2024 Report to the Interim Joint Committee on Appropriations and Revenue
Office of Medicaid Fraud and Abuse Control

The Kentucky Attorney General's Office of Medicaid Fraud and Abuse Control ("MFCU") is one of 53 such units in the United States. Congress authorized the operation of such 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. The majority of states operate their MFCU as part of the Office of the Attorney General. 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. KRS 209.990 is normally relied upon for allegations involving the abuse, neglect, and exploitation of vulnerable adults.

The General Assembly has instructed the 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.**

The following report contains MFCU data from January 1, 2024 through November 26, 2024.

The 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. The hotline can also be used to report instances of the abuse, neglect or exploitation of vulnerable adults. In 2024, the MFCU received thirty-five (35)[1] reports of alleged Medicaid fraud through the Medicaid fraud hotline. These reports[2] included fourteen (14) allegations of billing for services not rendered; one (1) allegation of charging cash for Medicaid services; one (1) allegation of billing Medicaid for workers compensation related injuries; one (1) allegation of billing commercial health insurance for Medicaid services; five (5) allegations of services not being provided within the accepted standard of care; one (1) allegation of bringing in patients from out-of-state and signing them up for Kentucky Medicaid; one (1) allegation of filling a prescription for one drug and billing for another; three (3) allegations of upcoding Medicaid billings; one (1) allegation of providing services without a license; two (2) allegations of the misuse of Medicaid funds; four (4) allegations of kickbacks; two (2) allegations of billing for medically unnecessary services; one (1) allegation of the falsification of documents; and one (1) report containing general and unspecified allegations of fraudulent billings.

In 2024, the MFCU opened fourteen (14) cases for active investigation that stemmed from Medicaid Managed Care Organization ("MCO") reports of fraud. The allegations contained in these reports of fraud include the fraudulent use of a Medicaid provider number; billing for medically unnecessary services; unbundling Medicaid billings; upcoding Medicaid billings; billing for services not rendered; allegations of kickbacks; and the insufficient documentation of services. The MFCU received an additional five (5) reports of fraud from the MCOs that did not meet the criteria for opening an active criminal investigation. The allegations of fraud in these

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

reports include double billing; billing for medically unnecessary services; billing for services not rendered; insufficient documentation of services; and improper pharmacy practices.

The MFCU also received four (4) reports of Medicaid waiver participant directed services fraud from the Cabinet for Health and Family Services, Office of the Inspector General. All four of these reports were accepted for active investigation. Other reports of fraud include reports from federal law enforcement that alleged one (1) report of improper prescribing and two (2) reported allegations of billing for services not rendered. Finally, two (2) reports from local law enforcement alleging Medicaid waiver participant directed services fraud were received. All of these reports resulted in the opening of active investigations.

During the 2024 calendar year, the MFCU had a total of 219 Medicaid fraud investigations. The monetary amount involved in the fraudulent activity cannot be specifically identified, until a case has been successfully prosecuted or a civil resolution has been reached (the total amount of criminal and civil fraud obligations established in 2024 will be addressed in the section of this report dealing with the resolution of reported fraud incidents). What can be identified is the amount of the Medicaid overpayments that the MCOs determined occurred in the previously discussed fourteen (14) 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 fourteen (14) fraud reports comes to a total of $6,940,902.30. 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 $32,844.24.

Of the reported Medicaid fraud allegations that were accepted for active investigation in 2024, all are still under active investigation as of the writing of this report. During the 2024 calendar year, the MFCU contributed to securing $22,508,822.28[3] in healthcare and other taxpayer related obligations. This amount includes $3,048,200.56 in Kentucky Medicaid state share dollars in obligations related to civil recoveries. This amount also includes $4,108,402.32 in state and federal share Medicaid dollars in obligations related to criminal restitution.

In addition to the MFCU's participation in significant monetary recoveries in 2024, the MFCU contributed in securing twelve (12) indictments related to Medicaid fraud (the MFCU's indictments related to adult abuse, neglect and exploitation are not addressed in this report). Three (3) of those indictments were obtained in Kentucky state court and nine (9) of those indictments were obtained in federal court (MFCU cases often result in federal prosecution).

The MFCU participated in securing a total of eleven (11) criminal guilty pleas, guilty verdicts and/or sentencings related to Medicaid fraud in 2024 (the MFCU's criminal resolutions related to adult abuse, neglect and exploitation are not addressed in this report). Of those criminal resolutions, seven (7) were in Kentucky state court and four (4) were in federal court.

Below are charts summarizing the statistics contained in this report.

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

Figure 1: Civil Obligations

Administrative Costs	$378,815.93
Medicaid (Federal and State Share Not Distinguished)	$200,000.00
Medicaid (Federal Share Only)	$9,491,956.16
Medicaid (State Share Only)	$3,048,200.56
Other Amounts Ordered	$2,414,803.67
Total Civil Obligations	**$15,533,776.32**

Figure 2: Criminal Obligations

Medicaid (Federal and State Share Not Distinguished)	$4,108,402.32
Fines and Court Assessments	$10,465.00
Other Amounts Ordered	$2,856,178.64
Total Criminal Obligations	**$6,975,045.96**

Figure 3: Medicaid Fraud Indictments

State Court Indictments	3
Federal Court Indictments	9
Total Indictments	**12**

Figure 4: Medicaid Fraud Guilty Pleas/Verdicts/Convictions

State Court Criminal Resolutions	7
Federal Court Criminal Resolutions	4
Total Resolutions	**11**

Figure 5: Hotline Allegations of Fraud

Billing for Services not Rendered	14 Allegations
Charging Cash for Medicaid Services	1 Allegation
Billing Medicaid for Workers' Compensation Related Injuries	1 Allegation
Billing Commercial Health Insurance for Medicaid Services	1 Allegation
Medicaid Services not Provided Within Accepted Standard of Care	5 Allegations
Signing Out-Of-State Patients Up for Medicaid	1 Allegation
Filling a Prescription for One Drug and Billing for Another	1 Allegation
Upcoding Medicaid Billings	3 Allegations
Providing Services Without a License	1 Allegation
Misuse of Medicaid Funds	2 Allegations
Kickbacks	4 Allegations
Billing for Medically Unnecessary Services	2 Allegations
Falsification of Documents	1 Allegation
General and Unspecified Allegations	1 Allegation
Total Hotline Allegations of Different Types of Fraud	**38 Allegations**