Tavern NPC Dialogue Master File

State-driven case dialogue for hotspots Guy_1 - Guy_7

Build date: January 28, 2026

Design notes

Each section is aligned to a single state case file. Every NPC is written as a click-initiated conversation (PLAYER ↔ NPC), with a short personality overview followed by dialogue that summarizes the assigned case.

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Section 1: Minnesota

Guy_1 — The Frost Witness

Case file: MN.txt

Personality overview

- Vibe: investigative whistleblower energy with a winter-cold stare.
- Humor style: dry, “I’m not mad, I’m disappointed” sarcasm.
- Knows the receipts: quotes numbers, channels, and choke points like a walking audit report.
- Bias: allergic to “we fixed it” statements without independent audits.

Dialogue

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PLAYER: You look like you’ve been through a blizzard.
GUY_1: Minnesota. Same thing. Except the blizzard is paperwork and the snow is missing
       money.
PLAYER: What happened here?
GUY_1: The case file calls it a $9+ billion Medicaid fraud scandal between 2020 and 2025.
       “One of the largest documented” in U.S. history.
PLAYER: Nine… billion?
GUY_1: Yes. Billion. With a B. Recovery? Under $70 million. That’s less than 1%.
PLAYER: How do you lose that much?
GUY_1: Two channels. That’s the whole trick.
GUY_1: Channel 1 is direct state payments - about 20% of spending, roughly $1.9B a year.
       Visible. Audited.
GUY_1: Channel 2 is MCO capitation - about 80% of spending, around $8B a year. Not
       independently audited in the big state audit. The MCOs audit themselves.
PLAYER: So fraud can hide in the big bucket.
GUY_1: Exactly. And while everyone’s staring at the 20% bucket like it’s the whole ocean,
       the other 80% is doing synchronized swimming.
PLAYER: What’s the ‘famous’ scheme?
GUY_1: Feeding Our Future. Fake nonprofits. Fake meals. Real money. Estimates in the file
       put it $250M to $350M.
PLAYER: How did they pull that off?
GUY_1: They created shell nonprofits, enrolled them, then billed for ridiculous meal coun
       Minimal verification. Payments in weeks. Then the money left the country.
PLAYER: Left the country how?
GUY_1: Wire transfers and laundering. Countries named in the case file include Somalia,
       Kenya, Turkey, the Maldives, and China. The file says likely billions went oversea
PLAYER: That’s… not subtle.
GUY_1: Fraud at scale isn’t subtle. It’s confident. Like it knows the system won’t bite.
PLAYER: Did the system bite?
GUY_1: Eventually. But the file argues there was political protection: donations, pressur
       whistleblower retaliation - 480 plus, per the document. Political accountability?
       Zero charged.
PLAYER: Who got charged?
GUY_1: Lots of defendants. 150+ charged, 100+ convicted. But that’s mostly the street-lev
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and mid-level operators.
PLAYER: So what’s the lesson?
GUY_1: Don’t build an audit that covers 20% and then celebrate it like it’s 100%.
GUY_1: Massive fraud needs three ingredients: exploitable system design, political protection, and institutional failure. This file claims Minnesota served the full buffet.
PLAYER: You okay?
GUY_1: Define “okay.” I’ve watched $8B a year flow through ‘trust me bro’ oversight. My s has an itemized receipt.

Section 2: Texas

Guy_2 — The Lone Star Claims Wrangler

Case file: texas_medicaid_fraud_report.txt

Personality overview

- Vibe: friendly on the surface, knife-sharp about incentives.
- Humor style: cowboy metaphors, corporate-speak mockery, cheerful pessimism.
- Obsessed with recovery rates and staffing ratios.
- Thinks ‘managed care’ is mostly ‘managed optics’ unless you measure it.

Dialogue

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PLAYER: You look like you’re about to tell me a horror story with a smile.
GUY_2: Partner, in Texas we do everything big. Including the fraud.
PLAYER: What’s the headline?
GUY_2: Texas Medicaid runs about a $41 billion annual system. And it routes 97% of
       beneficiaries through 16 Managed Care Organizations.
PLAYER: Sounds efficient.
GUY_2: It’s efficient at moving money. Detecting fraud is… more of a hobby.
PLAYER: How bad is it?
GUY_2: The case file estimates around $4 billion in annual fraud losses. Recovery rates?
       Somewhere between 5% and 15% of what gets stolen.
PLAYER: Why so low?
GUY_2: Incentives. MCOs get capitation. Higher costs can justify higher rates. Fraud
       inflates costs. Nobody’s excited to reduce their own baseline.
PLAYER: Any proof this is structural?
GUY_2: July 2025 CMS focused review. Four big MCOs. Eight major ‘observations’ that read
       like a tutorial on how not to run program integrity.
PLAYER: Like what?
GUY_2: Special Investigative Units understaffed. No proper staffing ratios for the member
       populations.
GUY_2: State law conflicts with federal payment-suspension rules, so the Fraud Control Un
       hasn’t requested a single payment suspension since 2015.
PLAYER: Ten years with zero suspensions?
GUY_2: Yep. Imagine catching a leak and deciding the fix is to stare at it harder.
PLAYER: Anything else?
GUY_2: No unannounced site visits. Ever, per the review. That’s how you catch phantom
       clinics. Texas said, “Nah, let them surprise us instead.”
GUY_2: Also: no requirement to verify beneficiaries actually got the services billed. Whi
       is… a bold approach to reality.
PLAYER: What about referrals to law enforcement?
GUY_2: The state OIG doesn’t even track MCO referrals to the Fraud Control Unit. So the
       state can’t tell whether MCOs are reporting fraud or just quietly denying claims a
       moving on.
PLAYER: Give me a recovery-rate gut punch.
GUY_2: One plan processed $12.8B in claims and recovered $426,467. That’s 0.003%.
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PLAYER: That’s basically… nothing.
GUY_2: It’s a rounding error wearing a cowboy hat.
PLAYER: Any others?
GUY_2: Amerigroup identified $26.8M over three years, recovered $5.5M. Superior identifie
$13.6M, recovered $3.1M. Parkland had 12 preliminary investigations and hit the
15-workday federal deadline exactly zero times.
PLAYER: So what’s the fix?
GUY_2: Treat fraud as an emergency, not a paperwork mood. Staff the SIUs. Do unannounced
visits. Verify services. Fix the payment-suspension conflict so the system can
actually stop bleeding.
PLAYER: You make it sound simple.
GUY_2: It is simple. It’s just inconvenient for people who prefer profits to accountabili
Texas has a long tradition of respecting… convenience.

Section 3: California

Guy_3 — The Analyst

Case file: california_fraud_report_clean.txt

Personality overview

- Vibe: West Coast ‘data-driven’ cynic with a spreadsheet for every scandal.
- Humor style: deadpan tech sarcasm, ‘this could have been an email’ energy.
- Hyper-focused on pay-to-play, suspended safeguards, and organized networks.
- Treats ‘oversight’ like a feature flag that gets turned off at the worst time.

Dialogue

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PLAYER: You’re staring at that screen like it owes you money.
GUY_3: It does. California’s case file is basically a ‘how-to’ guide for losing billions
       while sounding progressive about it.
PLAYER: What’s California’s big fraud story?
GUY_3: Multiple stories. That’s the point. It’s a whole season, not a single episode.
PLAYER: Start with the loudest one.
GUY_3: Monte Vista Pharmacy. The file says it stole $204 million in ten months by exploit
       suspended safeguards during a Medi-Cal pharmacy transition. Ten. Months.
PLAYER: Two hundred four million… from one pharmacy?
GUY_3: One pharmacy with the confidence of a startup and the ethics of a scam text.
PLAYER: What else?
GUY_3: Hospice. The file says hospice providers in California grew by 1,589% while the
       national number declined.
PLAYER: That’s… not normal.
GUY_3: Correct. And it cites a report showing 112 different hospices at the same physical
       address in Los Angeles County.
PLAYER: 112 at one address?
GUY_3: It’s either fraud… or the world’s busiest spiritual doorway.
PLAYER: Who’s running these schemes?
GUY_3: The file highlights Armenian organized crime networks using Los Angeles County as
       hub. And it describes laundering tactics like shell companies, real estate, and ev
       gold.
PLAYER: Gold?
GUY_3: Yup. One case mentioned $6 million plus in gold bars and coins bought with healthc
       fraud proceeds. Cash gets traced. Gold just sits there looking innocent.
PLAYER: Sounds like enforcement should be intense.
GUY_3: Enforcement exists, but the file describes reactive detection: whistleblowers and
       after-the-fact cases, not proactive controls.
PLAYER: Any political angle?
GUY_3: Oh, buddy. Pay-to-play is basically a subplot that ate the main plot.
GUY_3: The file cites an Open the Books finding: 979 state vendors donated $10,561,828 an
       received $6,201,978,173 in state payments. Roughly a 587-to-1 return.
PLAYER: That’s… a great investment.
GUY_3: Exactly. Imagine your retirement account performing like that. Now imagine it’s
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funded by taxpayers.
PLAYER: Specific examples?
GUY_3: The file describes donation patterns around major healthcare companies and contrac
including no-bid COVID-era deals and ‘behested payments’ - a loophole for unlimite
influence donations to pet causes.
PLAYER: So safeguards get suspended, money pours out, and everyone acts surprised?
GUY_3: That’s the template. Suspended prior authorization. Rapid provider growth. Weak
verification. Organized networks.
PLAYER: What’s the takeaway?
GUY_3: California isn’t just dealing with fraud schemes. It’s dealing with a system where
political influence, massive scale, and ‘black box’ oversight make fraud feel like
predictable outcome.
PLAYER: You seem… calm about this.
GUY_3: I work in analytics. Calm is what happens when screaming doesn’t compile.

Section 4: Illinois

Guy_4 — The Capitation Necromancer

Case file: illinois.txt

Personality overview

- Vibe: auditor-mage who can summon ‘deceased capitation’ from the void.
- Humor style: bureaucratic sarcasm, loves dunking on ‘missing contracts’.
- Proud of Illinois OIG analytics… furious at PBM opacity.
- Treats every middleman like a suspect with a polished LinkedIn.

Dialogue

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PLAYER: You look like you’re hunting ghosts.
GUY_4: I am. Illinois literally paid managed-care premiums for dead people. I’m just the
       holding the Ouija board.
PLAYER: Illinois Medicaid - what’s the structure?
GUY_4: HealthChoice Illinois. Near-universal managed care. Five major MCOs and a state
       agency trying to keep the machine from eating the manual.
PLAYER: What’s the fraud angle?
GUY_4: Two big ones: pharmacy money games and enrollment reality lag.
PLAYER: Explain.
GUY_4: PBM spread pricing. Auditor General found over $200 million in spread overbilling
       across two years. The state didn’t even have complete MCO-PBM contracts on file.
PLAYER: They didn’t have the contracts?
GUY_4: Correct. Illinois was auditing a deal it wasn’t allowed to read. Very ‘trust fall’
       energy.
PLAYER: And the dead people?
GUY_4: Illinois OIG used analytics to claw back $16.3 million in FY 2025 in capitation pa
       for deceased recipients. That money existed only because enrollment data and payme
       systems weren’t reconciling fast enough.
PLAYER: What about classic provider fraud?
GUY_4: Plenty. Lateena Smith billed $2.46 million in psychotherapy sessions that never
       happened using Medicaid identities. A COVID lab scheme billed $293 million; $65
       million was paid before the indictment.
PLAYER: Sounds like Illinois catches a lot though.
GUY_4: They do. OIG reported $51.9 million in collections and $142.5 million in questione
       costs in FY 2025. They’re good at post-payment enforcement.
PLAYER: Then what’s the problem?
GUY_4: Prevention. Transparency. And a Managed Care Oversight Commission that missed
       meetings because it couldn’t find a quorum.
PLAYER: Your summary?
GUY_4: Illinois can find the fraud after the money leaves the barn. But until PBM contrac
       and data reconciliation are real-time and visible, the barn door stays decorative.
PLAYER: You’re harsh.
GUY_4: I’m from Illinois. Harsh is our love language.
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Section 5: New York

Guy_5 — The Cyber DME Goblin

Case file: Newyork.txt

Personality overview

- Vibe: techno-paranoid investigator who reads indictments for fun.
- Humor style: sarcastic hacker metaphors, ‘everything is a shell company.’
- Knows big numbers, bigger laundering routes.
- Believes ‘global cap’ is a nice idea until criminals discover VPNs.

Dialogue

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PLAYER: You look like you just crawled out of the internet.
GUY_5: I did. New York is where Medicaid fraud meets cybercrime and they exchange busines
       cards.
PLAYER: Give me New York’s scale.
GUY_5: Over 7 million enrollees. Global cap target around $31.6 billion in FY 2025. Manag
       care spending is enormous, especially MLTC.
PLAYER: And the fraud?
GUY_5: Operation Gold Rush. Russian-based transnational network. Over $10.6 billion in
       fraudulent Medicare and Medicaid claims, mostly DME.
PLAYER: How do they hide?
GUY_5: VPS servers to mask IP addresses. Nominee owners to open accounts. Shell companies
       Then funds routed through banks in places like China, Singapore, and Pakistan. Cry
       helps fog the trail.
PLAYER: That’s… industrial.
GUY_5: Exactly. Fraud is scalable now. It comes with infrastructure.
PLAYER: Any local scams?
GUY_5: Transportation fraud. Unique Class Limo - $3.5 million. Phantom trips and trip
       splitting. Bribes to patients and drivers so the logs ‘agree.’
PLAYER: Classic.
GUY_5: Nursing homes too. Related-party transactions: divert Medicaid funds into real est
       or staffing companies the owners also control. Settlements like $45M and $12M show
       how big it can get.
PLAYER: Sounds like the state has oversight bodies.
GUY_5: It does - DOH, OMIG, AG MFCU. But CMS flagged a coordination gap: no established
       written procedure for MCOs to refer fraud directly to MFCU. Translation: fraud can
       get ‘handled internally’ and never reach prosecutors.
PLAYER: And MLTC?
GUY_5: MLTC is a fog bank. SADCs show up as a blind spot - cash bribes to get people to
       ‘attend’ centers that deliver minimal services, billed through plans.
PLAYER: Sum up New York in a sentence.
GUY_5: Massive scale plus self-reporting plus black-box algorithms equals plenty of cover
       for both cyber-enabled mega schemes and good old-fashioned kickbacks.
PLAYER: You okay?
GUY_5: I’m fine. I only trust three things: logs, hashes, and people who hate spreadsheet
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Section 6: Florida

Guy_6 — The Kickback Tour Guide

Case file: Florida.txt

Personality overview

- Vibe: sunny delivery, grim details. A walking ‘welcome brochure’ for corruption.
- Humor style: tourist-guide sarcasm (“and on your left, felony”).
- Deep on SMMC privatization, NEMT subcontracting, and pharma influence.
- Suspicious of ‘internal investigations’ and loves quoting CMS findings.

Dialogue

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PLAYER: Florida. You look… cheerful.
GUY_6: That’s how Florida gets you. Sunshine outside, felony inside.
PLAYER: What’s Florida’s system like?
GUY_6: Statewide Medicaid Managed Care. Mandatory managed care, over 5 million
       beneficiaries, 16 MCOs. Lots of subcontractors.
PLAYER: Sounds complex.
GUY_6: Complex enough to hide a marching band.
PLAYER: Big fraud stories?
GUY_6: 2025 national takedown in South Florida: 37 defendants, $14.6 billion in alleged
       fraud.
PLAYER: That’s… insane.
GUY_6: Case example: Newtech Medical Supply billed $2.9 million for DME that never showed
       up. Ghost equipment. Very on-brand.
PLAYER: Any corporate-level stuff?
GUY_6: Gilead settlement: over $3 million to resolve allegations of kickbacks to push
       high-cost HIV drugs like Biktarvy and Genvoya via meals, travel, awards.
PLAYER: ‘Educational dinners.’
GUY_6: Exactly. The syllabus is shrimp.
PLAYER: Provider scams?
GUY_6: PSR fraud: a Miami operation recruited patients with kickbacks to attend unnecessa
       services, billed over $1.2 million.
PLAYER: Where does managed care fail?
GUY_6: CMS review in 2025 said Florida’s MCOs lacked a formal procedure to refer potentia
       fraud to law enforcement, which violates federal requirements.
PLAYER: So MCOs can just… keep it internal.
GUY_6: They can ‘investigate’ and quietly move on. Also, service verification exists on
       paper, but the state doesn’t require regular reporting of those verification resul
PLAYER: And transportation?
GUY_6: NEMT is a classic. Subcontracting fragments the data trail. Ghost trips. Deadhead
       miles. Enough paperwork to paper-mache a boat.
PLAYER: Sum up Florida.
GUY_6: Aggressive privatization, huge money, subcontractor layers, and referral bottlenec
       Great weather for fraud. Bring sunscreen and a subpoena.
PLAYER: You’re kind of funny.
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GUY_6: I’m not funny. I’m traumatized with good timing.

Section 7: Colorado

Guy_7 — The Managed Fee-for-Service Philosopher

Case file: Colorado.txt

Personality overview

- Vibe: thoughtful bureaucrat who sounds like a TED Talk about loopholes.
- Humor style: polite cynicism; weaponized ‘as noted in the audit.’
- Fixates on conflicting incentives, RAC weirdness, and ‘self-audit’ risk.
- Believes program integrity is a system design problem, not a vibes problem.

Dialogue

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PLAYER: You seem… calm.
GUY_7: I’m from Colorado. We process disappointment at altitude.
PLAYER: What’s the Medicaid structure here?
GUY_7: Health First Colorado. Hybrid model: physical health is mostly fee-for-service, wh
       RAEs handle coordination and behavioral health. Managed, but not fully.
PLAYER: Why does that matter?
GUY_7: RAEs bear little to no financial risk for physical health spending. If you don’t f
       the cost, you don’t chase the overbilling very hard.
PLAYER: Big cases?
GUY_7: Premier Medical genetic testing kickbacks. Settlement: $27.5 million. Medicaid
       patients targeted for unnecessary screenings.
PLAYER: Any managed care angle?
GUY_7: Risk adjustment upcoding: Kaiser settlement announced at $581 million nationwide,
       with Colorado affiliates named. Allegations include inflating risk scores and know
       error rates were high for years.
PLAYER: Auditing seems important then.
GUY_7: Colorado uses a Recovery Audit Contractor program. But the audit evaluation noted
       contractor is paid based on overpayments identified, not recovered - with an 18% f
       That incentivizes overzealous findings that get overturned on appeal.
PLAYER: So ‘found fraud’ becomes a business model.
GUY_7: Precisely. And then there’s the entity risk: Gainwell is the Medicaid fiscal agent
       and acquired HMS, the RAC. Claims processor + claims auditor under one corporate
       roof. Self-audit vibes.
PLAYER: That seems like a conflict.
GUY_7: The audit said the state failed to obtain required conflict disclosures after the
       acquisition. So yes. A conflict with a bow on top.
PLAYER: What about enforcement?
GUY_7: Member fraud investigations increased to 2,574 in SFY 2024-25, but recoveries drop
       to $330,821 due to policy limits. More detection, less money back.
PLAYER: Sum it up.
GUY_7: Hybrid structure can blur accountability. Add perverse audit incentives and vertic
       integration, and you get a program that can detect problems while still rewarding
       conditions that create them.
PLAYER: That was almost see-through polite.
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GUY_7: Thank you. I practice being professionally horrified.