MEDICAID PROGRAM INTEGRITY MANUAL
CHAPTER 2 – MEDICAID INTEGRITY GROUP (MIG)

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

2000 – RESPONSIBILITIES OF MIG DIVISIONS

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

Office of the Group Director – serves as the primary point of contact on Medicaid provider fraud, waste, and abuse issues within CMS and with other partners, including law enforcement and the States; and directs the activities of MIG staff, including its four divisions.

Division of Medicaid Integrity Contracting (DMIC) – serves as the primary MIG focal point for procurement, functional administration and oversight of all MICs; develops statements of work and task orders for contractors; and develops performance measurements for MICs and monitors their contractual performance.

Division of Fraud Research & Detection (DFRD) – provides statistical and data support to the MIG; identifies emerging aberrant trends through data mining and other advanced analytical techniques; conducts special program integrity studies as appropriate; assists in the development of program integrity training curricula and conducting training; identifies appropriate performance measurements for State program integrity units; provides technical assistance to the DMIC and the MICs in the execution of provider oversight activities; and provides support and assistance to States through oversight, training, best practices and other forms of technical assistance.

Division of Field Operations (DFO) – serves as CMS' primary point of contact with State program integrity units; acts as CMS' primary liaison with the Medicaid Fraud and Abuse TAG; conducts Medicaid program integrity reviews; acts as primary Agency focal point for State provider audit issues; identifies and disseminates best practices in Medicaid & CHIP program integrity efforts to States and other program integrity partners; establishes and maintains a National Medicaid Fraud alert system; conducts environmental scanning on program integrity issues; identifies and executes technical assistance opportunities for States; coordinates the MIG's interactions with RO CMS Medicaid Financial Management staff and State representatives; collaborates with internal and external partners in the development and execution of anti-fraud strategies and activities; and develops program integrity training curricula and conducts training. The DFO has field offices in New York, Atlanta, Dallas, Chicago, and San Francisco.

Division of Audits & Accountability (DAA) – serves as the primary point of contact for the national Medicaid Audit Program under the MIP; provides leadership to the Medicaid Audit Resolution Team, as well as other components within the MIG regarding the Medicaid audit process; develops the MIP Report to Congress and CMIP; collaborates with internal and external partners to provide input and/or resolve issues related to critical functions that include the Health Information Technology for Economic and Clinical Health (HITECH) Act, PERM, legislation, Executive Order 13520 implementation (e.g., coordinates with internal and external partners to participate in, and respond to, conferences and issues related to OIG and GAO reports that affect the MIP; develops the

ROI methodology for the MIP and oversees the monitoring of that measure; and works as liaison with other Medicaid components (e.g. CMCS) on issues related to Medicaid program integrity).

2005 – DATA ANALYSIS AND INFORMATION GATHERING

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

Data utilized to identify potential improper payments are from the Medicaid Statistical Information System (MSIS). MSIS consists of eligibility and claims program data submitted from States to CMS. The five files, submitted quarterly, include one file which contains eligibility and demographic characteristics for each person enrolled in Medicaid at any time during the quarter, and four separate files of claims adjudicated for payment during the quarter for long term care services, drugs, inpatient hospital stays and all other types of services. The State-submitted data include over 40 million eligibility records and over 2 billion claims records per year.

To date, the MIG, working with its Review of Provider MICs, has developed 105 algorithms covering the following service areas: Dental, Durable Medical Equipment, Inpatient Hospitals, Lab and X-Ray, Nursing Facilities, Outpatient Hospitals, Pharmacy, Inpatient, Professional, Long term Care, Physicians, Prescribed Drugs, and Psychiatric.

Algorithms developed generally fall into three different categories: overpayment, metric, and model. Overpayment algorithms are developed to identify claims with possible overpayments and are used to identify providers suspected of high overpayment. Metric algorithms derive metric values for comparison of utilizations among providers. No overpayment amount is calculated by metric algorithms; however, suspicious activity may be identified. Algorithm models look at a number of indicators and data elements and produce a composite ranking based on the combination of those elements. Rather than a direct overpayment amount, an algorithm model identifies potential fraud, waste, and abuse activities, which may then be subject to further review.

2010 – AUDIT FOCUS AND PRIORITIZATION

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

The MIG uses a data driven approach to determine areas of audit focus and prioritization. While the MIG reviews all types of Medicaid providers, we have identified several areas of national focus. Using PERM findings, State corrective action plans from MIP audit contractor reviews, and Medicaid claims data CMS has identified several highly vulnerable/ high-risk areas that are the primary focus of our audit activities. The initial areas of national focus include:

- Long Term Care
- Home Health
- Inpatient Hospital Pharmacy

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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