MEDICAID PROGRAM INTEGRITY MANUAL
CHAPTER 1 – MEDICAID INTEGRITY PROGRAM (MIP)

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(Rev. 1, Issued: 09-23-11)

INTRODUCTION

1000 – PURPOSE OF MANUAL

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The purpose of the Medicaid Program Integrity Manual is to promote continuity and consistency of the Medicaid Integrity Program by providing a comprehensive guide to its overall operations. The Medicaid Program Integrity Manual will primarily serve as a reference tool to assist State Medicaid officials, providers, health care organizations, the Centers for Medicare & Medicaid Services (CMS) components, and other Federal agencies in the following:

1. Understanding the goals and objectives of the MIP;
2. Improving the communication and transparency of the MIP; and
3. Educating outside entities of the evolving functions of the MIP.

1005 – MEDICAID PROGRAM: BACKGROUND AND OVERVIEW

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

Medicaid is generally a means-tested health care entitlement program financed by States and the Federal Government that provides health care coverage to low-income families with dependent children, pregnant women, children, and aged, blind and disabled individuals. States have considerable flexibility in structuring their Medicaid programs within broad Federal guidelines governing eligibility, provider payment levels, and benefits. As a result, Medicaid programs vary widely from State to State. Medicaid covers a broad range of services to meet the health needs of eligible beneficiaries. Federally mandated services include hospital inpatient and outpatient services, comprehensive health screening, diagnostic and treatment services to children, home health care, laboratory and x-ray services, physician services, and nursing home care. Commonly offered optional services include prescription drugs, dental care, eyeglasses, prosthetic devices, hearing aids, home and community-based services and services in intermediate care facilities for individuals with a mental illness.

1010 – CENTER FOR PROGRAM INTEGRITY (CPI)/MEDICAID INTEGRITY GROUP (MIG) STRATEGY

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

Within the CMS, the MIG serves as one of five operating divisions organizationally located in the CPI that advises the Agency on program integrity matters.

As part of the CPI, the MIG has worked to accomplish the following:

Provide Training on Program Integrity (PI)

The Medicaid Integrity Institute (MII) was created in 2007 through a partnership with the Department of Justice (DOJ) Office of Legal Education. The MII provides high quality program integrity training to State Medicaid Agency employees at no cost to the States. By the end of FY 2010, the MII had convened 38 classes in a variety of disciplines such as data analysis, fraud investigation and Current Procedural Terminology (CPT) coding and trained approximately 1,900 students. The MII has 15 classes scheduled for FY 2011 with an anticipated 850 State program integrity staff participating in those courses.

Leverage the Information Technology Infrastructure

The Information Technology Infrastructure includes six years of State Medicaid claims data with an estimated 3 billion claims per year, and 60 million recipient records. The CMS and its Medicaid Integrity Contractors (MICs) use the Information Technology Infrastructure to review Medicaid claims to identify billing aberrancies and vulnerabilities for referral to the Audit MICs. Concurrently, the MIG is working to increase the number of data fields within the database to collect additional State provider and payment information to make analysis more precise in identifying actionable findings, which will result in better detection of improper payments.

Work with States to Identify Vulnerabilities and Share Best Practices

The CMS continues to provide States with technical assistance on PI activities, and to conduct systematic reviews of State program integrity operations. The CMS will identify and work to group States with similar Medicaid program integrity vulnerabilities. These grouped States will share information on fraud, waste, and abuse that penetrate across State lines. The CMS continues to work with the Medicaid Fraud and Abuse Technical Advisory Group (TAG) to learn more about emerging trends and to identify ways States need technical and other assistance. This feedback continuously updates and improves technical assistance and support to the States.

Expand Recovery Audit Contractors (RACs) to Medicaid

The Patient Protection and Affordable Care Act of 2010 (hereafter "Affordable Care Act"), requires CMS to expand the RAC program to Medicare Parts C and D, and Medicaid. In 2010, CMS worked with the States on the approach to Medicaid RACs. The expansion of the RAC program will aid the identification of overpayments in the Medicaid program and identify patterns to help prevent the program from making future improper payments.

Report Supplemental Measures of Medicaid Improper Payment Error Rates

In support of the implementation of Executive Order 13520 regarding improper payments, the CMS developed a plan to conduct supplemental measurements of payment errors. In 2010, the CMS identified four national focus areas that we encourage States to target for their supplemental error rates. This measurement must focus on higher risk areas within Medicaid and inform on root causes of error that a corrective action can fix. In addition, the supplemental measurement should leverage available and accessible information (e.g., claims, payments, files) for the current year rather than previous years, to the extent possible. The initial four focus areas are long-term care, home health, inpatient hospital services, and pharmacy services. However, these areas can/will change from year to year based on the Payment Error Rate Measurement (PERM) results and other data analysis.

1015 – MEDICAID INTEGRITY PROGRAM (MIP) BACKGROUND

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The CMS is committed to combating Medicaid provider fraud, waste, and abuse, which diverts dollars that would otherwise be spent to safeguard the health and welfare of Medicaid beneficiaries. In February 2006, the Deficit Reduction Act of 2005 (DRA), Pub. L. 109-171, was signed into law and created the MIP under section 1936 of the Social Security Act. The MIP is the first comprehensive Federal strategy to prevent and reduce provider fraud, waste, and abuse in the Medicaid program.

1015.1 – MIP RESPONSIBILITIES

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The CMS has two broad responsibilities under the MIP:

- To hire contractors to review Medicaid provider activities, audit claims, identify overpayments, and educate providers and others on MIP issues; and
- To provide effective support and assistance to States in their efforts to combat Medicaid provider fraud and abuse.

The Medicaid Integrity Group (MIG) is charged with implementing the MIP.

1020 – AFFORDABLE CARE ACT

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The Department of Health and Human Services was delegated the responsibility for implementing many major provisions of the historic health reform bill known as the Affordable Care Act. The CMS is responsible for implementing the provisions of the legislation that address Medicare, Medicaid, the Children's Health Insurance Program

(CHIP), and the American Health Benefit Exchanges and related private insurance provisions.

1020.1 – AFFORDABLE CARE ACT PROVISIONS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The provisions of the Affordable Care Act that most affect the MIP are as follows:

1. Section 6401 – Provider Screening and Other Enrollment Requirements under Medicare, Medicaid, and CHIP

   Section 6401 of the Affordable Care Act creates new provider screening requirements that apply to all Medicare, Medicaid, and CHIP providers, both individual and institutional. Section 6401(b), which creates a new section 1902(a)(77) of the Social Security Act (the Act) and amends Section 2107(e)(1) of the Act, sets forth specific provider and supplier screening, oversight and reporting requirements. These requirements include provider screening, provisional period of enhanced oversight, disclosure requirements, temporary moratorium on enrollment of new providers, compliance programs, reporting of adverse provider actions, enrollment and National Provider Identifier (NPI) for ordering or referring providers and other State oversight.

2. Section 6402 – Enhanced Medicare and Medicaid Program Integrity Provisions
   Section 6402(a) provides that:

   - An Integrated Data Repository be established which will include claims and payment data from Medicare, Medicaid, CHIP, health-related programs administered by the Secretary of Veterans Affairs and the Secretary of Defense, the program of old-age, survivors, and disability insurance benefits established under Title II of the Act, and the Indian Health Service and the Contract Health Service program. Data is to be shared and matched between various Federal agencies for the purpose of identifying potential fraud, waste and abuse under the Medicare and Medicaid programs.
   - The Inspector General of the Department of Health and Human Services may obtain information from any individual (including a beneficiary) or entity that is a provider of medical or other items or services, supplier, grant recipient, contractor or subcontractor; or directly or indirectly provides, orders, manufactures, distributes, arranges for, prescribes, supplies or receives medical or other items or services payable by any Federal health care program regardless of how the item or service is paid for, or to whom such payment is made.
   - The Secretary of Health and Human Services must impose an administrative penalty on individuals who knowingly participate in a

health care fraud offense or a conspiracy to commit a Federal health care fraud offense.

- Providers of services, suppliers, Medicaid managed care organizations, Medicare Advantage organizations or PDP sponsors that have received an overpayment must report the reason for that overpayment and return that overpayment.
- All Medicare and Medicaid providers of medical or other items or services and suppliers that qualify for a national provider identifier (NPI) must include their NPI on all applications for enrollment and claims submitted for payment in such programs.

Section 6402(h)(2) provides for the following:

- Federal Financial Participation (FFP) in the Medicaid program shall not be made with respect to any amount expended for items or services (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished by an individual or entity to whom a State has failed to suspend payments under the plan during any period when there is pending an investigation of a credible allegation of fraud against the individual or entity as determined by the State, unless the State determines that good cause exists not to suspend such payments.

Section 6402(j)(2) provides that:

- The contractor will provide the Secretary and Inspector General of the Department of Health and Human Services with performance statistics.
- The performance statistics reported must include:
  - number and amount of overpayments recovered;
  - number of fraud referrals; and
  - return on investment of these activities by the contractor.
- The Secretary will conduct evaluations of the Medicaid Integrity Program's contractors at least every 3 years.

NOTE: The Audit MICs have had the requirement to report on performance statistics added to their contracts, and at this time, they are the only type of MIG contractors providing this information.

3. Section 6411 – Expansion of the Recovery Audit Contractor (RAC) Program

   Section 6411(a) creates Section 1902(a)(42) of the Act, which requires States and territories to establish Medicaid RAC Programs consistent with State laws. States and territories are required to establish programs with one or more Medicaid RACs, by amending their State Plans, unless an exception is granted by CMS. Medicaid RACs must identify and recover overpayments and identify

underpayments. States must pay Medicaid RACs on a contingency fee basis for identification and recovery of overpayments. States will determine the fee paid to Medicaid RACs to identify underpayments. Payments to Medicaid RACs must be made only from amounts recovered. Medicaid RACs must coordinate their efforts with other auditing entities, including State and Federal law enforcement agencies.

4. Section 6501 – Termination of Provider Participation under Medicaid if Terminated under Medicare or Other State Plan

   Section 6501 creates a new section 1902(a)(39) of the Act, which requires States to terminate or exclude from Medicaid participation any individual or other entity that has been terminated from participation in Medicare or from another State's Medicaid program.

5. Section 6503 – Billing Agents, Clearing Houses, or Other Alternate Payees Required to Register under Medicaid

   Section 6503 creates a new section 1902(a)(79) of the Act, which requires any agent, clearinghouse, or alternate payee that submits claims on behalf of a health care provider to register with the State and HHS in a form and manner to be determined by HHS.

6. Section 6504 – Requirement to Report Expanded Set of Data Elements under MMIS to Detect Fraud and Abuse

   Section 6504 amends, in pertinent part, section 1903(r)(1)(F) of the Act and provides that in order for a State to receive federal payments for the use of automated data systems used in the administration of the State Plan, the State must provide enrollee encounter data (in a format consistent with the Medical Statistical Information System (MSIS)) that HHS determines necessary for program integrity, program oversight, and program administration at a frequency determined by HHS.

7. Section 6505 – Prohibition on Payments to Institutions or Entities Located Outside of the United States

   Section 6505 creates a new section 1902(a)(80) of the Act, which prohibits the State from paying for Medicaid items or services under the State Plan, or a waiver program to any financial institution or entity located outside the United States.

8. Section 6506 – Overpayments

   Section 6506 amends section 1903(d)(2) of the Act by extending the deadline for the State to return the Federal share of overpayments from 60 days to 1 year for most overpayments. For overpayments resulting from fraud where a final

determination of the amount of the overpayment is not made under an administrative or judicial process, the deadline extends to 30 days after the date of the final judgment (including any appeal).

9. Section 6507 – Mandatory State Use of National Correct Coding Initiative (NCCI)

   Section 6507 of the Affordable Care Act amends section 1903(r) of the Social Security Act (the Act) and requires each State Medicaid program to implement compatible methodologies of the National Correct Coding Initiative (NCCI), to promote correct coding and to control improper coding leading to inappropriate payment.

NOTE: On December 15, 2010, the President signed into law the Medicare and Medicaid Extenders Act of 2010, which repealed new section 1902(a)(78) of the Act, as originally added by Section 6502 of the Affordable Care Act. The MIG sent an Informational Bulletin on December 30, 2010 notifying States of the repeal.

1025 – EXECUTIVE ORDER 13520: REDUCING IMPROPER PAYMENTS AND ELIMINATING WASTE IN FEDERAL PROGRAMS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

Executive Order 13520, dated November 23, 2009, directed Executive Branch agencies to engage in a concerted effort to reduce improper payments. In Fiscal Year (FY) 2009, Federal agencies made $98 billion in improper payments, which represented an increase of 27% over the prior fiscal year. Among the measures outlined in this Order, the President directed the Secretary of the Treasury and the Director of the Office of Management and Budget (OMB), in consultation with the Council of Inspectors General on Integrity and Efficiency (CIGIE), the DOJ and program experts, to make recommendations for "actions designed to reduce improper payments by improving information sharing among agencies and programs, and where applicable, State and local governments and other stakeholders." The Order focuses on broad categories of action including boosting transparency and holding agencies accountable.

Under the Order, agencies with high-priority programs are required to establish annual or semi-annual measurements for reducing improper payments. The CMS was designated such an Agency due to the improper payment rate under Medicare and Medicaid. This measure must focus on higher risk areas within Medicaid and inform on root causes of error that can be fixed through corrective actions. Through the review and analysis of Payment Error Rate Measurement (PERM) findings the CMS identified several high vulnerability/high risk areas to work with States to target. The initial national focus areas include: nursing homes, inpatient hospital, home health and pharmacy. The CMS proposed Medicaid supplemental measures to demonstrate achievable improvements in improper payments while developing enhanced oversight and reporting mechanisms to evaluate the effectiveness of Federal and State program integrity efforts. The CMS is

actively engaged with States in efforts to have successful Payment Accuracy Improvement Groups (PAIGs). The purpose of the PAIG is to facilitate information sharing among States addressing similar issues and to enable the CMS to target staff and contractor resources to provide States with in-depth technical assistance to address and correct the identified problems in a meaningful way. States are expected to develop efforts to reduce improper payments. These efforts require "supplemental metrics" to evaluate the success of the PAIG intervention. The CMS will assist with technical assistance, contractor support, and State metric reporting to evaluate the success of the PAIG intervention.

1030 – MEDICAID INTEGRITY PROGRAM (MIP) EFFORTS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

1030.1 – MIG GOALS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The MIG has identified the following primary goals:

- Promote the proper expenditure of Medicaid program funds;
- Improve Medicaid program integrity performance nationally;
- Ensure the operational and administrative excellence of the MIP;
- Demonstrate effective use of MIP funds; and
- Foster collaboration with internal and external stakeholders of the MIP.

1030.2 – CORE BUSINESS PROCESSES UNDER 1936 OF THE ACT (THE MEDICAID INTEGRITY PROGRAM)

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The MIG has identified four core business processes and two main business operations to successfully meet its goals and the requirements of section 1936 of the Act.

The Core Business Processes are:

- Planning and Program Management
- Ensuring Accountability
- Communication and Collaboration
- Information Management and Research

1030.3 – MAIN BUSINESS OPERATIONS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The Main Business Operations are:

- **Medicaid Integrity Contracting:** procuring and managing contracts for Medicaid Integrity Contractors (MICs) and other MIP projects; and
- **State Program Integrity Operations:** providing effective support and assistance to States to improve Medicaid program integrity activities and conducting reviews of State Medicaid integrity programs.

1030.4 MIG EFFORTS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

Medicaid Integrity Institute (MII): The first national Medicaid program integrity-training venue, the MII offers training at no cost to State Medicaid PI staff in various disciplines. MII is located at the U.S. Justice Department's National Advocacy Center, where participants learn techniques to safeguard program dollars. The MII hosts numerous classes each year, training hundreds of State PI employees.

Review and Audit of Providers: Pursuant to section 1936 of the Act, MICs have been procured to review and audit providers' claims and identify potential overpayments.

Education of Providers and Others: Education on payment integrity and quality of care issues is available for Medicaid providers and others.

Fraud, Waste and Abuse Research: Fraud, waste, and abuse detection algorithms have been developed to assist MIG, State program integrity units, and the MICs in the detection of fraud, waste, and abuse. Moreover, State Performance Integrity Assessments (SPIAs) provide a baseline of Medicaid program integrity accomplishments across the country. The SPIA is the MIG's effort to identify a State-by-State baseline of program integrity demographics. It includes information on a wide variety of program integrity functions, staffing, and accomplishments. In FY 2009, the MIG published the first-ever compilation of SPIA results representing FY 2007 State demographics. The SPIA is now an annual process and will help identify strengths and opportunities for improvement in Medicaid's program integrity infrastructure.

Technical Assistance: Program integrity technical assistance is available to States and other stakeholders. The MIG provides guidance on selected provisions under section 1936 of the Act and other regulatory and legislative requirements.

The MIG's staff provides ongoing technical assistance to States on a variety of program integrity related topics including, but not limited to, provider fraud; billing concerns; provider enrollment; PERM; statistical analysis and program integrity regulations.

Upon request, the MIG staff provides resources to support State special projects to target suspect providers in high-fraud areas. Between October 2007 and March 2009, MIG employees took part in six special field projects. Five of these were investigations coordinated by the Florida Agency for Health Care Administration. One was an investigation coordinated by the California Department of Health Services. In each project, State and Federal staff interviewed Medicaid clients and providers and examined medical records, which allegedly supported the services billed. For three of these projects, the State Agency reviewed paid claims for similar time periods before and after the special projects. In each case, there was a significant decrease in paid claims after the project. The estimated savings from these three projects totaled approximately $10.1 million.

State Program Integrity (PI) Reviews:
The purpose of State PI reviews are to:

1. Determine compliance with Federal program integrity laws and regulations;
2. Identify program vulnerabilities and noteworthy practices;
3. Help the States improve their overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Through State comprehensive program integrity reviews, MIG staff identifies program integrity related issues in State operations and, in turn, help States improve program integrity efforts. Each State undergoes a comprehensive review every three years. In addition to evaluating State compliance and identifying issues in State operations, MIG staff use these reviews to identify and disseminate best practices.

In each of the State program integrity reviews, State staff answers questions in the review guide and provides supporting documentation in the areas of program integrity, provider enrollment, managed care, and information regarding the Medicaid Fraud Control Unit (MFCU). That information is then confirmed through review of documentation and interviews with program integrity, provider enrollment, managed care, and MFCU staff.

Best Practices Guidance: The MIG also provides technical assistance in the form of guidance documents. The MIG has issued State Medicaid Director Letters on topics such as enhanced Federal Financial Participation for false claims acts; false claims education requirements; tamper resistant prescription pad requirements; cooperation with the MIG; and provider exclusions. The State Medicaid Director Letters are available on the CMS Website at **http://www.cms.hhs.gov/SMDL/SMD/list.asp#TopofPage.** Also see Medicaid Program Integrity Manual Section 16005 – State Medicaid Director Letters Authored by MIG (in whole or in part).

In September 2008, the MIG issued CMS MIG Performance Standards for Referrals of Suspected Fraud from a Single State Agency to a MFCU in order to determine the percentage of accepted referrals that were provided by State Medicaid Agencies to their MFCUs. At no time previously had program integrity units been issued performance standards that measured the number of referrals made to their MFCUs. Along with the

Referral Performance Standards, the MIG issued a Best Practices document that elaborated on whether and when cases should be referred to the MFCU, the content of quality referrals, and how to maintain a good relationship between the State program integrity unit and the MFCU.

In May 2009, the MIG also issued its first annual summary of program integrity review results. It included information about effective practices, areas of vulnerability, and areas of non-compliance.

1035 – OVERPAYMENT AND ERRORS VERSUS FRAUD, WASTE, AND ABUSE

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

An **improper payment** is any payment that should not have been made or that was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements. Incorrect amounts include overpayments and underpayments. An improper payment includes any payment that was made to an ineligible recipient, payment for non-covered services, duplicate payments, payments for services not received, and payments that are for the incorrect amount. In addition, when an Agency's review is unable to discern whether a payment was proper because of insufficient or lack of documentation, this payment must also be considered an improper payment. (42 CFR § 431.958; Improper Payments Elimination and Recovery Act (IPERA); and Appendix C to OMB Circular A-123 (M-10-13))

Data processing errors are errors resulting in an overpayment or underpayment that is determined from a review of the claim and other information available in the State's Medicaid Management Information System (MMIS), related systems, and our outside sources of provider verification. The difference in payment between what the State paid and what the State should have paid, in accordance with the State's documented policies, is the dollar measure of the payment error. (42 CFR § 431.960(b)(1) and (b)(2))

Medical review errors are errors resulting in an overpayment or underpayment that is determined from a review of the provider's medical record or other documentation supporting the service(s) claimed. The difference in payment between what the State paid and what the State should have paid is the dollar measure of the payment error. (42 CFR § 431.960(c)(1) and (c)(2))

NOTE: Eligibility errors are not defined in this manual.

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. (42 CFR § 433.304 and 455.2)

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in

reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program. (42 CFR § 433.304 and 455.2)

In cases where there is suspected fraud, but the case has been refused by law enforcement, audit contractors deny the claim(s) and collect the overpayment after notifying law enforcement.
An actual overpayment is the sum of payments (based on the amount paid to the provider and Medicaid approved amounts) made to a provider for services which were determined to be medically unnecessary or incorrectly billed.

Section 6402 of the Affordable Care Act, which creates section 1128J of the Act, defines "**overpayment**" to mean "any funds that a person receives or retains under title XVIII or XIX to which the person, after applicable reconciliation, is not entitled under such title. (Sec. 1228J of the Social Security Act) Under section 6506 of the Affordable Care Act, States now have one year from the date of discovery of an overpayment for Medicaid services to recover, or attempt to recover, such overpayment before making an adjustment to refund the Federal share of the overpayment. Except in the case of overpayments resulting from fraud, the adjustment to refund the Federal share must be made no later than the deadline for filing the quarterly expenditure report (Form CMS-64) for the quarter in which the one-year period ends, regardless of whether the State recovers the overpayment.

Section 6506(a)(1)(B) of the Affordable Care Act further amended the Act by adding section 1903(d)(2)(D)(ii) pertaining to overpayments made due to fraud. Specifically, when a State has been unable to recover overpayments due to fraud within one year of discovery because of an ongoing judicial or administrative process, the State will have until 30 days after the conclusion of judicial or administrative processes to recover such overpayments before making the adjustment to the Federal share.

Additionally, the discovery date for overpayments due to fraud begins on the date of the final written notice of the State's overpayment determination to the provider. (42 CFR § 433.316).

1040 – RETURN ON INVESTMENT

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In addition to the MIP annual Report to Congress required under section 1936 of the Act, the MIG is required to report return on investment (ROI) for the Government Performance Results Act (GPRA). ROI is a performance measure used to evaluate the efficiency of an investment or to compare the efficiency of a number of different investments. To calculate ROI, the benefit (return) of an investment is divided by the cost of the investment, and the result is expressed as a percentage or a ratio. The purpose of this measure is to evaluate the success of the MIP.

1045 – PARTNERSHIP WITH OTHER COMPONENTS AND STAKEHOLDERS

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One of the primary goals of the MIG is to foster collaboration with internal and external stakeholders of the MIP. To that end the MIG has developed:

- Comprehensive Medicaid Integrity Plan (CMIP) – developed in consultation with required stakeholders.

- Medicaid Integrity Program Advisory Committee – In FY 2006, the MIG established the Medicaid Integrity Program Advisory Committee to provide input and consultation on the development of its oversight approaches to State program integrity operations and Medicaid Integrity contracting. The committee members included program integrity representatives from 16 States, the Federal Bureau of Investigation (FBI), HHS Office of Inspector General (OIG), and CMS' Regional Offices. The advisory committee last met in October 2008.

- Medicaid Fraud and Abuse Technical Advisory Group (TAG). Sponsored by CMS, the technical advisory group (TAG) consists of one State program integrity director per CMS region and a State program integrity director also serves as the chair of the TAG. The TAG meets by conference call on a monthly basis and face to face as needed. The TAG provides an important venue for CMS to obtain advice and counsel on program integrity issues.

- Internal Collaboration with CMS Program Integrity Partners. The MIG is engaged in the following activities:
    - Continues ongoing collaboration and communication with other components of CMS and other agencies within HHS.
    - Conducts regular standing meetings with other CMS and HHS components on program integrity issues, emphasizing the integration of program integrity into policy and programmatic decision-making.
    - Continues collaboration on joint initiatives with other CMS and HHS components and other program integrity partners.

- Other External Communication with Program Integrity Partners and Stakeholders. The MIG is engaged in the following activities:
    - Attend regular meetings with law enforcement at the management and staff levels to promote collaboration and communication.
    - Forward suspected cases of Medicaid provider fraud to HHS OIG.
    - Outreach via participation in CMS Open Door Forums/audio conferences and presentations to the Medicaid Integrity Program.
    - Conduct presentations on the Medicaid Integrity Program at conferences, industry meetings, and other venues.
    - Communication and coordination with State program integrity partners.
    - Conduct outreach calls on the MICs.

The following list provides examples of MIG's partners and the activities that convey the main communication messages the MIG uses to assist its various stakeholders:

State Medicaid Partners (e.g., Program Integrity Unit staff, MFCU) The MIG can assist these partners with resources and is not meant to duplicate these partners' current auditing efforts. Current efforts include: Introductory Calls; TAG Calls; ***National Association for Medicaid Program Integrity*** (NAMPI) presentations; and special projects with States.

Provider Community (e.g., Providers, Provider/Medical/Hospital Associations, Attorneys for Providers, Pharmacy Associations, Other Advocacy Groups) Current efforts include: Provider association forums and MIP Open Door Forums/audio conferences.

Federal law enforcement partners (e.g., DOJ, OIG)
The MIP is a complement to these partners' efforts and the MIP audits are not meant to duplicate these partners' current auditing efforts. Current efforts include: Vetting of targets to avoid duplication and regular meetings to collaborate/coordinate efforts.

Congress; Other Public Officials
Current efforts include: Report to Congress; and responding to inquiries and requests for technical assistance on a wide variety of Medicaid integrity issues from Congress and other public officials.

General Public
The MIP is in place to protect and improve the Medicaid program. Current efforts to share information with the public about goals and accomplishments include posting information to the CMS website at www.cms.hhs.gov.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R1MPI	09/23/2011	Initial Publication of Manual	09/23/2011	NA

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