Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

GEORGIA STATE MEDICAID FRAUD CONTROL UNIT: 2015 ONSITE REVIEW

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EXECUTIVE SUMMARY: GEORGIA STATE MEDICAID FRAUD CONTROL UNIT: 2015 ONSITE REVIEW
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WHY WE DID THIS STUDY

The Office of Inspector General (OIG) administers the Medicaid Fraud Control Unit (MFCU or Unit) grant awards, annually recertifies the Units, and oversees the Units' performance in accordance with the requirements of the grant. As part of this oversight, OIG conducts periodic reviews of all Units and prepares public reports based on these reviews These reviews assess Unit performance in accordance with the 12 MFCU performance standards and its compliance with applicable Federal requirements.

HOW WE DID THIS STUDY

We conducted an onsite review of the Georgia Unit in March 2015. We based our review on analysis of data from seven sources: (1) a review of policies, procedures, and documentation related to the Unit's operations, staffing, and caseload for fiscal years (FYs) 2012 through 2014; (2) a review of financial documentation for FYs 2012 through 2014; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured interviews with the Unit's management; (6) an onsite review of a sample of files for cases that were open in FYs 2012 through 2014; and (7) an onsite observation of Unit operations.

WHAT WE FOUND

For FYs 2012 through 2014, the Georgia Unit reported 34 criminal convictions, 58 civil judgments and settlements, and combined criminal and civil recoveries of $179 million. We identified areas where the Unit could improve its functioning. Specifically, 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. Additionally, the Unit did not report all convictions and adverse actions to Federal partners within required timeframes. We also found that the Unit did not always exercise proper fiscal control of its resources. Specifically, the Unit did not comply with special terms added to its grant in one year; and did not have fiscal controls necessary to ensure accurate and timely fiscal reporting.

WHAT WE RECOMMEND

We recommend that the Georgia 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. The Unit concurred with all four recommendations.

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OBJECTIVE

To conduct an onsite review of the Georgia State Medicaid Fraud Control Unit (MFCU or Unit).

BACKGROUND

The mission of State MFCUs, as established by Federal statute, is to investigate and prosecute Medicaid provider fraud and patient abuse and neglect under State law.[1] Pursuant to Title XIX of the SSA, each State must maintain a certified Unit unless the Secretary of Health and Human Services determines that operation of a Unit would not be cost-effective because (1) minimal Medicaid fraud exists in that State and (2) that the State has other adequate safeguards to protect Medicaid beneficiaries from abuse and neglect.[2] Currently, 49 States and the District of Columbia (States) have created such Units.[3] In fiscal year (FY) 2014, combined Federal and State grant expenditures for the Units totaled $235 million.[4, 5] That year, the 50 Units employed 1,958 individuals.[6]

To carry out its duties and responsibilities in an effective and efficient manner, each Unit must employ an interdisciplinary staff that consists of at least an investigator, an auditor, and an attorney.[7] Unit staff review complaints referred by the State Medicaid agency and other sources and determine their potential for criminal prosecution and/or civil action. In FY 2014, the 50 Units collectively obtained 1,318 convictions and 874 civil settlements or

[1] Social Security Act (SSA) § 1903(q). Regulations at 42 CFR § 1007.11(b)(1) add that the Unit's responsibilities may include reviewing complaints of misappropriation of patients' private funds in residential health care facilities.

[2] SSA § 1902(a)(61).

[3] North Dakota and the territories of American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands have not established Units.

[4] All FY references in this report are based on the Federal FY (October 1 through September 30).

[5] Office of Inspector General (OIG), *MFCU Statistical Data for Fiscal Year 2014*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2014-statistical-chart.pdf on February 25, 2015.

[6] Ibid.

[7] SSA § 1903(q)(6); 42 CFR § 1007.13.

judgments.[8] That year, the Units reported recoveries of approximately $2 billion.[9]

Units are required to have either statewide authority to prosecute cases or formal procedures to refer suspected criminal violations to an agency with such authority.[10] In Georgia and 43 other States, the Units are located within offices of State Attorneys General that have this authority. In the remaining six States, the Units are located in other State agencies; generally, such Units must refer cases to other offices with prosecutorial authority.[11] Additionally, each Unit must be a single, identifiable entity of State government, distinct from the single State Medicaid agency, and each Unit must develop a formal agreement—i.e., a memorandum of understanding (MOU)—that describes the Unit's relationship with that agency.[12]

Oversight of the MFCU Program

The Secretary of Health and Human Services delegated to OIG the authority both to annually certify the Units and to administer grant awards to reimburse States for a percentage of their costs of operating certified Units.[13] All Units are currently funded by the Federal Government on a 75-percent matching basis, with the States contributing the remaining 25 percent.[14] To receive Federal reimbursement, each Unit must submit an initial application to OIG.[15] OIG reviews the application and notifies the Unit if the application is approved and the Unit is certified. Approval and certification are for a 1-year period; the Unit must be recertified each year thereafter.[16] In addition to annual recertification, OIG performs periodic onsite reviews of the Units.

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[8] OIG, *MFCU Statistical Data for Fiscal Year 2014*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2014-statistical-chart.htm on February 25, 2015.

[9] Ibid.

[10] SSA § 1903(q)(1).

[11] OIG, *Medicaid Fraud Control Units*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp on February 25, 2015.

[12] SSA § 1903(q)(2); 42 CFR § 1007.9(d).

[13] The portion of funds reimbursed to States by the Federal Government for its share of expenditures for the Federal Medicaid program, including the MFCUs, is called Federal Financial Participation.

[14] SSA § 1903(a)(6)(B).

[15] 42 CFR § 1007.15(a).

[16] 42 CFR § 1007.15(b) and (c).

Pursuant to Title XIX of the SSA, States must operate Units that effectively carry out their statutory functions and meet program requirements.[17] To clarify the criteria that OIG applies in assessing whether a Unit is effectively carrying out these functions and meeting program requirements, OIG developed and issued 12 performance standards.[18] Examples of the standards include maintaining an adequate caseload through referrals from several sources, maintaining a training plan for all professional disciplines, and establishing policy and procedure manuals. See Appendix A for a description of each of the 12 performance standards.

Georgia MFCU

Located in Atlanta, the Unit is an autonomous entity within the Georgia Office of the Attorney General;[19, 20] it investigates and prosecutes cases of Medicaid fraud and patient abuse and neglect. To investigate and prosecute such cases, the Unit employs investigators, attorneys, and auditors, as well as nurses and analysts.[21] Cases are investigated using a team approach; teams are comprised of individuals from each of the above disciplines. At the time of our review, the Unit had six investigative teams, including five criminal teams and one civil team.

Referrals. The Unit receives referrals from a variety of sources, including the State Medicaid agency, local law enforcement, and private citizens. Unit referrals by referral source for FYs 2012 through 2014 can be found in Appendix B. For each referral received, Unit management meets to evaluate the referral and determine what action needs to be taken (e.g., whether to open a case for preliminary investigation).

Investigations and Prosecutions. When a case is opened, it is assigned to one of the five criminal teams or to the civil team for investigation. Generally, each team is comprised of an attorney, two investigators, an auditor, a nurse, and an analyst; the attorney serves as the team leader.

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[17] SSA § 1902(a)(61).

[18] 77 Fed. Reg. 32645 (June 1, 2012).

[19] Prior to our review period, the Unit operated through three State agencies: the Georgia Attorney General's Office, the Georgia Department of Audits, and the Georgia Bureau of Investigation. On July 1, 2011, the Unit was reorganized under the Attorney General's Office.

[20] The grantee for the Unit's operations is the Georgia Department of Law, which houses the Georgia Office of the Attorney General and the Unit. Hereinafter, we refer to the Department of Law as the Attorney General or the Office of the Attorney General.

[21] The Unit also employs administrative and information systems staff. At the time of our onsite review, the Unit employed 48 staff members.

All team members are involved in planning the investigative strategy and in making decisions related to that strategy.

The Unit investigates and prosecutes both criminal and civil cases. For cases that involve criminal referrals, the Unit completes a preliminary investigation within 90 days to determine whether a full investigation is warranted. If the Unit determines a full criminal investigation is not warranted, it decides whether to refer the case to the civil team, refer the case to another agency, or close the referral.

Previous OIG Onsite Review

In June 2008, OIG conducted an onsite review of the Georgia Unit and determined that the Unit did not maintain interim investigative memoranda, which note the progress of investigations. Although the Unit did note case progress in the Unit's automated case tracking system, OIG stated that the inclusion of interim investigative memoranda in official case files was necessary to fully satisfy the performance standards.

METHODOLOGY

We conducted the onsite review in March 2015. We based our review on an analysis of data from seven sources: (1) a review of policies, procedures, and documentation related to the Unit's operations, staffing, and caseload for FYs 2012 through 2014; (2) a review of financial documentation for FYs 2012 through 2014; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured interviews with the Unit's management; (6) an onsite review of a sample of files for cases that were open in FYs 2012 through 2014; and (7) an onsite observation of Unit operations. We also used these data sources to determine if any issues related to findings from the previous OIG onsite review persisted. Appendix C provides a detailed methodology.

Standards

These reviews are conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

For FYs 2012 through 2014, the Georgia Unit reported 34 criminal convictions, 58 civil judgments and settlements, and combined criminal and civil recoveries of $179 million

For FYs 2012 through 2014, the Unit reported 34 criminal convictions and 58 civil judgments and settlements. See Table 1 for yearly convictions and civil judgments and settlements. Of the Unit's 34 convictions over the 3-year period, 32 involved provider fraud and 2 involved patient abuse and neglect. See Appendix D for details on investigations opened and closed by provider category.

Table 1: Georgia MFCU Criminal Convictions and Civil Judgments and Settlements, FYs 2012–2014

Outcomes	FY 2012	FY 2013	FY 2014	3-Year Total
Criminal Convictions	14	10	10	34
Civil Judgments and Settlements	20	15	23	58

Source: OIG analysis of Unit-submitted documentation, 2015.

For the same period, the Unit reported combined criminal and civil recoveries of $179 million. See Table 2 for the Georgia Unit's yearly recoveries and expenditures. Most of the recoveries were obtained from "global" settlements, which accounted for 88 percent of all recoveries during the 3-year review period.[22]

Table 2: Georgia MFCU Recoveries and Expenditures, FYs 2012–2014*

Type of Recovery	FY 2012	FY 2013	FY 2014	3-Year Total
Global Civil	$92,780,423	$26,884,305	$38,359,021	$158,023,749
Nonglobal Civil	$2,255,582	$736,220	$2,151,847	$5,143,650
Criminal	$6,349,361	$1,789,638	$7,776,456	$15,915,455
Total Recoveries	**$101,385,366**	**$29,410,163**	**$48,287,325**	**$179,082,854**
Total Expenditures	$3,818,352	$4,046,590	$4,523,319	$12,388,261

Source: OIG analysis of Unit-submitted documentation, 2015.

* Due to rounding, dollar figures for each category of recoveries do not always sum to the total recoveries.

[22] "Global" cases are civil false claims actions involving the U.S. Department of Justice and a group of State MFCUs. The National Association of Medicaid Fraud Control Units facilitates the settlement of global cases.

Nearly a third of case files lacked documentation of supervisory approval to open cases; however, almost all case files included documentation of supervisory approval to close cases

Twenty-nine percent of the case files lacked documentation of supervisory approval to open the cases; however, 93 percent of the Unit's closed cases included documentation of supervisory approval to close the case. According to Performance Standard 5(b), Unit supervisors should approve the opening and closing of cases. Furthermore, the Unit's policy also requires that opening and closing documents be maintained in case files. Supervisory approval to open cases indicates that Unit supervisors are monitoring the intake of cases, thereby facilitating progress in the investigation. Supervisory approval of the closing of cases helps ensure the timely completion and resolution of cases. Point estimates and confidence intervals can be found in Appendix E.

Nearly half of the Unit's case files open longer than 90 days lacked documentation of periodic supervisory reviews

Forty-four percent of cases open longer than 90 days lacked documentation of periodic supervisory review. According to Performance Standard 7(a), supervisory reviews should be conducted periodically and noted in the case file. Further, the Unit's policy requires that the Unit Director meet with each team for a "case progress review" on a quarterly basis (i.e., every 90 days). Following the case progress review, the Unit's policy states that the Director is required to sign and date a "Quarterly Case Progress Report."[23] Periodic supervisory reviews ensure timely completion of cases and may identify potential issues during the investigation.

The Unit did not report all convictions and adverse actions to Federal partners within required timeframes

The Unit did not report all convictions to OIG for the purpose of program exclusion or all adverse actions to the National Provider Data Bank (NPDB) within the required timeframes. According to Performance Standard 8(f), the Unit should transmit to OIG reports of all convictions for the purpose of exclusion from Federal health care programs within 30 days of sentencing. Additionally, Federal

[23] "Georgia Medicaid Fraud Control Unit, Unit Internal Operating Procedures," Quarterly Case Progress Reviews, Number 15, p. 1.

regulations require that Units report any adverse actions generated as a result of investigations or prosecutions of healthcare providers to the NPDB.[24]

Nearly half of the Unit's convictions were not reported to OIG for program exclusion within the required timeframe

Sixteen of the Unit's 34 convictions were not reported to OIG for program exclusion within 30 days of sentencing. Of the cases that were not reported timely, 7 were reported over 100 days after sentencing, 6 were reported within 51 to 100 days of sentencing, and 3 were reported within 31 to 50 days of sentencing. If a Unit fails to ensure that convicted individuals are reported for exclusion, those individuals may be able to continue to submit claims to and receive payments from Medicaid and Federal healthcare programs.

The Unit's management explained that individuals are not reported to OIG until the Unit has adequate conviction information. Unit management reported that it must obtain copies of sentencing documents before referring the convicted individual to OIG. The Unit's management reported that delays may occur in obtaining sentencing documents from the various courts in which individuals are sentenced. As a result, the Unit may not report convictions within 30 days of sentencing.

Just over half of the Unit's adverse actions were not reported to the National Practitioner Data Bank within the required timeframe

Fourteen of the Unit's 25 adverse actions were not reported to the NPDB within 30 days of the action. Of the adverse actions that were not reported timely, 9 were reported over 90 days after the action; 3 were reported within 61 to 90 days of the action; and 2 were

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[24] SSA § 1128E(g)(1) and 45 CFR § 60.3. In addition to Federal regulations, the Performance Standards also require Units to report to NPDB. Performance Standard 8(g) states that the Unit should report "qualifying cases to the Healthcare Integrity & Protection Databank [HIPDB], the National Practitioner Data Bank, or successor data bases." The NPDB is intended to restrict the ability of physicians, dentists, and other health care practitioners to move from State to State without disclosure or discovery of previous medical malpractice and adverse actions. We reviewed the reporting of adverse actions under NPDB requirements because the HIPDB and the NPDB were merged during our review period (FYs 2012 through 201478). Fed. Reg. 20473 (April 5, 2013). Examples of final adverse actions include, but are not limited to, convictions, civil judgments (but not civil settlements), and program exclusions. Final adverse actions must be reported to the NPDB within 30 days following the action. See 45 CFR § 60.5.

reported within 31 to 60 days of the action. All of the Unit's adverse actions reported to the NPDB were convictions.

Similar to reporting convictions to OIG for program exclusion, the Unit's management reported that they have the same difficulties obtaining required information for reporting adverse actions to the NPDB. The Unit director reported that the sentencing documents contain specific information that is used to submit reports of adverse actions to the NPDB. Such information includes the date that the sentence is imposed which is required by the NPDB. As a result, the Unit may not report adverse actions within 30 days of the action as required.

In FY 2012, the Unit did not comply with special grant terms, resulting in a claim of $47,550 in unallowable Federal funds

The Unit did not comply with special grant terms, resulting in $47,550 in unallowable Federal funds in FY 2012. According to Performance Standard 1, Units must conform to all applicable statutes, regulations, and policy directives, including the terms and conditions of the grant award. When the Unit was reorganized under the Georgia Attorney General's Office in 2011, the Unit's police cars were retained by the Georgia Bureau of Investigations. To account for this, OIG added a special term to the Unit's FY 2012 Notice of Award, stating that the Unit's Federal award was being offset and reduced by $47,550. However, the Unit did not reduce its claims by the required amount, resulting in it claiming $47,550 in unallowable Federal funds.

During FYs 2012 through 2014, the Unit's fiscal controls did not ensure accurate and timely recording and reporting of expenditures

During FYs 2012 through 2014, the Unit's accounting systems and procedures did not ensure accurate recording of expenditures or timely determination and reporting of allowable expenditures, as required by the terms of the grant. According to Performance Standard 11, Units must exercise proper fiscal control over their resources.

Subsequent to the period of review, the Unit self-identified several errors that occurred during the review period. Some of the errors included: mistakenly claiming $141,578 in grant expenditures for invoices related to a one-time move of the Unit twice; not initially identifying and claiming allowable expenditures in 2013; and submitting inaccurate required reports for 2012, 2013, and 2014.

CONCLUSION AND RECOMMENDATIONS

For FYs 2012 through 2014, the Georgia Unit reported 34 criminal convictions and 58 civil judgments and settlements, and combined criminal and civil recoveries of $179 million.

We identified areas where the Unit could improve its functioning. Specifically, 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.

We also identified issues with the Unit's required reporting to Federal partners. Specifically, the Unit encountered challenges obtaining information needed for reporting convictions and adverse actions to Federal partners within 30 days as required.

Finally, we found that the Unit did not always exercise proper fiscal control of its resources. Specifically, the Unit did not comply with special terms added to its grant in one year; and did not have fiscal controls necessary to ensure accurate and timely fiscal reporting.

We recommend that the Georgia Unit:

Implement processes to ensure that case files include documentation of supervisory approval for opening and closing cases and periodic supervisory review

The Unit should implement processes to ensure that all case files include documented supervisory approval for opening and closing of cases. Such processes could include mechanisms to alert Unit staff when cases need approval for opening or closing and to ensure that documentation is maintained.

The Unit should implement processes to ensure that periodic case reviews are documented consistent with the Unit's policy. Such processes could include automated reminders to alert Unit staff when cases are due for periodic reviews and to ensure that documentation is maintained.

Implement processes to ensure that convictions and adverse actions are reported to Federal partners within required timeframes

The Unit should implement processes to ensure that convictions are reported to OIG within 30 days and that adverse actions are reported to NPDB within 30 days. Such processes could include contacting the various courts to explain the necessity of receiving copies of sentencing documents so that the Unit can make required reports

within the required timeframes. Additional processes could include automated reminders to alert Unit staff when to report convictions and adverse actions to Federal partners.

Work with OIG to repay the $47,550 offset that should have been made in FY 2012

The Unit should work with OIG to repay the $47,550 offset related to the police cars retained by the Georgia Bureau of Investigations after the Unit's reorganization under the Attorney General's Office.

Implement additional controls to ensure that the Unit's expenditures are accounted for timely, accurately, and in compliance with the terms of the grant

The Unit should evaluate its grant reporting procedures and implement additional controls to prevent errors in required reporting and claims for grant funds. Additional controls could include periodic reviews of Unit expenditures.

UNIT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

The Georgia Unit concurred with all four of our recommendations.

Regarding the first recommendation, the Unit stated that a form noting supervisory approval to open and close an investigation is now included in all case files. The Unit also stated that a form reflecting periodic supervisory reviews of the status of each case is now included in all case files and will be updated on a quarterly basis.

Regarding the second recommendation, the Unit stated that because of the challenges it faces when obtaining required court documents, its ability to report convictions within required timeframes is often outside its control. Nevertheless, the Unit stated that it will continue to report convictions and adverse actions within the required timeframes so long as it is able to do so.

Regarding the third recommendation, the Unit stated that it will repay the offset related to the police cars retained by the Georgia Bureau of Investigations.

Regarding the fourth recommendation, the Unit stated that it has implemented controls to ensure accurate and timely completion of the required reporting and claims for grant funds.

The full text of the Unit's comments is provided in Appendix F.

APPENDIX A

2012 Performance Standards[25]

1. A UNIT CONFORMS WITH ALL APPLICABLE STATUTES, REGULATIONS, AND POLICY DIRECTIVES, INCLUDING:
A. Section 1903(q) of the Social Security Act, containing the basic requirements for operation of a MFCU;
B. Regulations for operation of a MFCU contained in 42 CFR part 1007;
C. Grant administration requirements at 45 CFR part 92 and Federal cost principles at 2 CFR part 225;
D. OIG policy transmittals as maintained on the OIG Web site; and
E. Terms and conditions of the notice of the grant award.
2. 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.
A. The Unit employs the number of staff that is included in the Unit's budget estimate as approved by OIG.
B. The Unit employs a total number of professional staff that is commensurate with the State's total Medicaid program expenditures and that enables the Unit to effectively investigate and prosecute (or refer for prosecution) an appropriate volume of case referrals and workload for both Medicaid fraud and patient abuse and neglect.
C. The Unit employs an appropriate mix and number of attorneys, auditors, investigators, and other professional staff that is both commensurate with the State's total Medicaid program expenditures and that allows the Unit to effectively investigate and prosecute (or refer for prosecution) an appropriate volume of case referrals and workload for both Medicaid fraud and patient abuse and neglect.
D. The Unit employs a number of support staff in relation to its overall size that allows the Unit to operate effectively.
E. To the extent that a Unit maintains multiple office locations, such locations are distributed throughout the State, and are adequately staffed, commensurate with the volume of case referrals and workload for each location.
3. A UNIT ESTABLISHES WRITTEN POLICIES AND PROCEDURES FOR ITS OPERATIONS AND ENSURES THAT STAFF ARE FAMILIAR WITH, AND ADHERE TO, POLICIES AND PROCEDURES.
A. The Unit has written guidelines or manuals that contain current policies and procedures, consistent with these performance standards, for the investigation and (for those Units with prosecutorial authority) prosecution of Medicaid fraud and patient abuse and neglect.
B. The Unit adheres to current policies and procedures in its operations.
C. Procedures include a process for referring cases, when appropriate, to Federal and State agencies. Referrals to State agencies, including the State Medicaid agency, should identify whether further investigation or other administrative action is warranted, such as the collection of overpayments or suspension of payments.
D. Written guidelines and manuals are readily available to all Unit staff, either online or in hard copy.
E. Policies and procedures address training standards for Unit employees.
4. A UNIT TAKES STEPS TO MAINTAIN AN ADEQUATE VOLUME AND QUALITY OF REFERRALS FROM THE STATE MEDICAID AGENCY AND OTHER SOURCES.
A. The Unit takes steps, such as the development of operational protocols, to ensure that the State Medicaid agency, managed care organizations, and other agencies refer to the Unit all suspected provider fraud cases. Consistent with 42 CFR 1007.9(g), the Unit provides timely written notice to the State Medicaid agency when referred cases are accepted or declined for investigation.
B. The Unit provides periodic feedback to the State Medicaid agency and other referral sources on the adequacy of both the volume and quality of its referrals.

[25] 77 Fed. Reg. 32645, June 1, 2012.

C. The Unit provides timely information to the State Medicaid or other agency when the Medicaid or other agency requests information on the status of MFCU investigations, including when the Medicaid agency requests quarterly certification pursuant to 42 CFR 455.23(d)(3)(ii).
D. For those States in which the Unit has original jurisdiction to investigate or prosecute patient abuse and neglect cases, the Unit takes steps, such as the development of operational protocols, to ensure that pertinent agencies refer such cases to the Unit, consistent with patient confidentiality and consent. Pertinent agencies vary by State but may include licensing and certification agencies, the State Long Term Care Ombudsman, and adult protective services offices.
E. The Unit provides timely information, when requested, to those agencies identified in (D) above regarding the status of referrals.
F. The Unit takes steps, through public outreach or other means, to encourage the public to refer cases to the Unit.
5. 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.
A. Each stage of an investigation and prosecution is completed in an appropriate timeframe.
B. Supervisors approve the opening and closing of all investigations and review the progress of cases and take action as necessary to ensure that each stage of an investigation and prosecution is completed in an appropriate timeframe.
C. Delays to investigations and prosecutions are limited to situations imposed by resource constraints or other exigencies.
6. 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.
A. The Unit seeks to have a mix of cases from all significant provider types in the State.
B. For those States that rely substantially on managed care entities for the provision of Medicaid services, the Unit includes a commensurate number of managed care cases in its mix of cases.
D. As part of its case mix, the Unit maintains a balance of fraud and patient abuse and neglect cases for those States in which the Unit has original jurisdiction to investigate or prosecute patient abuse and neglect cases.
C. The Unit seeks to allocate resources among provider types based on levels of Medicaid expenditures or other risk factors. Special Unit initiatives may focus on specific provider types.
E. As part of its case mix, the Unit seeks to maintain, consistent with its legal authorities, a balance of criminal and civil fraud cases.
7. 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.
A. Reviews by supervisors are conducted periodically, consistent with MFCU policies and procedures, and are noted in the case file.
B. Case files include all relevant facts and information and justify the opening and closing of the cases.
C. Significant documents, such as charging documents and settlement agreements, are included in the file.
D. Interview summaries are written promptly, as defined by the Unit's policies and procedures.
E. The Unit has an information management system that manages and tracks case information from initiation to resolution.
F. The Unit has an information management system that allows for the monitoring and reporting of case information, including the following:
1. The number of cases opened and closed and the reason that cases are closed.
2. The length of time taken to determine whether to open a case referred by the State Medicaid agency or other referring source.
3. The number, age, and types of cases in the Unit's inventory/docket

4. The number of referrals received by the Unit and the number of referrals by the Unit to other agencies.
5. The number of cases criminally prosecuted by the Unit or referred to others for prosecution, the number of individuals or entities charged, and the number of pending prosecutions.
6. The number of criminal convictions and the number of civil judgments.
7. The dollar amount of overpayments identified.
8. The dollar amount of fines, penalties, and restitution ordered in a criminal case and the dollar amount of recoveries and the types of relief obtained through civil judgments or prefiling settlements.
8. A UNIT COOPERATES WITH OIG AND OTHER FEDERAL AGENCIES IN THE INVESTIGATION AND PROSECUTION OF MEDICAID AND OTHER HEALTH CARE FRAUD.
A. The Unit communicates on a regular basis with OIG and other Federal agencies investigating or prosecuting health care fraud in the State.
B. The Unit cooperates and, as appropriate, coordinates with OIG's Office of Investigations and other Federal agencies on cases being pursued jointly, cases involving the same suspects or allegations, and cases that have been referred to the Unit by OIG or another Federal agency.
C. The Unit makes available, to the extent authorized by law and upon request by Federal investigators and prosecutors, all information in its possession concerning provider fraud or fraud in the administration of the Medicaid program.
D. For cases that require the granting of "extended jurisdiction" to investigate Medicare or other Federal health care fraud, the Unit seeks permission from OIG or other relevant agencies under procedures as set by those agencies.
E. For cases that have civil fraud potential, the Unit investigates and prosecutes such cases under State authority or refers such cases to OIG or the U.S. Department of Justice.
F. The Unit transmits to OIG, for purposes of program exclusions under section 1128 of the Social Security Act, all pertinent information on MFCU convictions within 30 days of sentencing, including charging documents, plea agreements, and sentencing orders.
G. The Unit reports qualifying cases to the Healthcare Integrity & Protection Databank, the National Practitioner Data Bank, or successor data bases.
9. A UNIT MAKES STATUTORY OR PROGRAMMATIC RECOMMENDATIONS, WHEN WARRANTED, TO THE STATE GOVERNMENT.
A. The Unit, when warranted and appropriate, makes statutory recommendations to the State legislature to improve the operation of the Unit, including amendments to the enforcement provisions of the State code.
B. The Unit, when warranted and appropriate, makes other regulatory or administrative recommendations regarding program integrity issues to the State Medicaid agency and to other agencies responsible for Medicaid operations or funding. The Unit monitors actions taken by the State legislature and the State Medicaid or other agencies in response to recommendations.
10. 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.
A. The MFCU documents that it has reviewed the MOU at least every 5 years, and has renegotiated the MOU as necessary, to ensure that it reflects current practice, policy, and legal requirements.
B. The MOU meets current Federal legal requirements as contained in law or regulation, including 42 CFR § 455.21, "Cooperation with State Medicaid fraud control units," and 42 CFR § 455.23, "Suspension of payments in cases of fraud."
C. The MOU is consistent with current Federal and State policy, including any policies issued by OIG or the Centers for Medicare & Medicaid Services (CMS).
D. Consistent with Performance Standard 4, the MOU establishes a process to ensure the receipt of an adequate volume and quality of referrals to the Unit from the State Medicaid agency.
E. The MOU incorporates by reference the *CMS Performance Standard for Referrals of Suspected Fraud from a State Agency to a Medicaid Fraud Control Unit*.

11. A UNIT EXERCISES PROPER FISCAL CONTROL OVER UNIT RESOURCES.
A. The Unit promptly submits to OIG its preliminary budget estimates, proposed budget, and Federal financial expenditure reports.
B. The Unit maintains an equipment inventory that is updated regularly to reflect all property under the Unit's control.
C. The Unit maintains an effective time and attendance system and personnel activity records.
D. The Unit applies generally accepted accounting principles in its control of Unit funding.
E. The Unit employs a financial system in compliance with the standards for financial management systems contained in 45 CFR 92.20.
12. A UNIT CONDUCTS TRAINING THAT AIDS IN THE MISSION OF THE UNIT.
A. The Unit maintains a training plan for each professional discipline that includes an annual minimum number of training hours and that is at least as stringent as required for professional certification.
B. The Unit ensures that professional staff comply with their training plans and maintain records of their staff's compliance.
C. Professional certifications are maintained for all staff, including those that fulfill continuing education requirements.
D. The Unit participates in MFCU-related training, including training offered by OIG and other MFCUs, as such training is available and as funding permits.
E. The Unit participates in cross-training with the fraud detection staff of the State Medicaid agency. As part of such training, Unit staff provide training on the elements of successful fraud referrals and receive training on the role and responsibilities of the State Medicaid agency.

APPENDIX B

Georgia State Medicaid Fraud Control Unit Referrals by Referral Source for FYs 2012 Through 2014

	FY 2012			FY 2013			FY 2014		
Referral Source	**Fraud**	**Abuse & Neglect**	**Patient Funds**	**Fraud**	**Abuse & Neglect**	**Patient Funds**	**Fraud**	**Abuse & Neglect**	**Patient Funds**
Medicaid agency – PI/SURS[26]	22	2	0	37	0	2	13	7	10
Medicaid agency – other	6	18	14	3	4	17	5	1	7
Managed care organizations	0	0	0	0	0	0	0	0	0
State survey and certification agency	0	0	0	1	0	0	0	0	0
Other State agencies	0	0	0	7	0	0	5	0	0
Licensing board	0	0	0	0	0	0	0	0	0
Law enforcement	9	0	0	1	2	1	2	0	0
Office of Inspector General	5	1	0	7	0	0	4	0	0
Prosecutors	2	0	0	0	0	0	0	0	0
Providers	6	0	0	2	0	0	3	0	1
Provider associations	1	0	0	1	0	0	3	0	0
Private health insurer	0	0	0	0	0	0	0	0	0
Long-term-care ombudsman	0	0	0	0	0	0	1	0	1
Adult protective services	0	0	0	0	0	0	0	0	0
Private citizens	130	8	2	136	2	0	157	2	1
MFCU hotline	0	1	1	0	0	0	0	0	0
Self-generated	0	0	0	0	0	0	0	0	0
Other	13	1	0	6	0	0	4	0	0
Total	**194**	**31**	**17**	**201**	**8**	**20**	**197**	**10**	**20**
Annual Total			**242**			**229**			**227**

Source: OIG analysis of Unit-submitted documentation, 2015.

[26] The abbreviation "PI" stands for program integrity; the abbreviation "SURS" stands for Surveillance and Utilization Review Subsystem.

APPENDIX C

Detailed Methodology

Data collected from the seven sources below was used to describe the caseload and assess the performance of the Georgia MFCU.

Data Collection

Review of Unit Documentation. Prior to the onsite visit, we analyzed information regarding the Unit's investigation of Medicaid cases, including information about the number of referrals the Unit received, the number of investigations the Unit opened and closed, the outcomes of those investigations, and the Unit's case mix. We also collected and analyzed information about the number of cases that the Unit referred for prosecution and the outcomes of those prosecutions.

We gathered this information from several sources, including the Unit's quarterly statistical reports, its annual reports, its recertification questionnaire, its policy and procedures manuals, and its MOU with the State Medicaid agency. Additionally, we confirmed with the Unit director that the information we had was current as of January 2015, and as necessary, we requested any additional data or clarification.

Review of Unit Financial Documentation. To evaluate internal control of fiscal resources, we reviewed policies and procedures related to the Unit's budgeting, accounting systems, cash management, procurement, property, and staffing. We reviewed records in the Payment Management System (PMS)[27] and revenue accounts to determine the accuracy of the Federal Financial Reports (FFRs) for FYs 2012 through 2014. We also obtained the Unit's claimed grant expenditures from its FFRs and the supporting schedules. From the supporting schedules, we requested and reviewed supporting documentation for the selected items. We noted any instances of noncompliance with applicable regulations.

We selected three purposive samples of (1) transactions, (2) items from the Unit's inventory, and (3) documentation related to employees' time and effort. Specifically, using our professional judgment and experience, we selected a purposive sample of

[27] The PMS is a grant payment system operated and maintained by the Department of Health and Human Services, Program Support Center, Division of Payment Management. The PMS provides disbursement, grant monitoring, reporting, and case management services to awarding agencies and grant recipients, such as MFCUs.

100 items from 3,554 non-payroll transactions and manual accounting adjustments. We selected routine and nonroutine transactions representing a variety of budget categories and payment amounts.

We also selected and verified a purposive sample of 30 items from the current inventory list of 263 items. To ensure a variety in our inventory sample, we included items that were portable, high value, or unusual in nature (e.g., a pole camera).

Finally, to assess time and effort, we selected a purposive sample of 30 of 67 Unit employees that were paid during the review period. We selected employees representing a variety of job descriptions, salaries, and durations of employment. For each selected employee, we selected one pay period for review. We then requested and reviewed documentation (e.g., time card records) to support the time and effort of that employee in the selected pay period.

Interviews with Key Stakeholders. In February 2015, we interviewed key stakeholders, including officials in the United States Attorneys' Offices, the State Attorney General's Office, and other State agencies that interacted with the Unit (i.e., the Medicaid Program Integrity Unit, the Office of the State Long-Term Care Ombudsman, and the Healthcare Facility Regulation Division). We also interviewed supervisors from OIG's Region IV offices who work regularly with the Unit. We focused these interviews on the Unit's relationship and interaction with OIG and other Federal and State authorities, and we identified opportunities for improvement. We used the information collected from these interviews to develop subsequent interview questions for Unit management.

Survey of Unit Staff. In February 2015, we conducted an online survey of all 41 nonmanagerial Unit staff within each professional discipline (i.e., investigators, auditors, attorneys, analysts, and nurse investigators) as well as support staff. The response rate was 100 percent. Our questions focused on operations of the Unit, opportunities for improvement, and practices that contributed to the effectiveness and efficiency of Unit operations and/or performance. The survey also sought information about the Unit's compliance with applicable laws and regulations.

Onsite Interviews with Unit Management. We conducted structured interviews with the Unit's management during the onsite review in March 2015. We interviewed the Unit director, chief analyst, chief auditor, chief investigator, chief nurse investigator, and chief prosecutor. We asked these individuals to provide information

related to (1) the Unit's 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, and (4) clarification regarding information obtained from other data sources.

Onsite Review of Case Files and Other Documentation. We requested that the Unit provide us with a list of cases that were open at any point during FYs 2012 through 2014. This list of 743 cases included, but was not limited to, the current status of the case; whether the case was criminal, civil, or global; and the date on which the case was opened. From this list of cases, we excluded 259 cases that were categorized as "global," 45 cases categorized as "assistance rendered," and 7 cases that had been closed prior to the period of our review and thus should not have been included in the list.[28] The remaining number of case files was 432. We limited this population of 432 case files to cases that were open greater than 90 days, which resulted in 236 remaining case files.[29]

From the remaining 236 cases, we selected a simple random sample of 100 cases for review. This sample included 71 cases that were closed at some point during our review. Two of the sampled cases were not reviewed. One was an open case that the Unit was assisting Federal prosecutors with; the Unit was prohibited from releasing any information about the case to parties not involved with prosecuting it. The second was not actually a case file, but rather an open records request; it should not have been eligible for selection in the sample. Exclusion of these two sampled cases brought the total sampled cases we reviewed to 98.

Through our case file review, we determined that not all sampled cases required periodic supervisory review, despite limiting the population to cases that were open greater than 90 days. For 16 sampled cases, the Unit's investigative work ceased prior to the case being open 90 days, but the case was not officially closed until after 90 days. For example, the case may have been referred to another agency prior to 90 days, but the closing memo was not signed until after 90 days. For four more sampled cases, either the

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[28] Ten of the 45 cases categorized as "assistance rendered" were also closed prior to the period of our review.

[29] We limited the population of cases from which we selected the sample to those open greater than 90 days to ensure that every sampled case would be required to have at least one periodic review. We calculated the number of days each case in the population data was open based on the case opened and case closed dates provided to us by the Unit.

opened date or closed date the Unit provided was revised through our case review. Based on the revised opened or closed dates, these four cases were not open greater than 90 days. The one remaining sampled case was a referral that was never opened for full investigation. Only 77 sampled cases required periodic supervisory review.

Using the results of our review of the sampled case files, we made population estimates for various characteristics. All estimates and 95-percent confidence intervals for projections can be found in Appendix E.

From the initial sample of 100 case files, we selected a simple random sample of 50 files for a more indepth review of selected issues, such as the timeliness of investigations and case development. An OIG investigator conducted this indepth review. We did not make any population estimates based on the sample of 50 case files.

Onsite Review of Unit Operations. During our March 2015 onsite visit, we reviewed the Unit's workspace and operations. Specifically, we visited the Unit headquarters in the State capital. While onsite, we observed the Unit's offices and meeting spaces, security of data and case files, location of select equipment, and the general functioning of the Unit.

Data Analysis

We analyzed data to identify any opportunities for improvement and any instances in which the Unit did not fully meet the performance standards or was not operating in accordance with laws, regulations, or policy transmittals.[30]

[30] All relevant regulations, statutes, and policy transmittals are available online at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu.

APPENDIX D

Investigations Opened and Closed By Provider Category for FYs 2012 Through 2014

Table D-1: Fraud Investigations

Provider Category	FY 2012		FY 2013		FY 2014	
Facilities	**Opened**	**Closed**	**Opened**	**Closed**	**Opened**	**Closed**
Hospitals	29	12	28	26	26	20
Nursing facilities	4	3	3	5	1	2
Other long-term-care facilities	1	0	0	0	6	2
Substance abuse treatment centers	1	1	1	0	3	3
Other	10	8	7	12	8	6
Subtotal	**45**	**24**	**39**	**43**	**44**	**33**
Practitioners	**Opened**	**Closed**	**Opened**	**Closed**	**Opened**	**Closed**
Doctors of medicine or osteopathy	23	12	18	25	11	15
Dentists	3	6	5	5	10	7
Podiatrists	0	1	0	0	0	2
Optometrists/opticians	0	0	0	0	2	0
Counselors/psychologists	12	10	10	16	9	7
Chiropractors	0	1	1	0	0	0
Other	5	4	21	9	11	10
Subtotal	**43**	**34**	**55**	**55**	**43**	**41**
Medical Support	**Opened**	**Closed**	**Opened**	**Closed**	**Opened**	**Closed**
Pharmacies	13	4	11	19	19	8
Pharmaceutical manufacturers	28	21	33	125	19	13
Suppliers of durable medical equipment and/or supplies	8	7	9	7	13	4
Laboratories	4	1	9	12	7	2
Transportation services	3	2	2	3	4	3
Home health care agencies	13	3	9	14	13	14
Home health care aides	0	0	0	0	1	1
Nurses, physician assistants, nurse practitioners, certified nurse aides	1	1	0	1	0	0
Radiologists	0	0	0	1	1	2
Medical support—other	16	17	19	22	21	6
Subtotal	**86**	**56**	**92**	**204**	**98**	**53**

Table D-1 (Continued): Fraud Investigations

Program Related	Opened	Closed	Opened	Closed	Opened	Closed
Managed care	2	1	2	6	1	0
Medicaid program administration	2	0	1	3	0	0
Billing company	1	0	1	1	0	1
Other	15	3	9	18	11	11
Subtotal	**20**	**4**	**13**	**28**	**12**	**12**
Total Provider Categories	**194**	**118**	**199**	**330**	**197**	**139**

Source: OIG analysis of Unit-submitted documentation, 2015.

Table D-2: Patient Abuse and Neglect Investigations

Provider Category	FY 2012		FY 2013		FY 2014	
	Opened	Closed	Opened	Closed	Opened	Closed
Nursing facilities	14	17	1	4	3	3
Other long-term-care facilities	1	0	1	2	1	2
Nurses, physician's assistants, nurse practitioners, certified nurse aides	6	6	3	3	1	1
Home health aides	2	2	1	1	1	2
Other	8	7	2	4	5	5
Total	**31**	**32**	**8**	**14**	**11**	**13**

Source: OIG analysis of Unit-submitted documentation, 2015.

Table D-3: Patient Funds Investigations

Provider Category	FY 2012		FY 2013		FY 2014	
	Opened	Closed	Opened	Closed	Opened	Closed
Nondirect care	1	1	2	2	1	1
Nurses, physician's assistants, nurse practitioners, certified nurse aides	2	2	3	3	1	1
Home health aides	0	0	0	0	0	0
Other	7	7	15	13	17	16
Total	**10**	**10**	**20**	**18**	**19**	**18**

Source: OIG analysis of Unit-submitted documentation, 2015

APPENDIX E

Point Estimates and 95-Percent Confidence Intervals Based on Reviews of Case Files

Estimate	Sample Size*	Point Estimate	95-Percent Confidence Interval	
			Lower	Upper
Percentage of case files that lacked documentation of supervisory approval for opening	98*	28.6%	22.2%	35.9%
Percentage of closed case files that included documentation of supervisory approval for closing	71	93.0%	86.7%	96.4%
Percentage of case files that were open longer than 90 days that lacked documentation of periodic supervisory review	77	44.2%	35.8%	52.8%

*Two sampled case files were ineligible to be in the sample. One case file was an open grand jury case for which the Unit could not release information to us; the other one was an open records request rather than an actual case.

Source: OIG analysis of Georgia MFCU case files, 2015.

APPENDIX F

Unit Comments

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August 25, 2015

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For Evaluation and Inspections
Room 5660
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330 Independence Ave SW
Washington, DC 20201

Re: Georgia State Medicaid Fraud Control Unit
2015 Onsite Review OEI-07-15-00090

Dear Ms. Murrin,

This responds to your letter of July 28, 2015, in which you ask that this office comment on each of the recommendations made in the above-referenced onsite review report. I welcome the opportunity to do so.

As a preliminary matter, I want to express my appreciation to the review team for the time and effort that went into the onsite review, and to my own staff and others in the Georgia Department of Law who participated in providing information and documentation to the review team both prior to and during the onsite review. Although I have only been the director of the Unit since 2013, I am very proud of the work done by the dedicated professionals who work in this Unit and who share my goal of providing exceptional service in the fight against Medicaid fraud and patient abuse and neglect.

Recommendation Number One: Implement processes to ensure that case files include documentation of supervisory approval for opening and closing cases and periodic supervisory review.

Response: We concur with this recommendation but note that even prior to the onsite review, steps had been taken to ensure that consistent documentation concerning supervisory approval for opening, reviewing and closing case files was included in all case files. The review covered three fiscal years (FYI2 through FY14) during which a change occurred in the Unit leadership.

Although it is my understanding that supervisory approval was always obtained for opening and closing cases during the time period in question, such approval may not always have been consistently documented in the files on a specific form. Instead, the director's initials were noted in the file as authorizing the opening or closing of a file. In addition, regular case reviews were conducted by supervisors although such reviews were not always individually documented in each case file. It is further my understanding, based on comments at this year's MFCU Directors' Meeting in Washington DC, that there are no standard forms recognized by OIG to be used for the described purpose. Nevertheless, and consistent with the Unit's current policy, a specific form is now included in all case files noting supervisory approval of the opening or closing of an investigation. The files also include a form reflecting periodic supervisory review of the status of each case, which is currently done on at least a quarterly basis.

Recommendation Number Two: Implement processes to ensure that convictions and adverse actions are reported to Federal partners within required timeframes.

Response: Although we concur that convictions and adverse actions should be reported to Federal partners in a timely manner, the timeframe within which those reports are made are often outside the control of the Unit. The report notes that "the Unit encountered challenges obtaining information needed for reporting convictions" in accordance with Performance Standard 8(f) within 30 days of conviction; that "nearly half the Unit's convictions were not reported to OIG for program exclusion within the required timeframe;" and that "just over half of the Unit's adverse actions were not reported to the National Practitioner Data Bank within the required timeframe." At this year's MFCU Directors' Meeting, Tom Sowinski of OIG/HHS indicated that OIG/HHS was aware of the fact that the Units could not control the courts, making adherence to Performance Standard 8(f) impossible in many cases. Given this reality, Performance Standard 8(f) creates an unrealistic demand that actions be taken within a specific time period that is not within the Unit's ability to control. Accordingly, it is unfair to make adverse findings in situations where timely reports were not made for reasons wholly outside the Unit's control. We will, however, continue to report convictions and adverse actions to Federal partners within the specific timeframe so long as it is within the power of the Unit to do so.

Recommendation Number Three: Work with OIG to repay the $47,550 offset that should have been made in FY2012.

Response: We concur with this recommendation, noting only that this finding relates to the transfer of law enforcement motor vehicles to the Georgia Bureau of Investigation after the federal grant for the Georgia Medicaid Fraud Control Unit was transferred from the GBI to the Georgia Department of Law. At the time of the transfer, we worked with the HHS Grants Management Officer to assure proper handling of the transfer but, apparently through a miscommunication, the funds were not deducted from our budgeted funds. We have since discussed the situation with the Grants Management Officer and the money will be repaid by check within five business days of the date of this response.

Recommendation Number Four: Implement additional controls to ensure that the Unit's expenditures are accounted for timely, accurately, and in compliance with the terms of the grant.

Response: We concur with the recommendation, although we note that the specific errors identified in the review were discovered, self-reported and corrected by the Unit prior to the review. We have implemented controls to ensure accurate and timely completion of required reports, including monthly budget comparisons, and believe that errors of the kind noted in the report will not be repeated.

Thank you for the opportunity to provide these responses and for the professionalism and courtesy extended to this office throughout this process. We appreciate your efforts and look forward to continuing to have a good working relationship with HHS/OIG as we pursue the mission of this Unit to investigate and prosecute Medicaid provider fraud and patient abuse and neglect under state law.

Sincerely,

Van Pearlberg
Director,
Medicaid Fraud Control Unit
Georgia Department of Law

VP/jm

cc: Susan Burbach
by email to: Susan.Burbach@oig.hhs.gov

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This report was prepared under the direction of Brian T. Whitley, Regional Inspector General for Evaluation and Inspections in the Kansas City regional office.

Rae Hutchison served as the project leader for this study. Other Office of Evaluation and Inspections staff who conducted the study include Michael P. Barrett and Michala Walker. Office of Investigations staff also participated in the review. Central office staff who provided support include Susan Burbach, Kevin Farber, Lonnie Kim, and Jacquelyn Towns. Office of Audit Services staff who contributed to this study include Beverly Farley and Samantha Forey.

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