

Medicaid Fraud Control Division

The Medicaid Fraud Control Division protects vital public resources and helps ensure healthcare programs serve those who need them most. This work safeguards both taxpayer dollars and the integrity of services relied upon by vulnerable Tennesseans.

Investigations in this division require diligence, discretion, and persistence. Through careful analysis and collaboration with partners, the division addresses complex fraud and abuse cases – often out of public view, but always with accountability and service guiding the work.



The TBI's Medicaid Fraud Control Division works to protect public resources and safeguard vulnerable individuals by investigating healthcare fraud and abuse connected to the state's Medicaid program. Through careful analysis and coordinated enforcement efforts, the division holds offenders accountable while helping ensure critical services remain available to those who depend on them.

While much of this work focuses on criminal investigations involving Medicaid providers – often resulting in prosecutions in state and federal courts -- the division also plays a key role in civil enforcement actions. These cases, brought under the federal False Claims Act and the Tennessee Medicaid False Claims Act, have proven to be powerful tools in addressing healthcare fraud and have resulted in significant financial recoveries for the state.

In addition to fraud investigations, the division is responsible for investigating allegations of abuse, neglect, and financial exploitation involving individuals in Medicaid-receiving facilities, board and care facilities, and other settings connected to the delivery of Medicaid services. This work reflects a dual mission: protecting both public funds and the people those funds are intended to serve.

In 2025, the division's efforts resulted in 28 indictments, 29 convictions, and the identification of more than \$13 million in overpayments—achieved at an approximate cost of \$3 million to the state.

Fraud Investigations & Enforcement

From January 1 through December 31, 2025, the division's fraud investigations identified approximately \$10.7 million in overpayments. During that time, investigators opened 101 fraud cases, closed 84, obtained 12 indictments, and secured 19 convictions. The division continues to strengthen its approach by focusing on emerging fraud trends and data-driven



analysis. By prioritizing trend-based analytics – rather than relying solely on traditional link analysis – investigators are better positioned to identify systemic issues across Medicaid, Medicare, and commercial data sources.

This work is supported through strong partnerships with organizations such as the Healthcare Fraud Prevention Partnership and the National Healthcare Anti-Fraud Association, as well as close collaboration with TennCare, the Tennessee Office of Inspector General, the Tennessee Attorney General’s Office, and the Tennessee Department of Health’s Division of Health-Related Boards. Together, these partnerships enhance the state’s ability to detect, investigate, and prevent healthcare fraud.

Global Investigations & Recoveries

The division also participates in multi-state and national healthcare fraud investigations, often resulting in global settlements involving large healthcare providers. These cases allow Tennessee to recover funds in matters that may originate outside the state but impact its Medicaid program.

In 2025, the division participated in multiple National Association of Medicaid Fraud Control Units (NAMFCU) global settlements, resulting in \$2,334,421.49 in combined federal and state recoveries on behalf of Tennessee.

Protecting Vulnerable Populations

In addition to its fraud-related work, the division investigates allegations of abuse, neglect, and financial exploitation involving vulnerable adults. From January 1 through December 31, 2025, investigators opened 90 such cases—many involving multiple victims—resulting in 16 indictments and 10 convictions.

During that same period, the division received more

than 4,100 referrals related to abuse, neglect, and exploitation. These referrals primarily originate from the Tennessee Department of Human Services' Adult Protective Services and the Tennessee Department of Disability and Aging, as well as the division's hotline, website, and email reporting channels. Each referral undergoes a preliminary review to determine appropriate investigative action.

Through these efforts, the division not only holds offenders accountable, but also helps ensure individuals are reported to the Tennessee Abuse Registry and appropriate licensing boards when necessary – providing an additional layer of protection for those most at risk.



2025 Case Breakdown

Case Type	Number	Percentage
Fraud by Facility-Based Medicaid Providers & Programs	24	9%
Fraud by Physicians & Licensed Practitioners	54	21%
Fraud by Medical & Other Support Services	61	23%
Fraud by Other Individual Providers	38	14%
Fraud by Other Perpetrators, Family Members & Program-Related	10	4%
Patient Abuse/Neglect	76	29%
Total	263	100%