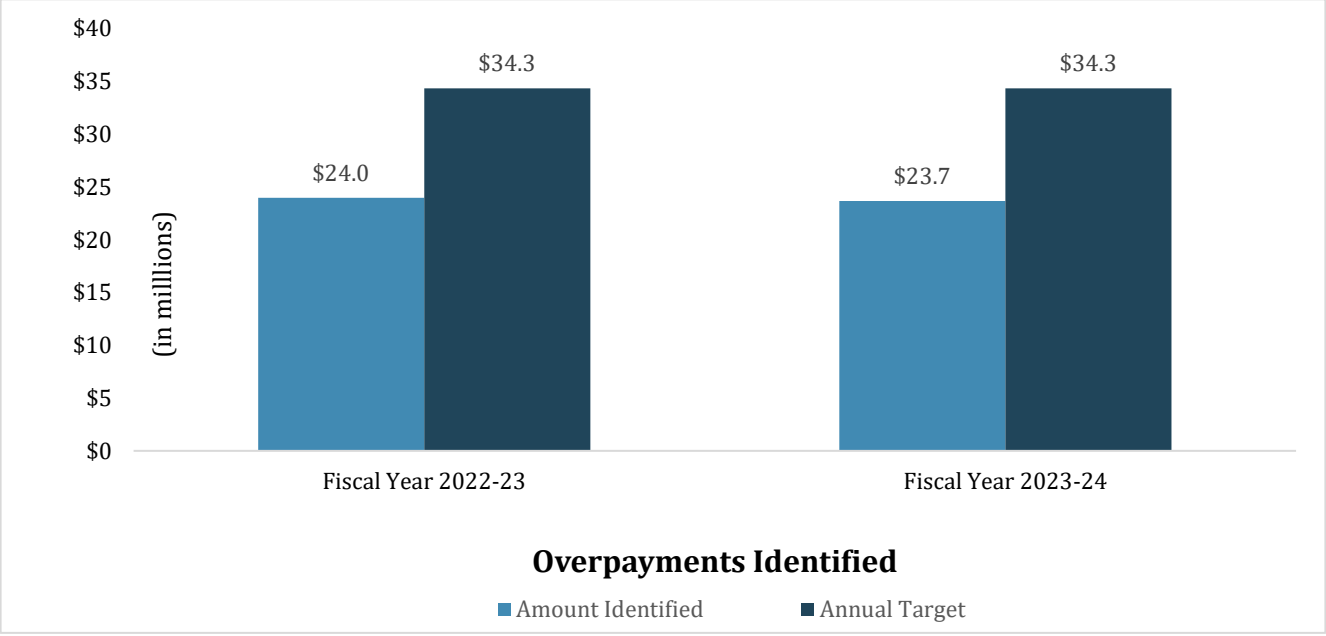
During the review period, MPI and MCOs had mixed results meeting detection and prevention performance targets

In Fiscal Years 2022-23 and 2023-24, MPI and MCOs demonstrated mixed performance in meeting detection and prevention targets. MPI did not meet the detection-based performance target in either year for overpayments identified but greatly exceeded its prevention-based target for overpayments prevented in both years. During the same period, MCOs did not consistently meet the detection-based performance target for fraud referrals.

MPI did not meet the detection-based performance target for overpayments identified, but exceeded prevention-based performance targets for overpayments prevented

MPI did not meet LRPP performance targets for overpayments identified in Fiscal Years 2022-23 and 2023-24. The total dollars in Medicaid overpayments MPI identified remained stable and, on average, MPI identified $23.8 million in overpayments. However, for both fiscal years, MPI failed to meet its specified annual target of $34.3 million. (See Exhibit 7.) On average, MPI fell $10.5 million short of its goals for overpayments identified. MPI underperformance on this target is consistent with findings from OPPAGA's 2024 MPI report. According to AHCA officials, the agency did not utilize a risk assessment or strategic plan when developing LRPP targets, including the target for overpayment identification. AHCA officials noted that use of a formal risk assessment process may have improved identification of high-risk areas and helped direct additional staffing and resources towards overpayment identification.

Exhibit 7
Medicaid Program Integrity Did Not Meet Annual Performance Targets for Overpayments Identified in Fiscal Years 2022-23 and 2023-24

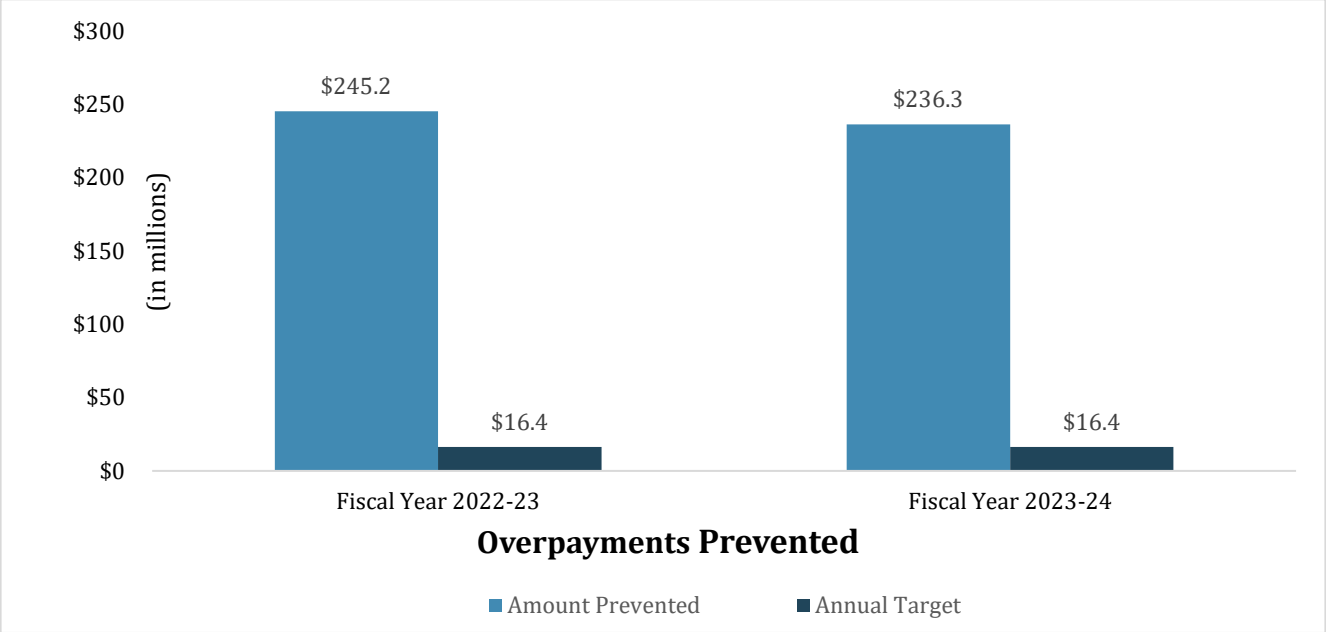


Source: Florida Agency for Health Care Administration.

MPI met AHCA LRPP annual performance targets for overpayments prevented in Fiscal Years 2022-23 and 2023-24. (See Exhibit 8.) In Fiscal Year 2022-23, $245.2 million in overpayments were prevented

compared to the annual goal of $16.4 million. In Fiscal Year 2023-24, $236.3 million in overpayments were prevented compared to the annual goal of $16.4 million. On average, MPI exceeded its goals for overpayments prevented by $224.4 million. According to AHCA officials, this overperformance was due to MPI placing significant attention and staffing on prevention efforts.

Exhibit 8
Medicaid Program Integrity Greatly Exceeded Annual Performance Targets for Overpayments Prevented in Fiscal Years 2022-23 and 2023-24



Source: Florida Agency for Health Care Administration.

MCOs have detection-based fraud referral performance targets, but MPI staff reported that there are no penalties for failing to meet targets

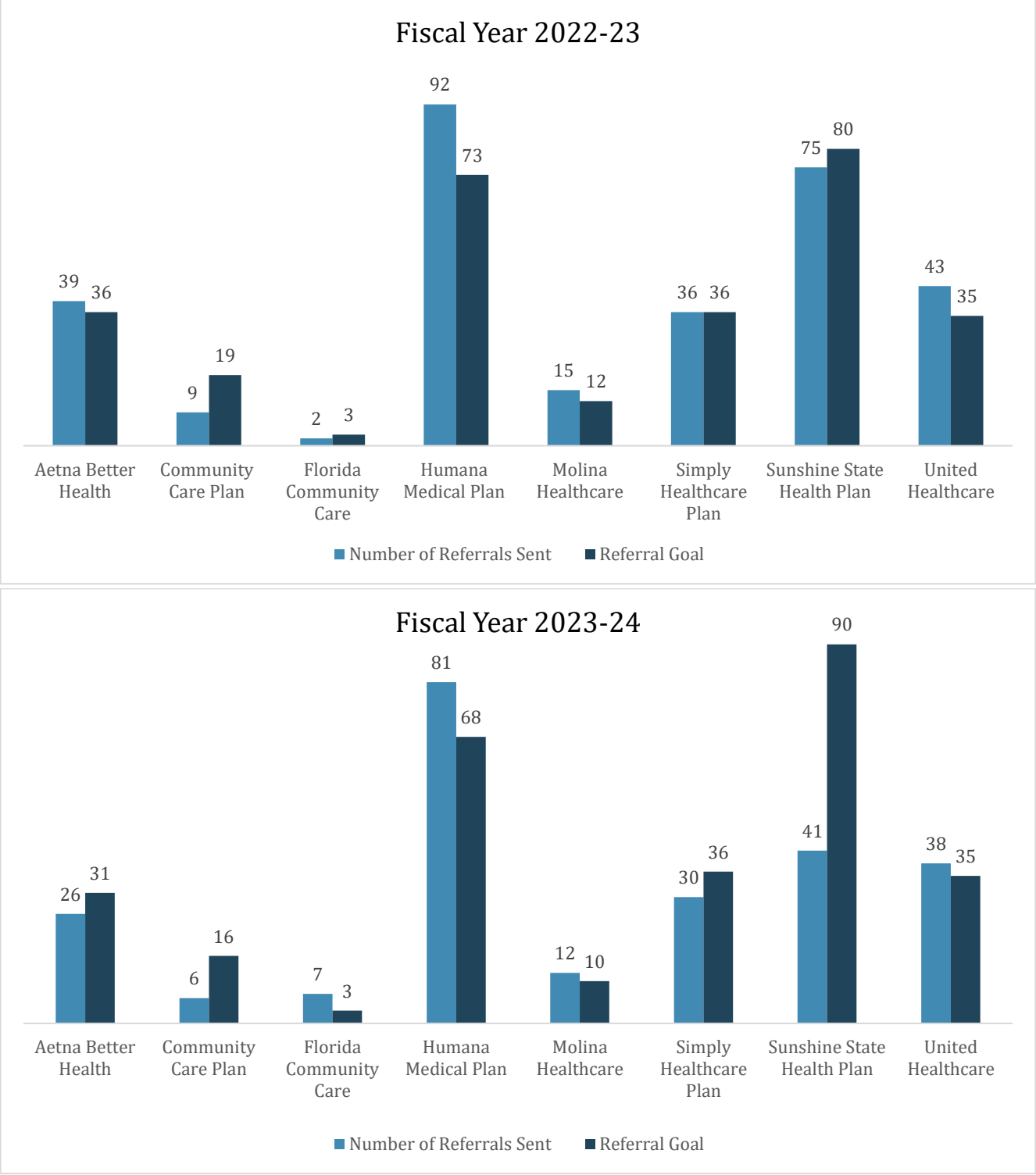
MCOs refer cases of suspected or confirmed fraud to MFCU. AHCA monitors and records the number of referrals MCOs submit. Referral numbers are compared with annual performance targets specified by the agency in its contracts with MCOs. Consistent with OPPAGA's prior report, MPI staff reported that there are no penalties for MCOs that fail to meet performance targets. Instead, MCO contracts outline penalties for failing to meet non-MPI related performance measures, such as administrative and service requirements.[24] In addition, interviews with MPI staff confirmed that MCOs have not historically been penalized for failing to meet contractually required referral targets. The lack of consequences for underperformance limits the utility of the referral targets as a tool for improving MCO performance.

While some MCOs met the annual referral-related target over the two-year review period, performance has been inconsistent. Of the eight MCOs, three (Humana Medical Plan, Molina Healthcare, and United Healthcare) met required targets for both Fiscal Years 2022-23 and 2023-24. In Fiscal Year 2022-23, five MCOs met referral targets. During this period, all eight MCOs submitted a total of 311 referrals, which exceeded the 294 referrals projected. In Fiscal Year 2023-24, four MCOs met referral targets. During this period, the eight MCOs submitted a total of 241 out of the 289 referrals

[24] AHCA may contractually impose liquidated damages on an MCO for more than 120 distinct compliance issues, including failure to timely report changes in MCO staffing, failure to timely report terminated providers for cause, and failure to provide medically necessary services to enrollees under the age of 21 years.

projected, a 22% decrease from the previous fiscal year. (See Exhibit 9.) AHCA reported that MCOs cited a shift towards greater prevention efforts by SIUs as well as issues in caseload management and resource allocation as contributing factors for not meeting referral goals.

Exhibit 9
In Fiscal Year 2022-23, Five Managed Care Organizations Met the Annual Performance Target for Number of Fraud Referrals; Four Managed Care Organizations Met This Target in Fiscal Year 2023-24



Source: Florida Agency for Health Care Administration.

According to national entities, collaboration is essential for program integrity; referral quality may be improved through greater communication and information sharing

National entities and industry stakeholders identify collaboration as essential for effective Medicaid program integrity efforts. Although increased communication and education have reportedly enhanced the quality of submitted Medicaid fraud referrals in Florida, clarification about the elements of a high-quality referral is needed.

Collaboration is critical for both Medicaid program integrity success and quality of submitted referrals; MPI communicates regularly with the MCOs, but quarterly meetings with MFCU to discuss fraud cases are recommended

U.S. Centers for Medicare & Medicaid Services (CMS) and National Health Care Anti-Fraud Association (NHCAA) cite collaboration as an integral component of successful Medicaid program integrity efforts. CMS reports that collaboration among MCOs, the state Medicaid office, and the state MFCU is an effective and important component in preventing, detecting, and reducing fraud and abuse. Moreover, ongoing communication about cases between entities has the reported benefit of improving the quality of referrals, particularly when the state MFCU provides input early in a case.[25]

In addition, NHCAA's workgroup recommended practices that promote effective collaboration among anti-fraud partners, which participants found was critical for detecting, preventing, investigating, and prosecuting health care fraud. The workgroup recommended that MPI units, state MFCU, and MCOs hold regularly scheduled meetings to discuss anti-fraud strategies, fraud trends and emerging schemes, investigative findings and data, and state expectations for MCOs. Such communication allows for consistent information exchange between key stakeholders, identification of successful analytics, and timely information, such as updating MCOs on the status of investigations so the organizations can proceed in taking mitigating action to prevent further losses.[26]

In Florida, MCOs communicate with MPI on an as-needed basis, with routine coordination on case updates, requests for information, investigative alerts, and audit findings. MCOs also participate in quarterly in-person meetings and periodic virtual sessions with MPI to discuss emerging issues, cases of interest, and state and national fraud trends. MFCU has given at least one informal presentation about fraud referrals at these meetings. MPI and MFCU also share information and updates related to fraud investigations. A 2022 CMS review noted that MPI has reported challenges in obtaining status updates on referred cases and maintaining regular, ongoing communication with MFCU.[27] CMS recommended that MPI and MFCU discuss cases and evaluate referral status on a quarterly basis in accordance with the current memorandum of understanding.

[25] This is consistent with a Medicaid and CHIP Payment and Access Commission finding that greater collaboration and information sharing may help support the development of stronger cases for suspected fraud. Medicaid and CHIP Payment and Access Commission. "Report to Congress on Medicaid and CHIP." Accessed December 31, 2025. https://www.macpac.gov/wp-content/uploads/2017/06/June-2017-Report-to-Congress-on-Medicaid-and-CHIP.pdf.

[26] MCOs cannot continue or take further actions, such as payment recovery and witness interviews, while an investigation is ongoing—up to 45 days after submitting a referral to MFCU.

[27] U.S. Department of Health and Human Services and Centers for Medicare & Medicaid Services, Center for Program Integrity. "Florida Focused Program Integrity Review Medicaid Managed Care Oversight May 2025 Final Report." Accessed January 3, 2026. https://www.cms.gov/files/document/florida-fy2022-focused-pi-review-final-report.pdf.

MPI and MFCU staff reported improved referral quality following increased communication and education; MCOs staff indicated that further improvements may be achieved with additional communication and collaboration

National and state stakeholders emphasize the importance of referral quality for evaluating and measuring program integrity activities, despite absence of formal criteria. CMS notes that the quality of fraud referrals is a critical component of Medicaid program integrity activities, and both CMS and NHCAA emphasize assessing referral quality rather than focusing solely on the volume of referrals submitted to state agencies or MFCUs.[28] These views are consistent with those of AHCA and MFCU, which note that submitting referrals primarily to meet number-based performance targets risks diminishing referral quality and wastes investigative resources.

Despite broad agreement among national and state stakeholders about the importance of referral quality, there is no formal guidance about what constitutes a quality referral. In the absence of formal criteria, MPI and MFCU staff reported determining referral quality based on prosecutability—whether MFCU investigators have enough information and evidence to pursue criminal prosecution of the provider for Medicaid fraud. In practice, this involves judgment and professional discernment on behalf of both the submitting MCO and reviewing investigator. MPI staff reported working with MFCU to define what makes a quality referral.

Since OPPAGA's last review, AHCA reported that fraud referral quality has improved. In OPPAGA's 2024 report, MFCU staff noted that the quality of MCO fraud referrals had been inconsistent.[29] For the current review period, MPI, MFCU, and MCO staff reported that referral quality has improved, citing increased direct verbal and written feedback to MCOs from MPI and MFCU. In its Fiscal Year 2023-24 Annual Fraud and Abuse Report, jointly published with MFCU, MPI reported that it had begun providing immediate feedback to MCOs with suggestions for making higher quality referrals, such as providing more detail regarding the alleged fraud. Similarly, MFCU officials reported frequent communication with MPI and MCOs about referrals submitted by MCOs. For example, MFCU contacts MPI and MCOs to request additional information needed to conduct its investigation. This may include clarifying information already provided or acquiring additional information, such as data pertaining to MCOs' contracted providers. MFCU also provides MPI and MCOs with investigation updates, such as arrests and case closures. MCO staff also reported increased communication with MPI and MFCU, including discussing open cases, asking questions (e.g., when to pause or resume investigative and recovery activities), and sharing issues that MCOs may be experiencing, such as uncertainty about contractual reporting requirements.

In addition, MCO staff reported that MFCU has provided helpful information regarding the submission of fraud referrals. For example, in spring 2025, MFCU gave a presentation on quality referrals to MCOs that included suggestions about necessary information and documentation MCOs should provide when submitting a referral to MFCU and a general description of the elements that comprise a quality referral. MFCU's presentation indicated that although the information and documentation varies by case, certain elements should always be considered for inclusion, if applicable, such as audit reports

[28] The U.S. Department of Health and Human Services Office of Inspector General is currently conducting an evaluation of state Medicaid agencies that will include a determination of how states evaluate the volume and quality of the fraud referrals made by managed care plans. The report is expected to be completed during federal Fiscal Year 2026.

[29] *Biennial Review of AHCA's Oversight of Fraud and Abuse in Florida's Medicaid Program*, OPPAGA Report 24-03.

and findings, medical records reviewed, complete data sets reviewed, provider contracts, communication with providers, and policies and procedures.

According to MFCU staff, about 90% of referrals from MCOs are accepted for further investigation. For referrals that are not accepted, MFCU staff reported that common issues related to missing information and insufficient documentation to support fraud allegations. MCO staff reported that when submitting referrals for MFCU investigation, the most common reasons for non-acceptance include not being Medicaid program related and lacking evidence to substantiate Medicaid fraud allegations or criminal activity.[30]

Some MCO staff reported that referral quality and overall program integrity efforts could be enhanced through greater communication, collaboration, and information sharing. Some MCO staff recommended improving communication and collaboration between AHCA and MFCU, between MCOs and state agencies, and among MCOs. For example, recommendations included increasing information and data sharing among MCOs on topics such as fraudulent billing practices and pending investigations against providers in multiple networks. This may allow MCOs to investigate suspicious providers across networks to detect potential fraud and abuse or prevent loss. These suggestions are consistent with CMS and NHCAA recommendations and could strengthen MCOs ability to submit high-quality and prosecutable referrals.

Although MPI staff issued guidance to MCOs in 2020 outlining required supplemental fraud referral information and documentation, MCO staff reported that the quality of fraud referrals would be improved if AHCA and MFCU also provided a referral submission checklist of essential elements (i.e., information, documentation). A fraud referral checklist is consistent with CMS and NHCAA recommendations, as well as a 2018 U.S. Health and Human Services Office of the Inspector General report on MCO fraud and abuse activities. The report found that some states require MCOs to use a standardized referral form and that those states reported subsequent improvement in the quality and consistency of submitted referrals.[31] This finding led the HHS-OIG to recommend that CMS work with states to standardize referrals across MCOs so that forms use standardized fields, definitions, and examples. According to MFCU officials, the unit is in the early stages of developing a referral form and checklist. Upon request, MFCU did not provide OPPAGA with a copy of either the form or checklist for review. AHCA subsequently confirmed that MPI and MFCU have been meeting regularly to discuss and develop a referral template. AHCA staff reported that this template was shared with two of the eight MCOs as part of a pilot process. MPI is expected to expand the pilot process and make any necessary revisions throughout 2026.

RECOMMENDATIONS

OPPAGA identified issues related to measuring efforts to prevent, detect, and deter Medicaid fraud and abuse. OPPAGA also identified opportunities for the Florida Agency for Health Care Administration, Florida Medicaid Fraud Control Unit, and managed care organizations to further improve communication and collaboration regarding the quality of fraud referrals.

As OPPAGA previously recommended, the overall utility of the MCO fraud referral performance target could be enhanced. To achieve this, AHCA should annually report the total number of MCO referrals to

[30] Although referrals may have not been accepted because of issues pertaining to quality, non-accepted referrals may include those that lacked sufficient information for MFCU to determine whether further action was warranted.

[31] U.S. Department of Health and Human Services Office of Inspector General. "Weaknesses Exist in Medicaid Managed Care Organizations' Efforts to Identify and Address Fraud and Abuse." Accessed December 29, 2025. https://oig.hhs.gov/oei/reports/oei-02-15-00260.pdf.

MFCU that meet a minimum standard of information for investigation. AHCA could model this revised target on previously released guidance by the U.S. Centers for Medicare & Medicaid Services.[32]

To address limitations in the measurement of program integrity, which in part stem from a lack of comprehensive measures, OPPAGA recommends that AHCA consider adding prevention-based performance targets to its contracts with MCOs. Further, current use of the fraud referral performance target could be enhanced by creating formal guidance and training materials about referral quality to ensure that AHCA, MFCU, and the MCOs all share common terminology and an understanding about the types of referrals that MCOs should submit. (See Exhibit 10.)

Exhibit 10
The Florida Agency for Health Care Administration Could Further Improve the Agency's Medicaid Fraud and Abuse Detection Activities by Improving Performance Measures

Topic	Concern	Recommendation
Performance Measures	The Florida Agency for Health Care Administration does not have comprehensive performance targets for measuring managed care organization prevention and detection efforts.	The Florida Agency for Health Care Administration should consider adding new performance measures to its contracts with managed care organizations to better reflect the totality of prevention and detection activities. Possibilities include adoption of prevention-based outcomes such as the number of prepayment reviews, payment suspensions, or total dollars generated from prevention activities.
Fraud Referrals	The Florida Medicaid Fraud Control Unit, the Florida Agency for Health Care Administration, and managed care organizations do not have an explicit definition of, nor criteria for, referral quality.	The Florida Agency for Health Care Administration should continue collaborating with the Florida Medicaid Fraud Control Unit to specify the elements that define a quality referral so that all parties (the agency, the Florida Medicaid Fraud Control Unit, and managed care organizations) share common terminology and an understanding as to what types of referrals should be made to the agency and the Florida Medicaid Fraud Control Unit. This effort could be complemented by developing formal guidance and training materials for managed care organizations.

Source: OPPAGA analysis.

[32] U.S. Centers for Medicare & Medicaid Services. "CMS-MIG Performance Standard for Referrals of Suspected Fraud From a Single State Agency to a Medicaid Fraud Control Unit." Accessed December 8, 2025. https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/fraudabuseforprofs/downloads/fraudreferralperformancestandardsstateagencytomfcu.pdf.

APPENDIX A

Types of Medicaid Provider Fraud

Fraud involves an intentional deception or misrepresentation to obtain an unauthorized benefit. Medicaid provider fraud can take many forms, such as manipulating billing codes and billing for unnecessary services or services not performed. Other fraudulent activities include collusion and misuse of Medicaid ID cards to improperly obtain reimbursement. (See Exhibit A-1.) The Florida Agency for Health Care Administration's Office of Medicaid Program Integrity, Florida Medicaid program managed care organizations, and the Florida Office of Attorney General's Medicaid Fraud Control Unit collaborate to prevent and detect these occurrences.

Exhibit A-1
There Are Several Types of Medicaid Provider Fraud

Type of Fraud	Examples
Billing for unnecessary services or items	Intentionally billing for unnecessary medical services or items
Billing for services or items not provided	Intentionally billing for services or items not provided
Unbundling	Billing for multiple codes for a group of procedures that are covered in a single global billing code
Upcoding	Billing for services at a higher level of complexity than provided
Card sharing	Knowingly treating and claiming reimbursement for someone other than the eligible beneficiary
Collusion	Knowingly collaborating with beneficiaries to file false claims for reimbursement
Drug diversion	Writing unnecessary prescriptions or altering prescriptions to obtain drugs for personal use or to sell them
Kickbacks	Offering, soliciting, or paying for beneficiary referrals for medical services or items
Multiple cards	Knowingly accepting multiple Medicaid ID cards from a beneficiary to claim reimbursement
Program eligibility	Knowingly billing for an ineligible beneficiary

Source: OPPAGA analysis of U.S. Centers for Medicare & Medicaid Services documentation.

APPENDIX B

Special Investigation Unit Activities of One Managed Care Organization

Managed care organization special investigation units perform various activities to prevent and detect fraud and abuse and recover funds lost due to improper payments. For example, one managed care organization's activities include reviewing claims and supporting documents prior to payment, using data analysis and automated processes (e.g., claims edits) to identify potential fraud or abuse, and utilizing payment recoupment methods (e.g., overpaid amount is offset against future claim payments). (See Exhibit B-1.)

Exhibit B-1
Special Investigation Unit Staff Engage in Various Prevention and Detection Activities

Tool or Method	Description
Prevention Activities	
Clinical pre-payment and non-clinical pre-payment reviews	Examine claims, supporting documentation, and billing and coding accuracy to identify potential fraud and abuse before payment to prevent improper payments.
Program integrity awareness and provider, enrollee, and employee training	Educates and trains providers, enrollees, and employees on how to detect and prevent fraud, abuse, and overpayment.
Pre-service authorizations	Evaluates the treatment or service and provides prior authorization before the treatment or service is rendered to ensure it aligns with established clinical guidelines to prevent unnecessary procedures and the misuse of resources.
Claims system edits	Evaluates claims for payment, and duplicate or incorrectly coded claims, using automated system edits to identify possible areas of concern and code scenarios.
Detection Activities	
Internal referrals	Receives fraud and abuse tips from various sources within the organization, such as special investigations unit tip hotlines and the organization's intranet.
External referrals	Receives fraud and abuse tips from various external sources, such as tip hotlines, other health plans, federal and state agencies, and national organizations.
Use of fraud detection software	Identifies providers with potential fraud and abuse behaviors and assigns a risk score.
Medical records review	Reviews medical records to assess the validity of the claim through an examination of variances between what is documented in the medical record and what has been submitted on the claim.
Predictive analytics	Uses multiple information technology software and anti-fraud solutions to conduct link analysis, data analytics, and anomaly detection capabilities to data mine for fraudulent or abusive billing patterns.
Duplicate check edits against member's claims history	Reviews claims with the same billed dates, modifiers, procedure codes, provider, diagnosis codes, units, and billed dollars to identify any potential services being unbundled/bundled based on current and historical claims.
Data analytics	Completes data mining to detect fraud and abuse trends in claims data. These reviews create business rules and models that generate weekly leads for special investigations unit staff to review and refer for investigation.
Site visits	Conducts provider site visits to determine whether allegations of fraud or abuse against Medicaid providers are sufficiently substantiated to warrant other interventions such as law enforcement referrals, recovery activities, or other administrative actions.
Health plan member interviews about provider services	Interviews health plan members or witnesses to verify services performed, prescriptions written, and member financial responsibility.
Credentialing and continuous screening processes	Conducts credentialing and screening checks to exclude providers barred from participating in the Medicaid program.
Comprehensive utilization management	Reviews eligibility for benefits for the care that has been or will be provided to patients to determine medical necessity and plan benefits.
Artificial intelligence	Utilizes a machine learning (artificial intelligence) solution to identify fraud and abuse cases to increase savings and recoveries.

Tool or Method	Description
Recovery Efforts	
Provider suspensions and terminations	Notifies the state of any action taken due to its investigation, including suspension or termination (voluntary or involuntary) of a provider or subcontractor contract, or recovery of improper payments made to network providers.
Recoup overpayments	If it is determined that an improper or overpayment has occurred, special investigations unit staff will pursue recovering funds from the provider. After notification of an identified overpayment, providers have the opportunity to submit a refund. If repayment is not received within an established timeframe (e.g., 60 days), recoupment methods, such as the withholding of future claim payments, are performed.

Source: OPPAGA review of information from a managed care organization.

OPPAGA

Office of Program Policy Analysis and Government Accountability

OPPAGA provides performance and accountability information about Florida government in several ways.

- Reports deliver program evaluation and policy analysis to assist the Legislature in overseeing government operations, developing policy choices, and making Florida government more efficient and effective.
- Government Program Summaries (GPS), an online encyclopedia, provides descriptive, evaluative, and performance information on Florida state government programs.
- PolicyNotes, an electronic newsletter, delivers brief announcements of research reports, conferences, and other resources of interest for Florida's policy research and program evaluation community.
- Visit OPPAGA's website.

OPPAGA supports the Florida Legislature by providing data, evaluative research, and objective analyses that assist legislative budget and policy deliberations. This project was conducted in accordance with applicable evaluation standards. Copies of this report in print or alternate accessible format may be obtained by telephone (850/488-0021), in person, or by mail (OPPAGA, Claude Pepper Building, Room 312, 111 W. Madison St., Tallahassee, FL 32399-1475).

Project supervised by Wendy Scott (850/717-0500)
Project conducted by Dan Dunleavy (850/717-0515), Daphne Holden, Rebecca Bouquio, and Kathy Joseph
Kara Collins-Gomez, Coordinator