Department of Health and Human Services
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May 2025 | OEI-06-23-00450

California Medicaid Fraud Control Unit: 2023 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 MFCU, and oversees the MFCUs' performance in accordance with the requirements of the grant. As part of this oversight, OIG conducts periodic inspections of MFCUs and issues public reports of its findings and observations.

What OIG Found

The California MFCU reported 180 indictments; 221 convictions; 65 civil settlements and judgments; and $544 million in recoveries during the review period of FYs 2021–2023. The MFCU maintained strong working relationships with external partners; implemented a new team approach for its investigations; and worked 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 MFCU experienced challenges maintaining adequate staffing levels for its investigators and auditors and had begun efforts to address its recruitment and retention issues.
- The Unit's written policies and procedures manual contained inconsistent policies during our review period.
- Despite the Unit's efforts to increase fraud referrals from the State Medicaid agency's program integrity unit and managed care organizations, it received few fraud referrals from such sources during our review period.
- The Unit took steps to maintain a continuous case flow but encountered issues with the State Medicaid data that limited its ability to investigate and identify allegations of provider fraud.
- The MFCU did not consistently report convictions and adverse actions to its Federal partners within the appropriate timeframes but had improved since the last OIG inspection.
- The MFCU claimed more than $37,000 in unsupported costs and $1.3 million in unapproved costs; made excess purchases; maintained an outdated and inaccurate inventory; and improperly claimed some of its indirect costs.

What OIG Recommends

To address the findings, we recommend that the MFCU (1) build upon its efforts to recruit and retain qualified staff; (2) develop a process to ensure that its policies and procedures manual is current; (3) build upon its efforts to increase fraud referrals from the Department of Health Care Services' program integrity unit and the managed care organizations; (4) work to improve the Unit's access to quality Medicaid claims data; (5) report all convictions and adverse actions to Federal partners within the appropriate timeframes; (6) refund the Federal grant for the unsupported costs, excess purchases, and improperly claimed indirect costs; and (7) strengthen its fiscal controls. The MFCU concurred with all seven recommendations.

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BACKGROUND

OBJECTIVE

To examine the performance and operations of the California 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] SSA § 1903(q)(3)-(4). Regulations at 42 CFR § 1007.11(b)(1) clarify that a Unit's responsibilities include the review of complaints of misappropriation of patients' private funds in health care facilities.

[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, Section 207.

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

[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. The Federal FY 2024 was from October 1, 2023, through September 30, 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 the Unit's external partners. 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 OIG guidance;[12] and the Unit's case outcomes.

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

California MFCU

The California MFCU, also known as the Division of Medi-Cal Fraud and Elder Abuse, is located within the California Department of Justice (DOJ).[13, 14] At the time of our inspection in October 2023, the Unit had eight offices, including a headquarters office located in Sacramento, and regional offices in Dublin, Fresno, Riverside, Burbank, West Covina, Orange, and San Diego (see Exhibit 1 on the next page). The Unit employed 244 staff—66 investigators (including 17 special agent supervisors, 4 Special Agents in Charge, and 1 chief investigator); 60 attorneys (including

[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.

[11] The most recent version of the MFCU performance standards is published at 89 Fed. Reg. 76431 (September 18, 2024). The previous version of these standards was applicable to 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 (September 26, 1994).

[12] OIG occasionally issues policy transmittals to provide guidance and instruction to MFCUs. Policy transmittals are located at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp.

[13] In September 2020, the Unit was elevated from a Bureau to a Division within the California Department of Justice.

[14] Medi-Cal is California's Medicaid program. DHCS, *Medi-Cal Resources*. Accessed at https://www.dhcs.ca.gov/services/medi-cal/Pages/default.aspx on March 13, 2024.

10 attorney supervisors, 2 chief attorneys, and the MFCU director); 28 auditors (including 4 auditor supervisors, 3 senior auditors, and 1 chief auditor); 24 legal support staff (including legal analysts and legal assistants); 4 nurse or medical consultants; and 62 administrative and support staff. During our review period of FYs 2021–2023, the Unit spent approximately $165 million (with a State share of approximately $41 million).

Exhibit 1: Map of Unit offices by region

Source: OIG review of Unit-provided documentation.

Referrals

During FYs 2021–2023, the Unit reported receiving referrals of Medicaid provider fraud from private citizens; the State Medicaid agency, also known as the Department of Health Care Services (DHCS); managed care organizations (MCOs); and other sources.[15] The Unit received referrals of patient abuse or neglect primarily from the California Department of Public Health and the Department of Social Services. See Appendix A for a list of Unit referrals by source for FYs 2021–2023.

The Unit can also self-generate cases via data mining, which is the practice of electronically uncovering patterns and relationships within Medicaid data to identify aberrant utilization or billing, or other practices that are potentially fraudulent.[16]

When the Unit receives a referral, the Unit's complaint intake division assigns an intake number to the matter and enters it into the Unit's case management system. Next, the Unit's multidisciplinary complaint assessment team reviews the matter to determine whether the referral has substantial potential for criminal prosecution and falls within the Unit's jurisdiction.[17] If the complaint assessment team accepts the referral, the Unit opens the referral for investigation. If the Unit declines a referral for investigation, the complaint assessment team may refer it to another agency.

[15] DHCS's managed care contracts require that MCOs refer suspected fraud to DHCS. MCOs may also simultaneously submit fraud referrals directly to the Unit. See 42 CFR § 438.608(a)(7).

[16] A data mining waiver permits Federal financial participation in costs of data mining if certain criteria are satisfied (see 42 CFR § 1007.20). OIG originally approved the California Unit's waiver in 2014, and most recently renewed it in July 2023.

[17] The Unit formed the complaint assessment team in FY 2023. The team, consisting of investigators, attorneys, and support staff, is responsible for reviewing all referrals that the Unit receives from all sources. This responsibility was previously assigned to one of the Unit's supervisory auditors, who alone reviewed all referrals and assigned them to the regional offices.

Investigations and Prosecutions

Once the Unit opens an investigation, regional management assigns an investigative team to the case; the team consists of at least one investigator, one auditor, and one attorney. Depending on the type of case, management assigns the investigator or auditor to lead the team (e.g., an auditor may be assigned to lead a financial abuse case). If management determines that the regional office does not have available staff to accept the case, it notifies the complaint assessment team, which may assign the case to one of the Unit's other regional offices.

Within 30 days of the case opening, the investigative team meets to determine an investigative plan. Every 60 days, the supervising investigator reviews each open criminal investigation to ensure case progression. During the investigation, the investigator and attorney, in collaboration with the supervising investigator and supervising attorney, determine if there is sufficient evidence to support a criminal or civil prosecution. The Unit has Statewide authority to prosecute violations of criminal law and collaborates with other Federal, State, and local prosecutorial authorities for both civil and criminal matters. If a criminal or civil case enters the prosecution phase, a supervising attorney reviews the case every 90 days to ensure that the prosecution is progressing in a timely manner. If the Unit decides to close a case, the investigative team writes a closing memo and forwards it to the assigned attorney and the Unit staff responsible for entering the case closure into the case management system.

California Medicaid Program

DHCS administers the California Medicaid program, which is the largest in the United States with expenditures of approximately $130 billion in FY 2023.[18] As of October 2023, the program served more than 15 million enrollees, of whom approximately 98 percent received services through 26 MCOs and 2 percent received services through fee-for-service.[19, 20, 21] In 34 of California's 58 counties, the DHCS-contracted MCO is the sole plan operating in that county.[22]

[18] OIG, *MFCU Statistical Data for FY 2023*. Accessed at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2023-statistical-chart.pdf on March 14, 2024.

[19] DHCS, *Medi-Cal Continuous Coverage Unwinding Dashboard*, October 2023. Accessed at https://www.dhcs.ca.gov/dataandstats/dashboards/Pages/Continuous-Coverage-Eligibility-Unwinding-Dashboard-October2023.aspx on March 3, 2024.

[20] DHCS, *Medi-Cal Managed Care Enrollment Report*, January 2024. Accessed at https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report on February 14, 2024.

[21] Kaiser Family Foundation, *Total Medicaid MCOs*, July 2021. Accessed at kff.org/medicaid/state-indicator/total-medicaid-mcos/?currentTimeframe=0&sortModel=%7B"colId":"Location","sort":"asc"%7D on February 15, 2024.

[22] For more information, see DHCS, *Medi-Cal Managed Care*. Accessed at https://www.dhcs.ca.gov/services/Pages/Medi-CalManagedCare.aspx on April 15, 2024.

Medicaid Program Integrity

DHCS's Audits and Investigations branch is the program integrity unit (PIU) responsible for California's Medicaid program integrity efforts.[23] The PIU conducts data analytics to identify potential provider fraud. It also receives and investigates referrals of suspected provider fraud from the public, other government agencies, and MCOs. According to the memorandum of understanding (MOU) between the PIU and the Unit, if the PIU's investigation determines that a referral is a credible allegation of fraud, it sends the referral to the Unit for further criminal investigation and prosecution. Additionally, the PIU must suspend all Medicaid payments to the provider after it determines that there is a credible allegation of fraud unless it has good cause not to suspend payments.[24] The MOU between the PIU and the Unit states that, within 10 business days of receiving a referral from the PIU, the Unit may request that the PIU not suspend Medicaid payments if such action may jeopardize an investigation. Further, the MOU states that the PIU may also refer suspected fraud to the Unit prior to completing its investigation, on the basis of mutual agreement between the PIU and the Unit. The Unit has 45 days to accept, decline, or request additional information after receiving a referral.

Prior OIG Report

OIG conducted a previous onsite review of the California MFCU in 2015.[25] In that review, which covered FYs 2012–2014, OIG found that (1) some Unit case files lacked certain required documentation regarding supervisory approval to open and close cases, periodic supervisory reviews, and explanations of investigative delays; (2) the Unit lacked a training plan for its investigators and auditors; (3) the Unit did not report most adverse actions to the National Practitioner Data Bank (NPDB) and convictions to OIG within appropriate timeframes; and (4) the Unit generally exercised proper fiscal control of its resources but improperly claimed some indirect costs.

OIG recommended that the Unit (1) develop and implement procedures to ensure that the Unit documents relevant information in its case files; (2) fully implement the new training plans for investigators and auditors; (3) develop and implement procedures to overcome challenges in obtaining information needed to report convictions and adverse actions to Federal partners within required timeframes; and (4) develop and implement procedures to ensure that the Unit properly claims its indirect costs. On the basis of information received from the Unit, OIG considered the recommendations implemented as of December 2016. As we discuss further below, some of the issues identified in the prior OIG report recurred in this inspection.

[23] DHCS, *Audits and Investigations.* Accessed at https://www.dhcs.ca.gov/individuals/Pages/AuditsInvestigations.aspx on February 15, 2024.

[24] 42 CFR § 455.23.

[25] OIG, *California State Medicaid Fraud Control Unit: 2015 Onsite Review*, OEI-09-15-00070, February 2016.

Methodology

OIG conducted an onsite inspection of the California MFCU in October 2023. Our inspection covered the 3-year period of FYs 2021–2023.[26] We based our inspection on an analysis of data and information from 8 sources: (1) Unit documentation; (2) financial documentation; (3) structured interviews with external partners; (4) structured interviews with the Unit's managers and selected staff; (5) an electronic survey of a sample of Unit staff; (6) a review of a random sample of 100 case files from the 2,599 nonglobal case files that were open at some point during the review period; (7) a review of all convictions submitted to OIG for program exclusion and all adverse actions submitted to the NPDB during the review period; and (8) onsite review of Unit operations in three of the Unit's offices. See the Detailed Methodology on page 31.

In examining the Unit's operations and performance, we applied the published performance standards, but we did not assess adherence to every performance indicator for every standard.[27]

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, but they are subject to the same internal quality controls as are other OIG evaluations, including internal and external peer review.

[26] OIG's review of the Unit's financial documentation covered FYs 2020–2022.

[27] The standards referred to throughout this report are those from 2012, which were in effect at the time of our review.

PERFORMANCE ASSESSMENT

Case Outcomes

The Unit reported 180 indictments; 221 convictions; and 65 civil settlements and judgments for FYs 2021–2023.

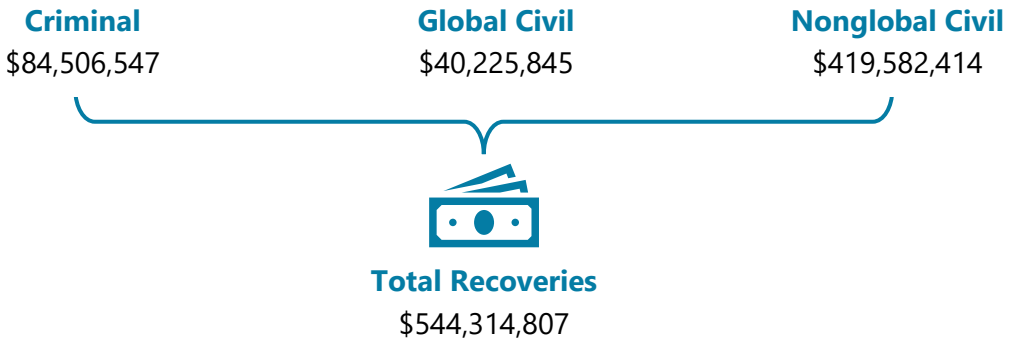
Of the 221 convictions reported by the Unit, 151 involved provider fraud and 70 involved patient abuse or neglect.[28]

180 Indictments

221 Convictions

65 Civil Settlements & Judgments

The Unit reported combined criminal and civil recoveries of approximately $544 million for FYs 2021–2023.



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

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

Performance Standard 1: Compliance with Requirements

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

The California Unit did not always comply with applicable requirements governing the MFCU.

The Unit did not comply with Federal regulations regarding the reporting of convictions and adverse actions to Federal partners, as described in the finding on page 17 (Performance Standard 8). In addition, some of the Unit's fiscal control practices did not adhere to Federal and State requirements, as explained on page 20 (Performance Standard 11).

Performance Standard 2: Staffing

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

Finding: The Unit experienced staffing shortages, resulting in high caseloads and case backlogs, but took steps to strengthen its recruitment efforts.

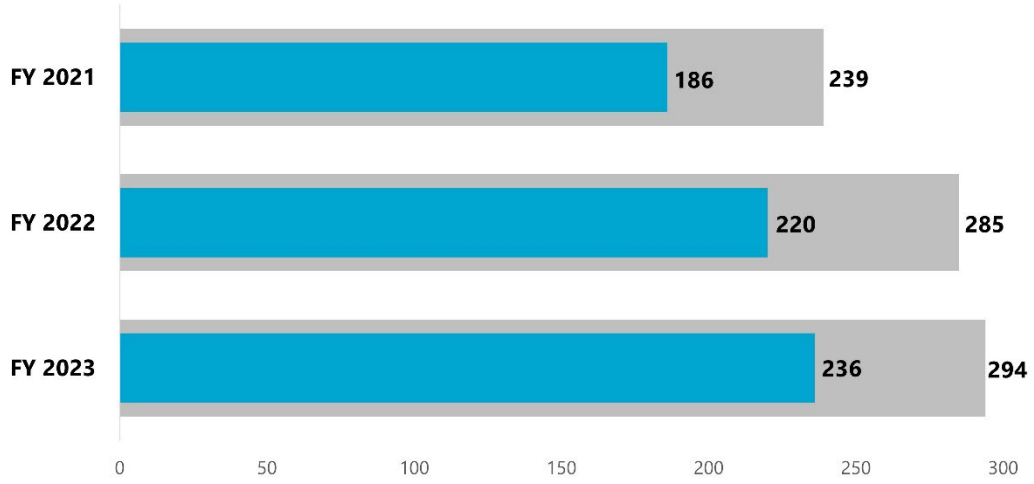
Performance Standard 2(A):
The Unit employs the number of staff that is included in the Unit's budget estimate as approved by OIG.

We found that the Unit did not maintain staffing levels in accordance with its approved budget during FYs 2021–2023, particularly for its investigators and auditors. Although the Unit's approved number of staff positions increased by 55 positions over the 3-year review period, the Unit experienced an average vacancy rate of 22 percent during that period.[29] At the time of our onsite inspection in October 2023, 58 of the Unit's 294 approved positions were vacant (see Exhibit 2 on the next page). Most of these vacancies were in the investigator and auditor positions, with 30 and 10 vacancies, respectively.[30]

[29] The Unit's vacancy rate was 22 percent in FY 2021, 23 percent in FY 2022, and 20 percent in FY 2023.

[30] Although the Unit had two vacant attorney positions at the time of our inspection, Unit management reported that it had not experienced many challenges recruiting and retaining attorneys.

Exhibit 2: Number of filled positions compared to approved positions in FYs 2021–2023



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

The Unit attributed recruitment and retention challenges to noncompetitive pay, a lengthy onboarding process, and a shortage of qualified applicants.

Unit management and staff explained that the Unit could not compete with the salaries offered by the private sector and other organizations. The Unit was also unable to provide locality pay, which made it difficult to attract applicants for vacant positions and retain existing staff, particularly in areas of the State with a higher cost of living. Further, Unit management stated that long onboarding timelines affected recruitment, as the Unit would sometimes lose applicants due to the lengthy background investigation, which could take up to 16 months for new employees.

The Unit experienced particular challenges with recruiting and retaining investigators and auditors. Unit investigative managers explained that there was a Statewide shortage of law enforcement officers, which made it difficult to recruit investigators.[31] They also said that the Unit faced challenges retaining staff when new opportunities opened in other California DOJ divisions. Notably, when the California DOJ created new investigative teams in 2020, the Unit's Burbank office experienced significant turnover when eight of its nine investigators transferred to the new teams. Additionally, the Unit had difficulty filling auditor positions, which management explained was largely due to a particular requirement in the class specifications for

[31] As of 2021, the rate of sworn law enforcement officers per 100,000 residents in California was the lowest since 1995. Public Policy Institute of California, *California's Notable Declines in Law Enforcement Staffing*, February 14, 2023. Accessed at https://www.ppic.org/blog/californias-notable-declines-in-law-enforcement-staffing/ on March 15, 2024.

California DOJ auditors (i.e., a specific college course involving business law) that disqualified many applicants.

Unit management and staff expressed concerns about the staffing shortages resulting in high staff caseloads and case backlogs.

In interviews, Unit managers explained that the staffing shortages created high caseloads for some of the existing staff, including for supervisors who sometimes had to carry cases when there were no available investigators.[32] The managers also noted that the high caseloads in turn created case backlogs, as the Unit sometimes accepted a case but was unable to assign it to an investigative team because there were none available to work the case. As a consequence of the limited staff and high caseloads, the Unit also sometimes had to decline potential cases and refer them to another agency.

> "In the last couple of years, we've been overloaded with cases because the personnel haven't been there."
> *– Unit Staff Member*

The Unit undertook several efforts to address its recruitment challenges, yielding some results, and was exploring more ways to fill its vacancies.

To attract potential hires, the Unit leveraged a California government policy that permitted the Unit to hire new employees at higher salaries than the DOJ's minimum rate when justified by the incoming staff's previous salary.[33] Unit management reported that the ability to leverage this incentive helped the Unit recruit new staff but said that this option would soon be ending.

The Unit also made improvements to its onboarding process to reduce the time involved in bringing new hires onboard and prevent the Unit from losing potential candidates in the process. To speed up onboarding, Unit management reported, it established an internal unit to conduct employee background investigations rather than relying on a different division within the DOJ to conduct them. The Unit director reported that this change helped background investigations progress more quickly for incoming staff by providing more control over the background investigation process and removing administrative delays.

To address the challenges related to hiring auditors, Unit management reported, it was pursuing changes to the class specifications for auditors to remove the specific course requirement. As an alternative, Unit management explained, it was also considering implementing a new special investigator position. This position would include higher pay and similar job duties to the Unit's current auditor position but would have different job requirements that would potentially increase the number of eligible applicants.

[32] We did not independently assess each staff member's caseload as part of our review.

[33] In California, the Hire Above Minimum procedure allows for payment above the minimum salary rate in a classification when there is difficulty in recruiting qualified employees for a classification or series. California Department of Human Resources, *1707 - Hiring Above Minimum (HAM)*. Accessed at https://hrmanual.calhr.ca.gov/Home/ManualItem/1/1707 on May 1, 2025.

Performance Standard 3: Policies and Procedures

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

Finding: The Unit's policies and procedures manual contained inconsistent policies during our review period.

Performance Standard 3(A): The Unit has written guidelines or manuals that contain current policies and procedures for the investigation and prosecution of Medicaid fraud and patient abuse and neglect.

We found that the Unit had written policies and procedures that were available to all staff electronically. The Unit reported that, during our review period, it organized its policies and procedures manual by professional discipline, storing the manual on the Unit's intranet as well as on a shared drive. Unit managers explained that when the Unit updates its policies, a manager distributes a memo explaining the policy to staff before uploading the memo to the intranet, where each policy is stored separately as an individual file.[34]

In reviewing the Unit's internal policies, we found several policies that contained inconsistent information during our review period. For example, the Unit had outdated policies regarding supervisory reviews of cases during investigations. In September 2019, the Unit updated its policy to require that supervising investigators review cases every 60 days during the investigation phase. However, during our onsite inspection in October 2023, we identified several active Unit policies that reflected the Unit's previous requirement of reviews every 30 days, indicating that the Unit had not updated those policies to reflect its current operations in more than 4 years.

Unit managers reported that, although the policies and procedures manual was previously disorganized, the current manual met the Unit's needs. The Unit director reported that, prior to her assuming her current position, the policies and procedures were "scattered," resulting in some containing outdated information and others not uploaded to the Unit's intranet. Unit managers also explained that staff were not always aware of the content of the policies due to their volume and the lack of organization, which sometimes caused confusion on Unit processes, particularly for newer staff. At the time of our inspection, Unit managers reported that the current policies and procedures were easily accessible and that they planned to continue updating them as they identified outdated or missing information, which would ensure consistency and reduce confusion.

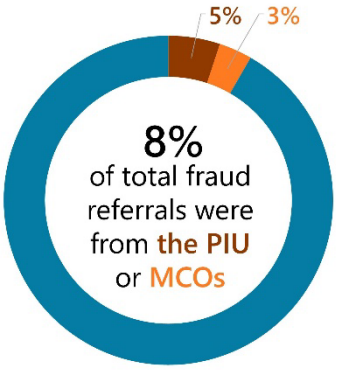
[34] The Unit stores internal policies and procedures for its investigative, legal, and administrative processes on its intranet, along with some of the California DOJ investigative policies and procedures.

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: Despite the Unit's efforts to increase fraud referrals from the program integrity unit and managed care organizations, it received few fraud referrals from such sources during our review period.

In accordance with Performance Standard 4, we found that the Unit took steps to increase fraud referrals from the PIU and MCOs. The Unit began meeting regularly with the PIU during our review period for deconfliction and to discuss new fraud referrals and trends; open investigations; and significant issues impacting their agencies, which the Unit reported improved the quality and coordination of PIU referrals. Further, in November 2022, the Unit added provisions to its MOU with the PIU for interagency collaboration and to clarify the referral process. Specifically, the MOU outlines the process for sending MCO referrals received by the PIU to the Unit and includes a requirement that the Unit must deconflict any referrals it receives from MCOs with the PIU. To encourage direct referrals from MCOs, the Unit requested, during our review period, that DHCS implement a requirement in its MCO contracts for MCOs to send referrals simultaneously to the Unit, though the agency did not implement the requirement. The Unit also hosted ongoing trainings for MCOs on current fraud trends, case work, and other educational topics, which Unit management reported led to the Unit receiving referrals from more MCOs than in the past.[35, 36]



Despite its efforts to increase fraud referrals from the PIU and MCOs, the Unit received few referrals from those sources during our review period. Of the 1,225 fraud referrals that the Unit reported receiving during FYs 2021–2023, only 8 percent (102 referrals) were from the PIU or MCOs. See Appendix A for a list of all referrals by source. A 2023 report by the Centers for Medicare & Medicaid Services (CMS) regarding California's Medicaid managed care program also expressed concern that the number of referrals submitted to the PIU by MCOs was low for a Medicaid program the size of California's.[37] The PIU oversees the largest Medicaid program in the United States, in which MCOs cover 98 percent of enrollees in California, and Federal regulations

[35] The Unit hosts these ongoing trainings quarterly for MCOs in Los Angeles, San Francisco, and Sacramento, and annually for all MCOs in the State. OIG staff attended MCO trainings hosted by the Unit in November 2023 and May 2024, which OIG observed resulted in productive, open communication between the Unit and MCOs.

[36] The Unit reported receiving referrals from 5 of 26 MCOs in FY 2023 compared to 2 MCOs in FY 2021.

[37] CMS Center for Program Integrity, *California Focused Program Integrity Review: Medicaid Managed Care Oversight*, September 2023. Accessed at https://www.cms.gov/files/document/california-fy-2022-pi-focused-review-final-report.pdf on April 11, 2024.

require the PIU to refer suspected cases of provider fraud to the Unit.[38, 39, 40] Accordingly, the PIU and MCOs should be significant fraud referral sources for the Unit.

The PIU director reported that a shift in DHCS leadership priorities was the primary factor influencing the PIU's referrals to the Unit. The changing priorities caused PIU staff to focus their resources on activities other than fraud investigations (e.g., special assignments and requests from DHCS program partners).

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: The Unit took steps to maintain a continuous case flow and completed cases within appropriate timeframes, but limited access to quality Medicaid data hampered its investigations and data mining efforts.

We found that the Unit undertook several efforts, such as increasing internal collaboration on cases and ensuring documentation of supervisory oversight, to maintain a continuous case flow and complete cases in a timely manner.[41] In early 2023, the Unit implemented new investigative processes to increase staff collaboration on cases by assigning an attorney, auditor, and investigator at the opening of each case, rather than assigning some staff later in the process. Unit management reported that this approach succeeded in enhancing the overall staff engagement and collaboration on cases. One innovative feature of the new approach was that the Unit could assign an auditor, rather than an investigator, to serve as the team lead for cases with a significant financial or quantitative component, such as pharmacy cases. The Unit reported case efficiencies from the new investigative approach, as it would reduce the caseloads for some staff.

[38] DHCS, *Medi-Cal Continuous Coverage Unwinding Dashboard*, October 2023. Accessed at https://www.dhcs.ca.gov/dataandstats/dashboards/Pages/Continuous-Coverage-Eligibility-Unwinding-Dashboard-October2023.aspx on March 3, 2024.

[39] In FY 2023, Medicaid expenditures in California were the highest in the United States at approximately $130 billion. OIG, *MFCU Statistical Data for FY 2023*. Accessed at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2023-statistical-chart.pdf on March 14, 2024.

[40] 42 CFR § 455.15(a)(1).

[41] Despite some cases being inactive in the Unit's backlog due to staffing shortages, most cases we reviewed did not have significant delays.

Performance Standard 5(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.

In addition, our review of the Unit's case files found that the Unit completed most of its investigations and prosecutions in a timely manner and nearly all of its case files contained appropriate documentation of supervisory approval for case openings and closings. Specifically, our review identified supervisory approval to open the case for investigation in an estimated 94 percent of case files, and supervisory approval to close the case in an estimated 100 percent of the Unit's closed cases. See Appendix B for point estimates and confidence intervals for our case file review.

Despite the Unit's efforts to maintain a continuous case flow, inadequate access to quality Medicaid data sometimes disrupted investigations and impeded data mining activities.

Federal regulations require that State Medicaid agencies comply with requests from Units for data stored by the agency and its contractors in any form requested by the Unit.[42] Although the MOU between the PIU and the Unit states that the PIU will provide such data, Unit management reported that it had limited access to the Medicaid claims system and data repository during our review period. Specifically, we found that the Unit lacked direct query access to the claims data, which required staff to download and recombine several separate data reports from the Medicaid data system. Unit managers explained that this was a time-consuming process and introduced the possibility for error in the data. The managers also reported that the Unit lacked access to dental claims and Medicaid prescription drug claims.

Poor quality of managed care data. Unit management reported challenges with the accuracy and completeness of MCO claims data. Specifically, management said that the Unit's data mining staff had found inconsistences in the MCO claims data. Management explained that, because of those inconsistencies, Unit staff needed to reach out to each MCO separately to request certified claims data to ensure that the data were accurate when staff used them in court, which added time during the investigative process. PIU management also noted that, historically, there have been issues with the quality of MCO claims data. A recent DHCS study of the completeness and accuracy of MCO claims data found that only 45 percent of the claims data elements reviewed met the audit's accuracy standards.[43] Given that 98 percent of Medicaid enrollees in California are enrolled in managed care, quality issues in MCO claims data are concerning, as potential fraud could be missed.

Limited data use for investigations. The Unit's limited access to and quality issues with claims data also posed challenges for the Unit when it used data for investigations. DHCS required licenses for Unit staff to access Medicaid claims data, but few Unit staff had such licenses during our review period. As a result, the Unit staff who had licenses to access the claims often ran ad-hoc claims data reports for

[42] 42 CFR § 455.21(a)(2)(ii).

[43] DHCS Quality Population Health Management, *2022–2023 Encounter Data Validation Study Report*, February 2024. Accessed at https://www.dhcs.ca.gov/dataandstats/reports/Documents/2022-23-Encounter-Data-Validation-Study-Report.pdf on April 15, 2024.

the Unit's investigative staff while putting their other duties aside. Unit management reported that DHCS sometimes took months to process the Unit's data requests and suggested that Unit investigations would benefit from additional licenses and direct access to the Medicaid claims data.

Limited data mining capability. We found that the claims data issues also affected the Unit's data mining efforts. Although the Unit is approved to conduct data mining, we determined that the lack of direct query access to the Medicaid claims data system limited the Unit's ability to perform analytics to identify potential fraud cases. For example, the Unit did not have the ability to query the full data warehouse, which prevented staff from implementing extensive data mining methods. Further, Unit management reported that the Unit did not pursue data mining of MCO claims due to their poor quality, which was potentially a significant missed opportunity for the Unit to identify possible fraud.

Efforts to improve data access. In FY 2022, Unit management reported that it communicated with leadership at DHCS, including its Chief Data Officer, to increase the Unit's access to the Medicaid claims data. As a result, DHCS granted the Unit additional licenses to access the data. However, the Unit director reported that, even with additional licenses, the Unit's ability to use the data was still limited because officials at DHCS had not granted the Unit full access to Medicaid data in the system.

Performance Standard 6: Case Mix

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

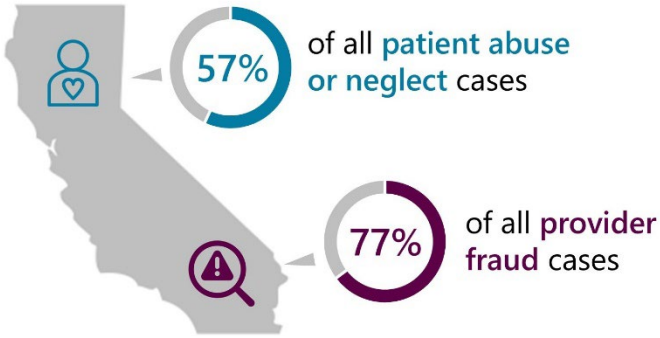
Observation: The Unit's caseload included a mix of provider types and fraud and patient abuse or neglect cases, and its case mix varied by region.

Of the Unit's 2,679 global and nonglobal cases that were open during FYs 2021–2023, 53 percent (1,432 cases) involved provider fraud and 47 percent (1,247 cases) involved patient abuse or neglect. We observed that the Unit's case mix included fraud cases involving high amounts of Medicaid expenditures, as well as systemic patient abuse and neglect cases against nursing homes and their owners.[44] During our review period, the Unit's cases covered 76 provider types, including nursing facilities, pharmaceutical manufacturers, and personal care services attendants.

[44] For certain patient abuse or neglect cases, the Unit has a "facilities enforcement team," consisting of attorneys and nurse evaluators, that handles cases of systemic patient abuse or neglect in long-term care facilities.

In our review of the Unit's cases, we also observed that its case mix varied by region. Specifically, we observed that the Unit's offices in Southern California investigated 77 percent (1,093) of the Unit's provider fraud cases and the offices in Northern California investigated 57 percent (712) of its patient abuse or neglect cases (see Exhibit 3).[45, 46] The Unit's offices in the South frequently participate in cases with the Los Angeles Strike Force—an interagency law enforcement team, consisting of both Federal and State investigators and prosecutors, that operates in Southern California to combat the high levels of billing fraud occurring in that region.[47] During our onsite inspection, Unit management reported that the Unit was changing how it distributed its case mix across the regional offices, explaining that the new complaint assessment team had begun to carefully assign cases on the basis of resource availability in the regions rather than their geographic location.

Exhibit 3: Offices located in Northern California primarily investigated patient abuse or neglect, and offices located in Southern California primarily investigated provider fraud



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

Performance Standard 7: Maintaining Case Information

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

Observation: The Unit generally maintained case files in an effective manner, but we observed some limitations of the Unit's case management system and inconsistencies in its case documentation.

Overall, we observed that the Unit maintained case files in an effective manner; however, we also observed some limitations with the Unit's case management system. At the time of our inspection, the Unit used an electronic case management system to record and track all case information. In interviews, Unit management and staff

[45] For analysis purposes, we considered the offices in Burbank, Orange, Riverside, San Diego, and West Covina as Southern and the offices in Dublin, Fresno, and Sacramento as Northern.

[46] We excluded four provider fraud cases from this analysis because they were not assigned to a specific regional office.

[47] For more information about the Strike Force Operations, see U.S. Department of Justice, *Strike Force Operations*, October 2023. Accessed at https://www.justice.gov/criminal/criminal-fraud/strike-force-operations#:~:text=Based%20on%20the%20success%20of,%2C%20Gulfport)%3B%20Tampa%3B%20Orlando%3B on April 12, 2024.

reported concerns about the system's connectivity and suitability. Unit management and staff reported that the responsiveness of the case management system was slow, which made it cumbersome to upload and access case documents. Several investigators also stated that they believed that the case management system was better suited for legal and administrative functions than for investigations. During our review of the Unit's case files, we also observed shortcomings in the system. For example, in addition to the system's slow connectivity, we observed that it lacked a designated field to identify whether the Unit was working cases jointly with another agency. Unit management explained that it was in the process of obtaining an additional, more user-friendly case management system that would have more investigative functionalities. For example, the new system would have the capability to create standardized investigative reports and connect with other law enforcement databases.

Performance Standard 7(B):
Case files include all relevant facts and information and justify the opening and closing of the cases.

We also observed some inconsistencies in the Unit's documentation in its investigative case files. In our review of the Unit's case files, we were unable to locate documentation explaining the reason(s) for opening some of the cases. Further, although few cases that we reviewed had significant investigative delays, we were unable to locate explanations for some of those delays. We also observed that case files did not consistently contain documentation of whether the Unit communicated the results of the case to the referring agency. Following our onsite inspection, OIG provided the Unit with technical assistance to improve consistency in the Unit's documentation of its case files.

Performance Standard 8: Cooperation with Federal Authorities on Fraud Cases

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

Finding: The Unit did not consistently report convictions and adverse actions to Federal partners within the appropriate timeframes but had improved since the last OIG inspection.

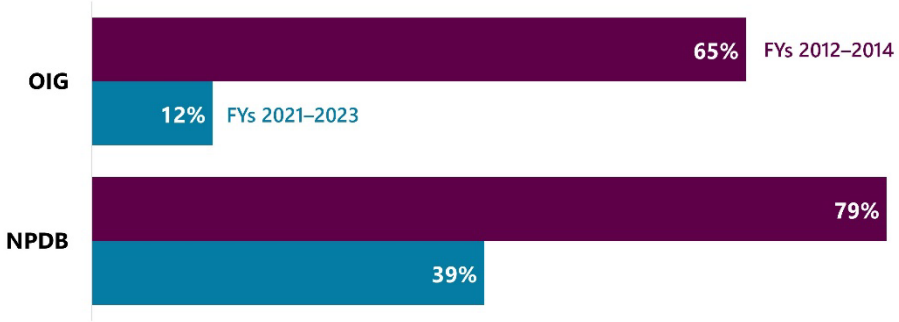
According to Federal requirements and Performance Standard 8(F), the Unit should transmit to OIG—within 30 days of sentencing, or as soon as practicable if the Unit encounters delays in receiving the necessary information from the court—reports of all Unit convictions for the purpose of permitting OIG to exclude the convicted parties from Federal health care programs.[48] We found that the Unit did not report 23 of the Unit's 190 convictions (12 percent) within 30 days or as soon as practicable after it received the information from the court. Of the 23 convictions reported late, the Unit reported 13 convictions between 31 and 60 days after sentencing; 6 convictions

[48] 42 CFR § 1007.11(g), effective March 22, 2019. Performance Standard 8(F) also states that Units should transmit to OIG, for purposes of program exclusions, all pertinent information on MFCU convictions within 30 days of sentencing, including charging documents, plea agreements, and sentencing orders.

between 61 and 90 days after sentencing; and 4 convictions more than 90 days after sentencing. We found that the Unit's submission of convictions to OIG had improved since OIG's 2015 onsite review, which found that 65 percent of the Unit's convictions were reported to OIG more than 90 days after sentencing (see Exhibit 4).[49] Late reporting of convictions to OIG delays the initiation of the program exclusion process, which may result in payments to providers by the Medicaid program or other Federal health care programs that should have been deemed improper, as well as possible harm to enrollees.

Federal regulations, consistent with Performance Standard 8(G), also require that any adverse actions against health care providers be reported to the NPDB within 30 calendar days of the final adverse action date.[50] The Unit did not report 77 of its 196 adverse actions (39 percent) within the appropriate timeframe. Of the 77 adverse actions reported late, the Unit submitted 45 between 31 and 60 days after the action; 17 between 61 and 90 days after the action; and 15 more than 90 days after the action. We found that the Unit's submission of adverse actions to the NPDB had improved since OIG's 2015 onsite review, which found that the Unit reported 79 percent of its adverse actions more than 90 days after the action (see Exhibit 4).[51] The NPDB is intended to restrict physicians, dentists, and other health care practitioners from moving State to State without disclosure or discovery of previous medical malpractice and adverse actions.[52] If a Unit fails to report adverse actions to the NPDB, other health care organizations may unknowingly hire individuals who have adverse actions made against them.

Exhibit 4: The Unit's timeliness in submissions of convictions to OIG and adverse actions to the NPDB improved substantially between the periods of FYs 2012–2014 and FYs 2021–2023



Source: OIG analysis of Unit submission of convictions to OIG and adverse actions to NPDB, FYs 2012–2014 and FYs 2021–2023.

[49] OIG, *California State Medicaid Fraud Control Unit: 2015 Onsite Review*, OEI-09-15-00070, February 2016.

[50] 45 CFR § 60.5. Examples of final adverse actions include, but are not limited to, convictions, civil judgments (but not civil settlements), and program exclusions (SSA § 1128E(g)(1)).

[51] OIG, *California State Medicaid Fraud Control Unit: 2015 Onsite Review*, OEI-09-15-00070, February 2016.

[52] NPDB, About Us. Accessed at https://www.npdb.hrsa.gov/topNavigation/aboutUs.jsp on February 15, 2024.

Unit management attributed the Unit's delays in submitting information to OIG and the NPDB to not receiving the necessary information from the court in a timely manner, holiday delays, staff shortages, and competing priorities of staff who were responsible for sending the submissions.[53] At the time of our inspection, the Unit director reported taking steps to improve the timeliness of submissions to OIG and the NPDB, including designating a staff member to serve as a coordinator for the submission process.

Observation: The Unit maintained a positive relationship with OIG and worked many cases jointly.

We observed that the Unit maintained a strong partnership with OIG's Office of Investigations' (OI's) offices in the San Francisco and Los Angeles regions. Unit and OI managers reported meeting regularly to discuss joint cases. The Unit and OI jointly investigated a total of 109 cases during our review period. An OI investigative supervisor who worked with the Unit described Unit staff as "great partners" and said that their relationship was continually improving.

Performance Standard 9: Program Recommendations

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

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

Although the Unit did not make any formal program recommendations to the State Medicaid agency, it made a request to the Medicaid agency regarding MCO contracts (see Performance Standard 4 on page 12). The Unit director reported that Unit management was in regular contact with the State Medicaid agency and was in the process of drafting several written recommendations to DHCS at the time of our onsite inspection.

Performance Standard 10: Agreement with Medicaid Agency

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

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

The California Unit and the PIU had a current MOU, amended in November 2022. The MOU reflected all applicable policy and legal requirements, as well as current practices, between the parties. The Unit and the PIU amended the MOU to include a required provision for the PIU to send referrals of any potential MCO fraud to the

[53] We excluded from our analysis convictions that the Unit submitted late due to court delays.

Unit.[54] If the Unit receives referrals directly from MCOs, the MOU requires the Unit to deconflict those cases with the PIU. For more information about the fraud referral process, see the finding on page 12 (Performance Standard 4).

Performance Standard 11: Fiscal Control

A Unit exercises proper fiscal control over its resources.

Finding: The Unit claimed $1,363,665 in unsupported or unapproved costs on its Federal grant and purchased excess amounts of some items.

Unsupported costs. We found that the Unit claimed $37,207 in unsupported costs on its Federal grant.[55] Federal regulation states that costs must be adequately documented to be allowable under Federal awards.[56] We found that the Unit did not maintain adequate documentation for 5 of 72 selected transactions that we reviewed, which included purchases of office alterations, supplies, and furniture. Of these five transactions, four lacked documentation for the receipt of all purchased items and one transaction was composed of multiple purchases that either lacked any supporting documentation or did not have sufficient documentation for OIG to determine whether the costs were attributable to the Unit and allowable on the Federal grant.[57, 58] Without adequate documentation of its purchases, the Unit cannot ensure effective control of and accountability for its assets, as required.[59]

Unapproved costs. We found that the Unit claimed $1,326,458 in unapproved costs for equipment and storage purchases on its Federal grant. Federal regulation requires the Unit to obtain prior approval from OIG on capital expenditures for general purpose equipment and buildings and before purchasing special purpose equipment that costs more than $5,000 per item.[60] We found that the Unit did not obtain prior approval for the purchase of general purpose equipment; storage units; and 100 handheld and 100 mobile radios, which cost more than $7,000 each. Failing to adhere to the mandated prior approval process restricts OIG's ability to ensure that the Unit's purchases are reasonable and necessary expenditures on the Federal grant. OIG is working with the Unit to retroactively approve the purchases that were

[54] 42 CFR § 1007.9(d)(3)(iv). The Unit's MOU with the State Medicaid agency must include procedures for referrals of potential fraud from MCOs.

[55] The dollar amounts throughout this finding are 75 percent of the Unit's total cost for each purchase. OIG funds 75 percent of Unit expenditures. See page 1 for more information.

[56] 45 CFR § 75.403(g).

[57] The Unit must document the receipt of purchased items. See California State Administrative Manual, Section 8422.201. Accessed at https://www.dgs.ca.gov/Resources/SAM/TOC/8400/8422-201 on March 5, 2025.

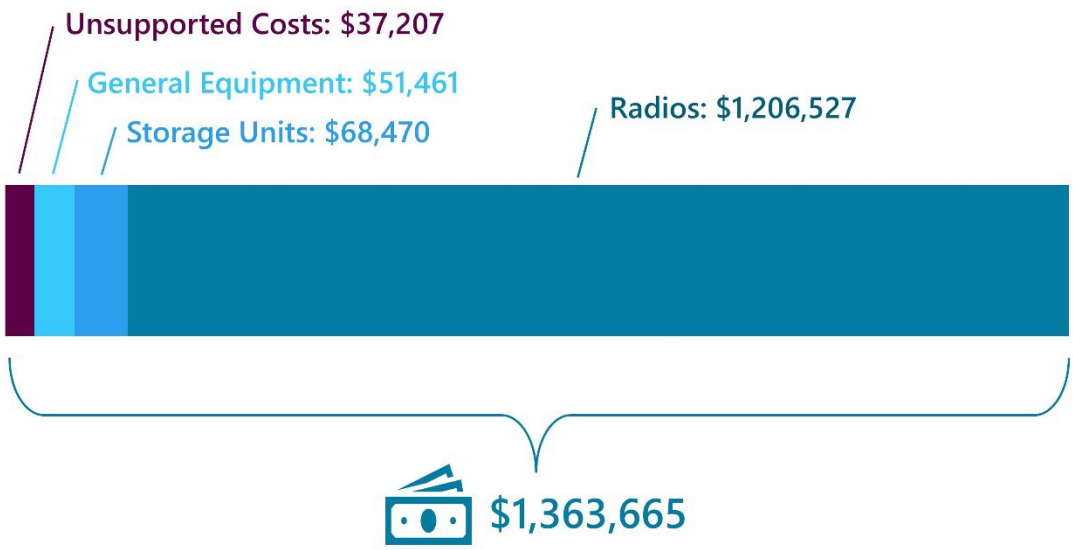
[58] Costs must be necessary, reasonable, and allocable (i.e., incurred specifically for the Federal grant) to be allowable under Federal grants. See 42 CFR §§ 75.403(a), 75.405(a).

[59] 45 CFR § 75.302(b)(4).

[60] Special purpose equipment, general purpose equipment, and capital expenditures are defined at 45 CFR § 75.2. See also 45 CFR § 75.439(b)(1)-(2).

necessary and allocable to the Federal grant. See Exhibit 5 below for a summary of the unsupported and unapproved costs.

Exhibit 5: The Unit's unsupported and unapproved costs totaled $1,363,665



Source: OIG analysis of Unit-provided documentation, FYs 2020–2022.

Excess purchases. We found that the Unit purchased excessive amounts of some items during FYs 2020–2022, indicating that these costs may not have been necessary or reasonable in accordance with Federal regulation. For example, the Unit purchased 100 handheld radios for a staff of 72 investigators during FY 2021. The Unit explained that it purchased the extra radios for staff whom it intended to hire and to allow each regional office to have backup radios, which is prohibited by Federal regulation and State policy.[61, 62] We found that the number of Unit investigators did not increase as the Unit expected; instead, it decreased from FY 2021 to FY 2022.[63]

The Unit also purchased excessive amounts of several office supplies. For example, the Unit purchased 88 tablets in FY 2022, but as of October 2023, 13 of those tablets were unassigned. We also identified an additional 20 tablets purchased in FY 2023 that remained unopened nearly a year later.[64] Similarly, of the 30 scanners that the Unit purchased in FY 2022, 19 were unassigned and in storage and 1 was unassigned in a Unit office space according to inventory logs in December 2023.[65] In FY 2021, the

[61] 45 CFR § 75.327(d). The Unit's procedures must avoid acquisition of unnecessary or duplicative items.

[62] California State Administrative Manual, Section 5001. Accessed at https://www.dgs.ca.gov/Resources/SAM/TOC/5000/5001 on December 20, 2024.

[63] Although the Unit had approval from OIG for 84 investigator positions in FY 2021, 12 of those positions were vacant. See the finding on page 8 (Performance Standard 2) for more information about the Unit's vacancies during FYs 2021–2023.

[64] Although this purchase was outside of our review period of FYs 2020–2022, the purchase of these additional tablets, which remained unassigned at the time of our review, raises questions about the necessity of the tablets purchased in FY 2022.

[65] 45 CFR § 75.321(a). The Unit should compensate the Federal government for its share after identifying the residual inventory of unneeded supplies associated with the grant.

Unit also purchased 100 travel bags for a staff of 72 investigators. See Exhibit 6 below for more information.

Exhibit 6: Unassigned vs. assigned items at the time of our review from three Unit purchases made during FYs 2020–2022

Source: OIG analysis of Unit-provided documentation, FYs 2020–2022.

Lack of clarity regarding which office was responsible for making purchase determinations may have contributed to the Unit's unsupported, unapproved, and excess purchases. Unit staff stated that the DOJ Division of Operations was responsible for determining which costs were allowable. However, when we spoke with staff within that Division, they said that they began deferring such determinations to the Unit in FY 2020. Further, the Unit director attributed four of the five unsupported costs to the DOJ not requiring the Unit to document when it receives those types of items. Although the DOJ Division of Operations provides administrative and financial oversight to the Unit, the Unit is ultimately responsible for ensuring that it exercises proper fiscal control of its resources in accordance with Performance Standard 11 and Federal regulations.[66, 67]

Finding: The Unit's equipment inventory was not regularly updated or accurate.

Performance Standard 11(B): The Unit should maintain an equipment inventory that is updated regularly to reflect all property under the Unit's control.

We found that the Unit did not maintain a regularly updated equipment inventory. State policy requires the Unit to conduct a physical inventory every 3 years.[68] We found that the Unit had conducted its last physical inventory in May 2017, more than 6 years prior to our onsite inspection.[69] The Unit is also required to conduct a physical inventory when it moves to a new office location.[70] We found that the Unit did not conduct an inventory after

[66] 45 CFR § 75.342(a).

[67] The Unit performs accounting tasks and submits purchase documents to the DOJ's Division of Operations, which processes invoices for payment and provides administrative and technical support to the Unit.

[68] California State Administrative Manual, Section 8652. Accessed at https://www.dgs.ca.gov/Resources/SAM/TOC/8600/8652 on September 19, 2024.

[69] After our onsite inspection, the Unit reported to OIG that it conducted a physical inventory in August 2023 but did not provide documentation to support that it conducted such an inventory.

[70] The Unit is required to conduct a physical inventory if it moves to a new office location, or if a reorganization takes place combining multiple units. DOJ Administrative Manual, chapter 11, § 11241.

it moved office spaces in 2020 and 2022. Without regular checks of its physical inventory, the Unit cannot ensure that it maintains effective control over and accountability for its property, as required by Federal regulation.[71]

We also found that the Unit did not properly account for 3 of 153 selected inventory items, including a vehicle, a camera, and a scanner.[72] Specifically, we could not locate the camera or the scanner during our review, and we found that the vehicle was previously transferred to another regional office. In addition, during our inventory review of the sampled items, we identified seven additional law enforcement equipment items that were physically located in one of the regional offices but not accounted for on the inventory list for that office.[73]

Finding: The Unit miscategorized two purchases and improperly claimed a portion of its indirect costs, which may have contributed to the Unit submitting inaccurate Federal Financial Reports.

> **45 CFR § 75.302(b)(2):**
> The financial management system of [the Unit] must provide for the … accurate, current, and complete disclosure of the financial results of each Federal award.

We found that the Unit incorrectly categorized two equipment purchases when it calculated its direct cost base, which may have skewed its overall indirect cost calculation.[74, 75] In addition, the Unit improperly claimed the 100-percent Federal reimbursement rate instead of the 75-percent rate for one of seven indirect cost transactions that we reviewed.[76] The Unit reported that it corrected this error, but OIG could not confirm that the Unit corrected the error with the documentation it provided to OIG.

Because the Unit's purchase categories and reimbursement rate calculations must be correct to accurately report its total indirect costs for each Federal grant, these errors may have contributed to the Unit submitting inaccurate FFRs. We found that the Unit inaccurately reported its total amount of indirect costs on its FFRs during each year of our review period. Specifically, we could not reconcile the total indirect costs the Unit reported on its FFRs with the total amount of indirect costs we calculated using Unit expenditure data from FYs 2020–2022.

[71] 45 CFR 75.302(b)(4).

[72] We reviewed the Unit's inventory by selecting 153 of the Unit's 3,069 assets and verifying the sample's existence. The inventory items were selected from two of the Unit's offices.

[73] The 7 inventory items were not included on the inventory records that were used to select the sample of 153 items.

[74] Indirect costs are those that have been incurred for common or joint purposes. 45 CFR § 75, Appendix VII(A)(1).

[75] The direct cost base, which is part of the Unit's indirect cost calculation, excludes equipment. Because the Unit did not appropriately categorize the equipment purchases, the purchases may have been improperly included in the Unit's indirect cost calculation.

[76] The State must fund 25 percent of the Unit's expenditures. See page 1 for more information.

Performance Standard 12: Training

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

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

Performance Standard 12(A): The Unit maintains a training plan for each professional discipline that includes an annual minimum number of training hours.

We observed that Unit staff received, on average, more than 40 hours of training per year during our review period. The training covered topics on health care fraud and program integrity; investigative tactics; and litigation, among other topics. Although the Unit's policies and procedures contained training requirements for investigators, attorneys, and auditors, it did not specify an annual number of training hours required for these staff during our review period. Despite the lack of a minimum training hour requirement, Unit management and staff reported that the Unit supported training opportunities and ensured that staff received appropriate training. The Unit updated its training plan after our onsite inspection to include minimum training hour requirements for each professional discipline and sent documentation supporting this update to OIG.

CONCLUSION AND RECOMMENDATIONS

We observed that the California Unit undertook several efforts to address challenges encountered by the Unit during our review period. From the information we reviewed, we observed that the Unit maintained positive working relationships with Federal and State partners, including OIG and the PIU. The Unit also updated its referral process to better distribute caseload; implemented a team approach for its investigations to improve case flow; and had well-documented and well-maintained case files.

However, we found several areas of concern which limited the Unit's operations, and for which we are issuing recommendations. The Unit experienced unique challenges recruiting and retaining staff—including not being able to offer locality pay in a State with a particularly high cost of living and a Statewide declining law enforcement workforce—which disproportionately impacted investigators and auditors. These staffing issues contributed to high caseloads for some staff and case backlogs. Despite taking steps to address the staffing issues, the Unit had an average vacancy rate of 22 percent during our review period.

We also found that, although the Unit undertook robust efforts to increase the volume and quality of referrals from the PIU and MCOs during our review period, it received few fraud referrals from those sources. The low number of referrals from the PIU and MCOs is particularly concerning, given the PIU's obligation to refer credible allegations of fraud to the Unit and that 98 percent of California's more than 15 million Medicaid enrollees receive care through MCOs.

Further, despite its steps to maintain a continuous case flow, the Unit had limited access to the Medicaid data system and struggled with inconsistencies in the MCO claims data, which hampered its investigations and data mining efforts. These limitations could result in the Unit missing potential fraud. Adequate access to quality Medicaid data is critical for the Unit to achieve its mission.

Finally, we found that the Unit did not always exercise proper fiscal control of its resources, which could put Federal funds at risk. Specifically, the Unit claimed nearly $1.4 million in Federal grant funds for unsupported and unapproved costs; purchased excessive amounts of some items; did not maintain an up-to-date and accurate physical inventory; and improperly claimed some of its indirect costs. These issues raise concerns about the Unit's fiscal control over its resources and whether the Unit is claiming the proper amounts on its Federal award.

To address the findings identified in this report, we made the following seven recommendations to the California Unit.

We recommend that the California Unit:

Build upon its efforts to recruit and retain qualified staff

The Unit should prioritize its efforts to fill its vacancies, particularly for investigators and auditors. As part of these efforts, the Unit could leverage any available California government or Department of Justice (DOJ) incentives to recruit qualified candidates. If possible, these efforts should include continuing to hire staff at higher salaries when justified. The Unit should also pursue, as appropriate, pay or cost-of-living adjustments with the California DOJ to allow the Unit to compete in the current market. In addition, the Unit should continue working with the DOJ to revise the class specifications for the investigative auditor classification to remove any unnecessary requirements. The Unit should also pursue alternative classifications, such as the special investigator position, to recruit qualified auditors.

Update its periodic supervisory review policies to reflect current operations and develop a process to ensure that its policies and procedures manual is current

The Unit should revise its policies and procedures that reference periodic supervisory reviews to reflect current operations. The Unit should also develop and implement a process to ensure that the policies and procedures manual is current and consistent with Unit operations and updated in a timely manner to reflect any new or amended policies or procedures.

Build upon its efforts to increase fraud referrals from the Department of Health Care Services' program integrity unit and the managed care organizations

The Unit should strengthen its recent efforts to increase fraud referrals from the PIU, including holding regular meetings and monthly deconfliction with the PIU. The Unit should also continue its outreach and training with MCOs to improve the volume and quality of fraud referrals. Further, the Unit should enhance its outreach with MCOs by targeting those that do not currently send fraud referrals to the Unit, which would increase the Unit's ability to investigate suspected provider fraud in the managed care setting. To increase managed care referrals, the Unit should strongly consider making a formal, written program recommendation for DHCS to contractually require that MCOs send referrals to DHCS and the Unit simultaneously. Additionally, the Unit should consider seeking approval from DHCS to increase its involvement in the MCO contract process to provide feedback and recommendations on managed care requirements.

Work with the Department of Health Care Services to improve the Unit's access to and the quality of Medicaid claims data

The Unit should build upon its efforts with DHCS and move quickly to obtain direct query access to the Medicaid claims data system for its staff. The Unit should also work with DHCS to obtain access to the other critical parts of the Medicaid data to which it currently lacks access, such as the dental and Medicaid prescription drug claims data. To address the poor quality of Medicaid data, the Unit should provide feedback to DHCS and the MCOs regarding the completeness and accuracy of the managed care claims data. The Unit should also consider collaborating with DHCS to provide technical assistance to the MCOs regarding the quality of the claims data, possibly as a part of its regular trainings with the MCOs.

Report all convictions and adverse actions to Federal partners within the appropriate timeframes

The Unit should ensure that it consistently 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 ensure that it reports all adverse actions to the NPDB within 30 days of the action.

Refund the Federal grant for the unsupported costs, excess purchases, and improperly claimed indirect costs

The Unit should refund the Federal grant $37,207 for the unsupported costs we identified. In addition, the Unit should work with OIG to refund the Federal grant for its excess purchases identified in this report and the indirect costs it improperly claimed on its FFRs. As part of its efforts to refund the Federal grant, the Unit should evaluate staff use of the excess equipment and supplies it purchased to determine what amount was unassigned as of December 2023. The Unit should refund the grant for those items that it identifies, which would have been unassigned for over a year after their purchase date and therefore not deemed necessary or reasonable in accordance with 45 CFR § 75.403(a). OIG is working with the Unit to retroactively approve the equipment purchases that were necessary and allocable to the Federal grant and is not requesting a refund for those items. However, the Unit should ensure that it refunds to the grant any equipment that was not in use by staff as of December 2023. In addition, the Unit should work with OIG to review its financial data to ensure that it correctly categorized its expenses and calculated its indirect costs, and that it claimed the appropriate Federal reimbursement rates. If further errors are identified, the Unit should refund the Federal grant accordingly.

Implement policies and procedures to ensure effective fiscal control of its funds, property, and other assets

The Unit should work with urgency to implement policies and procedures that address the significant gaps that we identified in the Unit's fiscal control. The policies and procedures should include detailed information to ensure that the Unit:

1) maintains adequate supporting documentation and requests prior approval from OIG for future expenditures on the Federal grant, when required;
2) conducts a physical inventory review at least every 3 years, when it moves office locations, and when it reorganizes its structure, in accordance with State policy;
3) regularly updates its inventory to ensure that all items are properly accounted for;
4) conducts adequate acquisition planning that includes a process for determining necessity of equipment and supplies before purchasing items, including steps to consider current inventory and justification for the number of items purchased; and
5) correctly calculates and claims its indirect costs on its FFRs, including appropriately categorizing expenses and claiming the correct Federal reimbursement rate.

In addition, the Unit should coordinate with the DOJ Division of Operations to determine what responsibilities each office has for fiscal controls and document the resulting agreement. The Unit should ensure that staff with responsibilities for fiscal control adhere to all Federal and State fiscal policies and regulations, as the Unit is ultimately responsible for exercising proper fiscal control of its resources.

UNIT COMMENTS AND OIG RESPONSE

The California MFCU concurred with all seven of our recommendations.

First, the Unit concurred with our recommendation to build upon its efforts to recruit and retain qualified staff. The Unit reported that it continues to prioritize efforts to fill its vacancies, particularly for investigators and auditors. The Unit has worked to pursue reclassification for the auditor position to allow it to pull from a larger candidate pool, which the Unit anticipates to be completed by October 2025. The Unit also reported working to change the class specifications for the auditor series to remove the business law course requirement.

Second, the Unit concurred with our recommendation to update its periodic supervisory review policies to reflect current operations and develop a process to ensure that its policies and procedures manual is current. The Unit reported that it added the updated policy to its manual in November 2023. The Unit also noted that it formed a committee tasked with reviewing Unit policies and procedures and recommending updates.

Third, the Unit concurred with our recommendation to build upon its efforts to increase fraud referrals from DHCS's program integrity unit and the MCOs. The Unit reported that, in March 2025, it made a formal program recommendation to DHCS to contractually require MCOs to simultaneously refer allegations of fraud to DHCS and the Unit. The Unit also stated that it has ongoing communication and collaboration with the MCOs and DHCS regarding fraud referrals. As a result of its efforts, the Unit reported, fraud referrals to the Unit increased 35 percent since the end of FY 2023.

Fourth, the Unit concurred with our recommendation to work with DHCS to improve the Unit's access to and the quality of Medicaid claims data. The Unit reported meeting with DHCS in the beginning of 2025 to obtain enhanced access to Medicaid claims data. As a result, the Unit noted, in March 2025 it obtained direct access to all Medicaid claims data through DHCS's data repository, which will allow the Unit to perform extensive data mining.

Fifth, the Unit concurred with our recommendation to report all convictions and adverse actions to Federal partners within the appropriate timeframes. The Unit stated that it will report convictions to OIG and NPDB within 30 days or as soon as practicable if there are delays in receiving the documentation from the court.

Sixth, the Unit concurred with our recommendation to refund the Federal grant for the unsupported costs, excess purchases, and improperly claimed indirect costs. The Unit reported that it will refund the $37,207 in unsupported costs and work with OIG to determine if any additional refund to the Federal grant is required.

Seventh, the Unit generally concurred with our recommendation to implement policies and procedures to ensure effective fiscal control of its funds, property, and other assets. The Unit acknowledged that there is room for improvement but disagreed with the characterization that the gaps were significant. The Unit reported that it will work with the DOJ Division of Operations and the staff responsible for fiscal control to implement policies and procedures to address the findings.

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

Review of Unit Documentation

Before the inspection, we reviewed the recertification materials for FYs 2021–2023, including (1) the Unit director's recertification questionnaires, (2) the Unit's MOU with the State Medicaid agency, (3) the program integrity director's questionnaires, and (4) the OIG Special Agent in Charge questionnaires. We also reviewed the Unit's policies and procedures manual and the Unit's self-reported case outcomes and referrals included in its annual statistical reports for FYs 2021–2023. We also examined the recommendations from the 2015 OIG onsite inspection and the Unit's implementation of those recommendations.

Review of Unit Financial Documentation

From October 2023 to September 2024, OIG auditors reviewed the Unit's internal fiscal controls and use of fiscal resources to identify any internal control issues or other issues involving the use of resources. We reviewed the Unit's responses to an internal controls questionnaire over its accounting, budgeting, procurement, property, and equipment. We also held discussions with Unit and DOJ Division of Operations staff to gain an understanding of policies, procedures, and practices.

Additionally, we examined the Unit's transaction detail reports for the claimed grant expenditures for FYs 2020–2022. For these expenditures, we (1) reconciled the expenditure amounts to the Unit's FFRs; (2) compared the expenditures with the Unit's approved budgets; (3) compared the expenditures with the Unit's approval and purchase order logs to identify additional information on the claimed expenditures; and (4) reviewed the HHS-approved indirect cost rates and expenditures charged to the Unit's indirect cost category.

While onsite, we reviewed two purposive samples to assess the Unit's internal control of fiscal resources:

1. We selected and reviewed support for a sample of 72 transactions totaling $5,552,497 to determine whether the expenditures met applicable Federal cost principles.

2. We reviewed the Unit's fixed asset inventory by selecting 153 of the Unit's 3,069 assets and verifying the sample's existence.

Interviews with External Partners

In September and October 2023, we interviewed external partners, including officials in the PIU; the Department of Public Health; two MCOs; and the U.S. Attorney's Offices for the Northern and Central Districts of California. We also interviewed two Special Agents in Charge from OIG's Office of Investigations. We focused these interviews on the Unit's relationship and interaction with the partner agencies, as well as opportunities for improvement. We used the information collected from these interviews to develop subsequent interview questions for Unit management and staff.

Interviews with Unit Management and Selected Staff

We conducted structured interviews with the Unit's management and selected staff in October 2023. Of the Unit management, we interviewed the director; two assistant bureau chiefs; the chief investigator; the chief attorneys for the criminal and civil divisions; and the chief auditor. We also interviewed three Special Agents in Charge, five special agent supervisors, five attorney supervisors, four auditor supervisors, and the supervisor of the Unit's data mining operations. In addition, we interviewed two staff members from the Unit's complaint assessment team. Finally, we interviewed the supervisor of the Unit—a Chief Deputy Attorney General in the California Department of Justice. 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.

Survey of Unit Staff

We conducted an electronic survey of a stratified random sample of nonmanagerial Unit staff from each of the Unit's regional offices. The survey asked about the Unit's adherence to the 12 performance standards, beneficial practices, and needs for improvement. We used the information collected from this survey to identify potential areas of concern for this inspection and to supplement Unit management perspectives obtained onsite.

Review of Case Files

To craft a sampling frame, we asked the Unit to provide us with a list of cases that were open at any point during FYs 2021–2023 and to 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 2,679.

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 80 global cases, leaving 2,599 case files.

We then selected a simple random sample of 100 cases from the population of 2,599 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 100 case files for adherence to the relevant performance standards and compliance with statutes, regulations, and policy transmittals. During the review of the sampled case files, we consulted MFCU staff to address any apparent issues with individual case files, such as missing documentation.

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

We also reviewed all convictions submitted to OIG during the review period (190) so that convicted individuals could be excluded from programs and all adverse actions submitted to the NPDB during the review period (196). 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 2021–2023. We also assessed the timeliness of the submissions to OIG and the NPDB.

Onsite Inspection of Unit Operations

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

APPENDICES

Appendix A: Unit Referrals by Source for Fiscal Years 2021–2023

Referral Source	FY 2021		FY 2022		FY 2023		3-Year Total		
	Fraud	Abuse or Neglect	Fraud	Abuse or Neglect	Fraud	Abuse or Neglect	Fraud	Abuse or Neglect	Total
Adult Protective Services	1	21	7	165	15	71	23	257	280
Anonymous	0	1	0	0	1	1	1	2	3
Federal Contractor(s)*	–	–	–	–	5	0	5	0	5
HHS-OIG	4	8	9	4	13	4	26	16	42
Law Enforcement—Other	5	43	8	59	9	73	22	175	197
Licensing Board	0	2	2	2	2	1	4	5	9
Local Prosecutor	0	1	1	2	1	1	2	4	6
Long-Term Care Ombudsman	0	12	0	6	0	21	0	39	39
Managed Care Organizations	5	0	9	0	26	0	40	0	40
PIU**	–	1	6	1	–	–	6	2	8
PIU—MCO Origination**	38	–	3	–	15	3	56	3	59
Private Citizen	142	396	143	347	386	226	671	969	1,640
Private Health Insurer	1	2	0	0	3	0	4	2	6
Provider	2	0	1	0	0	0	3	0	3
State Survey and Certification Agency***	23	2,348	139	4,659	114	4,899	276	11,906	12,182
State Agency—Other	7	448	17	501	60	587	84	1,536	1,620
Other	0	1	0	2	2	4	2	7	9
Subtotal	**228**	**3,284**	**345**	**5,748**	**652**	**5,891**	**1,225**	**14,923**	**16,148**
Total	**3,512**		**6,093**		**6,543**		**16,148**		

Source: OIG analysis of Unit annual statistical reports for FYs 2021–2023.
* In FY 2023, OIG updated its annual statistical report template to include a category for referrals from CMS contractors, including Unified Program Integrity Contractors. For more information, see CMS, *Review Contractor Directory – Interactive Map*, October 2023. Accessed at https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/review-contractor-directory-interactive-map on March 5, 2024.
** In FY 2023, OIG updated its annual statistical report template to include categories that identify referrals from the PIU that originated or did not originate from MCOs. OIG collected data on PIU referral origination for FYs 2021–2022 in Unit annual statistical reports.
*** The Department of Public Health and the Department of Social Services are the State Survey and Certification agencies for California.

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

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval	
			Lower	Upper
Percentage of All Cases That Had Supervisory Approval To Open	100	94.00%	87.50%	97.73%
Percentage of All Cases Closed at the Time of Our Review	100	58.00%	47.86%	67.64%
Percentage of All Closed Cases That Had Supervisory Approval To Close	55*	100.00%	93.57%	100.00%

Source: OIG analysis of California MFCU case files, FYs 2021–2023.

* We excluded three cases marked as "No Response" from the estimates for the percentage of closed cases that had supervisory approval to close.

ROB BONTA
Attorney General

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May 9, 2025

Ann Maxwell
Deputy Inspector General for Evaluations and Inspections
Office of Inspector General
Room 5660, Cohen Building
330 Independence Ave, SW
Washington, DC 20201

Re: California Medicaid Fraud Control Unit: 2023 Onsite Review OEI-06-23-00450.

Dear Ms. Maxwell:

Thank you for sharing HHS-OIG's draft report, California Medicaid Fraud Control Unit: 2023 Inspection, OEI- 06-23-00450, dated April 9, 2025. We have reviewed the report and your recommendations.

We are pleased that the OIG recognized our Medicaid Fraud Control Unit's ("Unit") successful work during the audit periods[1], including the 180 criminal indictments, 221 convictions, and 65 civil settlements and judgments, with a combined recovery of approximately $544 million. Additionally, we are pleased that the OIG's findings demonstrate that the Unit properly spent 99.98% of its $165 million in grant funds pursuant to grant requirements.

The OIG's report includes seven recommendations, the remainder of this letter outlines the Unit's response to each recommendation.

Recommendation 1: Build upon its efforts to recruit and retain qualified staff.
Finding: The Unit experienced staffing shortages, resulting in high caseloads and case backlogs, but took steps to strengthen its recruitment efforts.

Response: The Unit concurs with this recommendation. The Unit continues to prioritize its efforts to fill its vacancies, particularly for Special Agents and Investigative Auditors. The Unit is nearly finished reclassifying Investigative Auditors in the Criminal Section to Special

[1] The onsite aspect of the inspection audited federal fiscal years 2021 through 2023 while the fiscal audit covered an audit period of federal fiscal years 2020 through 2022.

Investigators. This reclassification will allow the Unit to pull from a larger candidate pool in our attempt to hire qualified individuals. We anticipate the reclassification being completed by October 2025. The Unit continues to work with CalHR to change the class specifications for the Investigative Auditor series in an effort to remove the Business Law requirement.

Recommendation 2: Update its periodic supervisory review policies to reflect current operations and develop a process to ensure that its policies and procedures manual is current.

Response: The Unit concurs with this recommendation. The updated policy related to periodic supervisory case review was added to the Unit's electronic policy and procedure manual in November 2023. The Unit continues to review its policies and procedures on an ongoing basis. Additionally, the Unit has formed a committee whose responsibility it is to review all Unit policies and procedures and recommend updates.

Recommendation 3: Build upon its efforts to increase fraud referrals from the Department of Health Care Services' program integrity unit and the managed care organizations.

Response: The Unit concurs with this recommendation. On March 19, 2025, the Unit made a formal program recommendation to DHCS asking that it contractually require MCOs to simultaneously refer allegations of fraud to DHCS and the Unit and plans to further request to be involved in the contract term development process. Additionally, the Unit continues to meet with the MCOs regularly, approximately nine times a year and with DHCS quarterly to discuss fraud referrals, in addition to regular informal meetings. As for the fraud referrals from DHCS, the Unit continues to work closely with them and meets routinely with members of the Program Integrity Unit. As a result of our close collaboration and cross-training, the CAF referrals to the Unit have increased approximately 35% since the end of the audit period.

Recommendation 4: Work with the Department of Health Care Services to improve the Unit's access to and the quality of Medicaid claims data.

Response: The Unit concurs with this recommendation. During the 1st quarter on 2025, the Unit participated in several meetings with DHCS in order to obtain enhanced access to Medicaid claims data. In March of 2025, the Unit obtained direct access to DHCS's Teradata repository which will allow direct access to all Medicaid claims data. This direct access will allow the Unit to perform extensive data mining to identify potentially fraudulent claims. The Unit continues to work with DHCS to identify specific algorithms to identify fraud.

Recommendation 5: Report all convictions and adverse actions to Federal partners within the appropriate timeframes.

Response: The Unit concurs with this recommendation. The Unit is pleased that the OIG recognized the significant improvement between the Unit's last inspection and the current inspection, noting that timely submissions to the OIG improved from 35% to 88% and submissions to the NPDB increased from 21% to 61%. The Unit will continue to report

convictions to OIG and NPDB within 30 days or as soon as practicable if there are delays in receiving the documentation from the court.

Recommendation 6: Refund the Federal grant for the unsupported costs, excess purchases, and improperly claimed indirect costs

Response: The Unit concurs with the recommendation to refund the Federal grant $37,207 for the unsupported costs identified by the OIG and will work with the OIG, as described in the recommendation, to determine if an any additional refund to the Federal grant is required.

Recommendation 7: Implement policies and procedures to ensure effective fiscal control of its funds, property, and other assets

Response: The Unit generally concurs with this recommendation. The Unit acknowledges there is room for improvement but disagrees with the characterization that the gaps are significant. The California Department of Justice has established uniform procedures to ensure that program resources, activities, and related charges are properly recorded for each respective cost center. DOJ's record keeping involves, in part, human efforts that though safeguarded are prone to unintentional errors. The gaps in fiscal control are minimal as evidenced by the findings resulting in only $37,207 in unsupported costs during a reporting period in which the Unit was responsible for managing $206 million. The Unit will refund the Federal grant $37,207 for the unsupported costs and will work with the DOJ Division of Operations and the staff responsible for fiscal control to implement policies and procedures to identify and address the minor gaps in fiscal controls.

The California MFCU appreciates the time and effort the OIG undertook during its nearly 20-month inspection of the Unit. The Unit is pleased that the hundreds of hours the Unit staff dedicated to this endeavor resulted in so many positive findings. We are committed to working with the OIG to address the recommendations discussed above.

Thank you for the opportunity to respond to the draft inspection report. Please feel free to contact me if you need any additional information.

Sincerely,

Jennifer Euler
Chief Assistant Attorney General

For ROB BONTA
Attorney General

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