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

DATA SNAPSHOT

March 2026 | OEI-09-26-00140

Medicaid Fraud Control Units Annual Report: Fiscal Year 2025

HHS Office of Inspector General
HIGHLIGHTS

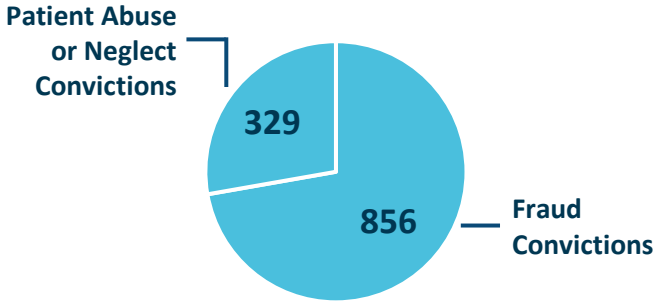
March 2026 | OEI-09-26-00140

DATA SNAPSHOT

Medicaid Fraud Control Units Annual Report: Fiscal Year 2025

MFCUs recovered $4.64 for every $1 spent in FY 2025

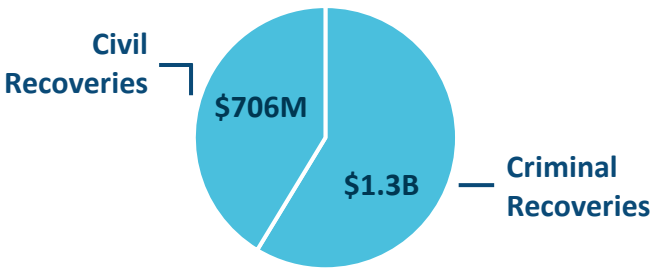
1,185 Convictions



900 Individuals or Entities Excluded from Federal Health Care Programs

674 Civil Settlements and Judgments

$2 Billion Recovered

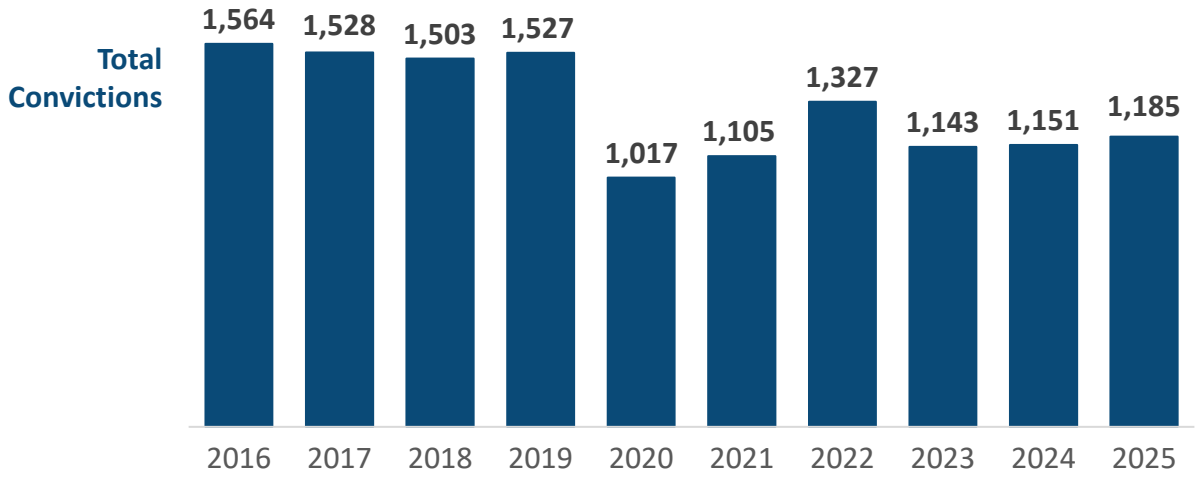


Medicaid Fraud Control Units (MFCUs or Units) investigate and prosecute Medicaid provider fraud and patient abuse or neglect. The Department of Health and Human Services Office of Inspector General (OIG) is the designated Federal agency that oversees the Units. MFCUs operate in all 50 States, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands.

This data snapshot provides aggregated case outcomes for 53 MFCUs for fiscal year (FY) 2025, along with case outcome trends over the past decade. We calculated the return on investment for the program by dividing the $2 billion in reported recoveries by the total MFCU grant expenditures. For FY 2025, combined Federal and State expenditures for the units totaled approximately $424 million, of which approximately $318 million represented Federal funds.

Total Convictions

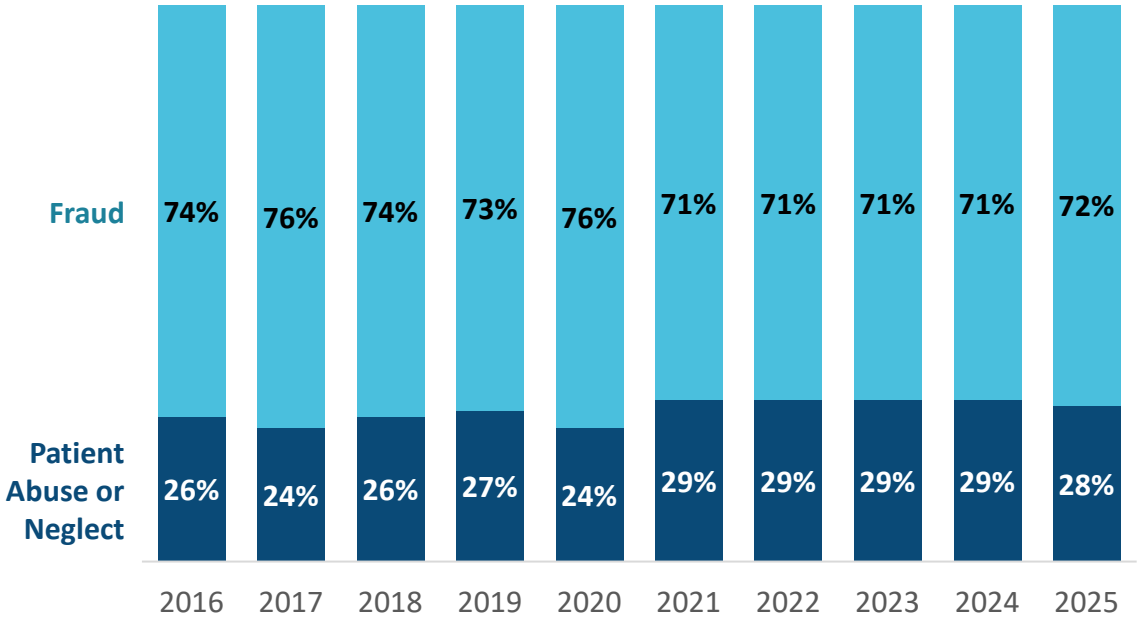
The number of individuals and entities convicted of fraud or patient abuse or neglect by MFCUs increased slightly in FY 2025 to 1,185 total convictions. Federal regulations require MFCUs to report convictions to OIG and adverse actions to the National Practitioner Data Bank (NPDB).[1] These reports help prevent individuals and entities convicted in one State from participating in Medicaid programs in another State. The OIG uses information it receives from MFCUs to exclude convicted individuals and entities from participating in federal health care programs.[2] In FY 2025, 32 percent of all OIG exclusions (900 of 2,837) were a result of MFCU convictions.



Source: OIG analysis of Annual Statistical Reports for FYs 2016 through 2025.

Convictions for Fraud and Patient Abuse or Neglect

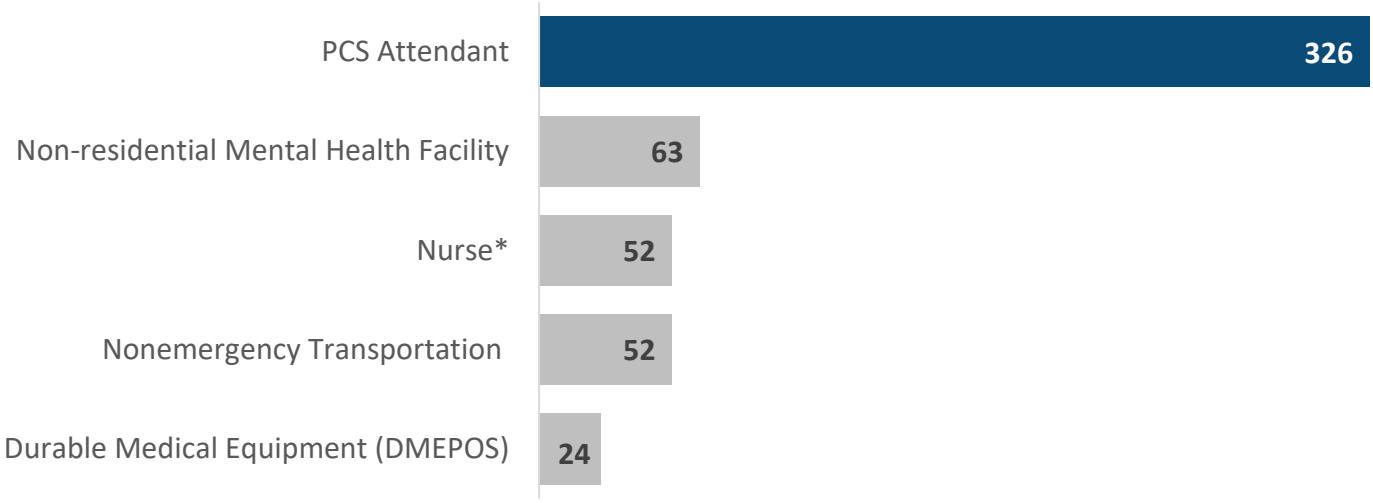
The proportions of fraud convictions and patient abuse or neglect convictions have remained consistent during the 10-year period, with fraud convictions ranging from 71 to 76 percent of the total. For FY 2025, MFCUs reported 856 fraud convictions and 329 patient abuse or neglect convictions.



Source: OIG analysis of Annual Statistical Reports for FYs 2016 through 2025.

Convictions by Provider Type

The number of fraud convictions involving personal care service (PCS) attendants was considerably higher than for any other provider type in FY 2025. PCS attendants assist Medicaid enrollees with activities of daily living (such as bathing, dressing, and meal preparation) in their homes and other community settings. Examples of fraud include PCS attendants or agencies billing for services not provided.

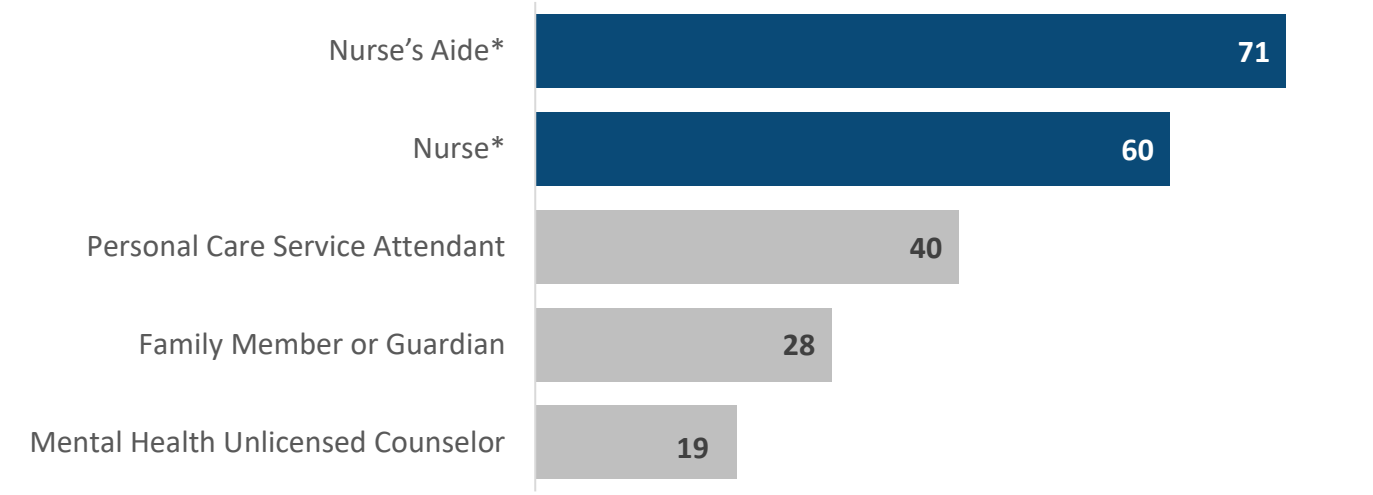


*Nurse is defined in the Annual Statistical Report instructions as Licensed Practical Nurse (LPN), Registered Nurse (RN), or other licensed nurse.

This chart shows the top five provider types (excluding "other" categories) based on the number of convictions for fraud in FY 2025.

Source: OIG analysis of FY 2025 Annual Statistical Reports.

Nurse's aides and nurses were the top two provider types convicted of patient abuse or neglect in FY 2025. Nurse's aides may provide basic direct patient care and assist with activities of daily living, while nurses may provide and coordinate direct patient care, including administering medication and diagnostic testing. Examples of patient abuse and neglect include sexual and physical abuse.



*Nurse's aide includes Certified Nurse Assistant or other nurse assistants. Nurse is defined in the Annual Statistical Report instructions as an LPN, RN, or other licensed nurse.

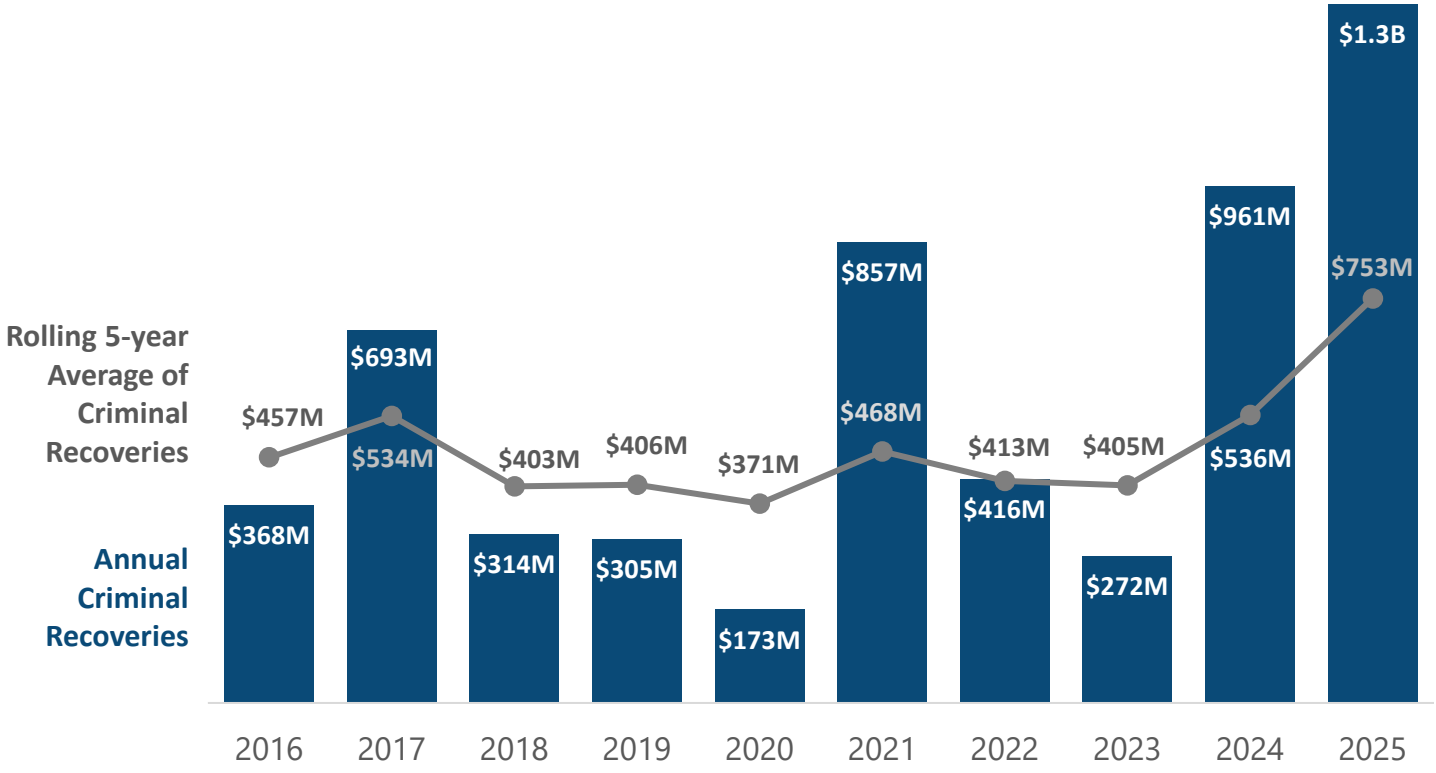
This chart shows the top five provider types (excluding "other" categories) based on the number of convictions for patient abuse or neglect in FY 2025.

Source: OIG analysis of FY 2025 Annual Statistical Reports.

Total Criminal Recoveries

For FY 2025, MFCUs reported $1.3 billion in total criminal recoveries, marking the highest amount in the past 10 years. Of these, fraud cases accounted for $1.2 billion and patient abuse and neglect cases for $17 million in criminal recoveries. As shown in the chart below, total criminal recoveries vary from year to year, depending on the types of cases that MFCUs investigate and when those cases are adjudicated. A large portion of the FY 2025 criminal recoveries was attributed to a case investigated by the Virginia MFCU, totaling $650 million in criminal recoveries (52 percent of FY 2025 reported criminal recoveries).

The rolling 5-year average of criminal recoveries increased in FY 2025. 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 2025 averages the total criminal recoveries from FYs 2021-2025.



Source: OIG analysis of Annual Statistical Reports for FYs 2016 through 2025.

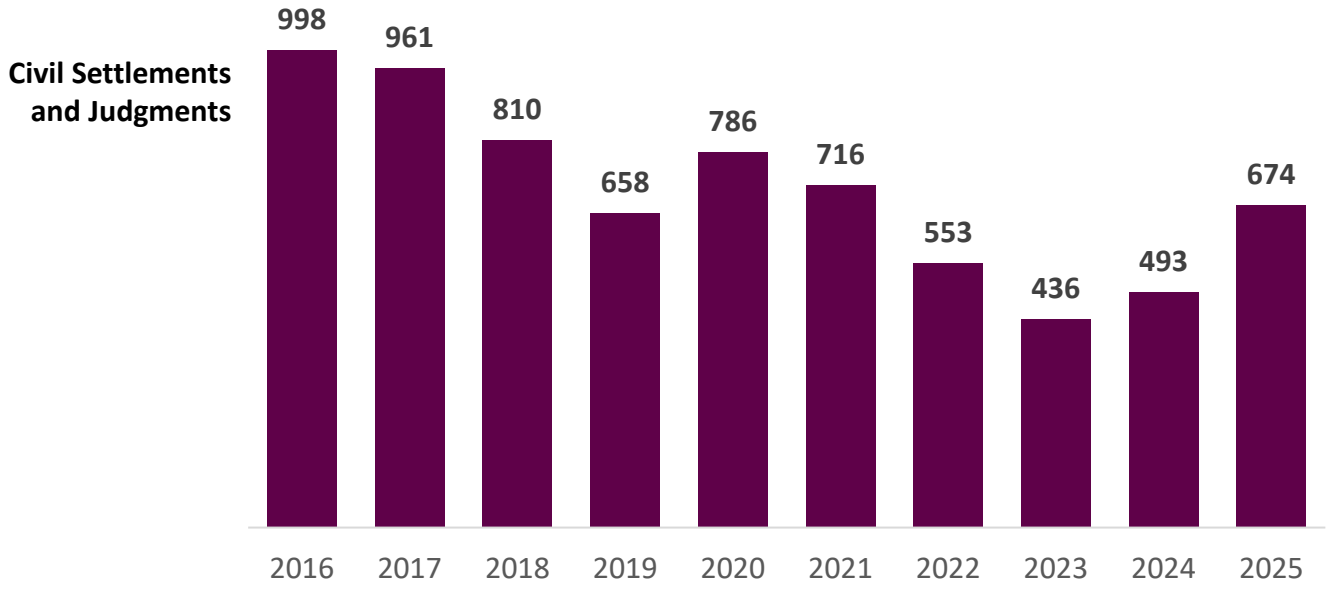
Case Example

The Virginia MFCU and multiple Federal partners collaborated on a criminal case that resulted in a $650 million resolution in FY 2025. As part of the government's resolution, a global management consulting firm agreed to pay penalties totaling $650 million. The resolution primarily pertains to advice that the consulting firm provided to its client, an opioid manufacturer, regarding the sales and marketing of an extended-release opioid drug. According to the Department of Justice press release, the case marks the first time a management consulting firm has been held criminally responsible for advice resulting in the commission of a crime by a client.

Source: DOJ Press Release: *Justice Department Announces Resolution of Criminal and Civil Investigations into McKinsey & Company's Work with Purdue Pharma L.P.; Former McKinsey Senior Partner Charged with Obstruction of Justice*. Accessed at https://www.justice.gov/archives/opa/pr/justice-department-announces-resolution-criminal-and-civil-investigations-mckinsey-companys on January 13, 2026.

Total Civil Settlements and Judgments

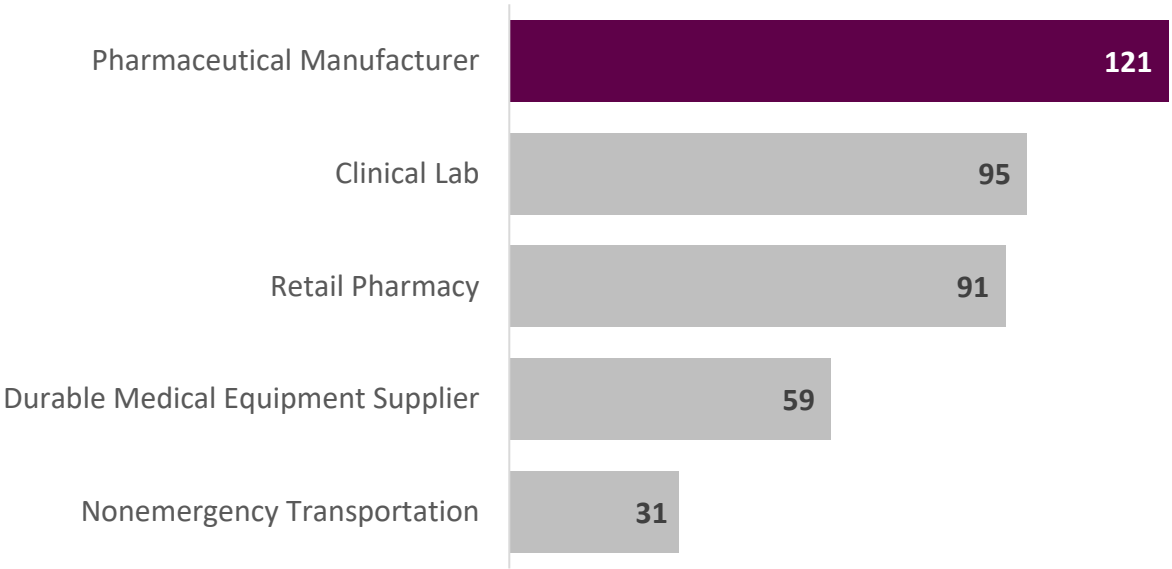
The number of civil settlements and judgments[3] increased by 37 percent from 493 in FY 2024 to 674 in FY 2025.



Source: OIG analysis of Annual Statistical Reports for FYs 2016 through 2025.

Civil Settlements and Judgments by Provider Type

Pharmaceutical manufacturers accounted for the largest number of civil settlements and judgments in FY 2025. An example of a civil settlement can include a pharmaceutical manufacturer involved in a kickback scheme.

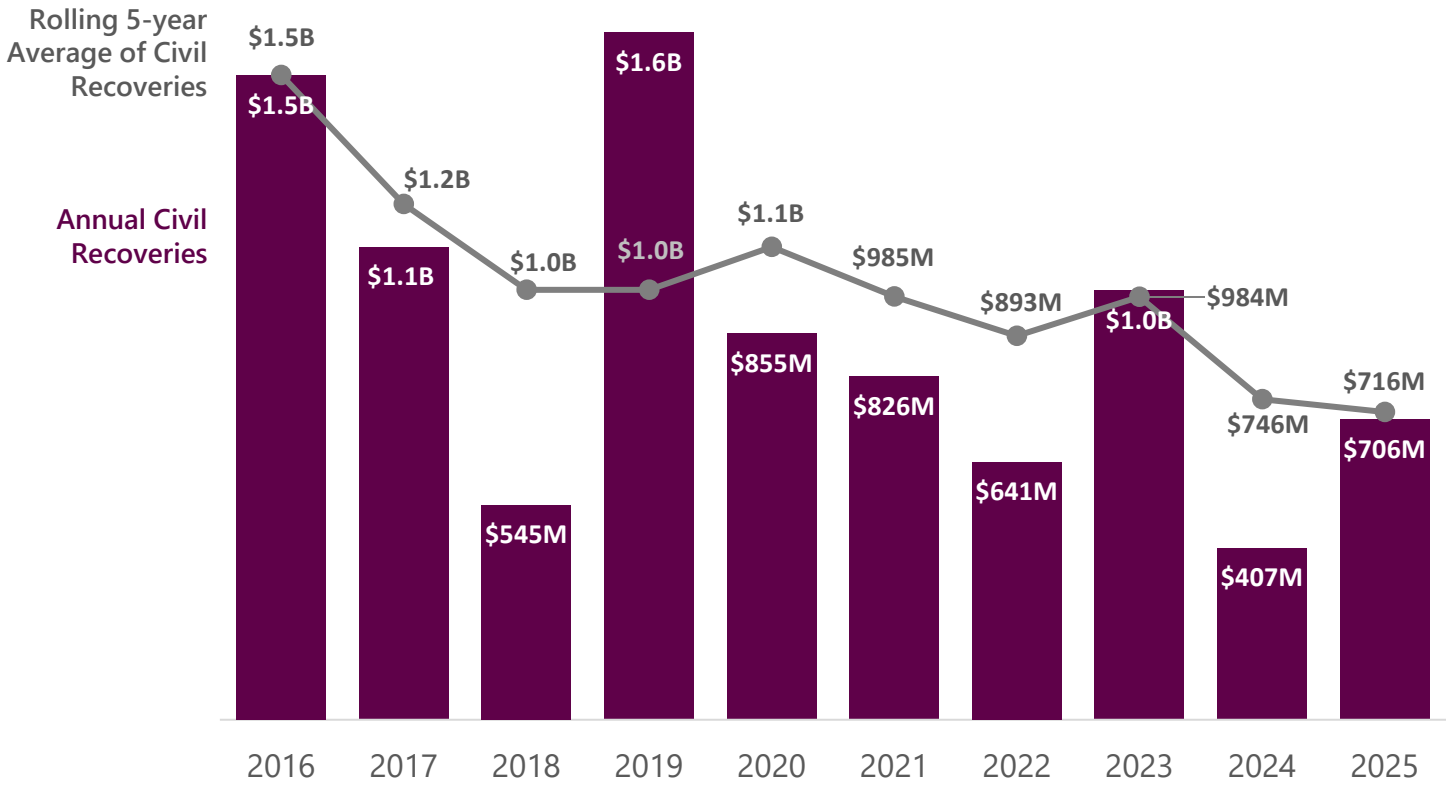


Source: OIG analysis of FY 2025 Annual Statistical Reports.

Total Civil Recoveries

Total civil recoveries substantially increased from $407 million in FY 2024 to $706 million in FY 2025. Four MFCUs—Indiana, New York, Colorado, and Georgia—accounted for half of the total civil recoveries in FY 2025. Similar to criminal recoveries, civil recoveries vary from year to year depending on the types of cases that MFCUs investigate and when those cases are settled or adjudicated.

The rolling 5-year average of civil recoveries slightly declined in FY 2025. 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 2025 averages the total civil recoveries from FYs 2021-2025.



Source: OIG analysis of Annual Statistical Reports for FYs 2016 through 2025.

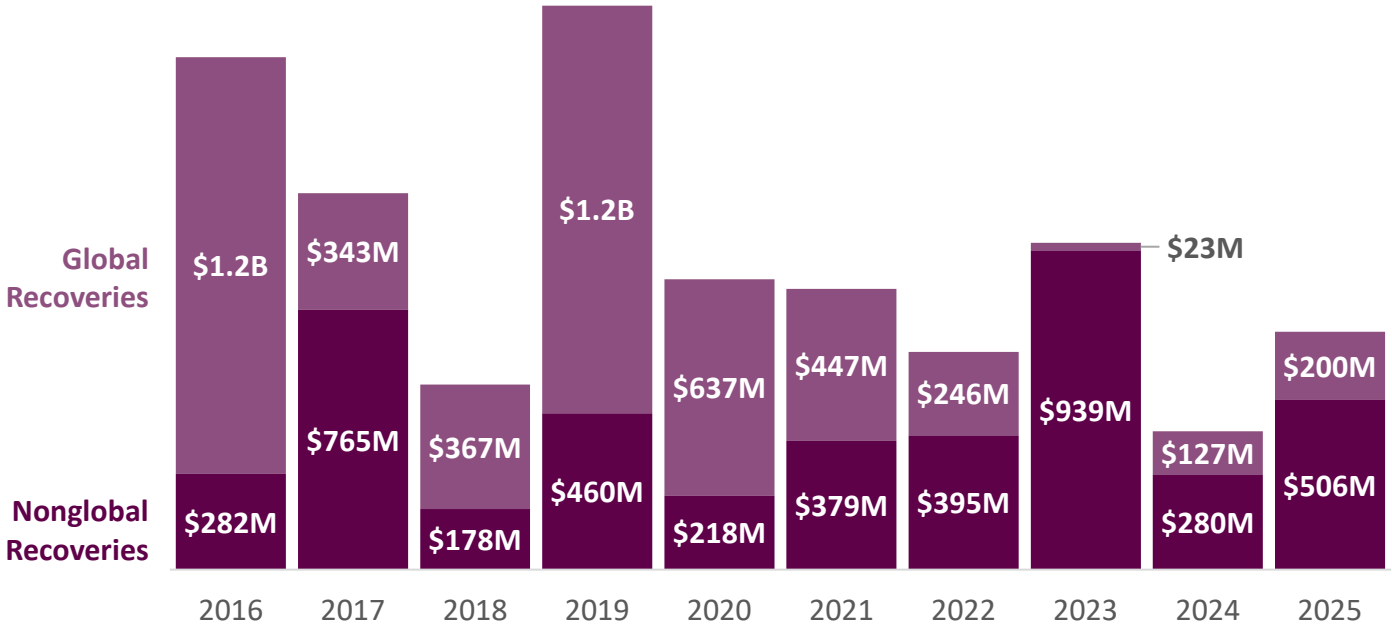
Case Example

The Indiana MFCU investigated a whistleblower case involving a hospital health network. The whistleblower filed a suit alleging that a hospital health network paid physicians that it directly employed or contracted with to refer their patients to the hospital health network's facilities. The hospital health network settled the case for $135 million in FY 2025.

Source: Indiana MFCU, *Annual Report 2024-2025.*

Nonglobal and Global Civil Recoveries

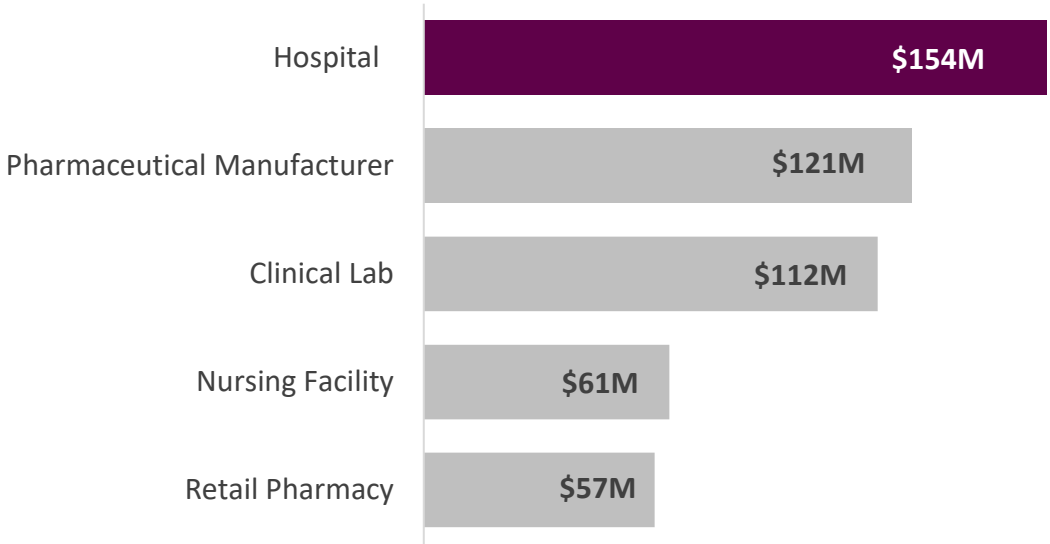
Nonglobal cases accounted for 72 percent, or $506 million, of the total civil recoveries in FY 2025. MFCUs in three states—Indiana, New York, and Georgia—reported 54 percent of nonglobal civil recoveries ($272 million). A nonglobal case is a matter directly investigated by an individual MFCU, or in some cases multiple MFCUs 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 2016 through 2025.

Civil Recoveries by Provider Type

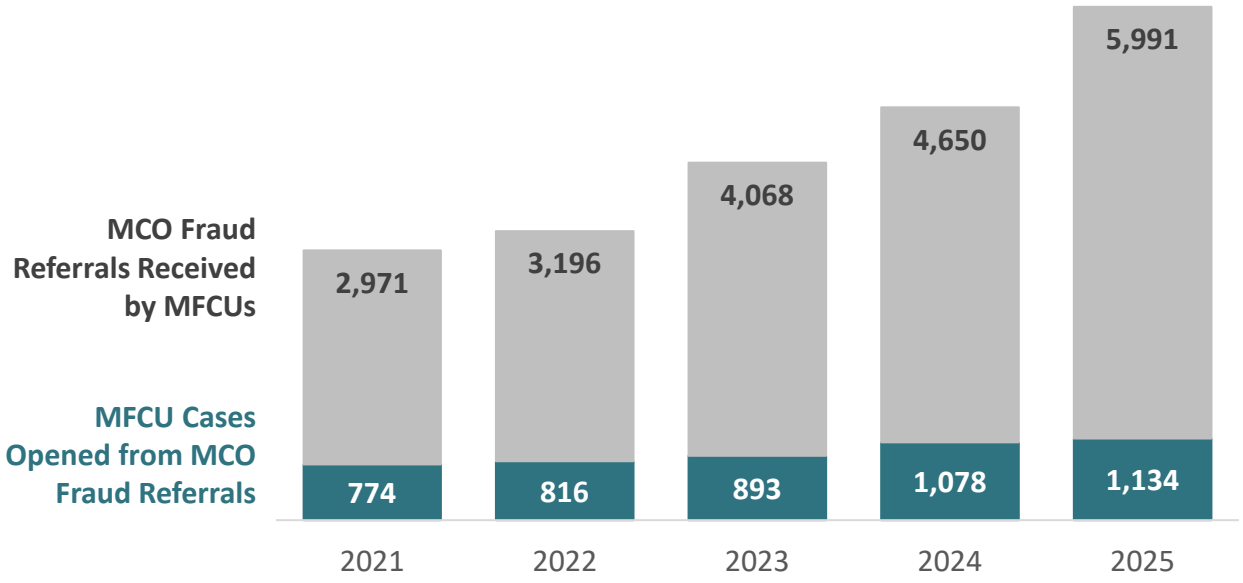
Hospitals accounted for the largest total amount of civil recoveries in FY 2025 followed by pharmaceutical manufacturers.



Source: OIG analysis of FY 2025 Annual Statistical Reports.

Fraud Referrals and Newly Opened Medicaid Managed Care Organization Fraud Cases

Both the number of fraud referrals received from Medicaid Managed Care Organizations (MCO)[4] and the number of MCO fraud cases opened by MFCUs from MCO referrals increased in FY 2025. In 2021, OIG launched an initiative to increase the number of fraud referrals MFCUs received from MCOs and the number of cases MFCUs opened as a result of those referrals.[5] MCO referrals are an essential component of a Unit's ability to identify, investigate, and prosecute Medicaid provider fraud. Cases opened through these referrals may lead to criminal convictions, civil settlements or judgments, exclusions, and/or recoveries.



Source: OIG analysis of Annual Statistical Reports for FY 2025.

Summary

Medicaid is a Federal-State partnership that provides health insurance for about 69 million individuals.[6] MFCUs play an important role in investigating Medicaid provider fraud and protecting patients from abuse or neglect. For FY 2025, MFCUs reported an increase in the number of convictions and civil settlements and judgments. Overall, MFCUs reported recovering almost $2 billion, with a return on investment of $4.64 for every $1 spent in FY 2025.

MFCU Program Background

MFCUs investigate and prosecute Medicaid provider fraud and patient abuse or neglect.[7] 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.[8] In FY 2025, all 50 States, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands operated MFCUs.[9, 10] For FY 2025, combined Federal and State expenditures for the Units totaled approximately $424 million, of which approximately $318 million represented Federal funds.

MFCU cases typically begin as referrals from external sources or are generated internally from data mining.[11] 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 longer to resolve.

OIG Oversight of the MFCU Program and Beneficial Practices

OIG recertifies each Unit annually; certification is necessary for the Unit to receive Federal reimbursement.[12] Annual recertification assesses 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.[13] For the recertification review, OIG examines MFCU's case statistics, reapplication packet, and questionnaire responses from State and Federal stakeholders.

OIG may further assess a Unit's performance by conducting inspections of Units that can result in findings and recommendations for improvement. During an inspection, OIG may also identify beneficial practices that could be useful to other Units. A list of these beneficial practices is available on the OIG website. Further, OIG provides ongoing guidance, consultation, and technical assistance to maximize Unit effectiveness.

To support its oversight, OIG collects and analyzes annual statistical data on performance outcomes (such as the numbers of open cases; convictions; and amounts of recoveries) and referrals.[14] These data can be accessed on the OIG website.

Standards

We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued in 2020 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] 42 CFR § 1007.11(g). Units must report adverse actions to the NPDB within 30 days of the final adverse action. See also 42 CFR § 60.5. Examples of adverse actions include, but are not limited to, health care-related criminal convictions and civil judgments.

[2] SSA § 1128. See also OIG, *Background Information*, https://oig.hhs.gov/exclusions/background.asp. Accessed on January 20, 2026.

[3] A single settlement or judgment may represent the resolution of a single case or multiple cases packaged together.

[4] 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.

[5] MFCU Performance Standard 4(A) states that the Unit takes steps to ensure that the State Medicaid agency, MCOs, and other pertinent entities refer to the Unit suspected provider fraud. Steps to ensure referrals may include having consistent communication and meetings with referring entities, providing feedback on the quality and volume of referrals, and training on the characteristics of an effective referral. MFCU performance standards are published at 89 Fed. Reg. 76431 (Sept. 18, 2024).

[6] Centers for Medicare and Medicaid Services, *November 2025 Medicaid & CHIP Enrollment Data Highlights*, https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/november-2025-medicaid-chip-enrollment-data-highlights. Accessed on February 27, 2026.

[7] 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.

[8] SSA § 1902(a)(61).

[9] 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. 44 Fed. Reg. 47809, 47811 (Aug. 15, 1979). 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).

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

[11] 42 CFR § 1007.20. MFCUs must receive approval from OIG to conduct data mining. As of January 2026, 26 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 January 20, 2026.

[12] 42 CFR §§ 1007.17(a) and 1007.19(d)(1).

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

[14] Since 2021, OIG has 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/documents/medicaid-fraud-control-units/10414/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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