Department of Health and Human Services
Office of Inspector General
Office of Evaluation and Inspections

September 2026 | OEI-04-25-00400

Alabama Medicaid Fraud Control Unit: 2025 Inspection

REPORT HIGHLIGHTS

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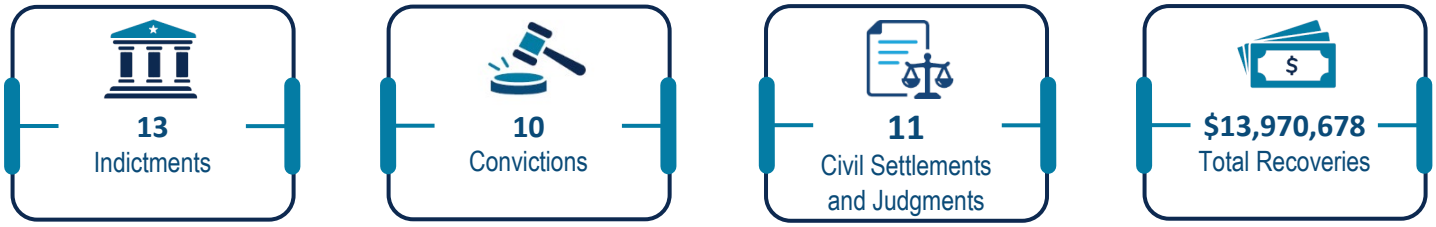
Alabama Medicaid Fraud Control Unit: 2025 Inspection

OIG administers the Medicaid Fraud Control Unit (MFCU or Unit) grant awards, annually recertifies each Unit, and oversees the Units' compliance with the requirements of the grant and adherence to 12 established performance standards that reflect practices identified by OIG and MFCUs that will improve Unit effectiveness. As part of this oversight, OIG conducts periodic onsite inspections of Units and issues public reports of its findings and observations.

AL MFCU Case Outcomes

With an average staff size of seven and $4.7 million in Federal and State funding during the review period (FYs 2023 through 2025), the MFCU reported:



Performance Assessment

PERFORMANCE STANDARD	FINDINGS	RECOMMENDATIONS
PERFORMANCE STANDARD 2 **Staffing**	Staffing levels consistently fell below OIG-approved levels and were low for State Medicaid expenditures	Hire additional staff Develop plan to expand the Unit size
PERFORMANCE STANDARD 3 **Policies and Procedures**	Policies did not address coordination on Unit cases with Federal law enforcement partners	Update policies to include Federal partner coordination
PERFORMANCE STANDARD 4 **Maintaining Adequate Referrals**	Few referrals from the State Medicaid agency's Program Integrity Unit (PIU), despite outreach	Reinforce the terms of the Memorandum of Understanding (MOU) with the PIU to increase referrals
PERFORMANCE STANDARD 7 **Maintaining Case Information**	Majority of case files lacked at least some documentation of periodic supervisory reviews Case management system did not efficiently manage or report accurate case information or performance data	Ensure that periodic supervisory reviews of case files are consistently documented Implement new case management system that allows for efficient access and accurate reporting
PERFORMANCE STANDARD 8 **Cooperation With Federal Authorities**	Positive working relationships with most Federal partners, but lack of regular communication with one Unit did not report one adverse action to the National Practitioner Data Bank (NPDB)	Improve communication with U.S. Attorney's Office in the Southern District Report all adverse actions to the NPDB within required timeframes
PERFORMANCE STANDARD 10 **Agreement With Medicaid Agency**	MOU did not reference CMS Performance Standard for Referrals, as required	Revise the MOU with the State Medicaid agency to reference the CMS Performance Standard for Referrals

The Unit concurred with all nine recommendations.

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BACKGROUND

OBJECTIVE

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

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 OIG's website.

Alabama MFCU

The Alabama Unit is located within the Office of the Attorney General (AGO) in Montgomery and has Statewide jurisdiction to prosecute Medicaid provider fraud and patient abuse and neglect cases. As of December 2025, the Unit employed:

- two attorneys (one of whom also serves as the Director),
- two investigators (one of whom is the Chief Investigator),
- one auditor,
- one nurse analyst, and
- one administrative assistant.

During our review period of Federal fiscal years (FYs) 2023–2025, the Unit spent approximately $4.7 million, with a State share of approximately $1.2 million.[1]

[1] The Federal FY is from October 1 through September 30. For example, FY 2025 was from October 1, 2024, through September 30, 2025.

Referrals

The Unit receives fraud referrals from several partners, including the Alabama Medicaid Agency's Program Integrity Unit (PIU).[2, 3] The Unit receives patient abuse and neglect referrals from the Alabama Survey and Certification Agency (i.e., the Department of Public Health).[4] The Director or Chief Investigator reviews all referrals submitted to the Unit, determines if the Unit has sufficient evidence to open a case, and responds in writing with the Unit's determination.

Investigations and Prosecutions

Once the Unit opens a case, the Director or Chief Investigator completes a case action form documenting the opening of an investigation and creates the case file in the Unit's case management system. The Director or Chief Investigator assigns the case to an investigator and conducts periodic supervisory reviews to ensure cases progress in a timely manner.[5]

An investigator can request to close a case for (1) insufficient evidence, (2) conclusion of a criminal prosecution, or (3) completion of investigative tasks requested by another agency.[6] When closing a case, the investigator completes a closing memo detailing the findings and justification for closing. The Director or Chief Investigator reviews and approves the closing memo and the case is closed in the case management system. Any cases closed because of insufficient evidence are reviewed by the Director or Chief Investigator to determine if the Unit could refer the case to another agency for recoupment or civil action.

[2] Alabama's Medicaid Agency is the Medicaid single State agency. Within Alabama's Medicaid Agency, the Program Integrity Division is the PIU responsible for executing Alabama's Medicaid program integrity activities.

[3] The Alabama Medicaid Program does not provide care through managed care organizations (MCOs). Therefore, the Unit does not receive referrals from or for MCOs. The Alabama Medicaid Program does have primary care case management networks, and any referrals for providers in these networks would come to the Unit through the PIU.

[4] The Alabama Department of Public Health serves as the State Survey and Certification Agency in Alabama. Health care facilities and the public can report facility-specific complaints to the Department of Public Health for further investigation.

[5] According to the Unit's recertification documentation, periodic supervisory reviews occur at least every 90 days.

[6] For example, the Minnesota MFCU requested assistance from the Alabama MFCU to determine whether a potential suspect lived and worked in Alabama.

Alabama Medicaid Program

As of December 2025, the Alabama Medicaid Program served approximately 750,000 enrollees, nearly 15 percent of Alabama's population.[7, 8] In FY 2025, Alabama's Medicaid expenditures were approximately $8.4 million.[9]

Prior OIG Inspection and Recertification

OIG conducted a previous onsite review of the Alabama MFCU in 2014.[10] OIG closed all recommendations from that review as of April 2018.

OIG recertified the Alabama MFCU on April 24, 2026.[11] In the recertification letter, OIG noted two concerns that may limit the effectiveness of the Alabama MFCU. The two concerns related to staffing and maintaining adequate referrals.

Methodology in Brief

OIG conducted the onsite inspection of the Alabama MFCU in December 2025. Our inspection covered the 3-year period of FYs 2023–2025. 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 key stakeholders; (4) structured interviews with the Unit's managers and other staff; (5) a review of a random sample of 64 case files from the 134 case files that were open at some point during the review period;[12] (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 the Unit's office. See the Detailed Methodology for more information about our methods.

[7] Centers for Medicare and Medicaid Services (CMS), *Updated May 2026 State Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment Data*. Accessed on July 24, 2026.

[8] The U.S. Census Bureau estimated that Alabama's population was just over 5.1 million in July 2025. U.S. Census Bureau, "QuickFacts Alabama." Accessed on Apr. 27, 2026.

[9] OIG, *MFCU Statistical Data for FY 2025*. Accessed on May 20, 2026.

[10] OIG, *Alabama State Medicaid Fraud Control Unit: 2014 Onsite Review* (OEI-06-13-00660), Apr. 10, 2015. Accessed on May 18, 2026.

[11] OIG, *Alabama Medicaid Fraud Control Unit Recertification Letter*, Apr. 24, 2026. Accessed on Aug. 11, 2026.

[12] We focused our review on "nonglobal" case files. "Global" cases involve the U.S. Department of Justice and a group of State MFCUs. Global cases are facilitated by the National Association of Medicaid Fraud Control Units. Because we wanted to assess the Unit's cases, specifically, we focused our review on nonglobal cases.

In examining the Unit's operations and performance, we applied the published performance standards, but we did not report whether the Unit adhered to every performance indicator for every standard. [13]

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.

[13] 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 (Sept. 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 2024 and 2012 performance standards are largely the same with respect to the findings of this report. The performance standards were originally published at 59 Fed. Reg. 49080 (Sept. 26, 1994).

PERFORMANCE ASSESSMENT

Case Outcomes

In FYs 2023 through 2025, the Unit reported 13 indictments, 10 convictions, and 11 civil settlements and judgments.[14]

Of the 10 convictions reported by the Unit, 7 involved provider fraud and 3 involved patient abuse or neglect.

In FYs 2023 through 2025, the Unit reported approximately $14 million in combined criminal and civil recoveries.

Source: OIG Analysis of Unit statistical data, FYs 2023–2025.
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.

[14] 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.

Performance Standard 1: Compliance With Requirements

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

Observation: The Unit assigned agents to work non-MFCU duties during our review period.

Federal regulation allows MFCU professional staff to perform non-MFCU assignments for the State government only to the extent that such duties are limited in duration.[15, 16] Four Unit investigators spent a total of 152 hours on non-MFCU activities during our 3-year review period. Unit staff assisted the Attorney General's Office (AGO) Special Investigations Unit with search warrants.

Federal regulation states that non-MFCU activities are not allowed to be reimbursed under the Federal grant.[17] We confirmed that the Unit appropriately excluded time spent on these activities from the Federal grant.

While the MFCU did not charge these costs to its grant, pulling investigators from an already understaffed Unit makes it difficult to ensure timeliness of current investigations and to increase the number of new investigations (see the finding under Performance Standard 2).

OIG found three additional areas of noncompliance with Federal requirements, with one finding under Performance Standard 3 and two findings under Performance Standard 8.

Performance Standard 2: Staffing

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

Finding: The Unit did not maintain staffing levels in accordance with its approved budget nor in relation to State Medicaid expenditures.

Performance Standard 2(A) states that the Unit will employ the number of staff that OIG approved in the Unit's budget; however, we found that the Unit did not maintain these staffing levels. The Unit was approved for 10 staff during the 3-year review period. However, for each year in our review period, the Unit had staffing levels

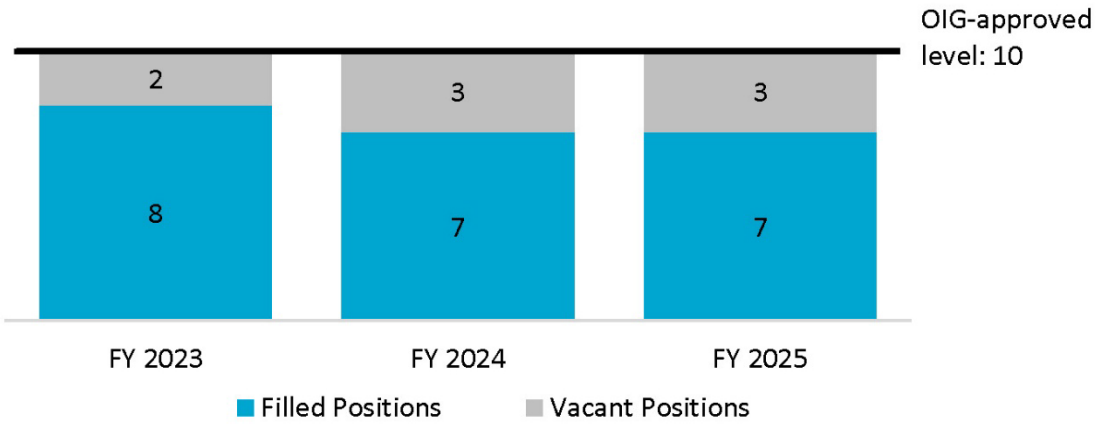
[15] 42 CFR § 1007.13(d)(3).

[16] OIG's State Fraud Policy Transmittal No. 2014-01 also states that non-MFCU duties should be truly temporary and a limited part of the employee's activities. The transmittal also states that, when deciding whether to allow a professional employee to perform temporary non-MFCU duties, the Unit should consider whether: (1) the assignment is of a limited and defined duration; (2) the assignment poses any conflict with MFCU operations; and (3) the skills and expertise of the employee are necessary for the assignment.

[17] 42 CFR § 1007.19(e)(7).

lower than OIG-approved levels. See Exhibit 1 for the number of filled versus vacant positions over the 3-year period.

Exhibit 1: Alabama staffing levels consistently fell below OIG-approved levels.



Source: OIG analysis of Alabama annual statistical report, 2025.

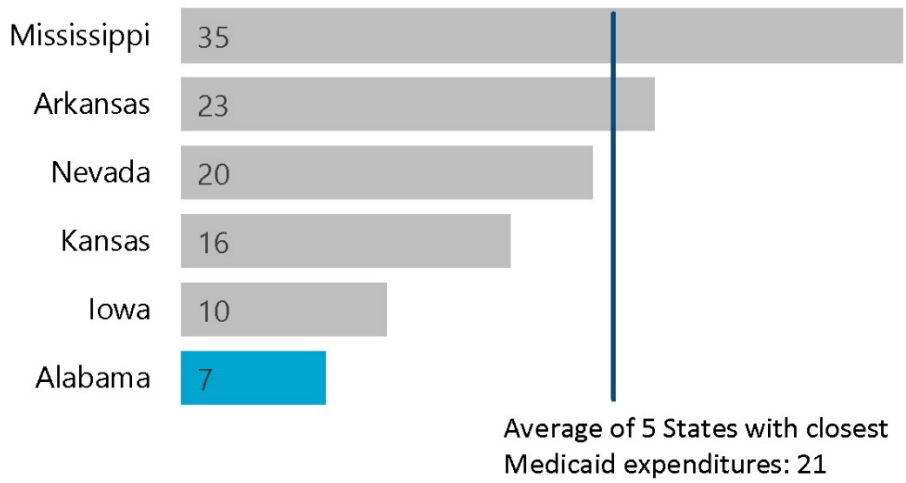
The staffing levels decreased during our review period because of staff turnover. From FY 2023 to FY 2025, the number of investigators decreased from four to two, with the departure of an investigator in August 2024 and the Chief Investigator in September 2024. The Unit did not employ a Chief Investigator for a year until it promoted one of the remaining investigators in September 2025. While the Unit filled two new positions (i.e., an attorney and an auditor) in 2023, the Unit has not hired a new investigator since 2016.

Additionally, according to Performance Standard 2(B), the Unit will employ a total number of professional staff that is commensurate with the State's total Medicaid program expenditures. However, we found that the Unit's overall staff size was low compared to that of other MFCUs with similar State Medicaid program expenditures. Specifically, our analysis indicated that a Unit with similar State Medicaid expenditures to Alabama would, on average, employ 21 staff.[18, 19] See Exhibit 2 for the number of staff in comparable Units in FY 2025.

[18] We assessed the Unit's staffing levels using a linear regression model to compare State Medicaid expenditures to staff size.

[19] OIG does not prescribe MFCUs' staffing levels. Factors other than Medicaid expenditures, such as the volume of case referrals received, may also influence the size of a MFCU.

Exhibit 2: In FY 2025, the Alabama Unit's staff size was a third of the average staff size of other Units with comparable Medicaid expenditures.



Source: OIG analysis of Units' FY 2025 statistical reports.

The Unit discussed the need for more investigators to ensure the timeliness of investigations. For each investigation, the Unit assigned two investigators to conduct interviews and other investigative work. With only two investigators, the Unit is limiting its ability to investigate cases in a timely manner.

Unit staff also reported the need for more investigators to increase the number of cases. The Unit receives few referrals from the PIU (see finding under Performance Standard 4). If the number of referrals increases, the Unit could not take on more cases due to limited staffing. In OIG's judgment, if the Unit increased staffing, the Unit could also conduct additional outreach to increase the number of referrals and cases.

> If you have just two agents investigating multiple cases, things are going to take a while. If we get a couple of big cases at one time, we are in trouble.
>
> —Chief Investigator

Further, we found that the Unit's limited staffing presented a challenge to its future operations. The Unit Director reported that almost half of current staff could retire soon. If the Unit loses any existing staff to retirement or additional departures, it may further hinder the timeliness and number of cases the Unit could investigate.

The Unit's supervisor in the State AGO acknowledged the limitations of having only two investigators and how this slows progress on the Unit's caseload. However, the supervisor also stated that there were not enough referrals and cases to prioritize hiring additional staff.

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.

Finding: The Unit maintained policies and procedures but did not address coordination on Unit cases.

During FYs 2023-2025, the Unit generally maintained policies and procedures that reflected current operations and practices. Unit staff reported that they were familiar with Unit policies and procedures and could access them electronically on the Unit's shared drive or physically in their office.

Federal regulation states that the Unit will establish written policy on coordinating cases with Federal investigators or prosecutors, including OIG and the U.S. Attorney's Office.[20] However, we found that the Unit's policies did not address coordination of cases with Federal law enforcement partners. The Unit did have regular practices to coordinate cases with Federal partners, despite the lack of policy.

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 received few fraud referrals from the PIU, despite outreach efforts.

The Unit received few fraud referrals from the PIU. Of the 32 fraud referrals the Unit reported receiving during FYs 2023−2025, 7 came from the PIU. See Appendix A for a list of all referrals by source.

Federal regulation and the MOU between the State Medicaid agency and the Unit require the PIU to send all suspected cases of fraud to the Unit.[21] Federal regulation requires the State Medicaid agency to send these referrals after conducting a "preliminary" investigation to determine whether there is sufficient basis to warrant a full investigation.[22] However, the PIU appeared to use a higher threshold for sending referrals to the Unit. Rather than sending "suspected" cases of fraud based on preliminary investigation, staff reported, the PIU limited the number of referrals it sent to the Unit by only sending referrals with "known" intent of fraud.

The low number of fraud referrals the Unit receives from the PIU is a continuing concern—OIG's 2014 review of the Alabama Unit similarly found that the Unit received few fraud referrals from the State Medicaid agency in FYs 2011 through 2013. At the time, the State Medicaid agency reported needing more guidance from the Unit regarding what constitutes a quality referral. OIG recommended that the

[20] 42 CFR 1007.11(e)(5).

[21] 42 CFR 455.21(a)(1); 42 CFR § 1007.9(d)(1).

[22] 42 CFR §§ 455.14, 455.15(a)(1).

Unit provide training to the State Medicaid agency regarding elements of a quality fraud referral, and OIG closed this recommendation as implemented in 2016.

Performance Standard 4(A) states that the Unit will take steps to ensure that the State Medicaid agency refers to the Unit all suspected provider fraud cases. During our review, we found that the Unit encouraged fraud referrals and maintained a positive working relationship with the PIU. The Unit reported trying several measures to increase referrals, including participating in quarterly meetings with the PIU to discuss ongoing cases and referrals as well as collaborating directly among the Unit's and PIU's investigators. The Unit Director also reported meeting with the PIU to discuss the use of technology to increase the number of referrals. Further, the Unit and PIU reported engaging in frequent ad hoc communication, outside of their scheduled quarterly meetings.

Performance Standard 5: Maintaining Case Progression

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 continuous case flow and completed nearly all cases without delays.

Consistent with Performance Standards 5(A)-(C), we observed, the Unit maintained a continuous case flow with minimal delays. The Unit documented supervisory approval for opening and closing nearly all cases in our review. To help ensure case progression, the Unit reported, there was constant communication about the status of cases between the investigators, attorney, and the Unit Director.[23] Due to the small staff size, the Unit Director reported, there was an "open door" policy to discuss cases when needed.

[23] We found that the Unit did not consistently document periodic supervisory reviews of cases during our review period (see finding under Performance Standard 7).

Beneficial Practice

The Unit reported developing a tool called the Narcotic Diversion Analysis Template (N-DAT) to streamline the investigation process for drug diversion cases.

To administer a controlled drug at a health care facility, a health care professional must sign the drug out on the Controlled Drug Record (CDR) and then document when the health care professional administered the drug to the patient on the Medication Administration Record (MAR).

When the Unit receives a referral of potential drug diversion, the Unit uses the N-DAT to compare the CDR and MAR. Individuals signing out drugs at a high frequency on the CDR but not recording administrations on the MAR at the same frequency indicates potential drug diversion.

The Unit shared this tool at the National Association of Medicaid Fraud Control Units Annual training as well as the Alabama Nursing Home Association's Annual Convention.

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 case mix included both fraud and patient abuse or neglect cases and covered a range of provider types.

Of the Unit's 134 nonglobal cases that were open during FYs 2023–2025, 71 percent involved provider fraud (95 cases) and 29 percent involved patient abuse and neglect (39 cases). During this period, the Unit's cases covered 31 different provider types, including nurses and nonresidential mental health facilities.

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.

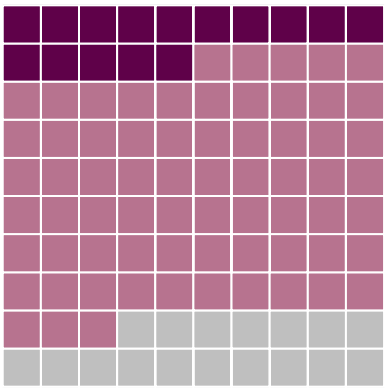
Finding: Of the Unit's cases open 90 days or more, the majority lacked at least some documentation of required periodic supervisory reviews.

Performance Standards 3(A) and 7(A) state that Unit supervisors periodically review the Unit's case files, consistent with written guidelines of MFCU policies and

procedures, and such reviews are noted in the case file.[24] However, we found that the Unit did not document the majority of its supervisory reviews consistently and had no policy that specified the timeframe to conduct these reviews. The Unit's policy states that the Unit Director or Chief Investigator will conduct periodic case file reviews, as appropriate. In its annual recertification documentation, the Unit stated that it conducted supervisory reviews on a quarterly basis (i.e., every 90 days). OIG used this timeframe to review case files for documentation of supervisory reviews every 90 days.[25]

We found that, for cases open longer than 90 days, 85 percent of files were missing at least some documentation of quarterly supervisory reviews. These cases varied in how frequently the Unit documented supervisory reviews. For example, one case file spanning 7 years contained documentation of annual supervisory reviews. Another case was open for over 2 years and had supervisory reviews documented closer to every 6 months.

Exhibit 3: The majority of case files lacked at least some documentation of periodic supervisory reviews.



15 percent had supervisory reviews documented every 90 days.

68 percent had supervisory reviews documented less frequently than every 90 days.

17 percent had no documentation of supervisory reviews.

The Director stated that there is ongoing, informal communication between the Director, investigators, and the attorney regarding case status. However, the Unit did not document these conversations in the case files.

Documentation of periodic supervisory reviews is a continuing concern—OIG's 2014 review found that the Unit did not conduct periodic supervisory reviews according to the Unit's policies and procedures. At the time, OIG found that the Unit Director conducted reviews less frequently than the timeframe outlined in the Unit's policies and procedures, and these reviews were not documented in the case files. OIG recommended that the Unit implement processes to ensure that supervisors conduct periodic case reviews, and OIG closed this recommendation as implemented in 2016.

[24] Under the new 2024 Performance Standards, Performance Standard 3(D) states that the policies and procedures, at a minimum, must address a timeframe for conducting periodic supervisory case reviews.

[25] We focused our review on cases open for at least 90 days. We did not review any global cases files.

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

Performance Standards 7(E)-(F) state that the Unit will have an information management system that (1) manages and tracks case information from initiation to resolution and (2) allows for the monitoring and reporting of case information. We found that the Unit's electronic case management system lacked capabilities for efficiently managing and reporting accurate case information and performance data. During our case file review, we found that the system requires time-intensive manual processes, such as completing file reviews by hand and scanning them into the system. Unit staff also described the current case management system as "antiquated" and stated that it does not generate accurate data for annual statistical reporting.

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 maintained positive working relationships with most Federal law enforcement partners but did not have regular communication with the U.S. Attorney's Office in the Southern District.

Federal regulation and Performance Standards require that the Unit communicate regularly with Federal law enforcement partners.[26] We found that the Unit participated in regular meetings and frequent, informal communication with several Federal law enforcement partners regarding cases and referrals. These Federal law enforcement partners included OIG's Office of Investigations (OI) and U.S. Attorney's Offices (USAOs). The Unit also participated in a Healthcare Fraud Working Group, which was hosted by various stakeholders, including Federal law enforcement partners (e.g., OI, USAOs).

The Unit maintained a positive working relationship with Federal law enforcement partners, including OI and two of the three USAOs. During our review period, the Unit and OI jointly investigated 26 cases, meeting regularly to discuss them. In addition, OI reported sharing office space with the Unit when investigating cases, which continued to foster a positive working relationship between them. The Unit also maintained strong, collaborative working relationships with the USAOs in the Northern and Middle Districts. The USAOs in these districts reported frequent, informal conversations with the Unit to discuss ongoing cases. These Districts designated the Unit Director as a Special Assistant U.S. Attorney within the USAOs, which allowed the Unit to prosecute its joint cases in Federal court. While these USAOs reported positive relationships, they reported openness to more regularly scheduled meetings with the Unit in the future.

[26] 42 CFR § 1007.11(e)(1)-(5) and Performance Standard 8(A).

However, the Unit did not frequently coordinate with the USAO in the Southern District. The last joint case between the MFCU and the USAO in the Southern District closed in 2023. The Unit reported collaborating more with the Middle and Northern Districts due to the volume of health care cases that occur in those jurisdictions. In contrast, the Unit reported that the Southern District did not have as many health care fraud cases, thus limiting the opportunities with the Southern District. Moreover, the Southern District recently hired several new staff, and they reported no interactions with the Unit but were aware of the Unit's role and purpose.

The limited communication with the Southern District is a continuing concern—OIG's 2014 review of the Alabama Unit found that the Unit did not have a cooperative working relationship with the USAO in the Southern District and that the Unit prosecuted few cases with the USAO in the Southern District. OIG also found that neither the Unit nor the USAO in the Southern District reported efforts to improve this relationship. OIG recommended, in part, that the Unit initiate efforts to improve the relationship, and OIG closed this recommendation as implemented in 2018.

Finding: The Unit did not report one adverse action to the NPDB within the required timeframes.

Federal regulation requires that the Unit report all final adverse actions to the National Practitioner Data Bank (NPDB) within 30 days; however, the Unit only reported 9 of its 10 adverse actions during our review period to the NPDB within 30 days.[27, 28] We notified the Unit of the missing submission, and the Unit promptly submitted it. This submission was over 3 years late. The Unit Director reported that this late submission was an oversight of the Unit.

The Unit reported its 10 convictions to OIG within the required timeframes.[29]

Performance Standard 9: Program Recommendations

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

Observation: The Unit made program recommendations to the State Medicaid agency during FYs 2023–2025.

Performance Standard 9(B) states that the Unit, when warranted, will make regulatory or administrative recommendations regarding program integrity issues to the State Medicaid agency. During our review period, the Unit made three recommendations to the State Medicaid agency: (1) define the duties and

[27] 45 CFR § 60.5. Examples of adverse actions include, but are not limited to, health care-related criminal convictions and civil judgments (but not civil settlements), and program exclusions. See SSA §§ 1128E(a) and (g)(1).

[28] 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."

[29] 42 CFR § 1007.11(g) and Performance Standard 8(F).

responsibilities of specific provider types in the billing manual, (2) assign National Provider Identifiers (NPIs) to counselors who provide mental health services, and (3) conduct background investigations of potential hires to the State Medicaid agency. The Unit reported that the State Medicaid agency took action to address these recommendations.

Performance Standard 10: Agreement With Medicaid Agency

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

Finding: The Unit's 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.*

According to Performance Standard 10(E), the MOU should incorporate by reference the *CMS Performance Standard for Referrals of Suspected Fraud From a State Agency to a Medicaid Fraud Control Unit*.[30] However, we found that the MOU did not reference these CMS standards.

Performance Standard 11: Fiscal Control

A Unit exercises proper fiscal control over Unit resources.

Observation: We identified no deficiencies in the Unit's fiscal control of its resources.

We identified no issues related to the Unit's budget process, accounting system, cash management, procurement, property, or personnel. In our inventory review, we identified no concerns regarding the 30 sampled inventory items.

Performance Standard 12: Training

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

Observation: Unit staff generally met the Unit's training requirements and completed training that aided in the Unit's mission.

From the information we reviewed, staff completed training that aided in the mission of the Unit, including training provided by the State AGO and the Associate of Certified Fraud Examiners. The Unit's training plan required each professional staff

[30] The *CMS Performance Standard for Referrals* defines minimum criteria for information a State Medicaid agency should provide to a MFCU as part of a referral of suspected provider fraud. This standard provides guidance on the volume and quality of referrals the PIU should provide the Unit for investigation.

member to take a minimum number of training hours each year, according to their specific discipline. Every member of the Unit's staff met the annual requirements.

RECOMMENDATIONS

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

Hire additional staff in accordance with its approved budget and in relation to State Medicaid expenditures

The Unit should hire additional staff to maintain OIG-approved staffing levels, focusing particularly on hiring additional investigators. Increased staffing will allow the Unit to conduct additional outreach to State and Federal partners, which may increase referrals to the Unit.

Develop a plan to expand the size of the Unit

The Unit should develop an expansion plan to increase its staffing levels to enhance the Unit's ability to protect the State's Medicaid program and its enrollees. The Unit should also assess which additional roles would be most beneficial to the Unit. The Unit should consider its future operations when developing a plan to ensure that the Unit maintains staffing levels if existing staff retire or depart.

Update its policies to include coordinating cases with Federal partners

The Unit should update its written policies for coordinating cases with Federal law enforcement partners in accordance with Federal regulation. These policies should reflect what the Unit already does in practice.

Reinforce the terms of the MOU with the PIU to increase the number of fraud referrals

The Unit should reiterate to the PIU that the MOU between the State Medicaid agency and the Unit states that all suspected cases of fraud should be referred to the Unit, and not just those with known fraudulent intent. The Unit should also meet monthly with the PIU to increase the number of fraud referrals.

Ensure that periodic supervisory reviews of case files are consistently documented

The Unit should develop and implement practices to ensure that supervisory reviews of case files are documented periodically. For example, the Unit should consider implementing more structured, periodic meetings between the Director, investigators, and the attorney regarding case status, during which supervisory reviews are documented in the case files. The Unit should also update policies to include a timeframe for conducting these reviews.

Implement a new case management system that allows for efficient access and accurate reporting

The Unit should take steps to implement a new case management system that enables the Unit to efficiently meet its needs. In addition, the new case management system should generate accurate case and performance data reports.

Improve communication with the USAO in the Southern District

The Unit should improve communication with the USAO in the Southern District. The Unit should set up introductory meetings with newer staff at the USAO in the Southern District who have not interacted with the Unit. The Unit should also explore with the USAO in the Southern District how to increase the number of joint cases.

Report all adverse actions to the NPDB within the required timeframes

The Unit should determine why the Unit failed to submit all adverse actions to the NPDB within 30 days of the final adverse action, and the Unit should take corrective action to ensure that all future adverse actions are submitted on time. For example, the Unit could consider training staff on these requirements and ensure that they are aware of their roles and responsibilities in the reporting process.

Revise the MOU with the State Medicaid Agency to reference the *CMS Performance Standard for Referrals*

The Unit should revise its MOU with the State Medicaid Agency to reference the CMS Performance Standard for Referrals of Suspected Fraud From a State Agency to a Medicaid Fraud Control Unit.

UNIT COMMENTS AND OIG RESPONSE

The Alabama MFCU concurred with our nine recommendations.

The Unit concurred with our first two recommendations (1) to hire additional staff in accordance with its approved budget and in relation to State Medicaid expenditures and (2) to develop a plan to expand the size of the Unit. The Unit reported that it received approval to hire two Special Agents and already has filled one of those positions. The Unit also reported that it expects to hire additional staff as provider referrals increase.

Third, the Unit concurred with our recommendation to update policies to include coordinating cases with Federal partners. The Unit reported updating its written policy for coordination with Federal partners and distributing this policy to all staff.

Fourth, the Unit concurred with our recommendation to reinforce the terms of the MOU with the PIU to increase the number of fraud referrals. The Unit reported that the Alabama Medicaid Agency has developed a new fraud detection program that has already resulted in an increase in fraud referrals from the PIU.

Fifth, the Unit concurred with our recommendation to ensure that periodic supervisory reviews of case files are consistently documented. The Unit reported that it reassigned the responsibility to conduct quarterly file reviews to the new Chief Investigator.

Sixth, the Unit concurred with our recommendation to implement a new case management system. The Unit reported that it is represented on a committee to identify a replacement for the current case management system.

Seventh, the Unit concurred with our recommendation to improve communication with the USAO in the Southern District. The Unit reported that it has reached out to representatives of the USAO in the Southern District to reestablish communication.

Eighth, the Unit concurred with our recommendation to report all adverse actions to the NPDB within the required timeframes. The Unit Director has taken responsibility for submitting convictions to the NPDB.

Finally, the Unit concurred with our recommendation to revise the MOU with the State Medicaid Agency to include reference to the *CMS Performance Standard for Referrals*. The Unit reported that it has updated the MOU to incorporate the *CMS Performance Standard for Referrals*.

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.

DETAILED METHODOLOGY

OIG conducted the onsite inspection of the Alabama MFCU in December 2025. Our inspection covered the 3-year period of FYs 2023−2025 and included follow-up with the MFCU, as needed, after our onsite review to clarify procedures and obtain additional documentation.

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.

In examining the Unit's operations and performance, we applied the published performance standards, but we do not report whether the Unit adhered to every performance indicator for each standard.

Review of Unit Documentation

Before the onsite inspection, we reviewed the recertification analysis for FYs 2023–2025, which involved examining the Unit's recertification materials, including (1) the Unit director's responses to recertification questionnaires; (2) the Unit's MOU with the State Medicaid agency; (3) the Program Integrity director's responses to questionnaires; and (4) the OI Special Agent in Charge's responses to questionnaires. We also reviewed the Unit's policies and procedures manual and the Unit's self-reported case outcomes, referrals, and other data included in its annual statistical reports for FYs 2023−2025. We examined the recommendations from the 2014 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 onsite 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 the Unit officials to clarify issues identified in the questionnaire about internal controls. While onsite, we also verified a purposive sample of 30 items from the Unit's inventory list.

Interviews with Key Stakeholders

In October 2025, we interviewed key stakeholders, including officials from the Alabama Department of Public Health, Federal Bureau of Investigation, and U.S. Attorney's Office for all three Districts of Alabama. We also interviewed the OI Assistant Special Agent in Charge and two Special Agents assigned to Alabama. In December 2025 during our onsite review, we interviewed the PIU. 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 Staff

We conducted structured interviews with the Unit's management and selected staff in December 2025. Of the Unit management, we interviewed the Director and the Chief Investigator. Of the selected staff, we interviewed one attorney, one investigator, one auditor, and one nurse analyst. In addition, we interviewed the Unit's supervisor—the Assistant Chief Deputy Attorney General. 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 2023−2025 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 145.

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 11 global cases, leaving 134 case files.

We then selected a simple random sample of 64 cases from the population of 134 cases. We reviewed the 64 case files for adherence to the relevant performance standards and compliance with statute, regulation, and OIG guidance. During our 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 NPDB and OIG

We reviewed all 10 adverse actions submitted to the NPDB, and all 10 convictions submitted to OIG for program exclusion for FYs 2023–2025. We also assessed the timeliness of the submissions to NPDB and OIG.

Onsite Review of Unit Operations

During the onsite inspection, we observed the workspace and operations of the Unit's office in Montgomery. 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 2023–2025

Referral Source	FY 2023		FY 2024		FY2025		3-Year Total		
	Fraud	Abuse or Neglect	Fraud	Abuse or Neglect	Fraud	Abuse or Neglect	Fraud	Abuse or Neglect	Total
HHS-OIG	9	0	6	0	4	0	19	0	19
Medicaid agency (PIU)	4	0	1	0	2	0	7	0	7
Provider	0	0	0	0	2	0	2	0	2
State survey and certification agency*	0	1,378	0	2,880	0	2,340	0	6,598	6,598
UPIC	4	0	0	0	0	0	4	0	4
Subtotal	**17**	**1,378**	**7**	**2,880**	**8**	**2,340**	**32**	**6,598**	**6,630**
Total	**1,395**		**2,887**		**2,348**		**6,630**		

*Note: The State survey and certification agency is the Alabama Department of Public Health. Source: OIG analysis of Alabama MFCU data, 2023-2025.

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 with significant investigative delays	64	3.1%	1.5%	9.0%
Percentage of all cases closed at the time of OIG's review	64	84.4%	75.4%	91.0%
Percentage of all cases that had supervisory approval to open	64	98.4%	93.3%	99.3%
Percentage of all cases that had supervisory approval to close	54	96.3%	88.8%	98.5%
Percentage of all cases that had documented periodic supervisory review(s) at least every 90 days	41	14.6%	6.7%	27.6%
Percentage of all cases that had documented periodic supervisory review(s) less than every 90 days	41	68.3%	53.7%	80.6%
Percentage of all cases that did not have documentation of any supervisory review	41	17.1%	8.2%	29.9%

Source: OIG analysis of Alabama MFCU case files, 2023–2025.

Appendix C: Unit Comments

STATE OF ALABAMA
OFFICE OF THE ATTORNEY GENERAL

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ATTORNEY GENERAL

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August 18, 2026

VIA ELECTRONIC MAIL

Ms. Ann Maxwell
Deputy Inspector General for Evaluation and Inspections
HHS Office of Inspector General

Dear Ms. Maxwell:

I am in receipt of the draft report of the 2025 inspection of the Alabama MFCU and respectfully submit the following comments in response to the recommendations contained therein.

HIRE ADDITIONAL STAFF AND DEVELOP A PLAN TO EXPAND THE SIZE OF THE UNIT.

COMMENT: I concur with this recommendation. As my supervisors have previously discussed with Inspector General Bell and other representatives of the Office of Evaluations and Inspections, they have approved the immediate hiring of two Special Agents. It is my understanding that my supervisors have committed to your representatives that additional staff will be hired as provider fraud referrals increase. We have hired a new Agent, who started August 17, 2026. He is an experienced white collar crime investigator who is transferring from the Alabama Securities Commission. We are actively seeking a second Special Agent. As previously explained to representatives of OEI, all hires at the Attorney General's Office are state civil service through the Alabama Personnel Department from employment registers established by that department.

UPDATE POLICIES TO INCLUDE COORDINATING CASES WITH FEDERAL PARTNERS.

COMMENT: I concur with this recommendation. The Unit has implemented a written policy for coordination and deconfliction with our Federal partners. A copy of the new policy was emailed to your office on August 4, 2026, and a printed copy was distributed to all Unit employees on August 5, 2026, with instructions to place it in their MFCU policies and procedures manual.

TAKE STEPS TO INCREASE FRAUD REFERRALS.

COMMENT: I concur with this recommendation. On July 17, 2026, I submitted a data mining waiver application to HHS-OIG. In addition, the Alabama Medicaid Agency has recently developed an AI-based fraud detection program and has provided the Unit with access to the program and training on its use, pending the approval of the Unit's data mining waiver. The new fraud detection program has already resulted in an increase in provider fraud referrals from the PIU.

ENSURE THAT PERIODIC FILE REVIEWS ARE CONSISTENTLY DOCUMENTED.

COMMENT: I concur with this recommendation. We have promoted one of our Agents to the position of MFCU Chief Investigator and assigned him the responsibility to conduct quarterly file reviews. Previously, I had been responsible for the duties of chief investigator, which included file reviews.

IMPLEMENT A NEW CASE MANAGEMENT SYSTEM.

I concur with this recommendation. The MFCU uses the same electronic case management system as our parent agency. The administration is aware of its shortcomings and the MFCU is represented on a committee working to identify a replacement for the current case management system.

IMPROVE COMMUNICATION WITH USAO IN THE SOUTHERN DISTRICT.

COMMENT: I concur with this recommendation. The MFCU enjoys an excellent relationship with the vast majority of Federal partners, as evidenced by the stakeholder interviews prior to the onsite inspection. Although the State Medicaid Agency and its fiscal intermediary are located in the Middle District of Alabama and prosecution of Medicaid provider cases could be accomplished by working exclusively with that USAO, the MFCU endeavors to have a productive working relationship with all three Federal districts in Alabama. I have reached out via email to representatives of the U.S. Attorney's Office in the Southern District to reestablish communication with that office.

REPORT ALL ADVERSE ACTIONS TO NPDB WITHIN REQUIRED TIMEFRAME.

COMMENT. I concur with this recommendation. Since the failure to submit that one adverse action to the NPDB, I have assumed responsibility for submitting convictions to HHS-OIG Exclusions and the NPDB.

REVISE THE MOU WITH THE SINGLE STATE AGENCY TO REFERENCE THE "*CMS PERFORMANCE STANDARDS FOR REFERRALS*."

COMMENT: I concur with this recommendation. On July 14, 2026, an updated MOU between the Alabama Medicaid Agency and the Alabama Attorney General's Office, that incorporates the CMS Performance Standards for Referrals, was signed. A copy of the updated MOU was emailed to your office on July 27, 2026.

Thank you for the opportunity to submit these comments. Please do not hesitate to contact me if you need any additional information.

Sincerely,

Bruce M. Lieberman
Assistant Attorney General
Director, MFCU

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