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Oklahoma Medicaid Fraud Control Unit: 2025 Inspection

Why OIG Did This Review

OIG administers the Medicaid Fraud Control Unit (MFCU or Unit) grant awards, annually recertifies each Unit, and oversees the Units' performance in accordance with the requirements of the grant. As part of this oversight, OIG conducts periodic inspections of Units and issues public reports of its findings and observations.

What OIG Found

The Oklahoma Unit reported 55 indictments, 49 convictions, 17 civil settlements, and \$10.1 million in recoveries during our review period of fiscal years 2022–2024. The Unit maintained positive working relationships with external partners; made recommendations to the State Medicaid agency to limit improper payments; and investigated fraud and patient abuse or neglect cases involving a mix of provider types. However, the Unit did not always adhere to the MFCU performance standards or comply with applicable requirements.



The Unit's policies and procedures did not address certain aspects of its operations.



The Unit took steps to maintain an adequate volume and quality of fraud referrals from the Program Integrity Unit (PIU) and managed care organizations (MCOs), but the Unit received few fraud referrals from these sources during our review period.



Sixteen percent of cases open during our review period had significant investigative delays.



The Unit lacked a case management system capable of efficiently managing and reporting case information and performance data.



The Unit did not consistently conduct and document periodic supervisory reviews of cases during our review period.



The Unit did not report substantial proportions of its adverse actions and convictions to Federal partners within the required timeframes.



The Unit's memorandum of understanding (MOU) with the State Medicaid agency generally reflected current practice, policy, and legal requirements, but the MOU did not reference the *CMS Performance Standard for Referrals*.

What OIG Recommends

To address the findings, we recommend that the Unit (1) update its policies and procedures manual to address certain aspects of its operations; (2) build upon its efforts to increase the volume and quality of fraud referrals from the PIU and MCOs; (3) take steps to mitigate investigative delays; (4) take steps to implement a case management system capable of efficiently managing and reporting case information and performance data; (5) take steps to conduct and document periodic supervisory reviews of cases in accordance with Unit policy; (6) take steps to ensure that it reports all convictions and adverse actions to Federal partners within the appropriate timeframes; and (7) revise its MOU with the State Medicaid agency to reference the *CMS Performance Standard for Referrals*. The Unit concurred with all seven recommendations.