

Department of Health and Human Services  
**Office of Inspector General**



Office of Evaluation and Inspections

June 2026 | OEI-06-25-00150

# **Florida Medicaid Fraud Control Unit: 2025 Inspection**



June 2026 | OEI-06-25-00150

## Florida 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.

### What OIG Found

From total Federal and State operational expenditures of approximately \$62.1 million, the Florida MFCU reported 217 indictments, 170 convictions, 39 civil settlements and judgments, and nearly \$182.9 million in recoveries during our review period of FYs 2022–2024. The Unit maintained strong working relationships with Federal partners, took steps to address vacancies and staff turnover, and maintained a continuous case flow. However, the Unit did not always adhere to the MFCU performance standards or comply with applicable requirements. We found:



The Unit took steps to improve the quality of referrals of fraud and patient abuse and neglect from its primary referral sources but further action is needed.



The Unit did not consistently report adverse actions to the National Practitioner Data Bank (NPDB) within the appropriate timeframe but had improved its reporting since the last OIG inspection.



The Unit's training plan lacked annual minimum training hour requirements for some of its investigators, although all staff received, on average, more than 30 hours of training each year.

### What OIG Recommends

To address the findings, we recommend that the Florida MFCU:

1. Build upon its efforts to improve the quality of referrals from its primary referral sources.
2. Take steps to ensure that it reports all adverse actions to the NPDB within the required timeframe.
3. Update its training plan to include annual minimum training hour requirements for each professional discipline.

The Unit concurred with all three recommendations.

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# BACKGROUND

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## OBJECTIVE

To assess the performance and operations of the Florida Medicaid Fraud Control Unit (MFCU or Unit).

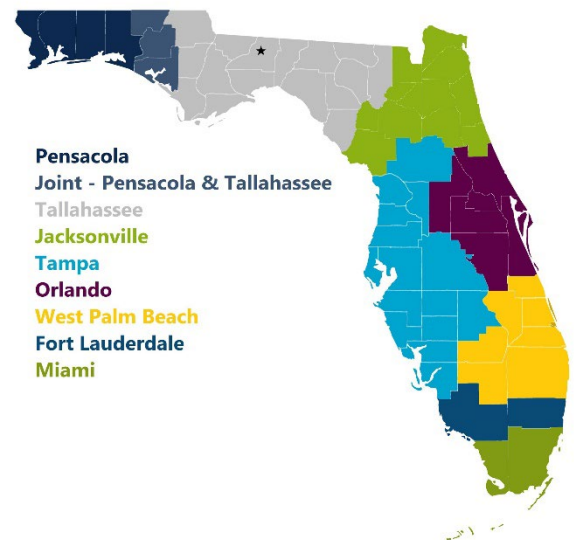
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The Office of Inspector General (OIG) administers the MFCU grant awards, annually recertifies each Unit, and oversees the Units' performance and operations in accordance with the requirements of the grant. As part of this oversight, OIG conducts periodic inspections of Units and issues public reports of its findings. For more information about MFCUs and OIG oversight of MFCUs, see pages 17 and 18 of this report.

## Florida MFCU

The Florida MFCU is located within the Florida Office of Attorney General. At the time of our inspection in June 2025, the Unit had eight offices, including a headquarters office located in Tallahassee and regional offices that were operationally grouped into three regions: Northern (Pensacola, Tallahassee, and Jacksonville), Central (Tampa and Orlando), and Southern (West Palm Beach, Fort Lauderdale, and Miami). See Exhibit 1 for a map of the geographic areas covered by each regional office. The Unit employed 128 staff—60 investigators (including 11 lieutenants, 3 regional captains, 1 major, and 1 colonel); 23 attorneys (including 3 regional bureau chiefs, 2 deputy directors, and the Unit director); 12 auditors (including the chief auditor); 16 analysts; and 17 legal and administrative support staff. During our review period of

**Exhibit 1: Map of Unit offices by covered geographic area**



Source: OIG review of Unit-provided documentation.

Federal fiscal years (FYs) 2022–2024, the Unit spent approximately \$62.1 million, with a State share of approximately \$15.5 million.<sup>1</sup>

## Referrals

During FYs 2022–2024, the Unit reported receiving referrals of potential Medicaid provider fraud from several sources, including the State Medicaid Agency, also known as the Agency for Health Care Administration (AHCA), and managed care organizations (MCOs).<sup>2</sup> The Unit received referrals of patient abuse or neglect primarily from the Department of Children and Families Adult Protective Services (DCF APS). See Appendix A for a list of Unit referrals by source for FYs 2022–2024.

When the Unit receives a referral of fraud or patient abuse or neglect, it enters the information into the Unit’s electronic case management system and the system assigns a case number to the matter. Next, the Unit’s complaint intake team reviews the matter to determine whether the referral falls within the Unit’s jurisdiction. If the complaint intake team accepts the referral, the team’s supervisor forwards the referral to the appropriate regional office for preliminary investigation. The captain (or a designated lieutenant) in the regional office assigns the matter to an investigative team, consisting of the captain, the regional bureau chief, a lieutenant, an investigator, and other professional staff (e.g., an auditor or analyst), as appropriate. The team has 60 days to conduct the preliminary investigation (which can be extended by 30 days if necessary) to determine whether a full investigation is warranted. Once the team completes the preliminary investigation, the investigator submits a report to the lieutenant with a recommendation for closing the matter, referring it, or opening it as a full investigation. If the Unit decides to close the matter or refer it to another agency, it documents its decision in the case file.

## Investigations and Prosecutions

When the Unit opens a full investigation, the regional bureau chief assigns an attorney to the investigative team. Within 14 days of the case opening, the team meets to discuss a plan for the investigation and documents the meeting in the case file. During the full investigation, the regional bureau chief or regional captain conducts quarterly reviews of the case file to ensure case progression.

After completing the full investigation, the investigative team determines whether the case warrants a referral for criminal prosecution and seeks approval from the

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<sup>1</sup> Federal FYs run from October 1 through September 30. For example, the Federal FY 2024 was from October 1, 2023, through September 30, 2024.

<sup>2</sup> The Unit can also self-generate fraud cases via data mining, which is the practice of electronically uncovering patterns and relationships within Medicaid data to identify aberrant utilization or billing, or other activities that are potentially fraudulent. A data mining waiver permits Federal financial participation in costs of data mining if certain criteria are satisfied (see 42 CFR § 1007.20). OIG originally approved the Florida Unit’s waiver in 2016 and most recently renewed it in June 2025.

regional bureau chief on the decision.<sup>3</sup> If the Unit proceeds with criminal prosecution, the Unit may refer the case to the Office of Statewide Prosecution, local State’s Attorney’s Offices, or the U.S. Attorney’s Office. Unit attorneys may also seek special designations or appointments from those prosecuting agencies to prosecute the cases themselves. If the Unit decides to adjudicate the case as a civil matter, the attorney assigned to the case submits it to both deputy directors and the Unit director, who review the case and recommend appropriate civil action. Once the prosecution or civil action is completed, or if referral for prosecution is declined, the investigator on the case prepares a closing report and submits it to the Unit director. If the closing report identifies potential administrative actions, the investigator makes a referral to the appropriate agency.

## Florida Medicaid Program

AHCA administers the Florida Medicaid program. As of August 2025, the program served more than 4 million enrollees, of whom approximately 73 percent received services through 9 MCOs and 27 percent received services through fee-for-service.<sup>4</sup> In FY 2024, Florida’s Medicaid expenditures were approximately \$36 billion.<sup>5</sup>

### Medicaid Program Integrity

AHCA’s Office of Medicaid Program Integrity (MPI) is responsible for Florida’s Medicaid program integrity efforts. AHCA MPI conducts audits and investigations of providers suspected of overbilling or defrauding the Medicaid program. It identifies potential fraud and abuse by reviewing complaints from external entities, generating leads through data analysis, and conducting program integrity activities with the MCOs. If AHCA MPI identifies suspected fraud through its program integrity efforts, it refers the allegations to the MFCU for investigation.

## Prior OIG Report

OIG conducted a previous onsite review of the Florida MFCU in 2015.<sup>6</sup> In that review, which covered FYs 2012–2014, OIG found that: (1) 42 percent of case files did not have documentation of periodic supervisory reviews consistent with Unit policy; (2) the Unit did not report all convictions and adverse actions to Federal partners within required timeframes; and (3) the Unit investigated one case that was not eligible for Federal funding.

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<sup>3</sup> The Unit refers all violations indicating a substantial potential for criminal prosecution to the Office of Statewide Prosecution or the appropriate State attorney. Florida Statute § 409.920(9)(d).

<sup>4</sup> AHCA, *Medicaid Monthly Enrollment Report*, August 2025. Accessed on October 20, 2025.

<sup>5</sup> OIG, *MFCU Activities and OIG Oversight, Expenditures & Statistics, FY 2024 Chart*. Accessed November 17, 2025.

<sup>6</sup> OIG, *Florida State Medicaid Fraud Control Unit: 2015 Onsite Review (OEI-07-15-00340)*, June 3, 2016.

OIG recommended that the Unit: (1) ensure that it conducts and documents supervisory reviews of Unit case files according to the Unit’s policies and procedures; (2) implement processes to ensure that it reports convictions and adverse actions to Federal partners within required timeframes; and (3) repay Federal matching funds spent on the case that was not eligible for Federal funding. On the basis of information received from the Unit, OIG considered these recommendations implemented as of January 2017.

## Methodology in Brief

OIG conducted the onsite inspection of the Florida MFCU in June 2025. Our inspection covered the 3-year period of FYs 2022–2024. We based our inspection on an analysis of data and information from seven sources: (1) Unit documentation; (2) financial documentation; (3) structured interviews with the Unit’s stakeholders; (4) structured interviews with the Unit’s managers and selected other staff; (5) a review of a random sample of 81 case files from the 1,781 case files that were open at some point during the review period; (6) a review of all convictions submitted to OIG for program exclusion and all adverse actions submitted to the National Practitioner Data Bank (NPDB) during the review period; and (7) an onsite review of Unit operations in two of the Unit’s offices. See the Detailed Methodology on page 19.

In examining the Unit’s operations and performance, we applied the published performance standards, but we did not assess adherence to every performance indicator for every standard.<sup>7</sup>

## 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. These inspections differ from other OIG evaluations in that they support OIG’s direct administration of the MFCU grant program, but they are subject to the same internal quality controls as are other OIG evaluations, including internal and external peer review.

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<sup>7</sup> As part of its oversight, OIG evaluates Units’ adherence to a set of performance standards. The most recent version of the MFCU performance standards is published at [89 Fed. Reg. 76431](#) (September 18, 2024). The previous version of these standards, which was applicable during the review period for this inspection, can be found at [77 Fed. Reg. 32645](#) (June 1, 2012). The performance standards were originally published at [59 Fed. Reg. 49080](#) (September 26, 1994).

# PERFORMANCE ASSESSMENT

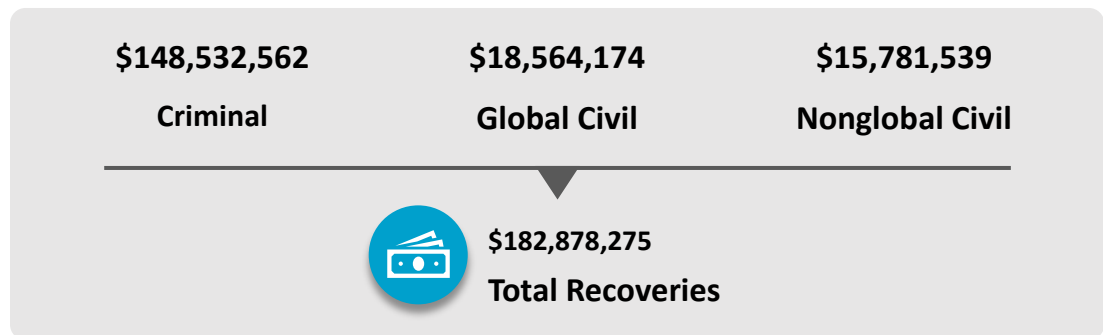
## Case Outcomes

The Unit reported 217 indictments, 170 convictions, and 39 civil settlements and judgments for FYs 2022 through 2024.<sup>8</sup>

Of the 170 convictions reported by the Unit, 128 involved fraud and 42 involved patient abuse or neglect.



From total Federal and State expenditures of approximately \$62.1 million, the Unit reported combined civil and criminal recoveries of \$182.9 million for FYs 2022 through 2024.



Source: OIG Analysis of Unit statistical data, FYs 2022–2024.

Note: “Global” civil recoveries derive from civil settlements or judgments in global cases, which are cases that involve the U.S. Department of Justice and a group of State MFCUs and are facilitated by the National Association of Medicaid Fraud Control Units.

<sup>8</sup> OIG provides information on MFCU operations and outcomes but does not require or otherwise establish specific case outcome thresholds that MFCUs must meet. MFCU investigators and prosecutors should apply professional judgment and discretion in determining what criminal and civil cases to pursue.

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## **Performance Standard 1: Compliance With Requirements**

**A Unit conforms with all applicable statutes, regulations, and OIG policy directives.**

**Observation: According to the information we reviewed, the Florida Unit generally complied with applicable requirements governing the MFCU, with some exceptions.**

We observed that the Unit was generally in compliance with applicable requirements, laws, and OIG guidance. However, we identified two areas in which the Unit did not adhere to the MFCU performance standards, as described in the findings on pages 8 and 13 (Performance Standards 4 and 12). We also identified one area in which the Unit did not comply with applicable regulations related to the Unit's reporting of adverse actions to the NPDB, as described in the finding on page 11 (Performance Standard 8).

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## **Performance Standard 2: Staffing**

**A Unit maintains reasonable staff levels and office locations in relation to the State's Medicaid program expenditures and in accordance with staffing allocations approved in its budget.**

**Observation: The Unit had vacancies and experienced staff turnover during our review period but took steps to address these issues and avoid operational disruption.**

During FYs 2022–2024, the Unit had an average vacancy rate of approximately 14 percent and experienced turnover across all professional disciplines, with 61 staff leaving the Unit over the course of our review period. Unit management attributed the vacancies and turnover to low salaries (particularly for attorneys, auditors, and analysts), retirements, return to in-person work after the COVID-19 pandemic, and other personal reasons.

The Unit took steps to address the staffing issues and was able to maintain relatively consistent staff levels and avoid significant operational disruption during the review period. For example, Unit management reported working with Florida Office of Attorney General officials to obtain salary raises for certain professional disciplines, such as attorneys, which helped with recruitment and retention. The Unit also cross-trained staff on certain operational functions to ensure continuity of operations in the event of staff turnover, as described in the beneficial practice below.

### Beneficial Practice

The Unit cross-trained some staff members on certain critical functions, which Unit management reported helped mitigate the effects of staff turnover and support succession planning. For example, staff responsible for processing incoming referrals, reporting convictions and adverse actions to Federal partners, and maintaining law enforcement accreditation had already trained or were planning to train other staff members on those functions.

Unit management used the term “three deep” for this practice to mean that three staff members would be trained and capable of performing each function in the event that a primary staff member was absent or departed from the Unit. The Unit also trained members of the Unit’s leadership team on key aspects of the Unit director’s role in preparation for the director’s anticipated retirement.

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## Performance Standard 3: Policies and Procedures

**A Unit establishes written policies and procedures for its operations and ensures that staff are familiar with, and adhere to, policies and procedures.**

**Observation: The Unit maintained policies and procedures and had recently updated them as part of the Florida law enforcement accreditation process.**

The Unit maintained policies and procedures, referred to as Standard Operating Procedures, which reflected current operations and practices. Unit management reported that all of the Unit’s policies and procedures were available to staff electronically through its case management system. At the time of our review, Unit management explained that the Unit was in the process of becoming an accredited law enforcement agency in the State of Florida, which required the Unit to incorporate specific law enforcement elements into its policies and procedures.<sup>9</sup> To meet the accreditation requirements, many of the Unit’s policies and procedures had been updated and standardized as of May 2025, shortly before our onsite inspection.

### Beneficial Practice

Unit management reported that staff were familiar with policies and procedures, crediting the Unit’s proactive requirement for all staff to review and acknowledge them upon joining the Unit, annually, and whenever changes occur. The Unit director reported that policies and procedures were updated on a continuous, as-needed basis. When updates occurred, staff were notified via email and prompted by the case management system to review and acknowledge the updates.

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<sup>9</sup> During our review period, the Florida Unit reported that it was pursuing law enforcement accreditation, which is recognized throughout the State as a means of maintaining the highest standards of professionalism. Through the accreditation process, law enforcement agencies must demonstrate that they have met certain requirements and standards through an independent review of the agency’s organization, management, operations, and administration. Florida Accreditation Office, “[Home](#)” and “[Benefits of Accreditation.](#)”

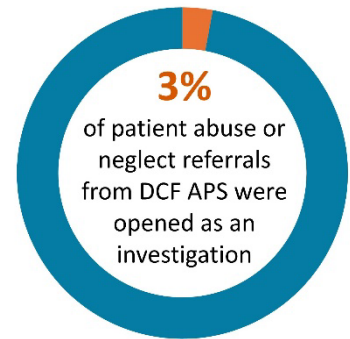
## Performance Standard 4: Maintaining Adequate Referrals

A Unit takes steps to maintain an adequate volume and quality of referrals from the State Medicaid agency and other sources.

**Finding: The Unit took steps to improve the quality of referrals received from its primary referral sources but further action is needed.**

We found that the Unit took steps to improve the quality of referrals of fraud and patient abuse and neglect but could expand these efforts. The Unit received patient abuse and neglect referrals primarily from DCF APS, and fraud referrals primarily from the MCOs, private citizens, and AHCA’s program integrity unit. During our review period, the Unit maintained positive working relationships and communicated regularly or as needed with its primary referral sources, and conducted outreach to encourage high-quality referrals. However, Unit management reported that there were opportunities for additional outreach to further improve referrals.

*Patient abuse or neglect.* During FYs 2022–2024, the Unit received 12,674 referrals of patient abuse or neglect, 99 percent of which originated from DCF APS. We found that only 3 percent (381 of 12,541) of the patient abuse or neglect referrals from DCF APS resulted in the Unit opening an investigation. Unit management explained that many of the referrals were not actionable for the Unit (i.e., did not rise to the level of a criminal allegation or were not within the Unit’s jurisdiction). Instead, many referrals were regulatory or administrative in nature, such as complaints about cold food. Unit management reported that the Unit received a high volume of these types of nonviable complaints, which staff had to spend time screening. Managers explained that this was particularly challenging for the Unit’s Central region, which received a large portion of the patient abuse and neglect referrals while dealing with staff turnover.



We found that the Unit had begun taking steps to address the large volume of nonactionable referrals. Unit management reported strategizing ways to streamline the intake process for these types of complaints and that it had plans to seek full access to DCF APS’s Serving Adults and Families Effectively (SAFE) system, which houses information on DCF APS investigations. At the time of our review, only a few Unit staff had access to the SAFE system. Before DCF APS’s transition to the SAFE system in 2023, the Unit had full access to DCF APS’s prior system. According to Unit management, this access enabled the Unit to obtain all information from DCF APS’s preliminary investigations, which allowed for more efficient and informed assessments of referrals. The Unit acknowledged that there were opportunities for additional process improvements and outreach with DCF APS. For example, management from the Unit and DCF APS both reported that attending joint training or working together to provide training to health care facilities would be beneficial.

*Fraud.* In interviews, Unit management reported that many of the fraud referrals received from the MCOs and AHCA during our review period were of poor quality. MCOs would typically send fraud referrals to the MFCU within 5 days of detection of the suspected or confirmed provider fraud.<sup>10, 11</sup> Unit management and other staff explained that some of the referrals, particularly from the MCOs, were of poor quality or did not contain adequate documentation, which they largely attributed to the short reporting window. As a result, when the Unit received a referral, Unit staff often had to follow up with the MCOs to request additional information.

The Unit took steps to improve the quality of the fraud referrals it received from these sources. For example, one of the Unit's supervisory investigators was working with AHCA to create a template for MCOs to use when making referrals. Unit managers explained that the template was intended to standardize referrals and improve the quality by clearly identifying what information to include. Unit management also attended quarterly meetings with AHCA and MCOs to discuss referrals, among other topics, and presented to MCOs on the necessary materials to include with each referral and the rationale. Unit management reported that the quality of the referrals was expected to improve as a result of the Unit's efforts.

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## Performance Standard 5: Maintaining Continuous Case Flow

**A Unit takes steps to maintain a continuous case flow and to complete cases in an appropriate timeframe based on the complexity of the cases.**

**Observation: The Unit maintained a continuous case flow using frequent team meetings and automated reminders from the case management system.**

We observed that consistent with Performance Standard 5, the Unit took steps to maintain a continuous case flow and complete cases within appropriate timeframes. In our review of the Unit's case files, we identified very few delays in the sampled investigations and no delays in the sampled prosecutions (see Appendix B on page 23).<sup>12</sup> Unit management attributed the effective case flow to the Unit's frequent team meetings and automated reminders in its case management system. For each case, a team composed of a captain, lieutenant, investigator, attorney, and if appropriate, an analyst and auditor met within 14 days of the case opening and regularly throughout the investigation. Managers said that this team approach, including the frequent team meetings, promoted timely case progression and

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<sup>10</sup> Federal regulation requires the prompt referral of any potential fraud, waste, or abuse that the MCO identifies to the State Medicaid program integrity unit or any potential fraud directly to the MFCU. See 42 CFR § 438.608(a)(7).

<sup>11</sup> The model managed care contract specifies that the MCOs have 5 days to notify AHCA of suspected fraud. The MFCU's memorandum of understanding (MOU) with AHCA outlines that AHCA should require MCOs to refer fraud to AHCA and the MFCU concurrently.

<sup>12</sup> The investigative delays, which ranged from 5 months to 2 years, were partly due to staffing constraints or delays in obtaining necessary information from the referral source.

collaboration. Further, the case management system sent managers and other staff regular reminders about key deadlines and reporting requirements, which helped prevent delays and maintain momentum.

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## **Performance Standard 6: Case Mix**

**A Unit's case mix, as practicable, covers all significant provider types and includes a balance of fraud and, where appropriate, patient abuse and neglect cases.**

**Observation: The Unit's caseload included fraud and patient abuse or neglect cases and covered a broad mix of provider types.**

Of the Unit's 1,781 cases that were open for full investigation at any point during our review period, 70 percent (1,252 cases) involved provider fraud and 30 percent (529 cases) involved patient abuse, neglect, or exploitation. The Unit's cases covered 65 different provider types.

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## **Performance Standard 7: Maintaining Case Information**

**A Unit maintains case files in an effective manner and develops a case management system that allows efficient access to case information and other performance data.**

**Observation: The Unit's electronic case management system allowed for efficient access to case information.**

During our review period, the Unit used an electronic case management system, HCL Notes, to record and track case information. We observed that the Unit's case management system allowed for efficient access to case information and had been maximized to meet the Unit's needs. For example, in addition to its case management capabilities, the system allowed the Unit to store policies and procedures and track staff training records, among other functions. The system also sent email reminders to staff about updated policies and procedures and upcoming case milestones, as mentioned in the observations on pages 7 and 9 (Performance Standards 3 and 5).

At the time of our onsite inspection, the Unit was in the process of searching for a new case management system, mainly due to the age of the current system and concerns about continued technical support. The Unit director indicated that the Unit would be coordinating with OIG during the process of selecting and transitioning to the new system.

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## Performance Standard 8: Cooperation With Federal Authorities on Fraud Cases

**A Unit cooperates with OIG and other Federal agencies in the investigation and prosecution of Medicaid and other health care fraud.**

**Finding: The Unit did not consistently report adverse actions to the National Practitioner Data Bank within the appropriate timeframe but had improved its reporting since the last OIG onsite inspection.**

Federal regulations require that any adverse actions against health care providers be reported to the NPDB within 30 calendar days of the final adverse action date.<sup>13, 14</sup> We found that the Unit did not report 26 of its 180 adverse actions (14 percent) to the NPDB within the appropriate timeframe. Of the 26 adverse actions reported late, the Unit submitted 13 between 31 and 60 days after the action; 7 between 61 and 90 days of the action; and 6 more than 90 days after the action. Unit administrative staff attributed the late submissions to delays in getting the necessary documents from the courts, particularly in the Southern region. We found that the Unit's submission of adverse actions to the NPDB had improved since OIG's 2015 onsite review, which found that the Unit reported nearly two-thirds of its adverse actions late.<sup>15</sup>

**Observation: The Unit maintained a collaborative relationship with Federal law enforcement partners and participated in the Medicare Fraud Strike Force.**

We observed that the Unit maintained a strong partnership with OIG Office of Investigations' (OI's) regional offices in the State. The relationship was particularly strong in Southern Florida, where the Unit participated in the Medicare Fraud Strike Force and had shared office space with OI investigators prior to the COVID-19 pandemic.<sup>16</sup> An OI manager described the Unit as an "essential partner" and said that the two agencies collaborated closely on cases and met frequently. During FYs 2022–2024, the Unit investigated a total of 86 joint Strike Force cases with OIG.

Additionally, we observed that the Unit maintained a positive working relationship with the U.S. Attorney's Office (USAO). A USAO official within the civil division in the Middle District of Florida reported that the USAO had an excellent working relationship with the Unit. During our review period, the Unit also had an attorney who was cross-designated as a Special Assistant U.S. Attorney with the USAO in the Southern District, which allowed the attorney to prosecute the Unit's criminal cases

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<sup>13</sup> 45 CFR § 60.5. Examples of final adverse actions include, but are not limited to, convictions, civil judgments (but not civil settlements), and program exclusions (Social Security Act (SSA) § 1128E(g)(1)).

<sup>14</sup> The NPDB is intended to restrict the ability of health care practitioners to move from State to State without disclosure or discovery of previous medical malpractice and adverse actions. For general information about the NPDB, see NPDB, [About Us](#). Accessed on November 4, 2025.

<sup>15</sup> OIG, [Florida Medicaid Fraud Control Unit: 2015 Onsite Review \(OEI-07-15-00340\)](#), June 3, 2016.

<sup>16</sup> The Medicare Fraud Strike Force brings together Federal, State, and local law enforcement, and data analytics, to prevent and combat health care fraud, waste, and abuse. For general information, see OIG, [Medicare Fraud Strike Force](#). Accessed on November 11, 2025.

in Federal court. USAO officials from the Middle and Southern Districts reported that they were open to more collaboration with the Unit in the future.

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## Performance Standard 9: Program Recommendations

**A Unit makes statutory or programmatic recommendations, when warranted, to the State government.**

**Observation: The Unit did not make any formal program recommendations to the State Medicaid agency during our review period.**

Although the Unit did not make any formal program recommendations to the State Medicaid agency during our review period, Unit management reported that it was in regular contact with AHCA officials and that communication between the agencies had improved after a recent leadership change. AHCA staff also noted regular communication between the two agencies and said that Unit management sometimes made informal process improvement suggestions to AHCA. They further expressed that AHCA was open to receiving formal program recommendations from the MFCU in the future.

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## Performance Standard 10: Agreement With Medicaid Agency

**A Unit periodically reviews its memorandum of understanding (MOU) with the State Medicaid agency to ensure that it reflects current practice, policy, and legal requirements.**

**Observation: The Unit's MOU with the State Medicaid agency reflected current practice, policy, and legal requirements.**

The Unit and AHCA had a current MOU, which was updated during our review period, in May 2024, and updated again shortly after our onsite inspection, in July 2025. The MOU reflected all applicable policy and legal requirements, as well as current practices between both parties. The Unit and AHCA updated the MOU to include a provision outlining requirements for joint meetings between the parties. The updated MOU requires bi-weekly case referral meetings, routine Medicaid MCO referral meetings, and quarterly reconciliation and data mining meetings.

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## Performance Standard 11: Fiscal Control

**A Unit exercises proper fiscal control over its resources.**

**Observation: From our limited review, we identified no deficiencies in the Unit's fiscal control of its resources.**

From the Unit's response to a detailed fiscal controls questionnaire and follow-up communication with Unit officials, we identified no issues related to the Unit's budget process, accounting system, cash management, procurement, property, or

personnel. In our inventory review of two of the Unit's offices, we located 30 of the 30 sampled inventory items.

## Performance Standard 12: Training

A Unit conducts training that aids the mission of the Unit.

**Finding: The Unit's training plan did not include annual minimum training hour requirements for some of its investigative staff.**

We found that the Unit maintained specific training plans for most of its staff (including sworn law enforcement investigators, attorneys, auditors, and medical investigators who were registered nurses), but lacked minimum annual training hour requirements for nonsworn investigators and medical investigators who were not registered nurses. Instead, for those staff, the training plan either did not specify a requirement or stated that professional training would be offered each year as funding allowed. Despite the lack of required minimum training hours, we found that all nonsworn investigators and medical investigators who were not registered nurses met, or were on track to meet, the same training standards as their counterparts. We found that Unit staff completed, on average, more than 30 hours of training per year during our review period.

### Performance Standard 12(A):

The Unit maintains a training plan for each professional discipline that includes an annual minimum number of training hours.

### Beneficial Practice

The Unit maintained a robust field training program for all newly hired investigators, including both sworn law enforcement officers and nonsworn investigators. The program consists of four phases: (1) orientation and administrative onboarding; (2) training on investigating patient abuse, neglect, and exploitation; (3) training on investigating Medicaid fraud; and (4) a practical application period, which refers to a new employee being assigned complaints and cases and investigating them under the supervision of a field training officer. The training program differs slightly for sworn and nonsworn investigators and is 2 weeks shorter for nonsworn investigators. At the end of each phase, the field training officer evaluates and scores the new employee, who may be required to undergo remedial training if necessary.

The Unit also provided specific training for newly hired attorneys. The Unit's deputy director of criminal enforcement explained that attorneys receive a full day of training on Medicaid fraud statutes when they join the Unit. Further, the Unit's deputy director of civil enforcement created a 2-hour presentation covering several relevant legal topics, including the Florida False Claims Act and the Anti-Kickback Statute. The deputy director obtained approval from the Florida Bar to accredit the training as 2 hours of continuing legal education for Unit attorneys.

# RECOMMENDATIONS

**To address the findings in this report, we recommend that the Florida Unit:**

## **Build upon its efforts to improve the quality of referrals from its primary referral sources**

The Unit should build upon its outreach efforts and provide feedback and education to its primary referral agencies on the quality and types of referrals that the Unit can investigate. For patient abuse and neglect referrals, the Unit could conduct cross-training with DCF APS to educate staff on what constitutes a high-quality referral that would rise to the level of criminal abuse or neglect. To further clarify what information to include in the referrals, the Unit could develop a template for DCF APS that outlines the components of an effective and actionable patient abuse or neglect referral—similar to the template that it is developing with AHCA for MCO fraud referrals.

The Unit should also proceed with requesting from DCF APS full access to the SAFE system to ensure that all relevant Unit staff can obtain information from DCF APS’s preliminary investigations. This would help the Unit in conducting more efficient and informed assessments of referrals.

The Unit should also assess its current intake process for referrals of patient abuse or neglect to identify potential improvements to the screening of the large volume of complaints. The Unit could consider implementing a process to redistribute some of the complaints to ease the burden on the Unit’s Central region.

For fraud referrals, the Unit should continue its practice of meeting with the MCOs and AHCA’s program integrity unit to discuss the components of an effective referral. Once the fraud referral template is finalized and actively in use, the Unit should periodically assess its effectiveness and make modifications as needed. The Unit could also consider making a formal, written program recommendation to AHCA to assess the timeframe for reporting suspected fraud in the managed care contracts, as the short reporting window appears to have affected referral quality.

## **Take steps to ensure that it reports all adverse actions to the National Practitioner Data Bank within the required timeframe**

The Unit should take steps to ensure that it consistently reports all adverse actions to the NPDB within 30 days of the action. These steps could include ensuring that all pertinent Unit staff receive training on the reporting requirement and are aware of their roles and responsibilities in the reporting process. Additionally, the Unit should consider developing quality assurance methods to ensure that staff adhere to the Unit's procedures for making timely submissions.

## **Update its training plan to include annual minimum training hour requirements for each professional discipline**

The Unit should revise its training plan to specify the minimum number of training hours required annually for all investigators, including nonsworn investigators and medical investigators who are not registered nurses. The Unit should also ensure that all staff are aware of their training hour requirements and the timeframes for completing those hours.

# UNIT COMMENTS AND OIG RESPONSE

The Florida MFCU concurred with all three of our recommendations.

First, the Unit concurred with our recommendation to build upon its efforts to improve the quality of referrals from its primary referral sources. The Unit reported that it is improving its referral intake processes and is developing templates for fraud and patient abuse, neglect, and exploitation referrals. The Unit also noted that it continues to meet with and conduct outreach to its primary referral sources, such as the program integrity unit and MCOs, to improve the quality of referrals.

Second, the Unit concurred with our recommendation to take steps to ensure that it reports all adverse actions to the NPDB within the required timeframe. The Unit reported that it has provided instructions and training to all pertinent staff on the NPDB reporting requirements and process. To ensure that staff adhere to the Unit's procedures for making timely submissions to NDPB, the Unit also reported, it developed automated and manual electronic reminders.

Third, the Unit concurred with our recommendation to update its training plan to include annual minimum training hour requirements for each professional discipline. The Unit reported that it has updated its training plan to include minimum training hour requirements for all investigators, and that all Unit staff have read and acknowledged receipt of the updated training plan.

We appreciate the steps the Unit has taken and plans to take to address the recommendations in this report. We believe that these steps will improve the Unit's adherence to performance standards and program requirements and will strengthen its operations. To close these recommendations, the Unit should submit to OIG documentation of its implementation of each recommendation within 6 months of the issuance of this report.

For the full text of the Unit's comments, see Appendix C.

# MFCUS AND OIG GRANT OVERSIGHT

## MFCUs

MFCUs investigate (1) Medicaid provider fraud and (2) patient abuse or neglect, and prosecute those cases under State law or refer them to other prosecuting offices.<sup>17, 18, 19</sup> Under the Social Security Act (SSA), a MFCU must be a “single, identifiable entity” of State government, “separate and distinct” from the State Medicaid agency, and employ one or more investigators, attorneys, and auditors.<sup>20</sup> Each State must operate a MFCU or receive a waiver.<sup>21</sup> Currently, 50 States, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands operate MFCUs.<sup>22</sup>

MFCUs are funded jointly by Federal and State governments. Each Unit receives a Federal grant award equivalent to 90 percent of total expenditures for new Units and 75 percent for all other Units.<sup>23</sup> In Federal FY 2024, combined Federal and State expenditures for the MFCUs totaled approximately \$395.8 million.<sup>24</sup>

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<sup>17</sup> SSA § 1903(q)(3)-(4). Regulations at 42 CFR § 1007.11(b)(1) clarify that a Unit’s responsibilities include the review of complaints of misappropriation of patients’ private funds in health care facilities.

<sup>18</sup> As of December 27, 2020, MFCUs may also receive Federal financial participation to investigate and prosecute abuse or neglect of Medicaid beneficiaries in a noninstitutional or other setting. Consolidated Appropriations Act, 2021, Public Law 116-260, Division CC, Section 207.

<sup>19</sup> References to “State” in this report refer to the States, the District of Columbia, and the U.S. territories.

<sup>20</sup> SSA § 1903(q).

<sup>21</sup> SSA § 1902(a)(61).

<sup>22</sup> The territories of American Samoa, Guam, and the Northern Mariana Islands have not established Units.

<sup>23</sup> SSA § 1903(a)(6). For a Unit’s first 3 years of operation, the Federal Government contributes 90 percent of funding, and the State contributes 10 percent. Thereafter, the Federal Government contributes 75 percent, and the State contributes 25 percent.

<sup>24</sup> OIG analysis of MFCU annual statistical reporting data for FY 2024.

## OIG Grant Oversight of MFCUs

OIG administers the grant award to each Unit and provides oversight of Units.<sup>25, 26</sup> As part of its oversight, OIG conducts a desk review of each Unit during the annual recertification process. OIG also conducts periodic inspections of Units. Finally, OIG provides ongoing training and technical support to the Units.

In its annual recertification review, OIG examines the Unit's reapplication materials, case statistics, and questionnaire responses from Unit stakeholders. Through the recertification review, OIG assesses a Unit's performance, as measured by the Unit's adherence to published performance standards; the Unit's compliance with applicable laws, regulations, and OIG guidance;<sup>27</sup> and the Unit's case outcomes.

OIG further assesses Unit performance by conducting inspections on selected Units. These inspections result in public reports of findings and recommendations for improvement. OIG reports may also include observations regarding Unit operations and practices, including beneficial practices that may be useful to share with other Units. Finally, OIG provides training and technical assistance to Units during inspections, as appropriate.

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<sup>25</sup> The SSA authorizes the Secretary of Health and Human Services to award grants (SSA § 1903(a)(6)) and to certify and annually recertify the Units (SSA § 1903(q)). The Secretary delegated these authorities to OIG in 1979. See 44 Fed. Reg. 47809, 47811 (Aug. 15, 1979); 42 CFR § 1007.15.

<sup>26</sup> As part of grant administration, OIG receives and examines financial information from Units, such as budgets and quarterly and final Federal Financial Reports that detail MFCU income and expenditures.

<sup>27</sup> OIG occasionally issues transmittals to provide guidance and instruction to MFCUs. OIG transmittals are located at <https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp>.

# DETAILED METHODOLOGY

OIG conducted the inspection of the Florida MFCU in June 2025. Our inspection covered the 3-year period of FYs 2022 through 2024.

We collected and analyzed data from the seven sources described below to identify any opportunities for improvement and instances in which the Unit did not adhere to the performance standards or was not operating in accordance with laws, regulations, or OIG guidance. We also used the data sources to make observations about the Unit's case outcomes as well as the Unit's operations and practices concerning the performance standards.

## Review of Unit Documentation

Before the inspection, we reviewed the recertification analysis for FYs 2022 through 2024, which involved examining the Unit's recertification materials, including (1) the Unit director's recertification questionnaires; (2) the Unit's MOU with the State Medicaid agency; (3) the program integrity director's questionnaires; and (4) the OIG Special Agent in Charge questionnaires. We also reviewed the Unit's policies and procedures manual, and the Unit's self-reported case outcomes and referrals included in its annual statistical reports for FYs 2022 through 2024. We examined the recommendations from the 2015 OIG onsite review report and the Unit's implementation of those recommendations.

## Review of Unit Financial Documentation

We conducted a limited review of the Unit's control over its fiscal resources. Before the inspection, we analyzed the Unit's response to a questionnaire about internal controls and conducted a desk review of the Unit's financial status reports. We followed up with Unit officials to clarify issues identified in the questionnaire about internal controls.

## Interviews With Stakeholders

In May and June 2025, we interviewed the Unit's key partner agencies, including officials in the AHCA MPI; DCF APS; two MCOs; and the U.S. Attorney's Office for the Middle and Southern Districts of Florida. We also interviewed two Assistant Special Agents in Charge from OIG's Office of Investigations. We focused these interviews on the Unit's relationship and interaction with the stakeholders, as well as opportunities for improvement. We used the information collected from these interviews to develop subsequent interview questions for Unit management and other staff.

## Interviews With Unit Management and Selected Other Staff

We conducted structured interviews with the Unit’s management and selected other staff at two of the Unit’s offices in June 2025. Of the Unit management, we interviewed the director, the deputy directors for criminal and civil enforcement, the law enforcement colonel, the law enforcement major, two regional bureau chief attorneys, three law enforcement captains, three analyst supervisors, four law enforcement lieutenants, and the chief administrative manager. Of the selected other staff, we interviewed an attorney and a medical investigator. In addition, we interviewed the Chief Deputy Attorney General who supervises the Unit. We asked these individuals questions related to (1) Unit operations; (2) Unit practices that contributed to the effectiveness and efficiency of Unit operations and/or performance; (3) opportunities for the Unit to improve its operations and/or performance; (4) clarification regarding information obtained from other data sources; and (5) the Unit’s training and technical assistance needs.

## Review of Case Files

To craft a sampling frame, we requested that the Unit provide us with a list of cases that were open at any time during FYs 2022–2024 and include the status of each case; whether the case was criminal, civil, or global; and the dates on which the case was opened and closed, if applicable. The total number of cases was 1,781.

We excluded all global cases from our review of the Unit’s case files because global cases are civil false claims actions that typically involve multiple agencies, such as the U.S. Department of Justice and a group of State MFCUs. We excluded 64 global cases, leaving 1,717 case files.

We then selected a simple random sample of 100 cases from the population of 1,717 cases. We reviewed 81 of the 100 case files for adherence to the relevant performance standards and compliance with statutes, regulations, and OIG guidance.<sup>28</sup> During the review of the sampled case files, we consulted MFCU staff to address any apparent issues with individual case files, such as missing documentation.

## Review of Unit Submissions to OIG and the National Practitioner Data Bank

We reviewed all convictions submitted to OIG during the review period so that convicted individuals could be excluded from programs (181) and all adverse actions submitted to the NPDB during the review period (180). We reviewed whether the Unit submitted information on all sentenced individuals and entities to OIG for

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<sup>28</sup> Shortly prior to our onsite inspection, we identified 19 cases in our sample that met OIG’s definition of a global case and therefore excluded those cases from our case file review and subsequent analysis.

program exclusion and all adverse actions to the NPDB for FYs 2022 through 2024. We also assessed the timeliness of the submissions to OIG and the NPDB.

### **Onsite Review of Unit Operations**

During the onsite inspection, we observed the workspace and operations of the Unit's offices in Tallahassee and Miami. We observed the Unit's offices and meeting spaces; security of data and case files; location of select equipment; and general functioning.

# APPENDICES

## Appendix A: Unit Referrals by Source for Fiscal Years 2022–2024

Referral Source	FY 2022		FY 2023		FY 2024		3-Year Total		
	Fraud	Abuse or Neglect	Fraud	Abuse or Neglect	Fraud	Abuse or Neglect	Fraud	Abuse or Neglect	Total
Adult Protective Services	0	4,968	0	3,966	1	3,607	1	12,541	12,542
Anonymous	20	0	0	0	0	1	20	1	21
HHS-OIG	0	0	11	0	13	0	24	0	24
Law enforcement—other	7	4	5	1	3	2	15	7	22
Local prosecutor	0	0	1	0	0	0	1	0	1
Managed care organizations	335	0	381	1	284	0	1,000	1	1,001
Medicaid agency—PI/SURS	11	10	19	3	42	1	72	14	86
Medicaid agency—other	3	1	0	0	0	0	3	1	4
Private citizen	132	37	126	24	207	34	465	95	560
Provider	12	0	8	3	10	0	30	3	33
State agency—other	10	1	10	2	9	3	29	6	35
Other	69	5	77	0	56	0	202	5	207
<b>Subtotal</b>	<b>599</b>	<b>5,026</b>	<b>638</b>	<b>4,000</b>	<b>625</b>	<b>3,648</b>	<b>1,862</b>	<b>12,674</b>	<b>14,536</b>
<b>Total</b>	<b>5,625</b>		<b>4,638</b>		<b>4,273</b>		<b>14,536</b>		

Source: OIG analysis of the Florida MFCU’s annual statistical data, FYs 2022–2024.

## Appendix B: Point Estimates and 95-Percent Confidence Intervals of Case File Reviews

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval	
			Lower	Upper
Percentage of all cases without significant delays in the investigative stage	81	92.59%	84.74%	97.20%
Percentage of all cases without significant delays in the prosecution stage	17*	100.00%	80.55%	100.00%

Source: OIG analysis of Florida MFCU case files, 2025.

\*The 95-percent confidence interval for this estimate exceeds 10-percent absolute precision.

## Appendix C: Unit Comments



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June 5, 2026

Ann Maxwell, Deputy Inspector General for Evaluation and Inspections  
Office of Inspector General  
United States Department of Health and Human Services  
330 Independence Ave., S.W.  
Cohen Building, Room 5660  
Washington, D.C. 20201

**Re: Florida Medicaid Fraud Control Unit: 2025 Inspection, OEI-06-25-00150**

Dear Deputy Inspector General Maxwell:

Thank you for sharing HHS-OIG's draft report, Florida Medicaid Fraud Control Unit: 2025 Inspection, OEI-06-25-00150, dated May 11, 2026.

We appreciate the HHS-OIG on-site inspection team members for their preparation, collegiality, and professionalism. We also thank the review team for recognizing our Unit for three areas of Beneficial Practices.

HHS-OIG's draft report includes three recommendations. Each recommendation is discussed below, as well as the affirmative steps the Unit has taken in response.

**Recommendation 1. Build upon its efforts to improve the quality of referrals from its primary referral sources.**

**Response: The Unit concurs with this recommendation.** The Unit is improving its Complaint Intake Unit processes and is developing templates for Patient Abuse Neglect and Exploitation (PANE) Referrals and Fraud Referrals. The Unit continues its meeting and other outreach efforts with the Florida Department of Children and Families' Adult Protective Services, Office of Medicaid Program Integrity, and Medicaid Managed Care Organizations (MCOs) to improve the quality of referrals.

**Recommendation 2. Take steps to ensure that it reports all adverse actions to the National Practitioner Data Bank within the required timeframe.**

**Response: The Unit concurs with this recommendation.** The Unit is pleased that the OIG recognized the significant improvement between the Unit's last inspection and the current inspection. The Unit will continue to report convictions to the NPDB within the required 30 day period. The Unit has provided instructions and training to all pertinent Unit staff on the NPBD reporting requirements and their roles and responsibilities in the reporting process. Automated and manual electronic reminders have been developed as quality assurance methods to ensure that staff adhere to the Unit's procedures for making timely NPDB submissions.

**Recommendation 3. Update its training plan to include annual minimum training hour requirements for each professional discipline.**

**Response: The Unit concurs with this recommendation.** The Unit has updated its Training Plan to specify the minimum number of training hours required for all investigators, including non-sworn investigators and medical investigators who are not registered nurses. Unit staff have read and acknowledged receipt of the updated Training Plan.

We value HHS-OIG's support and our relationships with our state and federal law enforcement partners. We are committed to meeting the highest standards of performance expected of the Unit. Thank you for the opportunity to comment on the recommendations of the review team.

Sincerely,



Kathleen Von Hoene, Director  
Office of the Attorney General  
Florida Medicaid Fraud Control Unit

KVH/kf

cc: Matt DeFraga, Medicaid Fraud Policy & Oversight Division  
Anna Brown, Medicaid Fraud Policy & Oversight Division

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