Department of Health and Human Services
Office of Inspector General
Office of Evaluation and Inspections

DATA SNAPSHOT

March 2025 | OEI-09-25-00090

Medicaid Fraud Control Units Annual Report: Fiscal Year 2024

HHS Office of Inspector General
HIGHLIGHTS

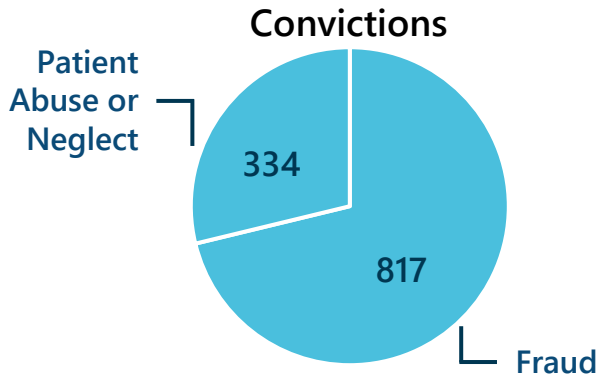
March 2025 | OEI-09-25-00090

DATA SNAPSHOT

Medicaid Fraud Control Units Annual Report: Fiscal Year 2024

MFCUs recovered **$3.46** for every **$1** spent in FY 2024

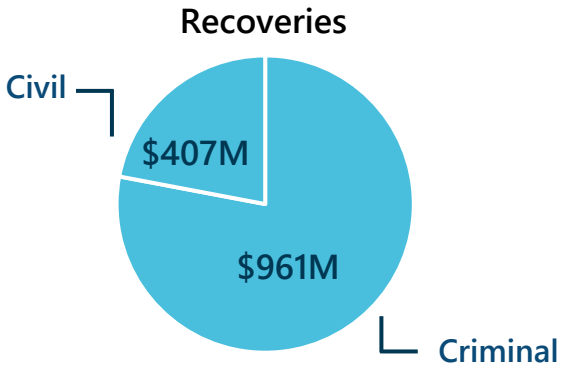
1,151 Convictions



1,042 individuals or entities excluded from federally funded programs

493 Civil Settlements and Judgments

$1.4 Billion Recovered

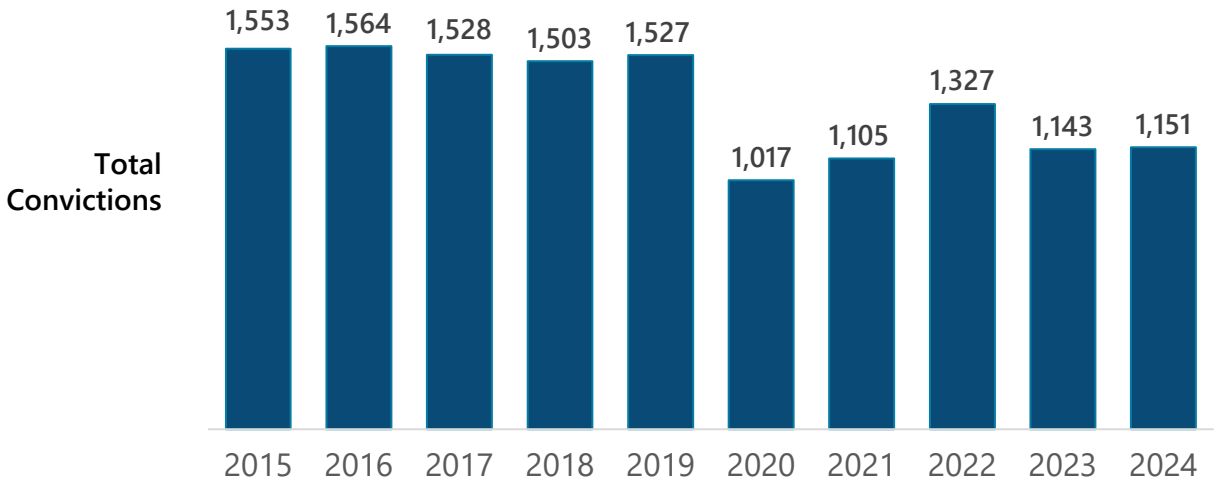


Medicaid Fraud Control Units (MFCUs or Units) investigate and prosecute Medicaid provider fraud and patient abuse or neglect. The Department of Health and Human Services Office of Inspector General (OIG) is the designated Federal agency that oversees and annually recertifies and approves Federal funding for each MFCU.

For this data snapshot, OIG analyzed the annual data on case outcomes (such as convictions; civil settlements and judgments; and recoveries) that 53 MFCUs submitted to OIG for fiscal year (FY) 2024, as well as other historical data. Those MFCUs operated in all 50 States, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands.

Total Number of Convictions

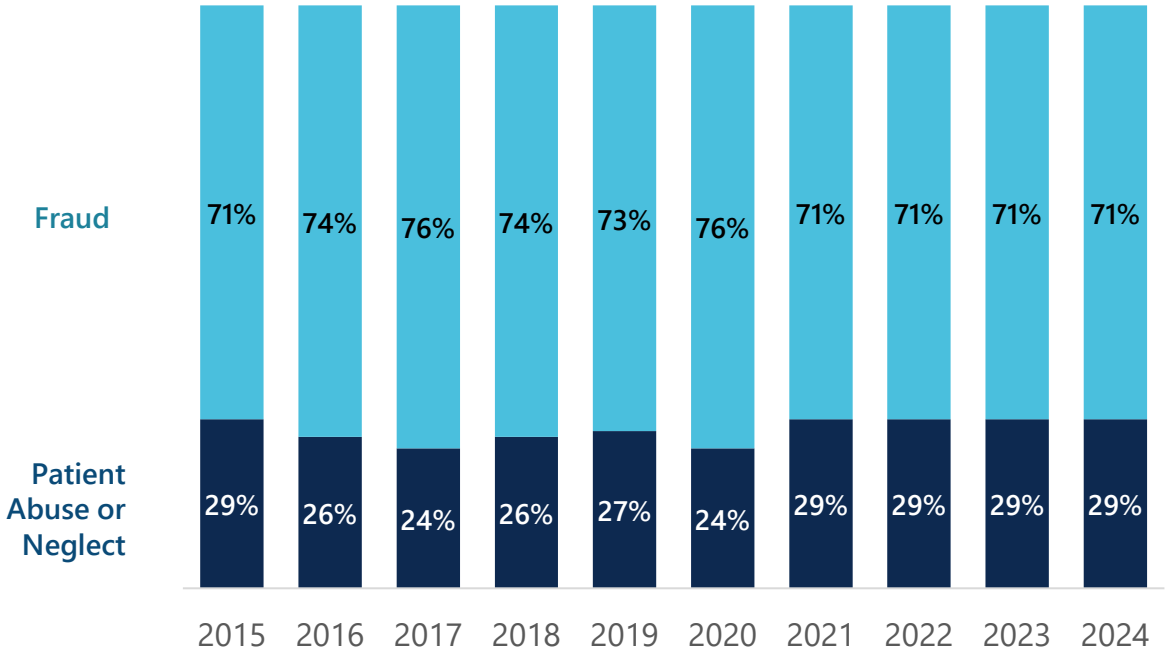
The number of annual convictions reported by MFCUs increased slightly in FY 2024 to 1,151 total convictions. OIG has the authority to exclude convicted individuals and entities from federally funded health care programs.[1] By informing OIG about convictions for fraud and patient abuse or neglect in their respective States, MFCUs help to ensure that individuals and entities convicted in one State can no longer participate in other State Medicaid programs or Federal health care programs. MFCUs were responsible for 32 percent (1,042 of 3,233) of all OIG exclusions in FY 2024.



Source: OIG analysis of Annual Statistical Reports for FYs 2015 through 2024.

Convictions for Fraud and Patient Abuse or Neglect

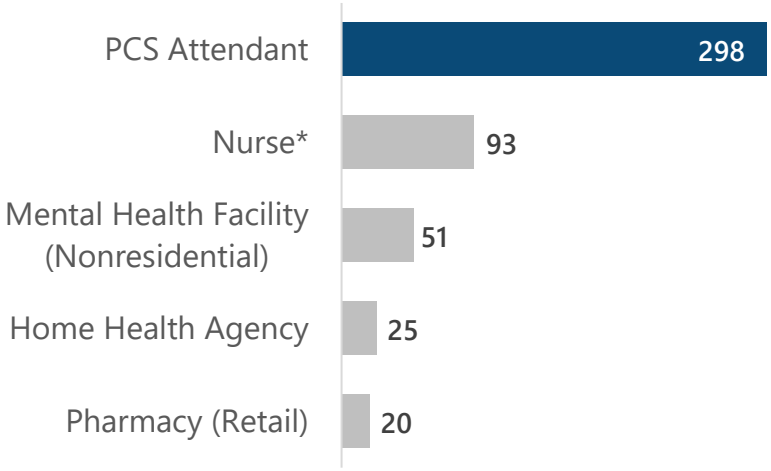
The proportions of fraud convictions and patient abuse or neglect convictions have remained consistent during the 10-year period, ranging from 71 to 76 percent. In FY 2024, MFCUs reported 817 fraud convictions and 334 patient abuse or neglect convictions.



Source: OIG analysis of Annual Statistical Reports for FYs 2015 through 2024.

Convictions for Fraud by Provider Type

The number of fraud convictions involving personal care service (PCS) attendants was considerably higher than any other provider type in FY 2024. PCS attendants assist Medicaid enrollees with activities of daily living (such as bathing, dressing, and personal hygiene) in their homes and other community settings.

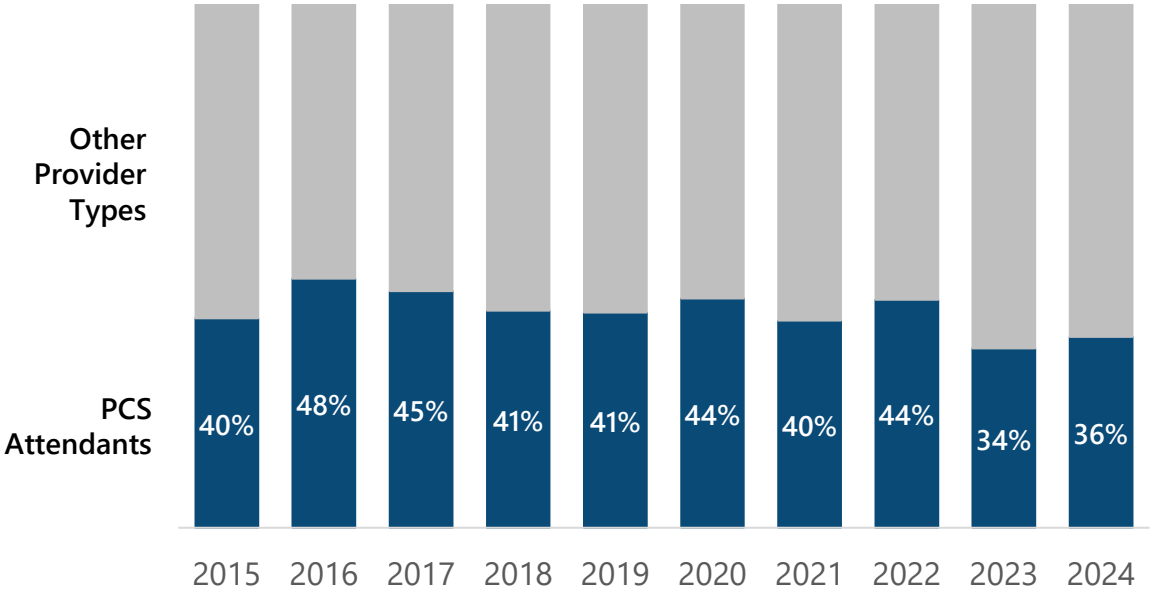


* Nurse is defined in the Annual Statistical Report instructions as Licensed Practical Nurse (LPN), Registered Nurse (RN), or other licensed nurse.

This chart shows the top five provider types (excluding "other" categories) based on the number of fraud convictions in FY 2024.

Source: OIG analysis of FY 2024 Annual Statistical Reports.

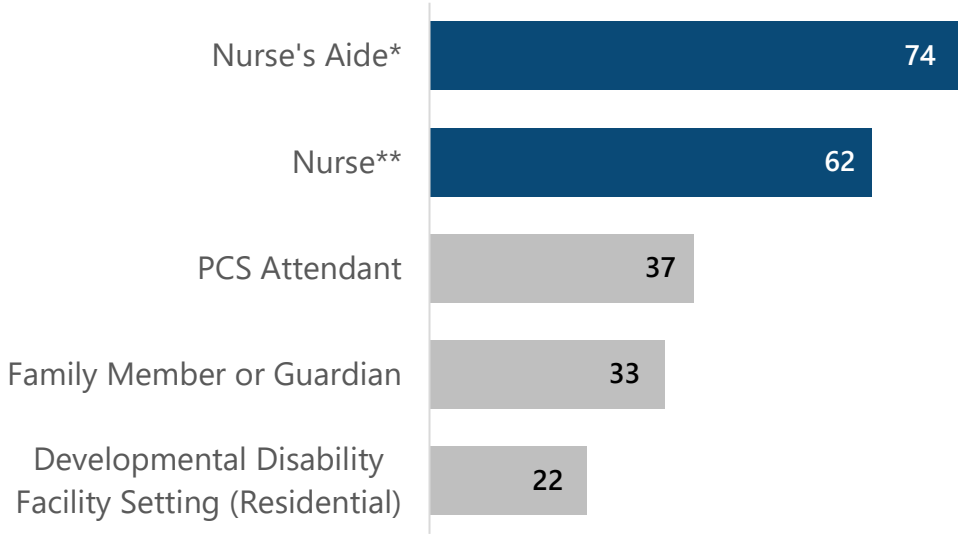
A sizable proportion of fraud convictions involved PCS attendants during FYs 2015 through 2024.



Source: OIG analysis of Annual Statistical Reports for FYs 2015 through 2024.

Convictions for Patient Abuse or Neglect by Provider Type

Nurse's aides and nurses were the top two provider types for patient abuse or neglect convictions in FY 2024. FY 2024 was the third year in a row in which they accounted for the largest number of convictions for patient abuse or neglect.



* Certified Nurse Assistant or other.
** Nurse is defined in the Annual Statistical Report instructions as a Licensed Practical Nurse (LPN), Registered Nurse (RN), or other licensed nurse. In FY 2022, this reporting category included Physician Assistant.

This chart shows the top five provider types (excluding "other" categories) based on the number of convictions for patient abuse or neglect in FY 2024.

Source: OIG analysis of Annual Statistical Reports for FY 2024.

Patient Abuse Case Example

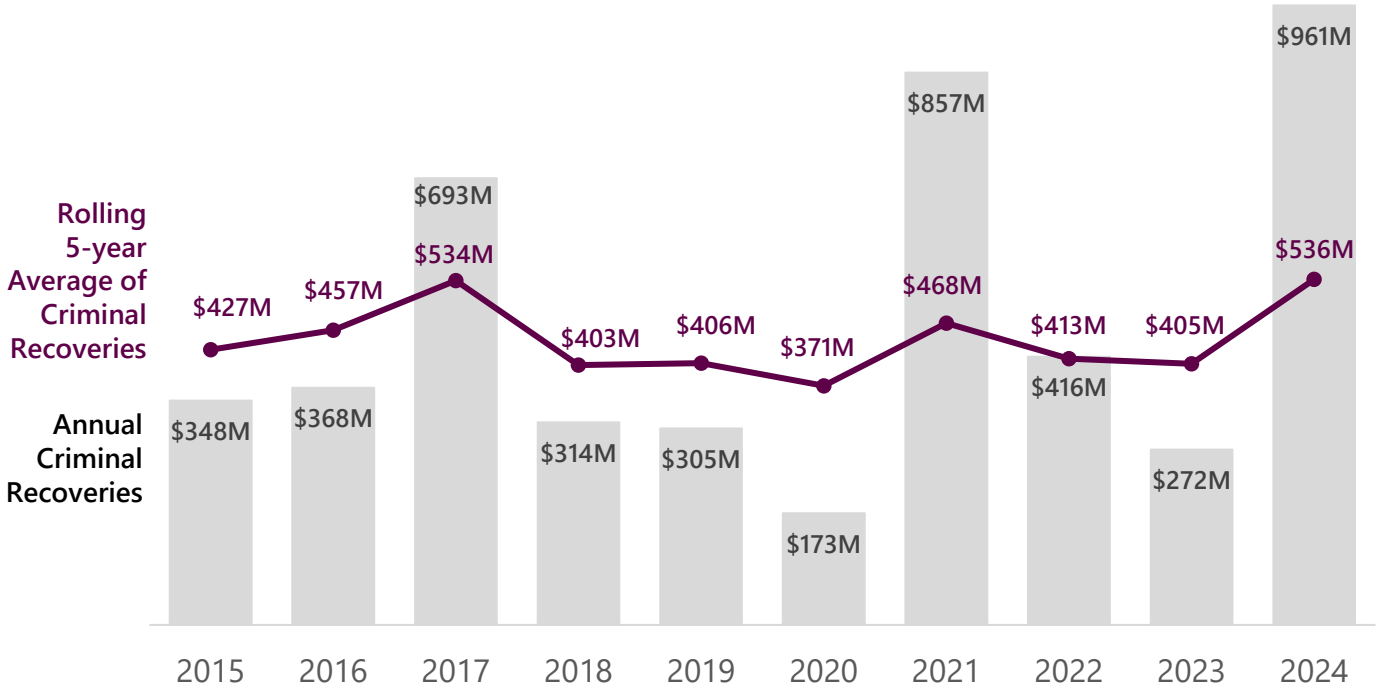
The Maryland MFCU investigated and prosecuted a geriatric nursing assistant for assaulting a 75-year-old Medicaid enrollee and causing an injury that, ultimately, contributed to his death. While in a post-acute care center, the nursing assistant pushed the patient who had–dementia–to the ground, fracturing his hip. Despite efforts at physical therapy, the patient was unable to walk and suffered health complications from inactivity that led to his death. The nursing assistant pleaded guilty to first degree assault and abuse, and was sentenced to 25 years of incarceration, with all but 7 years suspended. Upon release, the nursing assistant will be placed on supervised probation for 5 years during which she will be prohibited from caring for vulnerable adults.

Source: Maryland Attorney General, *Caretaker Sentenced in Case of First-Degree Assault and Vulnerable Adult Abuse*, https://www.marylandattorneygeneral.gov/press/2023/091923.pdf. Accessed on February 18, 2025.

Criminal Recoveries

In FY 2024, MFCUs reported the highest amount of total criminal recoveries over the 10-year period. The amount of annual criminal recoveries increased substantially from $272 million in FY 2023 to $961 million in FY 2024. This increase was primarily the result of multiple cases prosecuted by the California MFCU, totaling $513 million in criminal recoveries (53 percent of FY 2024 reported criminal recoveries).

The rolling 5-year average of criminal recoveries varied during FYs 2015-2024. The rolling average reflects a 5-year average amount of criminal recoveries reported by MFCUs; it includes the reporting year and the previous 4 years. For example, the value for FY 2024 averages the total criminal recoveries from FYs 2020-2024.



Source: OIG analysis of Annual Statistical Reports for FYs 2015 through 2024.

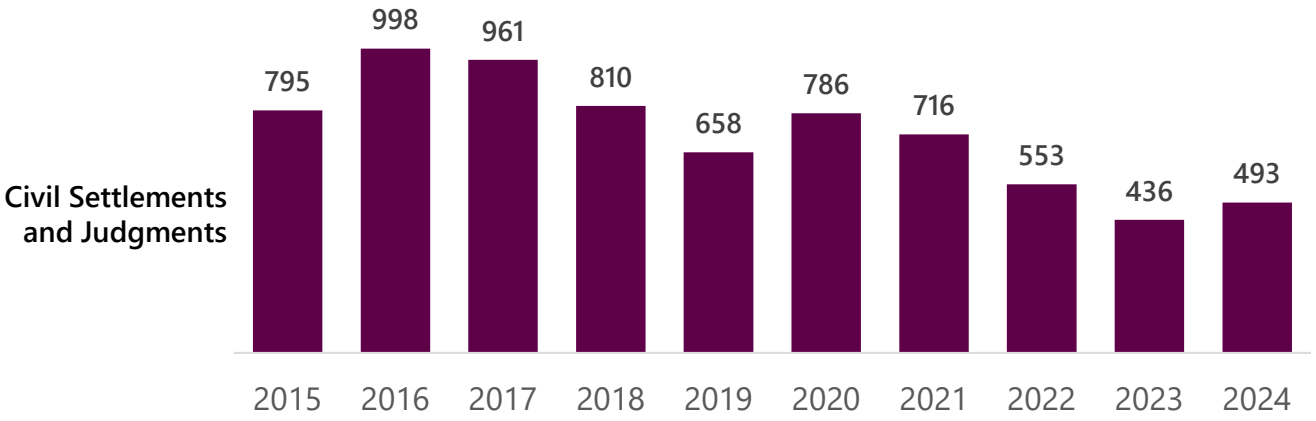
Criminal Fraud Case Example

The California MFCU, the Federal Bureau of Investigation, OIG, and Veterans Affairs OIG investigated and prosecuted a company owner for Medicaid fraud. The scheme involved billing the Medicaid program for durable medical equipment, such as knee braces, for elderly and disabled patients who did not need these items. After these items were ordered, the defendant received kickbacks from medical equipment suppliers for ordering the items. A Federal indictment was issued against the defendant, who was ordered to pay $421 million to the Centers for Medicare and Medicaid Services.

Source: California MFCU communication to HHS OIG, January 22, 2025.

Civil Settlements, Judgments, and Recoveries

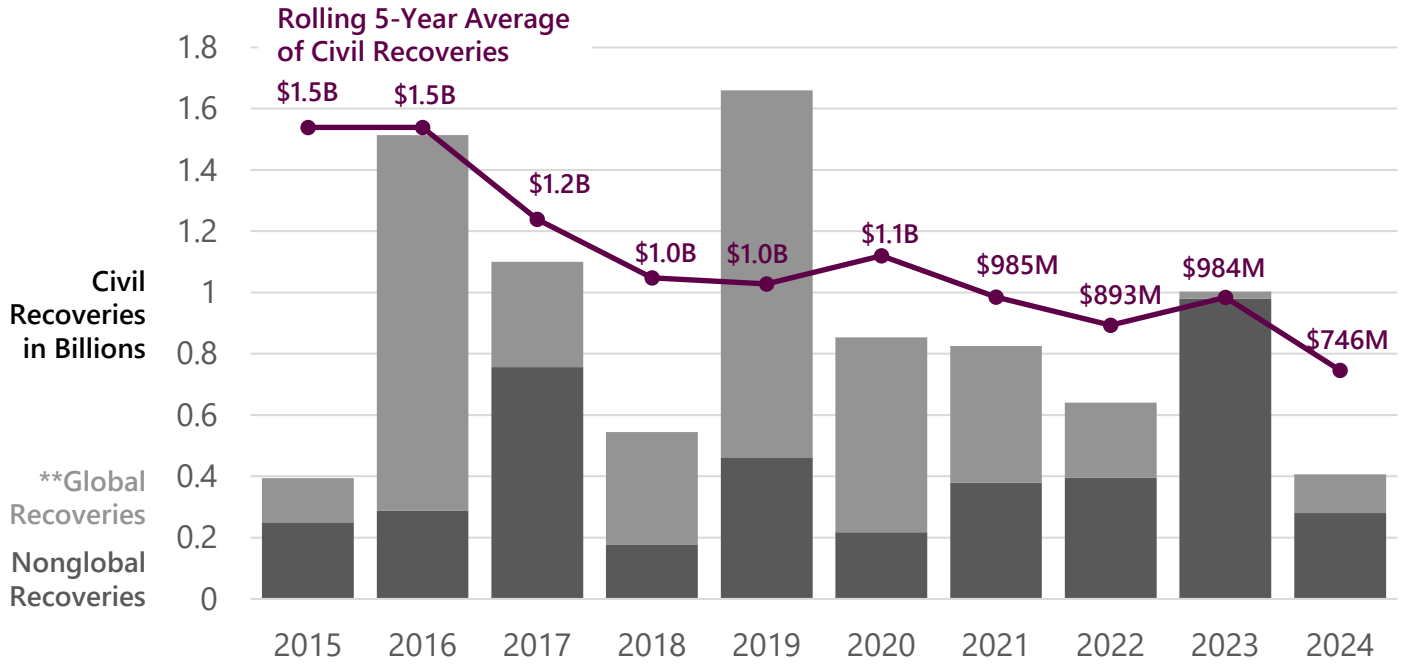
The number of civil settlements and judgments increased in FY 2024, after a general decline over the prior 3 years.



Source: OIG analysis of Annual Statistical Reports for FYs 2015 through 2024.

Total civil recoveries dropped by more than half in FY 2024, after reaching a 4-year high in FY 2023. The proportion of recoveries that came from nonglobal* cases was 69 percent of total recoveries in FY 2024, accounting for $280 million. In FY 2024, MFCUs in two States—New York and Georgia—reported 38 percent of these nonglobal civil recoveries ($107 million).

The rolling 5-year average of civil recoveries declined during FYs 2015-2024.[2] The rolling average reflects a 5-year average amount of civil recoveries reported by MFCUs; it includes the reporting year and the previous 4 years. For example, the value for FY 2024 averages the total civil recoveries from FYs 2020-2024.

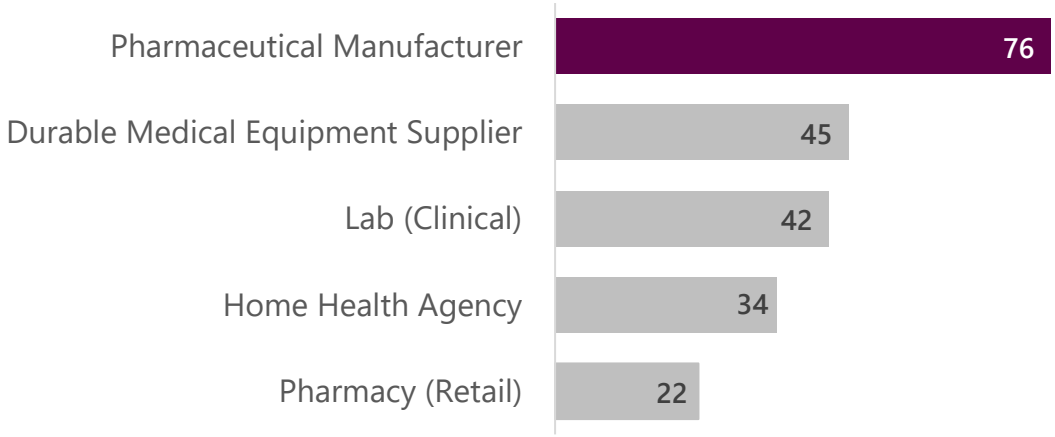


* A nonglobal case is conducted by a Unit, individually or with other law enforcement partners, and is not coordinated by the National Association of Medicaid Fraud Control Units (NAMFCU).
** A global case involves both the Federal Government and a group of States and is coordinated by the NAMFCU.

Source: OIG analysis of Annual Statistical Reports for FYs 2015 through 2024.

Civil Settlements, Judgments, and Recoveries by Provider Type

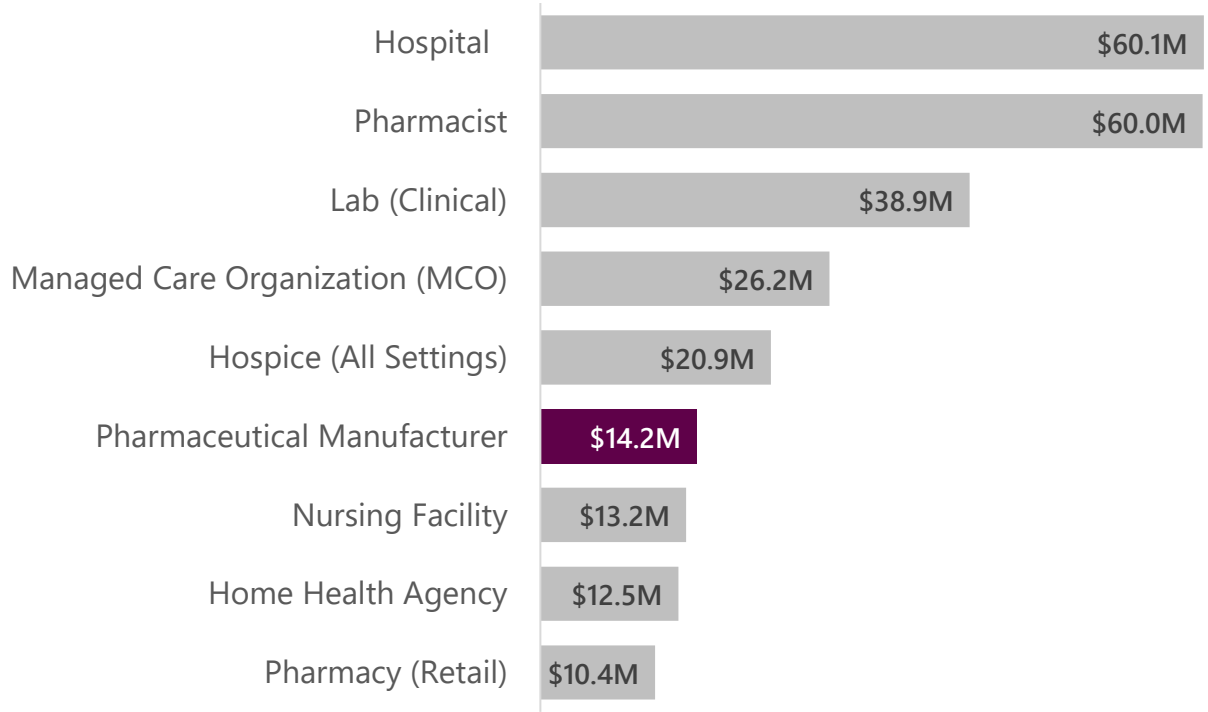
Pharmaceutical manufacturers accounted for more civil settlements and judgments than any other provider type in FY 2024. The top five provider types accounted for 44 percent (219 of 493) of all civil settlements and judgments reported by MFCUs for FY 2024).



This chart shows the top five provider types (excluding "other" categories) based on the number of civil settlements and judgments in FY 2024.

Source: OIG analysis of Annual Statistical Reports for FY 2024.

Hospitals and pharmacists accounted for the largest total amount of civil recoveries in FY 2024. Although pharmaceutical manufacturers accounted for the largest number of civil settlements and judgments in FY 2024, other provider types accounted for higher amounts in civil recoveries.

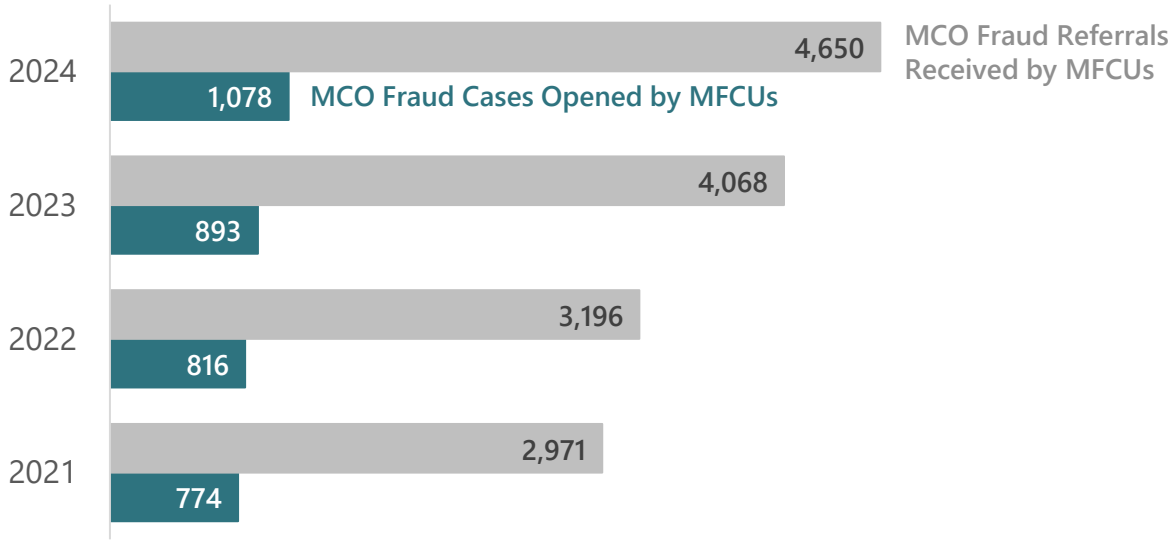


This chart shows the top nine provider types (excluding "other" categories) based on the number of civil settlements and judgments in FY 2024.

Source: OIG analysis of Annual Statistical Reports for FY 2024.

Fraud Referrals and Newly Opened MCO Fraud Cases

Both the number of fraud referrals received from MCOs[3] and the number of MCO fraud cases opened by MFCUs increased in FY 2024. The proportion of referrals that resulted in opened fraud cases increased slightly to 23 percent (1,078 of 4,650) in FY 2024 from 22 percent (893 of 4,068) in FY 2023. MFCUs reported receiving 14,780 referrals involving suspected fraud in FY 2024.



Source: OIG analysis of Annual Statistical Reports for FY 2024.

Conclusion

MFCUs reported varied case outcomes in FY 2024. Overall, they reported recovering almost three and a half times the money spent on their operations. MFCUs also reported the highest total amount of criminal recoveries over the last 10 years and a slight increase in convictions and civil settlements and judgments compared to FY 2023. However, the total amount of civil recoveries dropped by more than half.

MFCU Program Background

MFCUs investigate and prosecute Medicaid provider fraud and patient abuse or neglect.[4] The Social Security Act (SSA) requires each State to effectively operate a MFCU, unless the Secretary of Health and Human Services (HHS) determines that (1) the operation of a Unit would not be cost-effective because minimal Medicaid fraud exists in a particular State; and (2) the State has other adequate safeguards to protect enrollees from abuse or neglect.[5] In FY 2024, all 50 States, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands operated MFCUs.[6, 7] In FY 2024, combined Federal and State expenditures for the Units totaled approximately $396 million, of which approximately $297 million represented Federal funds.

MFCU cases typically begin as referrals from external sources or are generated internally from data mining.[8] MFCU staff review referrals of possible fraud and patient abuse or neglect to determine the potential for criminal prosecution and/or civil action.

Criminal prosecutions may result in convictions; civil actions may result in civil settlements or judgments. Both criminal prosecutions and civil actions may include the assessment of monetary recoveries. Some cases may be resolved in a relatively short period of time. Others are more complex, and may involve multiple suspects and take years to resolve.

OIG Oversight of the MFCU Program

Annually, OIG reviews each Unit's application for recertification; approval of this application is necessary for the Unit to receive Federal reimbursement.[9] To recertify a Unit, OIG performs a desk review to assess the Unit's compliance with the Federal requirements for MFCUs contained in statute, regulations, and OIG guidance. OIG also examines the Unit's adherence to 12 MFCU Performance Standards and provides training to Units, as appropriate.[10]

OIG further assesses a Unit's performance by conducting inspections of Units that may result in findings and lead to OIG making recommendations for improvement. During an inspection, OIG also makes observations regarding Unit operations and practices and may identify beneficial practices that could be useful to other Units. A list of these beneficial practices, including one added for FY 2024, is available on the OIG website.

OIG also collects and presents statistical data reported by each MFCU annually, such as the numbers of open cases; indictments; and convictions and amounts of recoveries.[11, 12] These data can be accessed on the OIG website.

Standards

Standards: We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

OIG inspections of the MFCUs and this annual report differ from other OIG evaluations in that they support OIG's direct administration of the MFCU grant program. They are subject to the same internal quality controls as are other OIG evaluations, including internal and external peer review.

Endnotes

[1] SSA § 1128; 42 U.S.C. § 1320a-7. See also OIG, Background Information, https://oig.hhs.gov/exclusions/background.asp. Accessed on February 18, 2025.

[2] A single settlement or judgment may represent the resolution of a single case or multiple cases packaged together [OIG Statement provided by Richard Stern, based on MFPOD's extensive experience working with MFCUs

[3] For purposes of this report, we use the acronym MCO to refer to a variety of managed care entities and health care plans that cover Medicaid enrollees, including comprehensive risk-based managed care organizations, managed care entities, prepaid ambulatory health plans, prepaid inpatient health plans, primary care case management systems, and other entities that provide services under capitated payment arrangements.

[4] Social Security Act (SSA) § 1903(q)(3)–(4). Regulations at 42 CFR § 1007.11(b)(1) add that a Unit's responsibilities may include reviewing complaints of misappropriation of patients' private funds in health care facilities and board and care facilities. As of December 27, 2020, MFCUs may also receive Federal financial participation to investigate and prosecute abuse or neglect of Medicaid enrollees in a noninstitutional or other setting. Consolidated Appropriations Act, 2021, P.L. No. 116-260, Division CC § 207.

[5] SSA § 1902(a)(61).

[6] The SSA authorizes the Secretary of HHS to award grants (SSA § 1903(a)(6)) and to certify and annually recertify Units (SSA § 1903(q)). The Secretary delegated this authority to OIG. See also 42 CFR § 1007.15. Units must meet several requirements established by the SSA and Federal regulations. For example, each Unit must (1) be a single, identifiable entity of State Government, separate and distinct from the State Medicaid agency (SSA § 1903(q)(2); 42 CFR §§ 1007.5(a) and 1007.9(a)); (2) employ an interdisciplinary staff that consists of at least an investigator, an auditor, and an attorney (SSA § 1903(q)(6); 42 CFR § 1007.13); (3) develop a formal agreement, such as a memorandum of understanding, describing the Unit's relationship with the State Medicaid agency (42 CFR § 1007.9(d)); and (4) have either statewide authority to prosecute cases or formal procedures to refer suspected criminal violations to an agency with such authority (SSA § 1903(q)(1); 42 CFR § 1007.7).

[7] The territories of American Samoa, Guam, and the Northern Mariana Islands have not established Units.

[8] 42 CFR § 1007.20. MFCUs must receive approval from OIG to conduct data mining. As of November 2024, 25 MFCUs were approved for data mining. OIG, *Data Mining Applications*, https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/data-mining.asp. Accessed on February 18, 2025.

[9] 42 CFR § 1007.19(d)(1).

[10] MFCU performance standards are published at 89 Fed. Reg. 76431 (Sept. 18, 2024).

[11] MFCU investigators and prosecutors should apply professional judgment and discretion in determining what criminal and civil cases to pursue. OIG provides information on MFCU operations and outcomes, but does not establish specific benchmarks for the number of cases that must be investigated or prosecuted.

[12] In FY 2021, OIG directed MFCUs to annually report the number of fraud referrals they received directly from MCOs, as well as those received indirectly, such as referrals that originated from MCOs but were submitted to MFCUs by the State Medicaid agency. OIG instructs MFCUs to report referrals from MCOs that are associated with "some investigative or legal review or action . . . undertaken by MFCU staff." https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/files/ASR-Definitions-Instructions.pdf.

Report Fraud, Waste, and Abuse

OIG Hotline Operations accepts tips and complaints from all sources about potential fraud, waste, abuse, and mismanagement in HHS programs. Hotline tips are incredibly valuable, and we appreciate your efforts to help us stamp out fraud, waste, and abuse.

TIPS.HHS.GOV

Phone: 1-800-447-8477

TTY: 1-800-377-4950

Who Can Report?

Anyone who suspects fraud, waste, and abuse should report their concerns to the OIG Hotline. OIG addresses complaints about misconduct and mismanagement in HHS programs, fraudulent claims submitted to Federal health care programs such as Medicare, abuse or neglect in nursing homes, and many more. Learn more about complaints OIG investigates.

How Does It Help?

Every complaint helps OIG carry out its mission of overseeing HHS programs and protecting the individuals they serve. By reporting your concerns to the OIG Hotline, you help us safeguard taxpayer dollars and ensure the success of our oversight efforts.

Who Is Protected?

Anyone may request confidentiality. The Privacy Act, the Inspector General Act of 1978, and other applicable laws protect complainants. The Inspector General Act states that the Inspector General shall not disclose the identity of an HHS employee who reports an allegation or provides information without the employee's consent, unless the Inspector General determines that disclosure is unavoidable during the investigation. By law, Federal employees may not take or threaten to take a personnel action because of whistleblowing or the exercise of a lawful appeal, complaint, or grievance right. Non-HHS employees who report allegations may also specifically request confidentiality.

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