Medicaid Integrity Institute (MII) 2026 Training Calendar

Clinical Validation Boot Camp *(virtual)*	**January 12-15, 2026**
Professional and Hospital Outpatient Services Boot Camp *(virtual)*	**January 26-30, 2026** **February 2-6, 2026**
Focused Outpatient and Professional Coding Series *(virtual)*	**February 9-12, 2026**
Payment Error Rate Measurement (PERM) Program Series (1 of 3): Program Overview & Medical Review Component *(virtual)*	**February 26, 2026**
Department of Health and Human Services Office of Inspector General (HHS-OIG) Fraud Schemes and Trends *(virtual)*	**March 4, 2026**
PERM Program Series (2 of 3): Eligibility Component *(virtual)*	**March 26, 2026**
Managed Care Program Integrity Toolkits *(virtual)*	**April 14, 2026**
PERM Program Series (3 of 3): Data Processing Review Component and Corrective Action Plan Promising Practices *(virtual)*	**April 30, 2026**
Turning Policy Development into Effective Programs – Medicaid Risk Assessment *(virtual)*	**May 13, 2026**
Machine Learning (ML) in the Medicaid Fraud Prevention System (FPS): Strengthening Program Integrity through Advanced Analytics Series (1 of 2) *(virtual)*	**June 2, 2026**
Medicaid Behavioral Health: Applied Behavioral Analysis (ABA) Policies and Program Integrity Oversight *(virtual)*	**June 17, 2026**
ML in the Medicaid FPS: Strengthening Program Integrity through Advanced Analytics Series (2 of 2) *(virtual)*	**July 14, 2026**
Bridging Gaps and Crushing Fraud: CPI Managed Care Plan (MCP) Audit Insights for State Partners *(virtual)*	**July 29, 2026**
Managed Care: Medicaid Medical Loss Ratio (MLR) Program Integrity Strategies *(virtual)*	**August 2026**
Auditing 101 Series (1 of 3): Data Analysis, Audit Development, and Methodology *(virtual)*	**September 2026**
Medicaid Provider Terminations *(virtual)*	**September 22, 2026**
Auditing 101 Series (2 of 3): Audit Plans, Protocols, Reports, and Proper Documentation *(virtual)*	**October 2026**
Managed Care – Law Enforcement Referrals *(virtual)*	**October 2026**
Auditing 101 Series (3 of 3): Audit Outcomes and Best Practices Panel and Case Study *(virtual)*	**November 2026**
Medicaid Provider Enrollment 101 *(virtual)*	**November 18, 2026**
Turning Policy Development into Effective Programs – Medicaid Risk Assessment (Repeated Session) *(virtual)*	**December 9, 2026**

**Course dates, titles, and descriptions are subject to change. Courses may be added or removed as the program integrity landscape changes throughout the year. CMS will update this calendar with additional in-person training opportunities at conferences and events, including a Program Integrity Director's Symposium.

Course Descriptions

Clinical Validation Boot Camp

Purpose: Participants will learn to accurately evaluate clinical validation and medical necessity for highly audited *International Classification of Diseases, Tenth Revision, Clinical Modification* (ICD-10-CM) conditions.

Key Elements:

- Examine the underlying pathophysiology of highly audited ICD-10-CM conditions, such as sepsis, encephalopathy, and malnutrition.
- Overview of documentation needed to support clinical validity.

Objectives: To apply best-practice review principles to identify unsupported diagnoses, assess documentation quality, and make consistent determinations.

Professional and Hospital Outpatient Services Boot Camp

Purpose: Participants will learn the fundamentals of professional and hospital outpatient coding and techniques to reduce coding errors.

Key Elements:

- ICD-10-CM
- Evaluation and Management (E/M) coding for professional services (category and level selection only)
- Current Procedural Terminology (CPT) surgical coding
- CPT modifiers (10000-69999 series)
- Medicaid National Correct Coding Initiative (NCCI) concepts
- Focus on a high-risk coding topic and provide additional guidance and insight.

Objectives: To reduce coding inaccuracies and improve participants ability to identify errors during medical record reviews, audits, and investigations.

Focused Outpatient and Professional Coding Series

Purpose: Participants will attend a four-day virtual workshop series designed to provide them with additional guidance and insight on specific high-risk coding topics.

Key Elements:

- February 9, 2026 – CPT Cardiac Electrophysiology and Ablations
- February 10, 2026 – CPT Spinal Fusions
- February 11, 2026 – Operationalizing Social Determinants of Health in Medicaid: From Federal Guidance to Code Assignment
- February 12, 2026 – CPT Emergency Department (ED) Services (Technical and Professional) and Common ED Procedures

Objectives: To reduce coding errors and improve participants ability to identify inaccuracies during medical record reviews, audits, and investigations.

Payment Error Rate Measurement (PERM) Program Series (1 of 3): Program Overview & Medical Review Component

Purpose: Participants will receive a detailed overview of the PERM program and gain a practical understanding of the specific requirements for the medical review component

Key Elements:

- PERM history and overview.
- PERM review timeline.
- PERM partners and responsibilities.
- Overview of the PERM review process:
  - Focus on PERM medical review component.
  - Review of common errors and best practices.
- PERM reporting.

Objectives: To enhance program integrity, improve stewardship of federal funds, and generate improved outcomes for Medicaid and Children's Health Insurance Program (CHIP) beneficiaries, while maintaining compliance with federal and state medical review requirements.

Department of Health and Human Services Office of Inspector General (HHS-OIG) Fraud Schemes

Purpose: Participants will learn from the HHS-OIG as they provide an overview of the agency, their current work, and recent Medicaid program integrity trends.

Key Elements:

- Discussion of the value of partnership between HHS-OIG, Medicaid Fraud Control Units (MFCUs), and state program integrity units.
- Overview of three HHS-OIG priority cases by the Office of Investigations.

Objectives: To highlight the importance of collaboration between state agencies and federal law enforcement in overseeing Medicaid fraud, waste, and abuse, and to increase awareness of common and emerging high-risk fraud schemes.

PERM Program Series (2 of 3): Eligibility Component

Purpose: Participants will gain a practical understanding of the PERM program's eligibility component.

Key Elements:

- PERM eligibility overview.
- PERM eligibility review process.
- Common errors and best practices.

Objectives: To ensure stronger program integrity, better stewardship of federal funds, and improved outcomes for Medicaid and CHIP beneficiaries, while maintaining full compliance with federal and state eligibility oversight requirements.

Managed Care Program Integrity Toolkits

Purpose: Participants will receive an overview of educational program integrity resources available to state Medicaid agencies (SMAs) and MCPs.

Key Elements:

- 42 Code of Federal Regulations (CFR) Part 438, Subpart H overview.
- Review CMS' Compliance Program Requirement toolkit, Prompt Referrals of Potential Fraud, Waste, or Abuse toolkit, Treatment of Recoveries and Overpayments toolkit, and Payment Suspensions Based on Credible Allegations of Fraud toolkit.

Objectives: To improve program integrity through greater oversight, accountability, and transparency by providing clarity on several program integrity provisions in 42 CFR Pt. 438, Subpart H, as well as incorporating the four published managed care toolkits on compliance, fraud referrals, overpayment recoveries, and payment suspensions into their daily operations.

PERM Program Series (3 of 3): Data Processing Review Component and Corrective Action Plan Promising Practices

Purpose: Participants will gain a practical understanding of the PERM program's data processing review component and corrective action plan processes.

Key Elements:

- PERM data processing overview.
- PERM data processing review process.
- Review common errors and best practices.
- Description of the next steps after the measurement.
- Corrective action plan process.

Objectives: To strengthen program integrity, improve stewardship of federal funds, and generate improved outcomes for Medicaid and CHIP beneficiaries, while ensuring compliance with federal and state data processing oversight requirements.

Turning Policy Development into Effective Programs – Medicaid Risk Assessment

Purpose: Participants will learn about recommended risk assessment practices to evaluate program integrity risk within the Medicaid program.

Key Elements:

- Overview of the Government Accountability Office (GAO) risk assessment framework and how states could use it to improve or implement their own risk assessment processes.
- Description of how the Center for Program Integrity (CPI) uses GAO's risk framework to assess and mitigate federal program integrity risks.
- Interactive breakout sessions to enhance exposure to the risk assessment and management process.

Objectives: To familiarize attendees with key concepts to conducting a risk assessment and managing risk using the GAO Fraud Risk Framework. Risk assessments are a dynamic tool to help address vulnerabilities in an evolving program integrity landscape.

Machine Learning (ML) in the Medicaid Fraud Prevention System (FPS): Strengthening Program Integrity through Advanced Analytics (1 of 2)

Purpose: Participants will gain a foundational understanding of ML concepts within the Centers for Medicare & Medicaid Services (CMS) Program Integrity (PI) environment. This course will introduce FPS and its core capabilities, explain key analytical approaches, and highlight how ML supports risk identification and lead prioritization.

Key Elements:

- Introduction to FPS and its core PI capabilities.
- Overview of MLR concepts and terminology.
- Types of analytical approaches used in FPS and their roles: anomaly detection, social network analytics, rule-based, and supervised/unsupervised models.
- Why ML is important in PI: Risk identification, fraud detection, and lead prioritization.

Objectives: To provide the foundational knowledge necessary to understand the FPS and how its core program integrity capabilities use ML for effective risk identification, fraud detection, and lead

prioritization.

Medicaid Behavioral Health: Applied Behavioral Analysis (ABA) Policies and Program Integrity Oversight

Purpose: Participants will gain the knowledge and tools necessary to identify, assess, and address program integrity issues related to Medicaid-funded ABA services within the Behavioral Health benefit. Additionally, participants will learn how to differentiate between appropriate ABA service delivery and misaligned or non-therapeutic "daycare-type" services, as well as how to evaluate supporting documentation to determine program compliance.

Key Elements:

- Identifying Improper "Daycare-Type" ABA Billing.
- Documentation Requirements for ABA Services.
- Defining "Normal Care" vs. Therapeutic Care in ABA Billing.
- Telehealth Delivery of ABA Services.
- PI activities related to ABA services.

Objectives: To support the prevention, detection, and reduction of improper payments and enhance program integrity across Medicaid behavioral health services by improving participants' understanding of ABA documentation requirements, service delivery expectations, and distinguishing therapeutic care from daycare-equivalent activities.

ML in the Medicaid FPS: Strengthening Program Integrity through Advanced Analytics (2 of 2)

Purpose: Participants will be provided with a deeper, more applied view of ML in PI operations, building on the introductory content from Part 1 of this series. This session will cover FPS model structure, interpretation of model outputs, and practical use cases demonstrating how ML supports PI investigations.

Key Elements:

- Deep dive into FPS model structure and integration with PI processes: how FPS incorporates ML models into risk scoring, lead generation, and PI workflows.
- How ML improves PI outcomes: prioritization, early detection, resource allocation, and supporting investigations.
- Interpreting model outputs: scores, flags, confidence levels.
- Applied case studies of CMS PI models: Hospice model and more.
- Future PI innovation and modernization roadmap: Enhanced automation, improved feedback loops, model monitoring, and emerging analytics opportunities.

Objectives: To equip non-technical professionals with an applied operational understanding of ML, improving their ability to effectively integrate ML insights into PI workflows.

Bridging Gaps and Crushing Fraud: CPI MCP Audit Insights for State Partners

Purpose: Participants will be equipped with actionable insights and practical strategies derived from CPI MCP audit findings. By exploring real-world lessons learned, participants will strengthen their understanding of compliance expectations, enhance program integrity efforts, and foster more effective collaboration with CMS. The course aims to translate audit outcomes into meaningful improvements in oversight, operations, and outcomes across Medicaid and CHIP programs.

Key Elements:

- Interpret key findings from CPI MCP audits and understand their implications for state-level Medicaid and CHIP program operations.

- Identify common compliance challenges and risk areas highlighted through audit outcomes.
- Apply lessons learned to strengthen internal oversight, documentation, and reporting practices.
- Enhance collaboration with CMS by aligning state processes with federal audit expectations and corrective action strategies.
- Develop action plans to address audit findings and proactively mitigate future risks.
- Leverage audit insights to inform policy updates, training initiatives, and quality improvement efforts within state programs.

Objectives: To improve audit readiness and program integrity in 2026 by equipping state partners with the tools to reduce coding inaccuracies, identify errors in medical records, and apply actionable insights from real-world audit findings to mitigate risks, align policies with federal standards, and strengthen collaborative oversight with CMS.

Managed Care - Medicaid Medical Loss Ratio (MLR) Program Integrity Strategies

Purpose: Participants will receive an overview of the strategies to improve oversight of Medicaid financing arrangements with Medicaid managed care. This course will explore the risks and vulnerabilities within Medicaid MLR policies and use real examples from CMS' Medicaid MLR audits over the past few years.

Key Elements:

- Overview of Medicaid MLR calculations and related financial documentation.
- Identify high-risk areas in Medicaid MLR for enhanced oversight efforts, including quality improvement activities (QIAs), provider incentive payments, state directed payments (SDPs), and non-claims costs and share common findings identified across states.

Objectives: To create a foundational understanding of Medicaid MLR reporting and related vulnerabilities, as well as identify mitigation actions to effectively oversee this program area.

Auditing 101 Series (1 of 3): Data Analysis, Audit Development, and Methodology

Purpose: Participants will gain a high-level understanding of conducting effective provider audits within Medicaid program integrity by examining the full audit lifecycle, from initial data analysis and methodology development to final documentation and reporting.

Key Elements:

- Overview of the audit process.
- Introduction to data for audit purposes.
- Audit focus and methodology.

Objectives: To provide an overview of the fundamentals of conducting effective provider audits within Medicaid program integrity, covering the process through three dedicated sessions.

Medicaid Provider Terminations

Purpose: Participants will receive an overview of Medicaid provider terminations and the applicable federal requirements.

Key Elements:

- Overview of the regulatory framework under 42 CFR §455.416 and Medicaid Provider Enrollment Compendium (MPEC) 1.10.2.
- Review the differences between mandatory and discretionary "for cause" terminations.
- Outline the process for reporting terminations to CMS through the Data Exchange System (DEX).

Objectives: To provide state personnel with best practices for ensuring accurate and timely reporting, drafting effective termination letters, and maintaining compliance and program integrity across states.

Auditing 101 Series (2 of 3): Audit Plans, Protocols, Reports, and Proper Documentation

Purpose: Participants will learn to develop effective audit plans, create standardized protocols, produce clear reports, and maintain proper documentation for provider audits within Medicaid program integrity.

Key Elements:

- Audit plans, protocols, and reports.
- Documenting an audit.

Objectives: To deepen understanding of conducting effective provider audits for a wide audience within Medicaid program integrity, emphasizing the crucial components of planning, reporting, and documentation covered across three key sessions.

Managed Care – Law Enforcement Referrals

Purpose: Participants will learn how federal program integrity regulations for Medicaid managed care require states to include contractual provisions that mandate MCPs implement and maintain procedures for preventing and detecting fraud, waste, and abuse, including the referral of investigations to law enforcement.

Key Elements:

- States must ensure MCPs have comprehensive fraud prevention programs.
- Federal regulations establish minimum standards for fraud detection and prevention.
- MCPs must have procedures not only for prevention and detection but also for proper referral of suspected fraud cases.
- Medicaid Fraud Control Unit (MFCU) personnel can share strategies and best practices regarding increasing fraud referrals from MCPs.

Objectives: To improve referral quality, provide greater clarity on whether an investigation will proceed administratively, and create a more cohesive and robust anti-fraud ecosystem that can adapt to evolving threats and protect Medicaid program resources, while simultaneously forging stronger connections between critical partners.

Auditing 101 Series (3 of 3): Audit Outcomes and Best Practices Panel and Case Study

Purpose: Participants will be presented with a panel discussion and case study analysis to understand effective audit outcomes and best practices within Medicaid program integrity.

Key Elements:

- Highlight audit best practices.
- Review and discuss case studies.

Objectives: To deepen stakeholders understanding of effective audit outcomes and best practices.

Medicaid Provider Enrollment 101

Purpose: Participants will learn the fundamental federal requirements governing Medicaid provider enrollment, including CMS oversight, state responsibilities, and core program integrity expectations under 42 CFR Part 455.

Key Elements:

- Highlight audit best practices.
- Overview of CMS' role in Medicaid provider enrollment, the Provider Enrollment and Oversight Group (PEOG), and the Medicaid Provider Enrollment Compendium (MPEC).
- Regulatory requirements under 42 CFR Part 455, Subparts B and E, including disclosures, screening, revalidation, site visits, and criminal background checks.

- State flexibility in setting enrollment standards and screening levels, including the use of Medicare screening.
- Requirements for enrolling ordering, referring, and prescribing (ORP) providers and managed care network providers.
- Application fee rules for institutional providers and conditions for waivers.
- Temporary moratoria processes and criteria for approvals.

Objectives: To create a streamlined understanding of provider enrollment requirements, the necessary screening and documentation expectations for compliance, and best practices for monitoring provider eligibility, reporting terminations, and supporting program integrity.