Department of Health and Human Services
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September 2026 | OEI-09-24-00410

Georgia Medicaid Fraud Control Unit: 2024 Onsite Inspection

REPORT HIGHLIGHTS

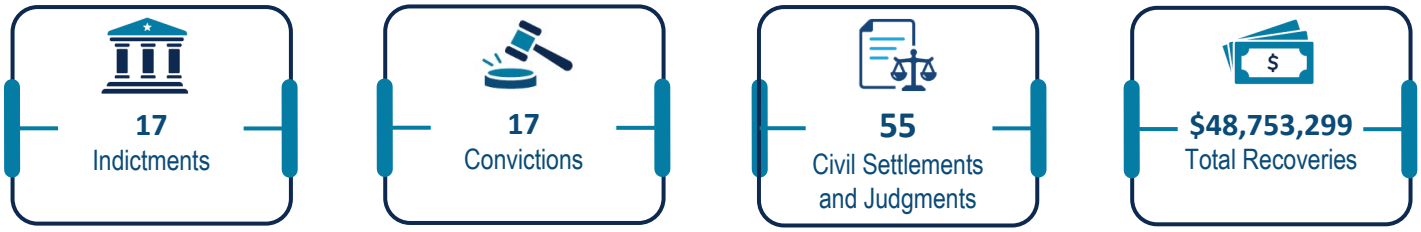
September 2026 | OEI-09-24-00410

Georgia Medicaid Fraud Control Unit: 2024 Onsite 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.

GA MFCU Case Outcomes

With an average staff size of 43 and total expenditures of $12.4 million during the review period, FY 2021 through FY 2023, the MFCU reported:



Performance Assessment

PERFORMANCE STANDARD	FINDINGS	RECOMMENDATIONS
PERFORMANCE STANDARD 2 **Staffing**	Understaffed during the review period Difficulty retaining staff and filling vacancies	Examine position descriptions and salaries to ensure a fair and competitive salary and benefit package that enables the Unit to recruit and retain qualified staff
PERFORMANCE STANDARD 3 **Policies and Procedures**	Did not always adhere to policies and procedures for documenting supervisory reviews Policies and procedures did not address maintaining an equipment inventory	See Performance Standards 7 and 11
PERFORMANCE STANDARD 4 **Maintaining Adequate Referrals**	Received a limited number of fraud referrals from the program integrity unit and managed care organizations Did not take sufficient steps to maintain adequate patient abuse or neglect referrals	Expand efforts to increase fraud and patient abuse or neglect referrals
PERFORMANCE STANDARD 7 **Maintaining Case Information**	Almost a quarter of case files were missing or contained late documentation of at least one supervisory review	Take steps to ensure that periodic supervisory reviews are documented in the case files
PERFORMANCE STANDARD 8 **Cooperation With Federal Authorities on Fraud Cases**	Did not report about half of convictions and adverse actions to Federal partners within the required timeframes	Take steps to ensure timely reporting of all convictions and adverse actions to Federal partners
PERFORMANCE STANDARD 11 **Fiscal Control**	Lacked policies and procedures for maintaining an equipment inventory Inventory list did not include equipment tracking information	Establish written policies and procedures for maintaining an equipment inventory and include information to track equipment Include information to track equipment in the Unit's equipment inventory list

The Unit concurred with all six recommendations.

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BACKGROUND

OBJECTIVE

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

Medicaid Fraud Control Units

MFCUs investigate Medicaid provider fraud and patient abuse or neglect and prosecute those cases under State law or refer them to other prosecuting offices.[1, 2, 3] Under the Social Security Act (SSA), a MFCU must be a "single, identifiable entity" of a State government, "separate and distinct" from the State Medicaid agency, and employ one or more investigators, attorneys, and auditors.[4] Each State must operate a MFCU or receive a waiver.[5] Currently, 50 States, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands operate MFCUs.[6]

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.[7] In Federal fiscal year (FY) 2025, combined Federal and State expenditures for the MFCUs totaled approximately $424 million, of which approximately $318 million represented Federal funds.[8]

[1] Social Security Act § 1903(q)(3)–(4). Regulations at 42 CFR § 1007.11(b) clarify that a Unit's responsibilities may include the review of complaints of misappropriation of patients' private funds in health care facilities or board and care facilities.

[2] As of December 27, 2020, MFCUs may also receive Federal financial participation (FFP) 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, § 207.

[3] References to "State" in this report refer to the States, the District of Columbia, and the U.S. territories that operate MFCUs.

[4] SSA § 1903(q).

[5] SSA § 1902(a)(61).

[6] The territories of American Samoa, Guam, and the Northern Mariana Islands have not established Units.

[7] 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.

[8] OIG analysis of MFCU annual statistical reporting data for FY 2025. The Federal FY 2025 was from October 1, 2024, through September 30, 2025.

OIG Grant Administration and Oversight of MFCUs

The Office of Inspector General (OIG) administers the grant award to each Unit and provides oversight of Units.[9, 10] As part of its oversight, OIG conducts a desk review of each Unit during the annual recertification process. OIG also conducts periodic inspections and reviews. When OIG determines that a MFCU is deficient in meeting one or more standards, OIG will provide technical assistance or make recommendations for improvement.

In its annual recertification process, OIG examines the Unit's reapplication materials, case statistics, and questionnaire responses from external partners of the Unit. Through the recertification process, OIG assesses a Unit's performance, as measured by the Unit's adherence to published performance standards;[11] the Unit's compliance with applicable laws, regulations, and adherence to OIG guidance;[12] and the Unit's case outcomes.

OIG further assesses Unit performance by conducting periodic inspections of 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. OIG also provides training and technical assistance to Units, as appropriate, during these onsite inspections.

Georgia MFCU

The Georgia MFCU is located within the Georgia Office of the Attorney General in Atlanta and investigates and prosecutes Medicaid fraud and patient abuse or neglect cases. In FY 2023, the Unit had 40 staff—6 attorneys, 11 investigators, 5 nurse investigators, 7 auditors, 4 analysts, and 7 investigative support staff (e.g., paralegals and investigative assistants).[13] During FYs 2021–2023, the Unit received a total of approximately $13.0 million in MFCU grant awards from OIG and spent $12.4 million.

[9] 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.

[10] 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. 47811 (Aug. 15, 1979).

[11] 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 was applicable to most of the review period for this inspection and can be found at 77 Fed. Reg. 32645 (June 1, 2012). The performance standards were originally published at 59 Fed. Reg. 49080 (Sept. 26, 1994).

[12] 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.

[13] The current MFCU director was appointed on June 1, 2023.

Referrals, Investigations, and Prosecutions

During FYs 2021–2023, the Unit reported receiving referrals of potential Medicaid provider fraud from the Program Integrity Unit (PIU) of Georgia's Department of Community Health (DCH), law enforcement, private citizens, and other sources. The Unit also receives fraud referrals from managed care organizations (MCOs).[14] MCOs initially send their referral to the PIU, which verifies the completeness of the referral and then sends the MCO's referral to the Unit. The Unit also received patient abuse or neglect referrals from Adult Protective Services (APS) and the Healthcare Facility Regulation Division (HFRD), among other sources.

When the Unit receives a referral for an allegation of fraud or patient abuse or neglect, the Unit conducts a preliminary investigation and determines whether to open a full investigation, decline the referral, or refer it to another agency. The Unit has 30 days to determine how to handle MCO referrals; for all other referrals, the Unit has 90 days to determine whether it will accept the referral, decline it, or refer it to another agency.

If the Unit decides to open an investigation, the matter is assigned to an investigative criminal or civil team that includes an attorney, at least one investigator, and an analyst. Throughout this investigative phase, Unit attorneys provide guidance to investigators and analysts to guide investigative activities. The Unit Director monitors case progression with periodic supervisory reviews. Upon completion of the investigative phase, the Unit Director determines whether to pursue the case as a criminal or civil matter or close the investigation.

Georgia Medicaid Program

DCH administers the Georgia Medicaid program. In 2024, Georgia operated about 75 percent of the Medicaid program through managed care plans.[15] The program served about 1.7 million enrollees, about 15 percent of Georgia's population.[16, 17] Georgia's Medicaid expenditures were approximately $16 billion in FY 2024.[18]

[14] In Georgia, managed care organizations are referred to as care management organizations. In this report we use the more common term "managed care organizations" to refer to care management organizations.

[15] Georgia Health Initiative, "Insights on Medicaid in Georgia," January 2025. Accessed on February 2, 2026.

[16] Kaiser Family Foundation, "Medicaid Enrollment and Unwinding Tracker." Accessed on May 20, 2025.

[17] The U.S. Census Bureau estimated that Georgia's population was just over 11 million in July 2024. U.S. Census Bureau, "QuickFacts Georgia." Accessed on May 22, 2025.

[18] Medicaid and CHIP Payment and Access Commission, "Exhibit 16. Medicaid Spending by State, Category, and Source of Funds," *MACStats* (December 2024).

DCH's PIU is responsible for Georgia's Medicaid program integrity efforts. The PIU identifies, investigates, and refers to the MFCU suspected fraud and patient abuse or neglect cases.

Prior OIG Report on Georgia MFCU

OIG conducted a previous onsite review of the Georgia MFCU in 2015.[19] In that review, which covered FYs 2012–2014, OIG found that (1) nearly a third of case files lacked documentation of supervisory approval to open cases and nearly half of the Unit's case files open longer than 90 days lacked documentation of periodic supervisory reviews; (2) the Unit did not report all convictions and adverse actions to Federal partners within the required timeframes; (3) in FY 2012, the Unit did not comply with special grant terms, resulting in a claim of $47,550 in unallowable Federal funds; and (4) the Unit did not always exercise proper fiscal control of its resources.

OIG recommended that the Unit (1) implement processes to ensure that case files include documentation of supervisory approval for opening and closing cases and periodic supervisory review; (2) implement processes to ensure that convictions and adverse actions are reported to Federal partners within required timeframes; (3) work with OIG to repay the $47,550 offset that should have been made in FY 2012; and (4) implement additional controls to ensure that the Unit's expenditures are accounted for timely, accurately, and in compliance with the terms of the grant. On the basis of information received from the Unit, OIG considered these recommendations implemented as of August 2016.

Methodology

OIG conducted an onsite inspection of the Georgia MFCU in September 2024. Our inspection covered the 3-year review period of FYs 2021–2023. We based our inspection on an analysis of data and information from 7 sources: (1) Unit documentation; (2) financial documentation; (3) structured interviews with external partners of the Unit; (4) structured interviews with the Unit's managers and other selected staff; (5) a review of a random sample of 82 case files from the 424 nonglobal case files that were open at some point during our 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 our review period; and (7) an onsite inspection of Unit operations. See the Detailed Methodology for more information.

In examining the Unit's operations and performance, we applied the 2012 MFCU performance standards,[20] which were applicable during our review period of

[19] OIG, *Georgia State Medicaid Fraud Control Unit: 2015 Onsite Review* (OEI-07-15-00090), Sept. 29, 2015.

[20] The 2012 MFCU performance standards are published at 77 Fed. Reg. 32645 (June 1, 2012).

FYs 2021–2023. We did not assess adherence to every performance indicator for every standard.

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.

PERFORMANCE ASSESSMENT

Georgia MFCU Case Outcomes

The Unit reported 17 indictments, 17 convictions, and 55 civil settlements and judgments for FYs 2021–2023.[21]

The Unit reported combined criminal and civil recoveries of approximately $48.8 million for FYs 2021–2023.

Source: OIG Analysis of Unit statistical data, FYs 2021–2023.
Notes: "Global" civil recoveries are a result of global 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. Because recoveries are rounded to the nearest dollar, they may not sum exactly.

[21] OIG provides information on MFCU operations and outcomes but does not direct or encourage MFCUs to investigate or prosecute a specific number of cases. MFCU staff 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 all applicable statutes, regulations, and policy directives.

Observation: The Georgia MFCU did not always comply with applicable statutes, regulations, and policy directives governing MFCUs.

The Unit did not comply with two Federal regulations regarding reporting convictions to OIG and reporting adverse actions to the NPDB, as described in the finding on pages 12 and 13 (Performance Standard 8).

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.

Finding: The Unit was understaffed during each year of our review period and reported difficulty retaining staff and filling vacancies.

During FYs 2021–2023, the Unit reported a total of 21 vacancies for positions such as attorneys and investigators. See Exhibit 1 for the number of filled and vacant positions over the 3-year period.

Exhibit 1: During our review period, the Unit experienced a total of 21 vacancies

	FY 2021	FY 2022	FY 2023
Vacant positions	3	8	10
Filled positions	47	42	40
Total budget-approved staffing positions	50	50	50

Source: OIG analysis of staff rosters provided by GA MFCU for FYs 2021–2023 for annual recertification. Staff rosters represent staffing levels for a specific point in time for each FY.

Within the 3-year review period, six attorneys, seven investigators, five auditors and analysts, and three support staff left the Unit. Unit management reported salaries as a factor in retaining staff and filling vacancies, sharing that at least three of the six attorneys left to work in the private sector or for other higher-paying public sector jobs. The Unit management further stated that a highly qualified investigator candidate stopped pursuing a position with the Unit upon learning of the limited salary. In FY 2023, investigators earned salaries between $50,470 and $77,250. Attorneys earned the highest salaries, between $68,958 and $125,149. Auditors and analysts earned between $44,290 and $92,071.

Beneficial Practice

The Unit reported hiring an attorney in early FY 2021 through the Georgia Office of the Attorney General's Honors Fellowship Program. The program recruits current or recently graduated law students who are committed to public service. Fellows can gain experience working with Unit attorneys, performing tasks such as helping to draft indictments and give grand jury presentations.

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's policies and procedures manual did not address all aspects of its operations, and the Unit did not always adhere to its current policies and procedures.

Performance Standard 3(A) states that a Unit should have written guidelines or manuals that contain current policies and procedures consistent with the performance standards. Although the Unit had written policies and procedures, we found that it did not address maintaining an inventory of its equipment to reflect all property under its control (see finding under Performance Standard 11).

Performance Standard 3(B) states that the Unit should adhere to current policies and procedures in its operations. However, the Unit did not adhere to its policies and procedures related to documentation of supervisory reviews (see finding under Performance Standard 7) and the required reporting of convictions and adverse actions to Federal partners (see finding under Performance Standard 8).

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.

Observation: The Unit took some steps to maintain an adequate volume and quality of fraud referrals from the PIU and MCOs.

In accordance with Performance Standard 4, the Unit took steps to maintain an adequate volume and quality of fraud referrals by conducting regular meetings with the PIU and MCOs. The Unit Director and investigators met monthly with the PIU to discuss what claims data analysis can help identify potential fraud referrals and to track the status of current fraud referrals. Additionally, the Unit held quarterly meetings with both MCOs and the PIU together to collaborate on developing potential fraud referrals. Further, after our review period, the Unit reported, it provided training to the PIU and MCOs on the characteristics of a quality fraud referral and other topics.

To further facilitate the fraud referral process with MCOs, the Unit worked with the PIU to jointly develop and implement a standardized checklist to ensure that fraud

referrals included essential information. The checklist includes information such as subject identifiers, service dates, and claim payments, which allows the Unit to reduce delays caused by incomplete submissions. The checklist allows the Unit to efficiently assess a fraud referral from an MCO within the 30-day review period, and determine whether to accept the referral, decline it, or refer it to another agency.

Finding: The Unit received a limited number of fraud referrals from the PIU and MCOs across the 3-year review period.

During FYs 2021–2023, of the 371 fraud referrals the Unit received from all sources, the PIU and MCOs each submitted only 19 referrals, for a combined total of 38 fraud referrals (10 percent) across the 3-year review period. According to Federal regulations, the PIU is required to refer all cases of suspected fraud and the MCOs are required to refer any potential fraud to the Unit.[22] See Exhibit 2 for the number of fraud referrals by year from MCOs and the PIU and Appendix A for a list of all fraud referrals by source during FYs 2021–2023.

Exhibit 2: Number of fraud referrals the GA MFCU received from MCOs (via the PIU) and the PIU during FYs 2021–2023

Fraud Referrals	FY 2021	FY 2022	FY 2023	Total
MCOs, via the PIU	4	1	14	**19**
PIU	2	11	6	**19**

Source: OIG analysis of Unit statistical data, FYs 2021–2023.

The PIU and an MCO mentioned factors that contributed to the low number of fraud referrals to the Unit during the review period. According to the PIU, during the COVID-19 public health emergency, DCH instructed the PIU to limit investigative activities during the first 10 months of FY 2021 to cases with a strong suspicion of provider fraud. While this instruction was intended to minimize disruption of Medicaid services during the COVID-19 public health emergency, the PIU mentioned that it limited the number of fraud referrals to the Unit. The PIU also reported that a staff shortage of nurse investigators limited the number of referrals to the MFCU. The Unit uses nurse investigators to review medical records and make determinations of medical necessity. One MCO cited difficulty meeting a monetary amount of alleged fraud that was adequate for a fraud referral as a contributing factor to its low volume of referrals. However, the Unit Director stated that no specific monetary minimum is required for fraud referrals.

[22] If the findings of a preliminary investigation give reason to believe that an incident of provider fraud or abuse has occurred in the Medicaid program, the State Medicaid agency must refer suspected fraud or abuse to the MFCU. See 42 CFR § 455.15(a)(1). Federal regulations also require the prompt referral of any potential fraud, waste, or abuse that the MCO identifies to the State Medicaid program integrity unit (e.g., the PIU) or any potential fraud directly to the State MFCU. See 42 CFR § 438.608(a)(7).

Finding: Although the MFCU maintained a positive working relationship with HFRD, the Unit did not take sufficient steps to ensure that it received patient abuse or neglect referrals.

The Unit received 31 referrals of patient abuse or neglect in institutional settings from HFRD during our 3-year review period. HFRD reported that it had not received training from the Unit during FYs 2021–2023. HFRD also mentioned that training could increase patient abuse and neglect referrals to the Unit and could be beneficial given HFRD's staff turnover. HFRD suggested that the Unit could present at HFRD's annual conference and provide training for HFRD surveyors. See Exhibit 3 for the number of patient abuse or neglect referrals by year from HFRD and Appendix A for a list of all patient abuse or neglect referrals by source during FYs 2021–2023.

Exhibit 3: Number of patient abuse or neglect referrals the GA MFCU received from HFRD during FYs 2021–2023

Patient Abuse and Neglect Referrals	FY 2021	FY 2022	FY 2023	Total
HFRD	16	13	2	**31**

Source: OIG analysis of Unit statistical data, FYs 2021–2023.

Performance Standard 5: Maintaining a 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 took steps to maintain a continuous case flow and completed cases within appropriate timeframes.

We observed that the Unit took steps to maintain a continuous case flow and completed cases within appropriate timeframes. To help ensure case progression, the Unit Director met quarterly with the investigative teams and the Chief Investigator to discuss the status of cases. Unit management reported that these meetings were an opportunity to find solutions to investigative challenges and maintain case progression. In addition, the Chief Investigator reviewed monthly updates from teams to ensure continuous case flow and inquired about potential areas of concern if a case appeared to be delayed. In reviewing a sample of the Unit's case files, we found that most cases were completed within appropriate timeframes, with no significant investigation or prosecution delays.

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 mainly included fraud cases, with a smaller proportion of patient abuse or neglect cases; cases covered a broad mix of provider types.

Of the Unit's nonglobal cases that were open at any point during FYs 2021–2023, 86 percent (361 cases) involved provider fraud and 14 percent (59 cases) involved patient abuse or neglect. The Unit's cases covered 67 different provider types, including clinical social workers, hospices, and pharmaceutical manufacturers.

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: Twenty-two percent of the Unit's case files were missing or contained late documentation of at least one supervisory review.

Performance Standard 7(A) requires that supervisory reviews be noted in the case file. The Unit's policies and procedures manual states that supervisory reviews should be conducted quarterly (in January, April, July, and October of each year) and documented in the electronic case file system. During the review period, we found that 22 percent of cases in our sample (17 of 76 cases) were missing documentation of at least one quarterly supervisory review or the reviews were documented late.[23] However, we did not find that the missing documentation of supervisory review had a significant impact on the Unit's ability to maintain a continuous case flow.

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.

Observation: The Unit communicated and collaborated with OIG and other Federal law enforcement partners regularly to investigate and prosecute health care fraud.

Performance Standard 8(A) requires that the Unit communicates on a regular basis with OIG's Office of Investigations and other Federal agencies investigating or prosecuting health care fraud in the State. The Unit communicated regularly with Federal partners. For example, the Unit and OIG's Office of Investigations reported a strong collaborative relationship involving frequent communication to discuss open investigations and new opportunities for collaboration, such as providing cross-

[23] The 95-percent confidence level corresponding to this estimate is 14 to 33 percent.

training for investigators with law enforcement certification. The Unit also reported frequent engagement with the Federal Bureau of Investigation and to a lesser extent, working with representatives from other Federal entities, such as the Drug Enforcement Agency.

Performance Standard 8(B) states that the Unit cooperates and, as appropriate, coordinates with OIG's Office of Investigations and other Federal agencies on cases being pursued jointly. We observed that the Unit jointly investigated 81 cases with OIG's Office of Investigations during our review period. In addition, United States Attorneys' Office (USAO) staff noted that the Unit cooperated with them on civil and criminal cases involving the False Claims Act and Qui Tam cases. The Unit's Director also worked with USAO districts in Georgia as a Special Assistant United States Attorney providing advice to support health care cases, including those involving medical necessity.

Finding: The Unit did not report about half of its convictions and adverse actions to Federal partners within the required timeframe.

Federal regulations, Performance Standard 8(F), and the Unit's policies and procedures require Units to submit to OIG reports of all MFCU convictions within 30 days of sentencing, or as soon as practicable if the Unit encounters delays in receiving the necessary information from the court.[24] The reports enable OIG to exclude convicted parties from Federal health care programs. We found that the Unit did not submit 53 percent (9 of 17) of its convictions to OIG within the required 30-day timeframe during our review period, not including late submissions related to court-related issues.[25] Of the nine convictions that were not submitted timely by the MFCU, five were reported to OIG between 31 and 91 days after sentencing, two were reported to OIG between 7 and 8 months after sentencing, and two convictions—identified through other sources in OIG—were excluded about 16 months after their convictions. We found that the Unit's submission of convictions to OIG had not improved compared to OIG's 2015 onsite inspection, which found that 47 percent (16 of 34) of the Unit's convictions were not reported within 30 days of sentencing.[26]

Federal regulations and Performance Standard 8(G) require Units to report adverse actions to the National Practitioner Data Bank (NPDB) within 30 days of the final adverse action.[27] Units report adverse actions to NPDB to help deter fraud and abuse within health care delivery systems. However, we found that the Unit did not

[24] 42 CFR § 1007.11(g). Performance Standard 8(F) also states that Units should transmit to OIG, for purposes of program exclusions, all pertinent information on MFCU convictions within 30 days of sentencing, including charging documents, plea agreements, and sentencing orders.

[25] Two convictions were delayed due to court-related issues such as waiting for necessary documentation to submit the conviction to OIG.

[26] OIG, *Georgia State Fraud Medicaid Control Unit: 2015 Onsite Review* (OEI-07-15-00090), Sept. 29, 2015.

[27] 42 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).

report 53 percent (9 of 17) adverse actions to the NPDB within the required 30-day timeframe during our review period. Of the nine adverse actions that the Unit reported past 30 days, three were reported to the NPDB between 31 and 60 days, two were reported between 61 and 90 days, and the remaining four were reported more than 90 days after the required timeframe. We found that the Unit's submission of adverse actions to the NPDB had slightly improved compared to OIG's 2015 onsite inspection, which found that 56 percent (14 of 25) of the Unit's adverse actions were not reported to the NPDB within the required 30-day timeframe.

Unit management attributed late reporting to OIG and the NPDB to staff error. In some cases, delays occurred because staff either forgot to take the necessary steps or there was miscommunication regarding who was responsible for submitting the data. Also, during an audit of case files for a departed attorney, the Unit discovered that the attorney did not complete documentation for reporting convictions to OIG. As a result of the audit, the Unit updated its procedures manual in January 2024 to require all staff to annually certify that they have reviewed the Unit's internal policies and operating procedures. Similar to OIG's 2015 onsite inspection, the Unit reported delays due to challenges obtaining court documents needed to report convictions and adverse actions.

Performance Standard 9: Program Recommendations

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

Observation: The Unit made one recommendation to the State Medicaid agency during the review period and monitored the agency's implementation of another recommendation.

Performance Standard 9(B) states that, when it is warranted and appropriate, the MFCU should make recommendations regarding program integrity issues to the State Medicaid agency and monitor actions in response to recommendations. In FY 2023, the Unit recommended to DCH that it revise its policy for Georgia's Community Care Services Program (a Medicaid waiver program) to prohibit a single individual from owning both a case management company and a company offering personal care services, to protect individuals from financial conflicts of interest by restricting providers of personal care services from providing case management to individuals who receive their services.

In addition, in early 2021, the Unit monitored a recommendation to DCH to address potential fraudulent claims for some of the most abused genetic testing codes in the Medicaid program. The recommendation was a result of the Unit's investigation of laboratory providers and telehealth physicians who submitted claims for genetic tests yet lacked a provider-patient relationship with the Medicaid enrollees. On the basis of the Unit's recommendation, in April 2021, DCH required prior authorization and submission of clinical notes to substantiate providers' requests for certain genetic tests.

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 policy and legal requirements.

The Unit and the PIU had an MOU that reflected current policy and legal requirements, last amended in May 2021. The MOU clarified how the Unit receives fraud referrals from MCOs via the PIU.

Performance Standard 11: Fiscal Control

A Unit exercises proper fiscal control over Unit resources.

Finding: The Unit lacked policies and procedures for maintaining its equipment inventory.

We found that the Unit did not have written policies and procedures for maintaining an equipment inventory, which are essential to ensure that all property under its control is properly accounted for.

Finding: The Unit's inventory list did not include equipment tracking information.

Performance Standard 11(B) states that the Unit maintains an equipment inventory list that is updated regularly to reflect all property under the Unit's control, such as computers, ammunition, and vehicles. We found that the Unit's inventory list did not include information to track equipment, such as the location of items or to whom items were assigned. From a sample of 30 items, we could not locate 10 during our onsite inspection. The missing items included printers, a desktop computer, and laptops. A Unit staff member was able to track 9 of the 10 items by providing hard copy receipts indicating their release to the State surplus program. However, these items were not removed from the Unit's inventory list after their release to the State surplus program. The remaining unaccounted item was a computer monitor that the Unit could not locate.

Performance Standard 12: Training

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

Observation: The Unit's training plan did not include minimum training hour requirements for each professional discipline, but the Unit updated the plan with the required hours after our onsite inspection.

Performance Standard 12(A) states that the Unit maintains a training plan for each professional discipline that includes an annual minimum number of training hours. Although the Unit maintained a training plan, it did not include the minimum training

hour requirements for its professional staff (i.e., investigators, attorneys, or auditors).[28] In November 2025, after our onsite inspection, the Unit revised its training plan to include minimum training hour requirements for each professional discipline.

Performance Standard 12(D) states that the Unit participates in MFCU-related training. We observed that staff participated in MFCU-related training on health care fraud and money laundering, digital investigations, and health care fraud prevention partnerships, among others.

[28] Regulations at 42 CFR § 1007.1 define a professional employee as an investigator, attorney, or auditor.

RECOMMENDATIONS

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

Examine position descriptions and salaries to ensure a fair and competitive salary and benefit package that enables the Unit to recruit and retain qualified staff

To address Performance Standard 2, the Unit should review and analyze salaries and benefits and adjust them to establish competitive compensation to retain staff and fill vacancies. The Unit could conduct a salary survey and gather information from other MFCUs or similar state agencies (e.g., local law enforcement agencies) to help identify gaps and adjust salaries to recruit and retain qualified staff. For example, the Tennessee Bureau of Investigation conducted a salary survey that confirmed and supported that MFCU employees were underpaid compared to some local law enforcement agencies in Tennessee. The survey provided evidence for the Governor and Tennessee State Legislature to approve salary increases for the MFCU. Also, the Unit could gather information from other MFCUs about financial incentives they offer to staff, such as pay-for-performance or certification/degree completion pay raises.

Expand efforts to increase fraud and patient abuse or neglect referrals

To address Performance Standard 4, the Unit should expand its activities to increase the volume of fraud referrals from the PIU and MCOs. The MFCU should clarify with the PIU and MCOs the Federal requirements for fraud referrals and continue to provide guidance on how to develop fraud referrals.

To increase the volume and ensure the quality of patient abuse or neglect referrals, the Unit should provide regular training to HFRD staff about developing and sending referrals to the Unit. For example, the Unit could present at HFRD's annual conference and provide training to HFRD surveyors.

Take steps to ensure that periodic supervisory reviews are documented in the case files

To address Performance Standard 7, the Unit should take steps to ensure adherence to its policy on documenting supervisory reviews in the case files. The Unit could implement automatic reminders in its electronic case file system to help ensure that supervisory reviews are documented quarterly. Documentation of periodic supervisory reviews helps to monitor the progress of the case.

Take steps to ensure timely reporting of all convictions and adverse actions to Federal partners

To address Performance Standard 8, the Unit should ensure that it consistently reports all convictions to OIG within 30 days of sentencing, or as soon as practicable if the Unit encounters delays in receiving the necessary information from the court. The Unit should also take steps to report all adverse actions to the NPDB within 30 days of the adverse action. In addition to requiring all staff to annually certify that they have read and understand the Unit's procedures manual and will comply with all policies and procedures, the Unit should also develop and implement quality assurance methods to ensure that staff adhere to the procedures. For example, the Unit could conduct regular monitoring to ensure timely reporting of convictions and adverse actions and take appropriate action for delayed reporting due to staff errors.

Regular monitoring may also help identify and track delays due to court-related issues (e.g., waiting for sentencing documents). This could provide additional support to the steps the Unit has taken to address our recommendation from the 2015 onsite inspection. In 2016, the Unit reported that it would encourage and provide written correspondence directing attorneys and their legal assistants to retrieve documents using the Federal court computerized tracking system and to use a legal research tool to retrieve relevant Federal and State court documents. Additionally, the Unit reported that it would direct attorneys and their legal assistants to routinely contact the Clerk of the court to ensure that sentencing documents and adverse actions are promptly provided to the Unit. Timely reporting of convictions and adverse actions helps ensure that individuals and entities convicted in one State are excluded from Medicaid programs in other States, as well as from other Federal programs related to health care.

Establish written policies and procedures for maintaining an inventory of the Unit's equipment

To address Performance Standard 11, the Unit should develop an internal equipment inventory policy. The policies and procedures should contain all relevant aspects of inventory management including instructions for tracking equipment and the process

for handling surplus items in the Unit's inventory such as removing those items from the Unit's inventory list. The Unit's inventory policies and procedures also should incorporate or reference any relevant State policies.

Include information to track equipment in the Unit's equipment inventory list

To address Performance Standard 11, the Unit should have an equipment inventory list that systematically collects information to track equipment. The list should capture to whom equipment is assigned, the assigned location, and, if applicable, how much was taken or used. The equipment inventory list should also include information about items that have been released to the State surplus program.

UNIT COMMENTS AND OIG RESPONSE

The GA MFCU concurred with all six of our recommendations.

First, the Unit concurred with our recommendation to examine position descriptions and salaries to ensure a fair and competitive salary and benefit package that enables the Unit to recruit and retain qualified staff. The Unit reported that it received funds to help close the gap between employment for the Attorney General's Office and other metro-Atlanta prosecutors and law enforcement entities. The Unit also switched to sworn law enforcement, which allows it to recruit more experienced applicants and offer higher starting salaries. Lastly, the Unit reported that its most recent grant request included a large allocation toward more comprehensive salary adjustments across all disciplines. The allocation creates a new level of supervisory investigator, which provides an incentive for staff seeking chances for career development and increased input in Unit outcomes. Rather than expansion, the Unit is focusing upon training and retention to achieve the greatest possible outcomes.

Second, the Unit concurred with our recommendation to expand efforts to increase fraud and patient abuse or neglect referrals. The Unit reported that it has taken several steps to increase referrals from the PIU and MCOs. The Unit undertook joint training on referrals with PIU staff and Medicaid program contractors in 2026, established twice-monthly conference calls with the PIU to expedite certain fraud referrals, and plans to develop annual training in conjunction with the PIU. Effective September 2026, the Unit reported, it will establish a steering committee to meet monthly with MCOs to discuss referrals and provide feedback to MCOs to improve the quality of referrals. Regarding abuse and neglect referrals, the Unit Director met with state agency leadership in July 2026, which led to a new process for automatic referral of substantiated abuse and neglect allegations to the Unit. The Unit also reported that it is conducting training with HFRD staff in September 2026 to increase the volume of referrals.

Third, the Unit concurred with our recommendation to take steps to ensure that periodic supervisory reviews are documented in the case files. The Unit reported that it implemented a new standardized naming convention for supervisory review reports, making it easier to identify reports and gaps in submission. Effective January 2025, the Policies & Procedures were updated to include coordination between the Unit Director, Assistant Director, and Chief Investigator on supervisory reviews. The Unit also reported that it standardized the process for investigative personnel to submit reports to allow for greater oversight over report submission.

Fourth, the Unit concurred with our recommendation to take steps to ensure timely reporting of all convictions and adverse actions to Federal partners. The Unit reported that responsible staff have been trained on both exclusions and NPDB reporting requirements and timelines, and the Unit Director reminds staff about

these obligations during monthly meetings with Unit attorneys and quarterly meetings with administrative staff, or as appropriate. The Unit reported that these efforts have been successful as evidenced by a 100-percent on-time submission to the exclusions portal for its 2025 and 2026 recertifications.

Fifth, the Unit concurred with our recommendation to establish written policies and procedures for maintaining an inventory of the Unit's equipment. The Unit reported that a policy implemented in November 2024 requires coordination between the Attorney General Financial Services Section, the Unit Director, and other appropriate staff to conduct an inventory review every September.

Finally, the Unit concurred with our recommendation to include information to track equipment in the Unit's equipment inventory list. The Unit reported that a policy implemented in November 2024 requires IT to maintain a near real-time inventory of assets assigned to Unit personnel. Non-IT equipment is managed by other personnel delegated by the Unit Director.

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 B.

DETAILED METHODOLOGY

Data Collection and Analysis

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 2012 MFCU performance standards or did not operate 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 onsite inspection, we examined the Unit's recertification materials for FYs 2022–2024, including (1) the Unit Director's responses to annual OIG recertification questionnaires; (2) the Program Integrity Director's responses to annual OIG questionnaires; and (3) the OIG Special Agent in Charge's responses to annual questionnaires. We also reviewed (1) the Unit's MOU with the State Medicaid agency; (2) the Unit's policies and procedures manual; and (3) the Unit's self-reported case outcomes, referrals, and other data included in its annual statistical reports to OIG for FYs 2021–2023. Additionally, we examined the recommendations from OIG's 2015 onsite review of the Georgia Unit 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 and did not identify concerns regarding its internal fiscal controls. Before the onsite inspection, we analyzed the Unit's responses to a questionnaire about internal controls and conducted a desk review of the Unit's quarterly financial reports. We followed up with staff from the Georgia Office of the Attorney General and the Unit 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 External Partners

In August 2024, we interviewed external partners of the Unit, including officials from the PIU, MCOs, DCH's HFRD, APS, OI, and USAOs for the Northern, Middle, and Southern Districts of Georgia. We focused these interviews on the Unit's relationship and interaction with partner agencies, as well as opportunities for improvement. We used the information collected from these interviews to develop subsequent interview questions for Unit management and staff.

Interviews With Unit Management and Other Selected Staff

We conducted structured interviews with the Unit's management and other selected staff in September 2024. Of the Unit management, we interviewed the Director, Deputy Director, Chief Investigator, Chief Criminal Investigator, Chief Auditor, Chief Analyst, and Chief Nurse Investigator. In addition, we interviewed three attorneys, two investigators, one nurse investigator, one auditor, one analyst, one investigative assistant, and one legal assistant. Finally, we interviewed the supervisor of the Unit—Chief Deputy Attorney General of the Georgia Office of the 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.

Onsite Inspection of Case Files

We reviewed a sample of case files during our onsite inspection. To select our sample of case files, we asked the Unit to provide us with a list of cases that were open at any point during FYs 2021–2023 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 that met these parameters was 888.

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 464 global cases, leaving 424 nonglobal case files.

We then selected a simple random sample of 86 cases from the population of 424 cases. This sample allowed us to make estimates of the overall percentage of case files with various characteristics with absolute precision of no more than +/- 10 percent at the 95-percent confidence level. In our sample of 86 cases, we excluded 4 cases that the Unit confirmed had been erroneously marked as global cases.

We reviewed our final sample size of 82 case files for adherence to the relevant performance standards and compliance with statutes, regulations, 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. For Performance Standard 7, we revised the sample size from 82 cases to 76 cases because the Unit did not actively investigate 6 cases for reasons outside of the Unit's control (e.g., the Unit was waiting for a settlement to be collected). Thus, documentation of supervisory review would not be expected.

Review of Unit Submissions to OIG and the NPDB

We also reviewed seven convictions during our review period that the Unit submitted to OIG for program exclusion and the nine adverse actions submitted to the NPDB. We reviewed whether the Unit submitted information on all sentenced individuals and entities to OIG for program exclusion and on all adverse actions to the NPDB.

Onsite Inspection of Unit Operations

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

APPENDICES

Appendix A: Fiscal Years 2021–2023 Referrals Received by Georgia MFCU

Referral Source	FY 2021		FY 2022		FY23		3 Year Total		
	Fraud	Abuse or Neglect	Fraud	Abuse or Neglect	Fraud	Abuse or Neglect	Fraud	Abuse or Neglect	Total
Adult Protective Services	0	0	0	0	0	0	0	0	0
Anonymous	4	0	1	0	4	0	9	0	9
Federal contractors(s)*	—	—	—	—	1	0	1	0	1
HHS-OIG	1	2	0	2	2	0	3	4	7
Law enforcement—other	8	2	1	0	3	1	12	3	15
Licensing board	0	0	0	0	1	0	1	0	1
Local prosecutor	1	0	0	0	0	0	1	0	1
Long-term care ombudsman	0	1	0	0	0	0	0	1	1
MCO	0	0	0	0	0	0	0	0	0
Medicaid agency—MCO origination**	4	—	1	—	14	0	19	0	19
Medicaid agency—PIU	2	2	11	0	6	2	19	4	23
Private citizen	105	19	84	4	82	8	271	31	302
Private health insurer	0	0	0	0	0	0	0	0	0
Provider	7	1	2	0	4	0	13	1	14
State survey and certification agency***	0	16	0	13	1	2	1	31	32
State agency—other	3	6	0	3	1	0	4	9	13
Provider association	0	0	0	0	0	0	0	0	0
Other	2	3	0	2	15	1	17	6	23
Subtotal	**137**	**52**	**100**	**24**	**134**	**14**	**371**	**90**	**461**
Total	**189**		**124**		**148**		**461**		

Source: Source: OIG analysis of Unit annual statistical reports for FYs 2021–2023.

* In FY 2023, OIG updated its annual statistical report template to include a category for referrals from CMS contractors, including Unified Program Integrity Contractors. For more information, see CMS, "Review Contractor Directory—Interactive Map," October 2023. Accessed at Review Contractor Directory—Interactive Map | CMS on March 31, 2026.

** In FY 2023, OIG updated its annual statistical report template to include categories that identify referrals from the State Medicaid agency PIU that originated or did not originate from MCOs. OIG collected data on PIU referral origination for FYs 2021–2022 in Unit statistical reports.

*** The Healthcare Facility Regulation Division is the State Survey and Certification agency for Georgia.

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August 25, 2026

VIA EMAIL to *Matt.Defraga@oig.hhs.gov*

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

Re: Georgia MFCU 2024 Onsite Review, OEI-09-24-00410

Dear Deputy Inspector General Maxwell:

I want to thank you for the opportunity to respond to the draft of the 2024 review of the Georgia Medicaid Fraud & Patient Protection Division, OEI-09-24-00410. Our Unit is appreciative of the professionalism, responsiveness, and candor of the HHS staff that we have engaged with throughout this process.

The report contained six recommendations for our Unit to consider. We address each of those recommendations in turn along with the concrete steps we have taken.

Recommendation 1: Examine position descriptions and salaries to ensure a fair and competitive salary and benefit package that enables the Unit to recruit and retain qualified staff

GMFPPD Response: **The Unit concurs with this recommendation.** Staffing and retention are challenging issues for any state agency, and the challenges encountered by our Unit are not unique even within the Georgia Attorney General's Office. The Attorney General's Office previously presented these concerns to the state legislature and received some funding that was specifically targeted at employee retention. These funds permitted the Unit to begin to close the gap between employment for the Attorney General's Office and other metro-Atlanta prosecutors and law enforcement entities.

Second, the Unit switched to employing only sworn law enforcement to conduct its criminal investigations. Review of retention practices identified that the average length of employment for non-sworn investigators progressively got shorter. The switch to sworn

law enforcement allows the Unit to recruit from an applicant pool that will typically arrive with greater training and credentials, which allows the Unit to offer higher starting salaries.

Finally, the Unit's most recent grant request included a large allocation towards more comprehensive salary adjustments across all disciplines. The allocation also creates a new level of supervisory investigator, which provides an incentive for staff seeking chances for career development and increased input in Unit outcomes. Rather than expansion, the Unit is focusing upon training and retention to achieve the greatest possible outcomes.

Recommendation 2: Expand efforts to increase fraud and patient abuse or neglect referrals

GMFPPD Response: **The Unit concurs with this recommendation.** As noted in the onsite inspection report, the review period included years impacted by the COVID pandemic. Interviews the OIG review team completed with the PIU also confirmed that staff and resource shortages within their organization, rather than within the Unit, hindered the submission of referrals. These factors are entirely outside of the Unit's control. However, the Unit agrees that more steps need to be taken. In the summer of 2026, the Unit undertook joint training with the single state agency to meet with PIU staff as well as contractors of the Medicaid program in a position to send referrals. A considerable amount of the training focused on referral content. The Unit plans to develop annual training in conjunction with the PIU to maintain this momentum. The Unit and PIU also agreed to new twice monthly conference calls where the sole focus will be expediting certain fraud referrals.

For the MCOs, a similar process is being implemented effective in September of 2026. Previously, Unit staff met with the PIU and MCOs on a quarterly basis to discuss active matters. While those meetings will continue to occur, a new steering committee meeting will be established to meet monthly to discuss MCO referrals. At these meetings, MCOs will be required to present on ongoing matters which may be appropriate for expedited referral to the Unit. The meetings will also be used by the Unit to provide immediate feedback to the MCOs to improve the quality of referrals being presented.

With respect to abuse and neglect referrals obtained from HFRD, the Unit is conducting training with new leadership staff for the agency in September of 2026. [1] Additionally, in July of 2026 the Unit Director met with leadership at the state agency which houses both the Medicaid program and HFRD. That meeting led to a new process for automatic referral to the Unit of substantiated abuse and neglect allegations. Leadership plans to review the outcome of that process this fall to determine if additional criteria are necessary to generate a greater volume of referrals.

External to direct agency collaborations, the Unit's Outreach Committee meets regularly

[1] The Unit originally scheduled this training for the Fall/Winter of 2025. During that time HFRD underwent staffing changes, and they cancelled the Unit led training after substantial back and forth to find a time conducive to their agency.

to identify other points of contact for outreach and referrals. As a part of that effort, the Unit Director sought input from all MFCUs about outreach opportunities and their observations about the best returns on investment.

Recommendation 3: Take steps to ensure that periodic supervisory reviews are documented in the case files

GMFPPD Response: **The Unit concurs with this recommendation.** When the current Unit Director took over in June of 2023, he began a process of reviewing and revising the Unit's Policies & Procedures. He also undertook a comprehensive review of the electronic case file system and file naming conventions. That process resulted in a new standardized naming convention for supervisory review reports to make it easier to quickly identify reports and any gaps in submission. Effective January 1, 2025, the Policies & Procedures were updated allowing for the Unit Director to coordinate with the Assistant Director and Chief Investigator on supervisory reviews. Finally, the process for investigative personnel to submit reports was standardized to allow greater oversight of report submission and filing by administrative staff.

Recommendation 4: Take steps to ensure timely reporting of all convictions and adverse actions to Federal partners

GMFPPD Response: **The Unit concurs with this recommendation.** As noted in the draft report, this particular issue has persisted since the 2015 inspection, but the root causes differed considerably. At the time of the 2015 inspection, the fundamental issue related to delays in obtaining the necessary paperwork and lack of follow-up from assigned staff. At the time of the 2024 onsite, the root causes related to failure of training and one particular, now departed, employee who failed to take necessary actions. The current Unit Director had prioritized improving this metric even prior to notice of OIG's onsite review. As noted at the time of the onsite, the 2024 IOP revisions require annual certification of knowledge and compliance with Unit procedures. Responsible staff were previously trained on both exclusions and NPDB reporting requirements and timelines. The Director meets monthly with Unit attorneys and quarterly with administrative staff. At these meetings, and as appropriate, the Director reminds staff about these obligations. When deficiencies are identified, associated staff must complete root cause analysis and provide concrete steps to improve performance to the Unit Director.

The Unit believes that these efforts have been successful. At the time the Unit received its 2025 and 2026 recertifications, OIG provided feedback that the Unit's on-time submission to the exclusions portal was 100%.

Recommendation 5: Establish written policies and procedures for maintaining an inventory of the Unit's equipment

GMFPPD Response: **The Unit concurs with this recommendation.** Following OIG's onsite, the Unit implemented a new Internal Operating Procedure specific to Inventory

and Inspection of Unit equipment. The policy was implemented on November 1, 2024. The policy requires coordination between the AG Financial Services section, the Unit Director, and other appropriate staff to conduct an inventory review each September. It also requires IT to maintain a close to real time inventory of assets assigned to Unit personnel. Non-IT equipment is managed by other personnel delegated by the Unit Director.

Recommendation 6: Include information to track equipment in the Unit's equipment inventory list

GMFPPD Response: **The Unit concurs with this recommendation.** Following OIG's onsite, the Unit implemented a new Internal Operating Procedure specific to Inventory and Inspection of Unit equipment. The policy was implemented on November 1, 2024. The policy requires coordination between the AG Financial Services section, the Unit Director, and other appropriate staff to conduct an inventory review each September. It also requires IT to maintain a close to real time inventory of assets assigned to Unit personnel. Non-IT equipment is managed by other personnel delegated by the Unit Director.

Our office remains committed to the important work of combatting fraud, waste, and abuse. There is no question that we are stronger together and recognize that we will be at our best working in conjunction with HHS-OIG to further our work. Thank you, again, for the chance to provide a response to the onsite report.

Sincerely,

Jim Mooney
Deputy Attorney General
Medicaid Fraud & Patient Protection Division

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