**2025 Report to the Interim Joint Committee on Appropriations and Revenue**
**Office of Medicaid Fraud and Abuse Control**

The General Assembly has instructed the Kentucky Attorney General's Office Medicaid Fraud Abuse Control Unit (MFCU) to prepare a report containing the following information:

> **The Office of Attorney General shall submit an annual report beginning December 1, 2024, to the Interim Joint Committee on Appropriations and Revenue. The report shall include the number of reported fraud incidents, the types of fraud reported, the number of reported fraud incidents investigated by the office, the monetary amount involved in the fraudulent activity, and the resolution of the reported fraud incidents.**

On December 1, 2024, the MFCU filed its initial report containing data from January 1, 2024, through November 26, 2024. The instant report contains MFCU data from December 1, 2024, through November 30, 2025. The requested information is set forth below.

## Background

The MFCU within the Office of the Kentucky Attorney General is one of 53 units in the United States. Like in the Commonwealth, most other Medicaid fraud units are located within state attorney general offices. Congress authorized the operation of Medicaid fraud units as part of the overall Medicaid Program in 42 U.S.C. § 1396 and as elaborated in 42 CFR §§455.15-21 and 1007. As the MFCUs receive seventy-five percent (75%) of their budget from the federal government, their jurisdiction is also governed by the terms of their federal grants.

The Kentucky MFCU investigates and prosecutes Medicaid provider fraud pursuant to Kentucky Revised Statute ("KRS") Chapters 194A and 205. The MFCU is also authorized to investigate the abuse, neglect and exploitation of vulnerable adults at facilities which receive Medicaid funding, and in board and care facilities, regardless of whether they receive Medicaid funding. Additionally, a recent increase in jurisdiction from the federal government allows the MFCU to investigate cases of abuse, neglect or exploitation of Medicaid patients in any setting,

so long as the abuse, neglect or exploitation occurred in the context of receiving Medicaid services from a Medicaid provider. Section 209.990 of the KRS is normally relied upon for allegations involving the abuse, neglect, and exploitation of vulnerable adults.

**Reports of Potential Fraud Submitted to the Kentucky Office of the Attorney General's MFCU for December 1, 2024 to November 30, 2025**

The Kentucky MFCU operates a Medicaid fraud hotline, through which members of the public can report Medicaid fraud either through an online portal or by calling. The hotline can also be used to report instances of the abuse, neglect or exploitation of vulnerable adults. During the time-period of this report, the MFCU received fifty-eight (58)[1] individual reports of alleged Medicaid fraud through the Medicaid fraud hotline. These reports[2] include thirty-two (32) allegations of billing for services not rendered; five (5) allegations of charging cash for Medicaid services; ten (10) allegations of upcoding Medicaid billings; five (5) allegations of providing services by unqualified individuals; three (3) allegations of kickbacks; five (5) allegations of billing for medically unnecessary services; eight (8) allegations of the falsification of documents; one (1) allegation of unbundling; one (1) allegation of prescribing under a different provider's name; one (1) allegation of providing services without sufficient oversight; one (1) allegation of billing through a provider no longer associated with the billing entity; one (1) allegation of recruiting patients for the purpose of providing medically unnecessary services; one (1) allegation of billing without supporting documentation; one (1) allegation of falsifying business expenses; one (1) allegation of not providing necessary services; three (3) allegations of controlled substances violations; one (1) allegation of requiring Medicaid patients to change their MCO; and one (1) general allegation of incorrect Medicaid billings.

[1] Some of the reports alleged multiple types of fraud.
[2] See Figure 5 at the conclusion of this report.

The MFCU also received six hotline reports of fraud from federal HHS-OIG. These were reports that the federal HHS-OIG received through its fraud hotline, and that the federal HHS-OIG declined to investigate. The allegations contained in those reports include allegations of billing for services not rendered, billing for services not medically necessary, and the provision of services by unqualified employees.

During the reporting period, the MFCU opened six (6) cases for active investigation that stemmed from Medicaid Managed Care Organization ("MCO") reports of fraud. This number is down from fourteen (14) active cases opened in the prior year based on MCO referrals. The MFCU attributes the decrease to one MCO no longer serving as a Kentucky MCO, as a significant portion of the MFCU's MCO fraud referrals came from that MCO.

The allegations contained in these MCO reports of fraud include overlapping days of service and impossible hour days, suggesting the possibility of billing for services not rendered; billing for services on days with limited operating hours, suggesting the possibility of billing for services not rendered; upcoding; fraudulent claims for reimbursement; and the insufficient documentation of services. The MFCU received an additional four (4) reports of fraud from the MCOs that did not meet the criteria for opening an active investigation. The allegations of fraud in these reports include upcoding; and insufficient documentation of services.

The MFCU also received two (2) reports of Medicaid waiver participant directed services fraud from the Cabinet for Health and Family Services, Office of the Inspector General. Both of those reports were accepted for active investigation. Other reports of fraud include reports from federal law enforcement that alleged one (1) report of medically unnecessary services; and two (2) reports of billing for services not rendered. A report of fraud was emailed directly to a MFCU detective that alleged billing for services not rendered. Finally, a report of fraud was received from

the Kentucky Department of Insurance alleging services being performed by unqualified individuals. All of these matters were opened for active investigation.

Finally, the MFCU received an additional referral from federal HHS-OIG in November of 2025, in which a federal unified program integrity contractor ("UPIC") identified an overpayment of $2,594,559.00. It is not known at this time whether that overpayment was made as a result of fraud. In all likelihood, the UPIC will administratively collect on that identified overpayment while the MFCU will investigate the Medicaid provider in conjunction with federal law enforcement.

**Investigations, Prosecutions, and Monetary Recoveries Participated in Kentucky Office of the Attorney General MFCU**

The MFCU had a total of 207 Medicaid fraud investigations that were open at some point during the reporting period covered by this report. Until a case has been successfully prosecuted or a civil resolution has been reached, the monetary amount involved in the fraudulent activity cannot be specifically identified. (The total amount of criminal and civil fraud obligations established from December 1, 2024 through November 30, 2025 will be addressed in the section of this report dealing with the resolution of reported fraud incidents.) What can be readily identified is the amount of the Medicaid overpayments that the MCOs determined occurred in the previously discussed six (6) MCO reports of fraud that were accepted for active investigation. While a Medicaid overpayment is not necessarily equivalent to an act of Medicaid fraud, it does serve as a good starting point to identify the potential fraud exposure at issue. The combined overpayments the MCOs identified in those six (6) fraud reports comes to a total of $520,529.99. Additionally, the Medicaid waiver participant directed services fraud reports from the Cabinet for Health and Family Services, Office of the Inspector General, come to an alleged overpayment total of $40,722.25.

Of the reported Medicaid fraud allegations that were accepted for active investigation during the time-period of this report, all are still under active investigation. From December 1, 2024, through November 30, 2025, the MFCU contributed to securing $22,200,615.09[3] in healthcare related obligations. This amount includes $3,054,569.40 in Kentucky Medicaid state share dollars in obligations related to civil recoveries. This amount also includes $873,313.15[4] in combined state and federal share Medicaid dollars in obligations related to criminal restitution.

In addition to the MFCU's participation in significant monetary recoveries, during the reporting period the MFCU secured eleven (11) indictments related to Medicaid fraud (the MFCU's indictments related to adult abuse, neglect and exploitation are not addressed in this report). All eleven (11) of those indictments were obtained in Kentucky state court. The MFCU additionally participated in securing one (1) indictment by information in federal court.

The MFCU participated in securing a total of thirteen (13) criminal guilty pleas, guilty verdicts and/or sentencings related to Medicaid fraud from December 1, 2024, through November 30, 2025. Of those criminal resolutions, one (1) was in Kentucky state court and twelve (12) were in federal court. (The MFCU's criminal resolutions related to adult abuse, neglect and exploitation are not addressed in this report and are not included in the totals set forth in the sentences immediately above.)

The attached addendum contains charts summarizing the statistics contained in this report. Please contact Kentucky Office of the Attorney General MFCU Executive Director Matthew Kleinert or Deputy Director David Startsman for additional information or for any follow-up

[3] See Figures 1 and 2 at the end of this report.

[4] The MFCU is currently waiting on federal sentencing for nine defendants in federal court. Three were found guilty following trial in March of 2025, two pleaded guilty in July of 2025, one pleaded guilty in August of 2025 and three pleaded guilty in November of 2025. At this time, restitution has not been formally established for these nine individuals as sentencing is still pending. However, it is anticipated that the restitution amount owed to the Kentucky Medicaid Program in state and federal share dollars is expected to be approximately $2,000,000.

questions. During the period of this report, Deputy Director Startsman became a Special Assistant United States Attorney for the Western District of Kentucky and will be assisting with federal healthcare fraud cases involving losses to the Kentucky Medicaid Program.

# Addendum

**Figure 1: Civil Obligations**

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|---|---|
| Administrative Costs | $512,841.64 |
| Medicaid (Federal and State Share Not Distinguished) | $904,067.46 |
| Medicaid (Federal Share Only) | $13,820,670.84 |
| Medicaid (State Share Only) | $3,054,569.40 |
| Other Amounts Ordered | $2,912,683.56 |
| **Total Civil Obligations** | **$21,204,832.90** |

**Figure 2: Criminal Obligations**

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|---|---|
| Medicaid (Federal and State Share Not Distinguished) | $873,315.15 |
| Fines and Court Assessments | $22,765.50 |
| Other Amounts Ordered | $99,701.54 |
| **Total Criminal Obligations** | **$995,782.19** |

**Figure 3: Medicaid Fraud Indictments**

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| State Court Indictments | 11 |
| Federal Court Indictments | 1 |
| **Total Indictments** | **12** |

**Figure 4: Medicaid Fraud Guilty Pleas/Verdicts/Convictions**

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|---|---|
| State Court Criminal Resolutions | 1 |
| Federal Court Criminal Resolutions | 12 |
| **Total Resolutions** | **13** |

**Figure 5: Hotline Allegations of Fraud**

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| Billing for Services not Rendered | 32 Allegations |
| Charging Cash for Medicaid Services | 5 Allegations |
| Upcoding | 10 Allegations |
| Billing for Services by Unqualified Individuals | 5 Allegations |
| Kickbacks | 3 Allegations |
| Billing for Medically Unnecessary Services | 5 Allegations |
| Falsification of Documents | 8 Allegations |
| Unbundling | 1 Allegation |
| Prescribing Under a Different Provider's Name | 1 Allegation |
| Providing Services Without Sufficient Oversight | 1 Allegation |
| Billing Through a Provider No Longer Associated with the Billing Entity | 1 Allegation |
| Recruiting Patients for the Purpose of Providing Medically Unnecessary Services | 1 Allegation |
| Billing Without Supporting Documentation | 1 Allegation |

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|---|---|
| Falsifying Business Expenses | 1 Allegation |
| Not Providing Necessary Services | 1 Allegation |
| Controlled Substances Violations | 3 Allegations |
| Requiring Medicaid Patients to Change their MCO | 1 Allegations |
| General Allegation of Incorrect Billings | 1 Allegation |
| **Total Hotline Allegations** | **81 Allegations** |