MEDICAID PROGRAM INTEGRITY MANUAL
CHAPTER 5 – COORDINATION WITH LAW ENFORCEMENT AGENCIES

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

5000 – SETTLEMENT AGREEMENTS

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

The MIG Director frequently coordinates program content perspectives with the appropriate, relevant CMS components regarding specifics in proposed settlement agreements between DOJ and other private entities. Additionally, when States have concerns regarding OIG/DOJ provider exclusion and/or overpayment settlements, the MIG Law Enforcement Coordinator may act as a facilitator between States and Federal law enforcement.

5005 – MEMORANDA OF UNDERSTANDING (MOU)

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

The MIG currently has MOUs with OIG laying out a protocol for referrals of suspected fraud discovered by MICs, and also has signed MOUs with both OIG and numerous MFCUs regarding notice to these entities by MIG of planned MIC audits. MOUs have provisions requiring that they be reevaluated periodically for possible amendment.

5010 – FALSE CLAIMS ACT

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

Under section 1909 of the Act, a State that enacts a false claims act (FCA) determined by the HHS-OIG to meet specific requirements set forth in this statute is entitled to an enhanced Federal medical assistance percentage (FMAP). States will receive a 10 percent increase on any amounts recovered pursuant to a State FCA action. In September 2006, CMS released a State Medicaid Director Letter regarding this provision and the availability of the FMAP adjustment for those States that enacted approved laws **(http://www.cms.gov/smdl/downloads/SMD091906.pdf).**

Since enactment of the DRA, 36 States and the District of Columbia have enacted their own State FCAs. Many of these State FCAs mirror the essential terms of the Federal FCA, although many State FCAs contain various elements that distinguish them from the Federal FCA. Prior to March 2011, the HHS-OIG approved 14 State FCAs as qualifying for the financial incentives described above. Since enactment of the DRA in early 2006, several pieces of legislation have amended the Federal FCA, and on March 24, 2011 the OIG announced that, prospectively, it will analyze a State's eligibility for the DRA's financial incentives in light of the Federal FCA as amended by the Fraud Enforcement and Recovery Act of 2009 (FERA), the ACA, and the Dodd-Frank Wall Street Reform and Consumer Protection Act (the Dodd-Frank Act) **(see http://oig.hhs.gov/fraud/state-**

false-claims-act-reviews/index.asp). As of July 2011, the OIG has not approved any State FCAs as DRA-compliant under its new assessment standards, and it has granted the 14 previously approved States a grace period until March 31, 2013 to amend their State FCAs to come into compliance with the new standards.

5015 – RESPONDING TO REQUESTS FOR ASSISTANCE

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

A "request for assistance or information" is a communication from law enforcement or health care fraud investigative personnel to the MIG asking for help regarding the investigation and/or prosecution of suspected fraud or abuse of funds by providers. The request could be in connection with a particular matter, or be concerned with general procedures, systems, rules or processes for such investigations.

The MIG may receive requests for assistance or information from a variety of law enforcement or health care fraud investigative personnel. These sources include:

- Special agents from OIG;
- Investigators or attorneys from State MFCUs;
- Local law enforcement staff (such as county or city police);
- Assistant United States Attorneys or other U.S. Department of Justice attorneys or staff;
- Special agents or staff from other Federal law enforcement agencies, such as the FBI, Internal Revenue Service, or United States Postal Inspection Service;
- State Medicaid program integrity staff; or
- Medicare program integrity or Medicare contractor staff.

When appropriate, MIG staff should make reasonable attempts to follow up with the person making the request to determine the resolution of the matter at issue.

5020 – REFERRALS OF SUSPECTED FRAUD

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

All allegations of fraud, abuse or other misconduct related to Medicaid (e.g., patient abuse) must be reported to the appropriate oversight entity. This includes, but is not necessarily limited to the State Medicaid Agency, the State MFCU, the State provider licensing board, or the OIG. Such allegations typically involve suspected fraud or abuse by a Medicaid enrolled provider, Medicaid managed care organization, Medicaid waiver program contractor, or their employees, agents or subcontractors, or Medicaid State Agency employees.

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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