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December 2025 | OEI-07-25-00060

Oklahoma Medicaid Fraud Control Unit: 2025 Inspection

REPORT HIGHLIGHTS

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Why OIG Did This Review

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

What OIG Found

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

- The Unit's policies and procedures did not address certain aspects of its operations.
- The Unit took steps to maintain an adequate volume and quality of fraud referrals from the Program Integrity Unit (PIU) and managed care organizations (MCOs), but the Unit received few fraud referrals from these sources during our review period.
- Sixteen percent of cases open during our review period had significant investigative delays.
- The Unit lacked a case management system capable of efficiently managing and reporting case information and performance data.
- The Unit did not consistently conduct and document periodic supervisory reviews of cases during our review period.
- The Unit did not report substantial proportions of its adverse actions and convictions to Federal partners within the required timeframes.
- The Unit's memorandum of understanding (MOU) with the State Medicaid agency generally reflected current practice, policy, and legal requirements, but the MOU did not reference the *CMS Performance Standard for Referrals*.

What OIG Recommends

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

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BACKGROUND

OBJECTIVE

To examine the performance and operations of the Oklahoma 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 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) 2024, combined Federal and State expenditures for the MFCUs totaled approximately $396 million, of which approximately $297 million represented Federal funds.[8]

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

[2] As of December 27, 2020, MFCUs may also receive Federal financial participation to investigate and prosecute abuse or neglect of Medicaid beneficiaries in a noninstitutional or other setting. Consolidated Appropriations Act, 2021, Public Law 116-260, Division CC, § 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 2024.

OIG Grant Administration and Oversight of Medicaid Fraud Control Units

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. Finally, OIG provides ongoing training and technical support to the Units.

In its annual recertification review, OIG examines the Unit's reapplication materials, case statistics, and questionnaire responses from external partners of the Unit. Through the recertification review, 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 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 inspections and reviews.

Oklahoma MFCU

The Oklahoma Unit is located within the Office of the Attorney General (OAG) and has offices in Oklahoma City and Tulsa.[13] The Unit has Statewide authority to prosecute Medicaid provider fraud and cases of patient abuse or neglect. At the time of our inspection in February 2025, the Unit employed 24 staff—6 attorneys (including the Director and the Deputy Director, 3 criminal prosecutors, and 1 civil attorney);

[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] At the time of the inspection, the Unit's Tulsa office was staffed with only one person (an attorney).

12 agents (including 1 Agent in Charge and 1 supervisory agent[14, 15]); 1 data analyst, who served as the Unit's auditor; 1 nurse analyst; and 4 support staff. During our review period of FYs 2022–2024, the Unit spent approximately $10.3 million, with a State share of approximately $2.6 million.

Referrals

During FYs 2022–2024, the Unit reported receiving referrals of potential Medicaid provider fraud and patient abuse or neglect from several sources, including private citizens; law enforcement entities; and other State agencies, including the Oklahoma Department of Human Services and the Oklahoma State Department of Health. An intake committee consisting of the Director, Deputy Director, Agent in Charge, and supervisory agents reviews referrals and decides whether to open a case or decline it for investigation.

Investigations and Prosecutions

Once the Unit opens a case, the supervisory agent assigns the matter to a case team consisting of an agent, a criminal attorney, a civil attorney, a data analyst, and a nurse analyst. The case team participates in periodic supervisory reviews of its cases with the supervisory agent and the Agent in Charge. Upon completion of investigative activities, the case is closed, charged criminally, or filed civilly. If a case is closed without prosecution, the assigned agent completes a case closing request, which must be reviewed and approved by the entire case team, the supervisory agents, the Agent in Charge, the Deputy Director, and the Director.

Oklahoma Medicaid Program

The Oklahoma Health Care Authority (OHCA) administers the Oklahoma Medicaid program. As of March 2025, the program served approximately 896,000 enrollees.[16] During February–April 2024, the Oklahoma Medicaid program began transitioning from a fee-for-service model to serving many enrollees via three managed care organizations (MCOs) and two contracted dental plans. According to an OHCA official, approximately 57 percent of Oklahoma Medicaid enrollees received services through MCOs as of November 2024. In FY 2024, Oklahoma's Medicaid expenditures were approximately $9.3 billion.[17]

[14] The Unit has two supervisory agent positions, but one position was vacant at the time of our inspection. One supervisory agent supervises agents who specialize in fraud investigations, and the other supervisory agent supervises agents who specialize in patient abuse or neglect investigations.

[15] The Agent in Charge serves as the Unit's senior investigator and supervises the supervisory agents.

[16] Centers for Medicare and Medicaid Services (CMS), *Updated March 2025 State Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment Data*. Accessed on Aug. 20, 2025.

[17] OIG, *MFCU Statistical Data for FY 2024*. Accessed on May 12, 2025.

OHCA's Program Integrity Unit (PIU), known as the Program Integrity and Accountability Division, is responsible for Medicaid program integrity efforts. According to the Memorandum of Understanding (MOU) between the Unit and OHCA, OHCA conducts preliminary investigations of potential provider fraud, including matters referred to OHCA by MCOs. The MOU states that after completing a preliminary investigation, OHCA refers all cases of suspected provider fraud to the Unit.[18]

Methodology

OIG conducted an onsite inspection of the Oklahoma MFCU in February 2025. Our inspection covered the 3-year period of FYs 2022–2024. 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 90 case files from the 506 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 review of Unit operations. See the Detailed Methodology.

In examining the Unit's operations and performance, we applied the published performance standards,[19] but 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 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. They are subject to the same internal quality controls as are other OIG evaluations, including internal and external peer review.

[18] An OHCA official confirmed that, within OHCA, the PIU conducts preliminary investigations and refers cases of suspected provider fraud to the Unit.

[19] We evaluated the Unit's adherence to the 2012 performance standards applicable during most of our review period of FYs 2022–2024.

PERFORMANCE ASSESSMENT

Case Outcomes

The Unit reported 55 indictments, 49 convictions, and 17 civil settlements for FYs 2022–2024.

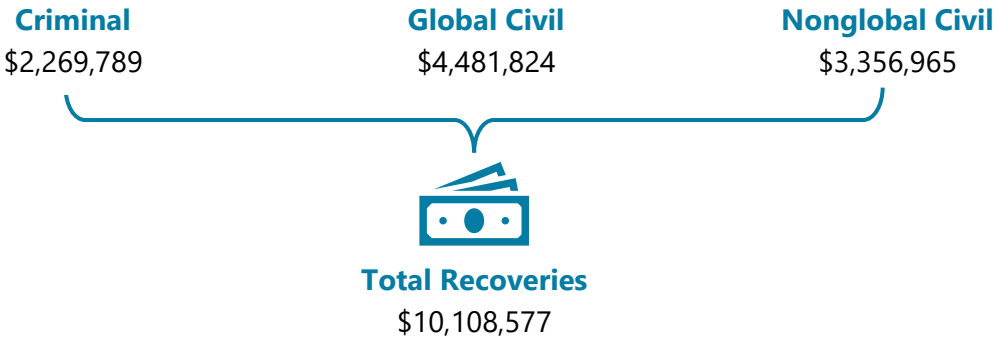
Of the 49 convictions reported by the Unit, 15 involved provider fraud and 34 involved patient abuse or neglect.[20]

55 Indictments

49 Convictions

17 Civil Settlements

The Unit reported combined criminal and civil recoveries of approximately $10.1 million for FYs 2022–2024.



Source: OIG analysis of Unit statistical data, FYs 2022–2024.
Note: "Global" civil recoveries derive from civil settlements or judgments in global cases, which are cases that involve the U.S. Department of Justice and a group of State MFCUs and are facilitated by the National Association of Medicaid Fraud Control Units. Because recoveries are rounded to the nearest dollar, they may not sum exactly.

[20] 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: Unit agents were assigned non-MFCU duties during our review period.

We observed that 24 Unit staff—primarily agents—reported spending a total of 980 hours on various types of non-MFCU activities during our 3-year review period, and we confirmed that the Unit appropriately excluded time spent on these non-MFCU activities from the Federal grant.[21, 22] The Unit reported that, beginning in April 2024, all OAG agents (including those employed by the Unit) must participate every 3–4 weeks in a 1-week on-call roster to support the OAG's Organized Crime Taskforce. The Unit reported that on-call agents may be called to help the taskforce with significant marijuana eradication events. In interviews, agents typically reported that they had been called upon for this assistance only once or twice since April 2024, but when called upon, they could sometimes be required to assist the taskforce for the bulk of a workday. The Unit also reported that, during our review period and on a continuing basis, Unit agents are required to spend one day per month providing security and administrative support at the main OAG office building. Agents reported that this typically entails sitting in an office and that they are able to simultaneously complete MFCU-related tasks such as writing reports. Finally, the Unit reported that Unit agents were assigned to conduct background checks of OAG job candidates beginning in January 2023, but also that these assignments ceased prior to our onsite inspection. Unit managers reported that staff time spent on these non-MFCU activities may have contributed to investigative delays (see the finding under Performance Standard 5).

Observation: The Unit did not comply with three regulations governing MFCUs.

The Unit did not comply with Federal regulation regarding establishing written policy for cooperating with Federal partners (see the finding under Performance Standard 3). Additionally, the Unit did not comply with two Federal regulations regarding reporting adverse actions to the NPDB and reporting convictions to OIG (see the finding under Performance Standard 8).

[21] Federal regulation allows MFCU professional staff to perform non-MFCU assignments for the State government only to the extent that such duties are limited in duration and under the direction and supervision of the MFCU Director. See 42 CFR § 1007.13(d)(3–4). Non-MFCU activities are not allowed to be reimbursed under the Federal grant. See 42 CFR § 1007.19(e)(7).

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

Performance Standard 2: Staffing

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

Observation: The Unit experienced significant agent turnover and reduced the staffing levels of its Tulsa office during our review period.

The Unit experienced turnover of 15 staff, including 11 agents, during or shortly following our review period. Unit managers and other staff attributed the agent turnover to a lack of competitive pay early in our review period, as well as new investigative positions created elsewhere in the OAG and the State that attracted Unit agents. Unit managers and other staff reported that Unit agent pay increased substantially during our review period and is now competitive relative to that of other State agencies.

The Unit reduced the staffing levels of its Tulsa office during our review period. Three agents departed the Tulsa office during this period, and the Unit replaced these vacant positions with positions in its Oklahoma City office. As a result, the Unit's Tulsa office was staffed with only one person (an attorney) at the time of our inspection. Unit managers reported that they planned to wait to restaff the Tulsa office until the Unit could fully staff the office with appropriate supervisors as well as staff from each discipline, to facilitate a collaborative team approach to cases. Managers and agents reported that the lack of investigative staff in the Tulsa office sometimes contributed to long drive times when they conducted investigations.

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 did not address certain aspects of its operations.

According to Performance Standard 3, the Unit should establish written policies and procedures for its operations. The Unit maintained a policies and procedures manual that was updated during our review period; however, we found that the manual did not reflect three aspects of the Unit's operations.

First, the Unit lacked written policy for providing information, coordinating, communicating, and referring appropriate cases to Federal investigators and attorneys, as required by Federal regulation.[23] Nonetheless, we observed that the Unit maintained cooperative working relationships with Federal partners.

Second, the Unit's policies and procedures did not fully address training requirements for data analysts. Performance Standard 3(E) states that the Unit's policies and procedures should address training standards for Unit employees, and Performance

[23] 42 CFR § 1007.11(e)(5).

Standard 12(A) states that the Unit should maintain a training plan for each professional discipline that includes an annual minimum number of training hours. We found that the Unit's policies and procedures manual contained appropriate training requirements for agents and attorneys, but did not include annual minimum training requirements for data analysts. Despite the lack of annual training requirements, the Unit's data analyst completed relevant training during our review period.

Finally, we found that the Unit's policies and procedures manual did not fully address the Unit's process for documenting periodic supervisory reviews of cases. For example, the manual did not specify which staff members were responsible for documenting the reviews or where the documentation should be saved (see the finding under Performance Standard 7).

Performance Standard 4: Maintaining Adequate Referrals

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

Finding: The Unit took steps to maintain an adequate volume and quality of fraud referrals from the PIU and MCOs, but the Unit received few fraud referrals from these sources during our review period.

In accordance with Performance Standard 4, we found that the Unit took steps to maintain an adequate volume and quality of referrals from the State Medicaid agency's PIU. The Unit maintained a positive working relationship with the PIU, with monthly meetings to discuss active cases and potential referrals. The two entities also reported engaging in frequent ad hoc communication; the Unit's data analyst reported talking to PIU staff "almost daily." Further, the Unit and the PIU reported sharing case lists quarterly, and that the PIU sends the Unit a copy of every audit it completes.

During February–April 2024, the Oklahoma Medicaid program began transitioning a majority of enrollees to receiving services via MCOs, and the Unit worked to establish positive working relationships with the MCOs. This included participating in a separate monthly meeting with the PIU and the MCOs to discuss active cases and potential referrals. Unit managers and other staff reported that former MFCU agents were hired as program integrity managers in the three medical MCOs, which contributed to strong working relationships between the MCOs and the MFCU.

Although the Unit maintained positive working relationships and consistent communication with the PIU and MCOs, the Unit did not provide formal training to these entities during our review period on the characteristics of successful fraud referrals. Performance Standard 12(E) states that, as part of cross-training with fraud detection staff of the State Medicaid agency, the Unit should provide training on the elements of successful fraud referrals. Additionally, a recent OIG evaluation found that MCOs that received training from the State Medicaid agency or the MFCU on the

fraud referral process submitted more referrals to MFCUs or other entities.[24] In interviews, PIU and MCO staff reported that the Unit offered guidance on referrals during monthly meetings, but Unit and MCO staff suggested that formal training on this topic from the Unit could be beneficial.

Despite taking some steps to maintain an adequate volume and quality of fraud referrals from the PIU and MCOs, the Unit received few fraud referrals from these sources during our review period. Of the 509 fraud referrals the Unit reported receiving during FYs 2022–2024, only 11 of these referrals came from the PIU. See Appendix A for a list of all referrals by source. Additionally, the Unit did not report receiving any fraud referrals originating from MCOs during February–September 2024.[25] The Unit subsequently reported receiving five fraud referrals during October 2024–July 2025 that originated with MCOs.

Referrals from the State Medicaid agency and MCOs are an essential component of a Unit's ability to effectively investigate and prosecute Medicaid provider fraud. Further, Federal regulation requires the PIU to refer all cases of suspected provider fraud to the Unit.[26] However, the low number of fraud referrals the Unit receives from the PIU is a continuing concern—OIG's 2014 review of the Oklahoma Unit similarly found that the Unit received few fraud referrals from the PIU in FYs 2013 and 2014.[27]

Performance Standard 5: Maintaining Continuous Case Flow

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

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

Performance Standards 5(A) and 5(C) state that each stage of an investigation should be completed within an appropriate timeframe and delays to investigations should be limited to situations imposed by resource constraints or other exigencies. From our review of a sample of Unit case files open during FYs 2022–2024, we found that 16 percent of cases open during this period had significant delays in the investigation. In five of these cases, the case file indicated that the investigation did not commence until 5 months to 1 year after the Unit opened the case. We also identified three other cases that contained little or no evidence of investigative activities for periods ranging from just under 6 months to 1.5 years. See Appendix B for point estimates and confidence intervals from our case file review.

[24] OIG, *Some Medicaid Managed Care Plans Made Few or No Referrals of Potential Provider Fraud* (OEI-03-22-00410), September 2025.

[25] An MCO manager acknowledged that "for the first few months [of the MCO's operations in Oklahoma], there weren't a lot of claims data." This may have limited MCO referrals during our review period.

[26] 42 CFR § 455.15(a)(1).

[27] OIG, *Oklahoma State Medicaid Fraud Control Unit: 2014 Onsite Review* (OEI-06-14-00630), April 2016.

Investigative delays may have reduced the effectiveness of the Unit's investigations in some instances. For example, delays in initiating investigative activities after opening a case can impact a Unit's ability to obtain and use credible witness testimony or other evidence. In one case, we found, interviews of key witnesses did not take place until a year after case opening, and witnesses reported not remembering important details. We also identified a case involving patient abuse or neglect that exceeded the statute of limitations because of delays in the investigation. By impacting the prosecutorial viability of cases, investigative delays can allow suspects to continue to commit fraud and/or patient abuse or neglect.

The Unit's case intake process may have contributed to relatively high caseloads for agents and investigative delays. Unit managers reported that the Unit lacked established criteria for determining which referrals should be opened as cases.[28] Further, managers reported that agent supervisors did not have sufficient time to conduct preliminary reviews of referrals to evaluate their relative merits as cases. The lack of a consistent, selective process for opening cases may have limited the Unit's ability to focus its investigative resources on its most meritorious cases, which may have contributed to relatively high caseloads for agents. At the time of the inspection, Unit managers and other staff reported typical caseloads of approximately 20 cases for agents specializing in patient abuse or neglect investigations and 15 cases for agents specializing in fraud investigations.[29] Unit managers and other staff reported that these caseloads contributed to investigative delays. After our onsite inspection, the Director reported that the Unit hired an intake officer, with the intention of implementing a more deliberate approach to the case intake process.

Agent turnover, a lack of consistent supervisory reviews of cases during our review period, and staff time spent on non-MFCU activities may have also contributed to investigative delays. Eleven agents left the Unit during or shortly following our 3-year review period, and reassigning cases following an agent's departure can result in increased caseloads for other agents. Further, case reassignments can delay investigations because newly assigned agents must spend time familiarizing themselves with the case. We also found that the Unit did not consistently conduct and document supervisory reviews of cases during our review period, including during a 1-year period when the Unit ceased conducting formal reviews (see the finding under Performance Standard 7). Without consistent supervisory reviews of all cases in the Unit's caseload, supervisors may not be able to effectively prioritize investigative resources across cases to ensure that cases are completed in an appropriate timeframe. Additionally, Unit managers reported that staff time spent on non-MFCU activities may have contributed to investigative delays.

[28] For example, managers reported that the Unit lacked criteria for opening a case based on the severity of the allegation.

[29] Caseloads can vary from time to time for various reasons, and these estimates may not reflect agents' consistent caseloads throughout our review period.

Performance Standard 6: Case Mix

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

Observation: The Unit's case mix included both fraud and patient abuse or neglect cases and covered a range of provider types.

Of the 892 cases that were open during FYs 2022–2024, 66 percent (588 cases) involved provider fraud and 34 percent (304 cases) involved patient abuse or neglect. During this period, the Unit's cases covered 61 different provider types, including pharmaceutical manufacturers, nurse's aides, and nursing facilities.

Performance Standard 7: Maintaining Case Information

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

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

Performance Standards 7(E) and 7(F) state that the Unit should have an information management system that manages and tracks case information and that allows for the monitoring and reporting of case information. During our review period, the Unit used an electronic case management system that lacked capabilities for efficiently managing and reporting case information and performance data. Unit managers and other staff reported that the case management system was cumbersome to use, and that the system was designed for managing prosecutions rather than investigations. As a result, agents stored investigative documents on a shared drive, and then moved the documents to the electronic case management system at the conclusion of the investigation. The electronic case management system also lacked functionality for monitoring performance data and reporting them to OIG and other agencies. Unit staff manually maintained a case tracking spreadsheet for these purposes, which resulted in inaccurate data. For example, during our inspection, we identified—and the Unit corrected—inaccuracies in the numbers of convictions the Unit reported annually to OIG.

At the time of the inspection, the OAG was in the process of replacing the Unit's electronic case management system with two separate OAG-wide systems for managing investigations and prosecutions. The case management system for investigations was implemented following our onsite inspection, and the Unit reported that the OAG plans to implement the system for prosecutions in 2026. Unit managers said they anticipated that the Unit would also continue to store case information on its shared drive alongside these two new systems. Further, the Director reported that, until the case management system for prosecutions is implemented, the Unit would continue to use its current case management system alongside the new system for investigations and the shared drive.

In addition to the deficiencies of the case management system the Unit used during our review period, we identified two potential concerns with the two new case management systems that could impact the Unit's overall performance. First, case information would be stored across at least three different repositories (i.e., the two case management systems, a shared drive, and potentially a case tracking spreadsheet). This can lead to organizational challenges and could create a risk of missing documents during discovery. Given the significant agent turnover in the Unit, it is particularly important that Unit staff—including any staff who may be newly assigned to an ongoing case—be able to efficiently locate case information. The Director said that the OAG's request for the new case management system for prosecutions included a requirement that the system would communicate with the case management system for investigations.

Second, at the time of the inspection, Unit managers and other staff said they anticipated that the two new systems may not have adequate functionality for monitoring and reporting performance data, including the performance data Units report annually to OIG. This could limit Unit managers' ability to monitor the Unit's performance and report performance data without investing staff time and effort to manually track this information. Further, manually tracking performance data may lead to inaccuracies and inconsistencies in data that are stored in duplicate across multiple repositories.

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

Performance Standard 7(A) states that reviews by supervisors should be conducted periodically, consistent with the Unit's policies and procedures, and the reviews should be noted in the case file. During our review period, the Unit's policies and procedures manual stated that supervisory reviews should be conducted quarterly. According to Unit staff, supervisory review meetings during our review period included the case team, the supervisory agent, the Agent in Charge, the Deputy Director, and the Director.

Unit managers and other staff reported that the Unit ceased conducting formal, documented supervisory reviews during September 2023–September 2024 because managers and other staff considered the review meetings overly time-consuming and unhelpful. Unit managers reported that supervisors and teams continued to discuss cases during this period, but these discussions were informal and typically undocumented. At the time of the inspection, Unit managers and other staff reported that the Unit had resumed conducting quarterly supervisory review meetings, but the Director and Deputy Director no longer attended the meetings.

From our review of Unit case files, we found that 39 percent of applicable cases were missing documentation of some or all quarterly supervisory reviews. OIG's 2014 review of the Oklahoma Unit similarly found that 42 percent of applicable Unit case files lacked documentation of periodic supervisory reviews during FYs 2012–2014.

The Unit's policies and procedures manual did not fully address the Unit's process for documenting periodic supervisory reviews of cases, which may have contributed to

the absence of documentation of reviews. Specifically, the manual did not state which staff members were responsible for documenting the reviews or where the documentation should be saved. In practice, the Unit used a form to document the reviews, and supervisory agents (with the assistance of administrative support staff, if needed) added the completed forms to the electronic case files. However, Unit managers reported that the supervisory agents and support staff did not consistently add completed case file review forms to the case files during our review period.

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 maintained positive working relationships with Federal law enforcement partners.

We observed that the Unit maintained a positive working relationship with OIG's Office of Investigations (OI). During our review period, the Unit and OI jointly investigated a total of 15 cases, and Unit and OI managers and other staff reported engaging in consistent case-specific communication.

The Unit also maintained positive working relationships with the U.S. Attorney's Offices (USAOs) in Oklahoma. In particular, the Unit maintained strong, collaborative working relationships with both the criminal and civil divisions of the USAO for the Western District. Staff from the Unit and the USAO for the Western District reported consistently investigating cases jointly, with strong communication between the two entities. One of the Unit's attorneys was also appointed as a Special Assistant U.S. Attorney in the Western District. Although the Unit primarily worked with the USAO for the Western District, the Unit also maintained positive working relationships with the USAOs for the Northern and Eastern Districts.[30] The Unit investigated a small number of cases during our review period with the USAOs for the Northern District and the Eastern District, and managers and other staff from the Unit and the USAO for the Eastern District reported working to increase their communication during our review period.

Managers and other staff from the Unit and partner agencies reported coordinating through quarterly Health Care Fraud Taskforce meetings, which included representatives from the Unit, OI, the USAO for the Western District, and other Federal agencies.

[30] Unit managers and other staff reported that the Unit works most closely with the USAO for the Western District because the Unit typically files its fraud cases in Oklahoma County, which is where the USAO for the Western District is located.

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

Federal regulation requires Units to report any adverse actions resulting from investigations or prosecutions of health care providers to the NPDB within 30 days of the final adverse action.[31, 32] We found that the Unit did not report any of its 48 adverse actions during our review period to the NPDB within the required timeframe; all 48 were submitted more than 90 days after the action date. OIG's 2014 review of the Oklahoma Unit also found that the Unit did not report 38 percent of its adverse actions to the NPDB within the required timeframe.

Federal regulation also requires Units, for the purpose of excluding convicted parties from Federal health care programs, to transmit information on all convictions to OIG within 30 days of sentencing, or "as soon as practicable" if the Unit encountered delays in receiving the necessary information from the court.[33] We found that the Unit did not report nearly half (24/49) of its convictions during our review period to OIG within the required timeframe. Of the 24 convictions submitted late to OIG, 12 were submitted over 90 days after sentencing. OIG's 2014 review of the Oklahoma Unit similarly found that the Unit did not report 45 percent of its convictions to OIG within the required timeframe.

Prior to September 2024, the Unit's policies and procedures manual did not contain procedures for submitting adverse actions and convictions to the NPDB and OIG, which may have contributed to the lateness of submissions.[34] In September 2024, the Unit updated its manual to include procedures requiring attorneys to notify the Director and administrative assistant of reportable convictions or civil judgments within 10 days of the action date and provide the required documentation to the administrative assistant. The updated manual also stated that prior to closing a case, the agent should verify that all necessary reporting to the NPDB and OIG has occurred.

Unit managers attributed the late submissions to the NPDB and OIG to staff turnover and a lapse in oversight by Unit management. The administrative assistant who was previously responsible for reporting adverse actions and convictions to the NPDB and OIG left the Unit in 2021. According to the Director, Unit management did not verify that NPDB reporting continued after the staff member left, and the Unit's NPDB submissions did not resume until 2024. The Director also stated that he had not

[31] 45 CFR § 60.5. Examples of adverse actions include, but are not limited to, health care-related criminal convictions and civil judgments (but not civil settlements), and program exclusions. See SSA §§ 1128E(a) and (g)(1).

[32] 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.

[33] 42 CFR § 1007.11(g). Also, Performance Standard 8(F) states that Units should transmit convictions to OIG within 30 days of sentencing. The 2024 updated Performance Standard 8(G) reflects the regulatory language at 42 CFR § 1007.11(g).

[34] Prior to September 2024, the manual did contain procedures for submitting adverse actions to a legacy data bank that became part of the NPDB in 2013.

realized the Unit was frequently exceeding the required timeframe for submitting convictions to OIG.

Performance Standard 9: Program Recommendations

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

Observation: The Unit made program recommendations to the State Medicaid agency during our review period.

During our review period, the Unit made three written recommendations to the State Medicaid agency to limit potentially improper payments. In one instance, the Unit identified incorrect payment rates for a covered service and alerted the State Medicaid agency to the inaccuracies. As a result, the State Medicaid agency reported to the Unit that it had corrected the payment rates. In another instance, the Unit identified potential overpayments for dental exams and recommended that the State Medicaid agency take steps to prevent such overpayments. In response, the State Medicaid agency reported to the Unit that it had implemented a claims edit to mitigate this issue. In a third instance, the Unit alerted the State Medicaid agency to potentially inappropriate payments being made for care coordination services and recommended that the State Medicaid agency take steps to prevent such inappropriate payments. The Unit reported that the State Medicaid agency had not implemented this recommendation as of October 2025.

Performance Standard 10: Agreement with Medicaid Agency

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

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

According to Performance Standard 10(E), the Unit's MOU with the State Medicaid agency should incorporate by reference the *CMS Performance Standard for Referrals of Suspected Fraud From a State Agency to a Medicaid Fraud Control Unit*.[35] We found that the Unit's MOU with the State Medicaid agency was last updated in July 2024 and generally reflected current practice, policy, and legal requirements. However, the MOU did not incorporate by reference the *CMS Performance Standard for Referrals*.

[35] The *CMS Performance Standard for Referrals* defines minimum criteria for information a State Medicaid agency should provide to a MFCU as part of a referral of suspected provider fraud.

Performance Standard 11: Fiscal Control

A Unit exercises proper fiscal control over its resources.

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

From the Unit's responses to a detailed fiscal controls questionnaire and follow-up with fiscal staff, we identified no significant issues related to the Unit's budget process, accounting system, cash management, procurement, property, or personnel. In our inventory review, we identified no significant concerns regarding the 30 sampled inventory items.

Performance Standard 12: Training

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

Observation: Unit staff generally met the Unit's training requirements.

From the information we reviewed, professional staff completed training that aided in the mission of the Unit, including training provided by the National Association of Medicaid Fraud Control Units. The Unit's agents and attorneys generally met the requirements outlined in the Unit's training plan. Although the Unit's training plan did not include annual minimum training requirements for data analysts (see the finding under Performance Standard 3), the Unit's data analyst also completed relevant training during our review period.

CONCLUSION AND RECOMMENDATIONS

The Oklahoma MFCU reported case outcomes of 55 indictments, 49 convictions, 17 civil settlements, and approximately $10.1 million in recoveries for FYs 2022–2024. From the information we reviewed, we observed that the Unit maintained positive working relationships with external partners; made recommendations to the State Medicaid agency to limit improper payments; and worked fraud and patient abuse or neglect cases involving a mix of provider types.

We also identified areas in which the Unit should improve its compliance with Federal regulations; improve its adherence to performance standards; and/or strengthen aspects of its operations. We made the following recommendations to the Oklahoma Unit.

Update its policies and procedures manual to address certain aspects of its operations

The Unit should update its policies and procedures manual to ensure that the Unit complies with certain Federal regulatory requirements and that it adheres to the performance standards. This should include establishing written policies for coordinating with Federal investigators and attorneys in accordance with Federal regulation.[36] Additionally, this should include updating its policies and procedures manual to specify annual minimum training requirements for data analysts.

Build upon its efforts to increase the volume and quality of fraud referrals from the PIU and MCOs

The Unit should continue and expand upon its current efforts to communicate and collaborate with the PIU and MCOs. As part of its continued efforts to receive an adequate volume and quality of referrals from the PIU and MCOs, the Unit should develop supplemental or more formalized training about the characteristics of quality fraud referrals and the referral process.

Take steps to mitigate investigative delays

The Unit should take steps to identify and address factors contributing to investigative delays. This should include evaluating its case intake process and, as appropriate, implementing modifications to this process. The Unit could consider establishing a uniform set of standards for determining which referrals will be opened for investigation. For example, the Unit could assess whether the matter falls within

[36] 42 CFR § 1007.11(e)(5).

the MFCU grant authority, the extent of harm, the likelihood of repeat conduct, and the Unit's capacity to investigate the case within an appropriate timeframe. These standards could enable the intake officer to effectively evaluate which referrals merit further investigation and which should be declined or referred to other agencies. By focusing its resources on the cases most likely to result in successful adjudication, the Unit can optimize the use of its limited resources and reduce agents' caseloads, thereby mitigating investigative delays. Additionally, the Unit should assess the extent to which non-MFCU duties pose a conflict with Unit operations (e.g., by contributing to investigative delays) and, as appropriate, take steps to mitigate the impact of non-MFCU assignments on case progression.

Take steps to implement a case management system capable of efficiently managing and reporting case information and performance data

The Unit should take steps to implement a case management system that can efficiently manage and report case information and Unit performance data. Specifically, the Unit should work with the OAG to either: (a) implement a single case management system that fully addresses the Unit's needs (including, but not limited to, those detailed below); or (b) ensure that the OAG-wide case management systems contain features that fully address the Unit's needs.

To support the effective operation and performance of the Unit, the case management system or systems should address two core needs. First, the system(s) should allow Unit managers and other staff to efficiently manage (i.e., store, retrieve, and organize) case information. If the Unit uses multiple case management systems, the systems should include functionality for synchronizing case information across the multiple repositories. Second, the system(s) should allow for efficient monitoring and reporting of case information and performance data. The system(s) should include data fields and functionality for generating reports of pertinent case information (e.g., joint case information) and performance data (including data reported annually to OIG).

Take steps to conduct and document periodic supervisory reviews of cases in accordance with Unit policy

To help ensure consistent case progression, the Unit should take steps to ensure that supervisory reviews of cases are conducted periodically, consistent with Unit policy and MFCU performance standards, and that the reviews are documented in case files. This should include fully addressing in its policies and procedures manual its process for documenting supervisory reviews, including specifying which staff members are responsible for documenting the reviews and where this documentation should be saved.

Take steps to ensure that it reports all convictions and adverse actions to Federal partners within the appropriate timeframes

The Unit should take steps to ensure that it reports all convictions to OIG within 30 days of sentencing, or as soon as practicable if there are delays in receiving the necessary information from the court. The Unit should also take steps to ensure that it reports all adverse actions to the NPDB within 30 days of the action. These steps should include ensuring that all pertinent Unit staff receive training on these reporting requirements and are aware of their roles and responsibilities in the reporting process.

Revise its MOU with the State Medicaid agency to reference the CMS Performance Standard for Referrals

In accordance with Performance Standard 10(E), the Unit should revise its MOU with the State Medicaid agency to reference the *CMS Performance Standard for Referrals of Suspected Fraud From a State Agency to a Medicaid Fraud Control Unit*.

UNIT COMMENTS AND OIG RESPONSE

The Oklahoma Unit concurred with all seven recommendations.

First, the Unit concurred with our recommendation to update its policies and procedures manual to address certain aspects of its operations. The Unit reported that it plans to update sections of its policies and procedures manual pertaining to coordinating with Federal investigators and attorneys. The Unit also reported that it plans to update the manual with additional details regarding annual training requirements for data analysts.

Second, the Unit concurred with our recommendation to build upon its efforts to increase the volume and quality of fraud referrals from the PIU and MCOs. The Unit reported that it recently began providing training to PIU and MCO staff, including training on the characteristics of effective referrals and a case study of a recent successful enforcement.

Third, the Unit concurred with our recommendation to take steps to mitigate investigative delays. In addition to hiring an intake officer, the Unit reported developing case opening criteria; increasing Unit leadership's oversight of cases with potential delays; and engaging in discussions with OAG leadership regarding non-MFCU duties assigned to Unit staff.

Fourth, the Unit concurred with our recommendation to take steps to implement a case management system capable of efficiently managing and reporting case information and performance data. Although the Unit reported that the OAG had not yet implemented one of the two OAG-wide case management systems, the Unit wrote that preliminary information indicated that the two OAG-wide case management systems will allow data to be consolidated across the two repositories. The Unit also reported, on the basis of preliminary information, that the two systems will allow the Unit to monitor and report pertinent case information and performance data.

Fifth, the Unit concurred with our recommendation to take steps to conduct and document periodic supervisory reviews of cases in accordance with Unit policy. The Unit reported that it is in the process of updating its policies and procedures manual to include additional details regarding its periodic supervisory review process, including how the reviews should be documented.

Sixth, the Unit concurred with our recommendation to take steps to ensure that it reports all convictions and adverse actions to Federal partners within the appropriate timeframes. The Unit reported that it is in the process of updating sections of its policies and procedures manual pertaining to reporting convictions and adverse actions. Further, the Unit reported implementing a checklist that must be completed at the resolution of any enforcement, and that the checklist includes prompts to help ensure appropriate and timely reporting of pertinent actions. The Unit also reported creating a compliance coordinator position to monitor these reporting requirements.

Seventh, the Unit concurred with our recommendation to revise its MOU with the State Medicaid agency to reference the *CMS Performance Standard for Referrals*. The Unit reported that it is working to update the MOU to include this reference.

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

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

DETAILED METHODOLOGY

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 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 2022–2024. Additionally, we examined the recommendations from OIG's 2014 onsite review of the Oklahoma 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. 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 OAG 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 January 2025, we interviewed external partners of the Unit, including officials from the PIU; the Long-Term Care Ombudsman's office; an MCO; OI; and the USAOs for the Northern, Western, and Eastern Districts of Oklahoma. We focused these interviews on the Unit's relationships and interactions with the external partners, as well as opportunities for improvement. We used the information collected from these interviews to develop subsequent interview questions for Unit management and other staff.

Onsite Interviews with Unit Management and Other Selected Staff

We conducted structured interviews with the Unit's management and other selected staff in February 2025. Of the Unit management, we interviewed the Director, Deputy Director, Agent in Charge, and supervisory agent. In addition, we interviewed five agents, three attorneys, the data analyst, and the nurse analyst. Finally, we interviewed the supervisor of the Unit, a Senior Deputy Attorney General in the OAG. 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 Review of Case Files

To craft a sampling frame, we requested that the Unit provide us with a list of cases that were open at any time during FYs 2022–2024 and include the status of each case; whether the case was criminal, civil, or global; and the dates on which the case was opened and closed, if applicable. The total number of cases that met these parameters was 892.

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 386 global cases, leaving 506 case files.

We then selected a simple random sample of 90 cases from the population of 506 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.

We reviewed the 90 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.

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

We also reviewed all 49 convictions during our review period that the Unit submitted to OIG for program exclusion and all 48 adverse actions during our review period that the Unit 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 for FYs 2022–2024. We also assessed the timeliness of the submissions to OIG and the NPDB.

Onsite Review of Unit Operations

During the onsite inspection, we observed the workspace and operations of the Unit's primary office in Oklahoma City. 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: Unit Referrals by Source for Fiscal Years 2022–2024

Referral Source	FY 2022		FY 2023		FY 2024		3-Year Total		
	Fraud	Abuse or Neglect	Fraud	Abuse or Neglect	Fraud	Abuse or Neglect	Fraud	Abuse or Neglect	Total
Adult Protective Services	0	2	0	0	0	6	0	8	8
Anonymous	6	2	12	2	1	0	19	4	23
HHS-OIG	0	0	7	1	3	0	10	1	11
Law enforcement—other	6	43	11	66	7	59	24	168	192
Licensing board	0	0	2	19	5	18	7	37	44
Local prosecutor	0	0	0	6	0	0	0	6	6
Long-Term Care Ombudsman	0	7	0	3	1	3	1	13	14
Medicaid agency—other	0	0	1	0	0	0	1	0	1
Medicaid agency—PIU*	2	1	3	0	6	0	11	1	12
Private citizen	72	46	72	25	79	23	223	94	317
Provider	3	1	9	4	4	5	16	10	26
State agency—other	4	7	36	4	70	8	110	19	129
State survey and certification agency	0	0	0	2	0	0	0	2	2
Other	0	0	43	1	44	4	87	5	92
Subtotal	**93**	**109**	**196**	**133**	**220**	**126**	**509**	**368**	**877**
Total	**202**		**329**		**346**		**877**		

Source: OIG analysis of Oklahoma MFCU data, 2025.
* Note: Beginning in February 2024, Oklahoma Medicaid began transitioning many enrollees to receiving services via MCOs. None of the FY 2024 referrals from the PIU originated with MCOs.

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

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval	
			Lower	Upper
Percentage of cases without documentation of supervisory approval to open	85	1.2%	0.2%	6.1%
Percentage of applicable cases missing some or all documentation of periodic supervisory reviews	66	39.4%	28.3%	51.4%
Percentage of applicable cases with significant investigative delays	81	16.0%	9.3%	25.1%
Percentage of closed cases without documentation of supervisory approval to close	58	0.0%	0.0%	5.9%

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

OFFICE OF ATTORNEY GENERAL
STATE OF OKLAHOMA

December 1, 2025

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

Re: Oklahoma Medicaid Fraud Control Unit 2025 Inspection
OEI-07-25-00060

Dear Deputy Director Maxwell,

The Oklahoma Medicaid Fraud Control Unit (MFCU) of the Oklahoma Attorney General's Office (OAG) has reviewed the draft report dated October 28, 2025, in relation to the on-site review made in February 2025. This document sets forth the MFCU's formal response to the findings and recommendations included in the draft report.

As an initial matter, we want to take this opportunity to commend the members of the on-site team for their preparation, collegiality, and professionalism. Our staff found the experience to be a positive one, and we have already seen improvements to our operations.

Regarding the draft report, we concur with all the recommendations, and submit the following additional comments and observations related thereto.

Recommendation 1: Update its policies and procedures manual to address certain aspects of its operation.

The Unit concurs with this Recommendation.

The Unit continues to review periodically (and update as necessary) its Policy and Procedures Manual ("PPM") as it works to improve its ability to carry out its mission in an increasingly complex environment. While the PPM already includes language addressing these areas, we acknowledge that additional details can be included. Among the areas designated for updates are: (a) the supplementation and additional guidance on providing information to, coordinating with, and referring appropriate cases to Federal investigators and attorneys, consistent with 42 CFR

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1007.11(e)(5); and (b) updating the Unit's training matrices to include more details regarding the annual training and continuing education of auditors and data analysts. (The Unit notes that that Auditor/Analyst regularly attended appropriate training during the review period.)

The Unit anticipates all PPM updates and revisions will be completed within the next sixty days.

Recommendation 2: Build upon its efforts to increase the volume and quality of fraud referrals from the PIU and MCOs.

The Unit concurs with this Recommendation.

Even prior to the 2024 introduction of managed care into the Oklahoma Medicaid system, the PIU (Program Integrity Unit of the Oklahoma Health Care Authority) and MFCU recognized the need for increased communication, collaboration, and education, and met periodically. The arrival of managed care heightened that need. In 2024, the PIU, MFCU, and Managed Care Organizations (MCOs), scheduled and took part in regular, monthly meetings, most of which occurred remotely, but some were in-person. In 2025, the MFCU began providing live training to MCO and PIU personnel. The first training was conducted by the MFCU Director, at an in-person meeting, hosted by the PIU at the Oklahoma Health Care Authority (OHCA), the State's Medicaid agency. The training, which included lectures and a Q&A session, focused on what makes an effective referral. In a subsequent event, MFCU personnel, (including an agent, nurse analyst, and attorney), presented a live case study of a recent successful enforcement, starting with the case opening and concluding with the final enforcement's successful resolution. The audience was a nationwide meeting of one MCO's Special Investigations Unit ("SIU") personnel from across the country. Both 2025 events yielded positive feedback from the MCOs.

More training events and communications are contemplated, including the scheduling of regular training opportunities for PIU and MCO personnel.

Recommendation 3: Take steps to mitigate investigative delays.

The Unit concurs with this Recommendation.

The Unit has already implemented improvements, including the addition of an Intake Officer and the development of case opening criteria. The Unit has an ongoing dialogue with OAG leadership in hopes of reducing non-MFCU work for Unit staff, particularly MFCU Agents, to ensure MFCU personnel stay focused on MFCU investigations, enforcement, compliance, and administration.

During the budget creation and approval process in 2024, for Federal Fiscal Year 2025, MFCU leadership planned for the addition of a dedicated Intake Officer. The Unit's efforts included the design of the position's duties and tasks, a renewed focus on finding better ways to intake and evaluate referrals, and deliberations on case-opening criteria and setting minimum qualifications for opening new matters.

In May 2025, the MFCU hired its first Intake Officer. The Intake Officer's process includes gathering complete intake information, following up on pre-investigation items for clarification or supplementation, and presenting materials to the MFCU supervisory agents and leadership for decisions about which intakes should be opened as cases, declined for investigation, or referred elsewhere. The newly enacted process has increased the quality and completeness of new cases, given the team a stronger starting position on each new case, and freed up some time for

supervisory agents to provide more direct supervision of their subordinate agents and their investigations.

Further, MFCU leadership have increased their scrutiny of cases that might be slow to start, cases that have periods of investigative inactivity, and investigations showing signs of "investigative creep".

Additionally, the Unit and OAG leadership have been assessing the extent to which "off grant" non-MFCU duties and responsibilities conflict with MFCU operations and/or contribute to investigative delays in MFCU cases. As part of an ongoing internal discussion, the OAG is in the process of determining ways to alleviate non-MFCU demands made of MFCU personnel and resources.

Recommendation 4: Take steps to implement a case management system capable of efficiently managing and reporting case information and performance data.

The Unit concurs with this Recommendation.

The Unit's case management system during the review period was a combination of several different programs, records, and storage mechanisms. During the on-site team's review, the OAG was in the process of moving all OAG Agent-related records and reports into a new software solution (ACISS). The OAG had planned, but not yet implemented, the migration of all non-Agent materials into a second software solution (KARPEL PBK). The two new programs will interface with each other, but their implementation has not been concluded. The OAG's scheduled completion date for the dual migration of MFCU's materials is March 2026.

Based on initial information, it appears that the combined two software systems will allow for the consolidation of storage repositories. The combined systems will also allow for reporting, both *ad hoc* and routine, of statistical information such as the number of cases assigned per Agent and Assistant Attorney General, provider types being investigated, hours logged in any given case, etc. The new systems will allow for Unit leadership to have increased insights into asset allocation, case progression and success rates. This should also allow for easier reporting of the Unit's Annual Statistical Report.

Recommendation 5: Take steps to conduct and document periodic supervisory reviews of cases in accordance with Unit policy.

The Unit concurs with this Recommendation.

The MFCU utilizes quarterly reviews of its cases. The Unit is in the process of updating its PPM to improve its ability to carry out its mission in an increasingly complex environment. While the PPM already includes language addressing the areas of periodic case reviews, additional details can be included. Among the areas designated for updates are: (a) the regular, quarterly frequency of case reviews, and (b) the recording of relevant reviews, updates to investigative plans, and assessments in the case files. These reviews and documentation are the responsibility of the MFCU's supervisory agents. The Unit will complete these updates (including these two, and others) in the next sixty days.

Recommendation 6: Take steps to ensure it reports all convictions and adverse actions to Federal partners within the appropriate timeframes.

The Unit concurs with this Recommendation.

As noted above, the Unit is in the process of updating its PPM in several areas, one of which is compliance with the reporting of convictions and related information to partners like the National Practitioner Data Bank (NPDB) and OIG's Exclusions Branch. The Unit has implemented a checklist that must be completed at the resolution of any enforcement that includes prompts to ensure appropriate and timely notifications. The Unit also created the new position of Compliance Coordinator to monitor these ongoing but variable obligations. The Unit also notes that its FFY 2025 reporting to both NPDB and OIG Exclusion Branch (within 30 days of convictions and adverse actions) exceeded success rates of 92% in both categories. The Unit considers this strong evidence of the improvement in these areas of compliance.

Recommendation 7: Revise its MOU with the State Medicaid agency to reference the CMS Performance Standards for Referrals.

The Unit concurs with this Recommendation.

During the review period, and currently, the MFCU and Oklahoma State Medicaid agency (Oklahoma Health Care Authority "OHCA") will refer matters of suspected provider fraud to each other, as well as other entities as appropriate. The referrals have been consistent with the controlling Memorandum of Understanding (MOU) between MFCU and OHCA. The current MOU expires in 2029, but the MFCU will endeavor to execute a revised MOU to include the following language:

> A fraud referral to the Oklahoma MFCU is for the express purpose of obtaining a complete, independent review of possible fraud by a provider in the Program. The referral shall include the information set out in the CMS' *Performance Standards of Suspected Fraud from a State Agency to a Medicaid Fraud Control Unit.*

The OHCA has recently undergone significant, multi-level changes in leadership. Although this may complicate communications and coordination of the MOU update, the Unit anticipates completing the revision process within the next forty-five days.

Respectfully submitted,

Charles A. Dickson, III
Director, Oklahoma Medicaid Fraud Control Unit

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