Shumaker

MARCH 31, 2026 | PUBLICATION

Client Alert: Florida Medicaid Fraud Investigation

The Issue: As part of a broader effort from the Trump Administration to identify excessive spending and ways to reduce waste and abuse, Medicaid fraud has come under particular scrutiny in Florida.

INDUSTRY SECTOR

Health Care

SERVICE LINE

Health Law

RELATED PROFESSIONALS

Grant P. Dearborn
Sean Schrader

MEDIA CONTACT

Wendy M. Byrne
wbyrne@shumaker.com

As such, based on investigations already happening in several other states like Minnesota, New York, Maine, and California, there is a broad interest in investigating potential Medicare fraud in Florida and implementing corrective actions. Specifically, Dr. Mehmet Oz, the Administrator of the Centers for Medicare & Medicaid Services (CMS), has identified several prior cases of fraud that justify the investigations:

- CEO of Health Care Software Company Convicted of $1B Fraud Conspiracy
- Two Health Care Executives Convicted for Exploiting Elderly Medicare Advantage Beneficiaries in $34 Million Fraud Scheme
- Florida Laboratory Owner Pleads Guilty to $52M Medicare Fraud Scheme Involving Genetic Tests
- Attorney General James Uthmeier Announces Arrests in Central Florida Medicaid Fraud Scheme

CMS believes current high-risk areas are within:

- Durable Medical Equipment (DME)
- Pharmacies
- Telemedicine
- Genetic testing/labs
- Applied Behavior Analysis (ABA) Therapy
- Adult day centers
- Personal care services

As a first step, on March 17th, questions regarding the current integrity of the Medicaid program, Medicaid provider oversight, and determination of high-risk Medicaid services were submitted to Florida officials (Governor DeSantis and Attorney General Uthmeier, among others).They have 30 days to respond and provide input.

Possible Impacts:

Florida officials, including Attorney General James Uthmeier and Chief of Staff to the Governor Jason

Weida, have responded positively to this request and will comply.

Following this initial period of the investigation, the most likely outcome will involve enhanced enforcement to prevent further fraudulent activity and, if deemed appropriate, the implementation of a corrective action plan. This could include:

- Increased audits and prepayment reviews
- Additional provider revalidations and screenings
- Stronger managed care organization fraud oversight requirements
- Expanded use of payment suspensions for non-compliance

At this initial stage, it's important to be aware of the scope of this investigation and its possible implications. For health care facilities and practitioners, this will most likely lead to an increase the number of billing reviews and audits. Moreover, it will increase the value of timely and appropriate documentation, internal validation of billing processes, and the availability of documentation for services and goods. Finally, this should be seen as an opportunity to reassess your compliance program and related policies.

If you have any questions regarding the new investigations into Medicaid fraud, please contact Grant Dearborn or Sean Schrader.

© 2026 Shumaker, Loop & Kendrick, LLP. All Rights Reserved. Privacy Policy/Disclaimer

Shumaker