Centers for Medicare & Medicaid Services

Center for Medicaid & State Operations

Medicaid Integrity Group

Comprehensive Medicaid Integrity Plan
of the
Medicaid Integrity Program

FY 2006 - 2010

July 2006

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Executive Summary

The Deficit Reduction Act (DRA) of 2005 takes the partnership between the Centers for Medicare & Medicaid Services (CMS) and the States to a new level. The Medicaid Integrity Program (MIP) offers a unique opportunity to identify, recover and prevent inappropriate Medicaid payments. It will also support the efforts of State Medicaid agencies through a combination of oversight and technical assistance.

Through the DRA, Congress has provided CMS with resources to establish the Medicaid Integrity Program. MIP represents CMS' first national strategy to detect and prevent Medicaid fraud and abuse in the program's history. Under the leadership of the Center for Medicaid & State Operations (CMSO), the agency will design a program to combat fraud, waste, and abuse in Medicaid. This initial Comprehensive Medicaid Integrity Plan (CMIP) will guide CMSO's efforts to fulfill that mission. There are two broad operational responsibilities under this new program.

- **Reviewing the actions of those providing Medicaid services.**
- **Providing support and assistance to the States to combat Medicaid fraud, waste, and abuse.**

Congress specifically required the use of contractors to review the actions of those seeking payment from Medicaid, conduct audits, identify overpayments and educate providers and others on payment integrity and quality of care. It further mandated that CMS employ 100 full-time equivalent employees to provide support to the States. Congress has appropriated funds to CMS which will reach a total of $75 million annually by fiscal year 2009 and each year thereafter.

CMSO's planning for MIP operations is based on four key principles.

- **National leadership in Medicaid program integrity.**
- **Accountability for its own activities and those of its contractors and the States.**
- **Collaboration with internal and external partners and stakeholders.**
- **Flexibility to address the ever-changing nature of Medicaid fraud.**

Four major functions to accomplish the requirements of the legislation have been identified. They will be implemented by the newly-created Medicaid Integrity Group (MIG) which reports directly to the CMSO Director.

- Creation of the **Comprehensive Medicaid Integrity Plan** in consultation with internal and external partners to guide CMS' efforts.
- Procurement and oversight of **Medicaid Integrity Contractors** who will conduct reviews, audits, and education.

- **Field Operations** to conduct state program integrity oversight reviews and provide training and technical assistance to States.
- **Fraud Research & Detection** to provide statistical data support, identify emerging fraud trends and conduct special studies.

The Medicaid Integrity Group will employ the following major strategies to ensure success.

- **Collaboration and coordination** with internal and external partners.
- **Consultation with interested parties** in the development of the CMIP.
- **Targeting vulnerabilities** to the Medicaid program.
- **Balancing MIP roles:**
    - Between providing training and technical assistance to the States and exercising oversight of the States; and
    - Between supporting criminal investigations of suspect providers while concurrently seeking administrative sanctions.
- Employing **lessons learned** in developing guidance and directives aimed at fraud prevention.
- Developing effective **return on investment** strategies.

Key among the collaborative relationships is MIP's partnership with the Office of Financial Management's (OFM) Program Integrity Group. Medicare program integrity staff has the responsibility for the **Medi-Medi data matching project** and the Medicaid Payment Error Rate Measurement **(PERM)** project. Each initiative, as it evolves, will **inform and interface** with the rest of the MIP strategies. Collaboration with OFM's Program Integrity Group will also ensure that CMSO's efforts in MIP work in concert with those of Medicare.

This initial CMIP describes in detail how CMSO will make the Medicaid Integrity Program fully operational. It specifically discusses statutory requirements, program philosophy, implementation, evidence based strategies, and organizational structure. It also includes appendices on relevant sections of the Deficit Reduction Act, MIP's five year implementation plan, CMSO's new organizational chart and functional statements for the Medicaid Integrity Group.

Ensuring the financial health of the Medicaid program involves working to see that the partnership between the States and the Federal government is a healthy and cooperative one. It is critical that individuals furnishing services to the program do not engage in fraudulent or abuse practices that degrade Medicaid fiscal integrity. The resources entrusted to CMS are a welcome addition to the arsenal of tools used to combat the constantly changing nature of fraud, waste, and abuse in the Medicaid program.

Introduction

> ***The fraud control game is dynamic, not static. Fraud control is played against opponents: opponents who think creatively and adapt continuously and who relish devising complex strategies; this means that a set of fraud controls that is perfectly satisfactory today may be of no use at all tomorrow, once the game has progressed a little. Malcolm K. Sparrow*** [1]

The Centers for Medicare & Medicaid Services (CMS) welcomes the opportunity to implement the Medicaid Integrity Program (MIP). MIP was established by the Deficit Reduction Act (DRA) of 2005. This legislation provided needed resources to CMS for the prevention, earlier detection and reduction of fraud, waste and abuse in the $300 billion Medicaid program.

The Medicaid Integrity Program represents CMS' first national strategy to combat fraud and abuse in the 41-year history of the Medicaid program. Although individual States work to ensure the integrity of their respective Medicaid programs, MIP provides CMS with the ability to more directly ensure the accuracy of Medicaid payments and to deter those who would exploit the program. It advances these goals which are shared by the States and the Federal government. The combined Federal and State resources for preventing fraud will be marshaled more effectively than ever.

Within CMS, the Center for Medicaid & State Operations (CMSO) is organizationally responsible for the administration of the Medicaid Integrity Program. CMSO began its planning and implementation efforts in February 2006.

CMS has developed this initial Comprehensive Medicaid Integrity Plan (CMIP) as mandated by the DRA. Within it, the reader will find an overview of MIP's statutory requirements, organizational philosophy, structure, functions and five year implementation plan. The CMIP also reflects CMS' evidence based approach to ensuring the integrity of the Medicaid program nationally. In subsequent years, CMSO will update the CMIP as well as provide Congress with its annual report on the use and effectiveness of the funds appropriated for MIP.

The Deficit Reduction Act takes CMS' partnership with and oversight of States to a new level. The Medicaid Integrity Program offers a unique opportunity to identify, recover and prevent inappropriate Medicaid payments. CMS will build on its own experiences and the efforts of others, such as the Office of Inspector General (OIG) and the Medicaid Fraud Control Units (MFCU), in implementing the Medicaid Integrity Program. It will also support the efforts of State Medicaid agencies through a combination of oversight and technical assistance. The resources entrusted to CMS are a welcome addition to the

[1] *License to Steal: How Fraud Bleeds America's Health Care System – Updated Edition*, Malcolm K. Sparrow. Westview Press, Boulder, CO, 2000, p 126.

arsenal of tools used to combat the constantly changing nature of fraud, waste, and abuse in the Medicaid program.

Medicaid Integrity Program Statutory Requirements

Section 6034 of the DRA established the Medicaid Integrity Program which dramatically increased CMS' resources to combat Medicaid fraud and abuse. Congress appropriated $5 million in fiscal year (FY) 2006 with an additional $50 million in each of fiscal years 2007 and 2008 and $75 million annually in FY 2009 and each year thereafter. Section 6034 can be found in Appendix A of this report.

Comprehensive Planning

The DRA requires "a comprehensive plan for ensuring the integrity of the program established under this title by combatting fraud, waste, and abuse." The CMIP reports on activities beginning in FY 2006 and covers the "5-fiscal year period beginning with fiscal year 2006 and each such 5-fiscal year period that begins thereafter."

Congress mandated that CMS consult with several entities in the development of the CMIP. Those partners include "the Attorney General, the Federal Bureau of Investigation, the Comptroller General of the United States, the Inspector General of the Department of Health and Human Services, and State officials with responsibility for controlling provider fraud and abuse under State plans under this title." MIP's planning group has broadly interpreted "State officials" to include representative directors from State Medicaid programs, their program integrity units, and Medicaid Fraud Control Units.

Report to Congress

The DRA also requires an annual report to Congress. By April 2007 and annually thereafter, the Secretary of the Department of Health and Human Services (HHS) must report on the use of the funds that Congress has appropriated for MIP. That report must also include information on the effectiveness of the use of those funds.

Medicaid Integrity Contractors

MIP requires CMS to use contractors for four specific functions: a) the review of actions of those seeking payment from State Medicaid plans; b) the audit of those claims; c) the identification of overpayments related to those claims; and d) the education of providers and others with respect to payment integrity and quality of care. The law further describes requirements for those contractors. CMSO is developing its plan for the procurement of these entities which will be known as Medicaid Integrity Contractors (MIC). That effort is described later in this report.

Support & Assistance to the States

From its annual appropriation, CMS is directed to employ 100 full-time equivalent employees "whose duties consist solely of protecting the integrity of the Medicaid program established under this section by providing effective support and assistance to States to combat provider fraud and abuse." Organizationally, most of these new employees will fall within CMS' newly created Medicaid Integrity Group (MIG). The organizational structure of MIG and the specific functions of each area are also described later in this plan.

State Cooperation

The DRA further requires that States "must comply with any requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program established under Section 1936 [of the Social Security Act]." A review of those and other potential regulatory requirements is underway.

OIG & Medi-Medi Funding

Within Section 6034 of the DRA, both the Office of Inspector General and the Office of Financial Management's (OFM) Program Integrity Group received enhanced funding for Medicaid fraud efforts. This funding is separate and apart from the Medicaid Integrity Program allocation. The DRA provides OIG with $25 million annually from FY 2006 to FY 2010 to expand its Medicaid fraud activities.

The Medicare Integrity Program will receive additional funds for a national expansion of the Medi-Medi pilot project. In FY 2006, this appropriation is $12 million and increases each year thereafter in $12 million increments until FY 2010. At that time, the Medi-Medi project will receive $60 million annually.

MIP Philosophy

The Medicaid Integrity Program has articulated four key principles upon which its planning, implementation and operations are based.

Leadership

CMSO enthusiastically accepts its national leadership role in Federal and State Medicaid program integrity efforts. This responsibility will be accomplished through training and other technical assistance to the States. It will also include increased oversight of State program integrity units with an eye to the establishment of program integrity benchmark practices and standards. Through its oversight of and assistance to the States, MIP will play a vital role in promoting the integrity of the Medicaid program.

Accountability

CMSO will oversee and report on not only its own activities and those of its contractors, but also the States' program integrity efforts. The success of the Medicaid Integrity Program depends on ensuring accountability for all. The annual report to Congress on the use and effectiveness of its appropriation will describe MIP's return on investment (ROI) for its audit, oversight and technical assistance activities.

Collaboration

MIP will be in continuous communication and coordination with its internal and external program integrity partners, particularly CMS' Office of Financial Management's Program Integrity Group and HHS' Office of Inspector General. CMSO will develop strategic partnerships with those entities, other Federal and State law enforcement agencies and State Medicaid Agencies. In addition, MIP will work closely with organizations such as the National Association of State Medicaid Directors, the National Association of Surveillance and Utilization Review Officials and the National Association of Medicaid Fraud Control Units. Through these collaborations, MIP will leverage its resources for the benefit of all.

Flexibility

To the greatest degree possible, CMSO expects its leadership and staff to be flexible in their efforts to combat fraud and abuse. The evolving nature of fraud demands that MIP be nimble, mapping its tactics to an ever changing fraud landscape. The CMIP will reflect an overall strategy that keys on the most important vulnerabilities without committing disproportionate resources to any single area. The organizational structure of the Medicaid Integrity Group, particularly in the Divisions of Fraud Research & Detection and Field Operations, must remain similarly flexible to address the most critical issues.

Implementing the Medicaid Integrity Program

In February 2006, under the direction of CMSO, a planning team began working on the implementation of the Medicaid Integrity Program. It included a cross-section of skills and experience in both Medicaid operations and program integrity.

Organizational Leadership

One of the first questions CMS addressed upon creation of the Medicaid Integrity Program was its organizational placement. While valid arguments could be made to co-locate this program with the (Medicare) Program Integrity Group within OFM, the final decision was to place it under the jurisdiction of the Center for Medicaid & State Operations.

There are several sound reasons for this decision. It is important that MIP administrators understand how State Medicaid partnerships function. It is also a reflection that, historically, CMSO had this responsibility under MIP's predecessor, the Medicaid Alliance for Program Safeguards (MAPS). CMSO is directly responsible for CMS' oversight of the Medicaid program. This effectively places accountability for MIP's success on the doorstep of the CMSO Director.

Finally, as stated earlier, the Medicaid Integrity Program expects a high return on investment from its prevention efforts, whether it comes from amending CMSO practices or those of the States. In either event, such change will more effectively and efficiently occur if the Medicaid Integrity Group is "at the table" when Medicaid policy is determined by CMSO.

Strategic Contractors

The two main activities of the Medicaid Integrity Program are conducting audits and supporting the States' program integrity efforts. As part of MIP's overall effort, two strategic contractors are currently being sought to assist in the design and development of each of those functions. These strategic contractors will collaborate with CMS staff and each other in fulfilling these activities.

While CMSO has a wealth of experience in the financial management of the Medicaid program, the auditing of those who provide direct services to Medicaid beneficiaries has always been the responsibility of the States. The Audit Program Development (APD) contractor will be expected to design and develop a Medicaid payment integrity audit program and develop audit protocols, methodologies, and standards for MIP. Its deliverables will include:

- Developing a strategic auditing system which focuses on a high return on investment and which will also result in knowledge that can be transformed into regional/national guidance to States to prevent future overpayments;

- Examining all aspects of developing this audit program, including data sources, using both Medicare and Medicaid data to strengthen ROI on Medicaid-only audits, statistically valid random sampling and overpayment extrapolation, how to best share knowledge gained with the States and others, and ensuring that CMS' audits do not conflict with other Federal or State investigative and audit activities;
- Surveying the landscape of State Medicaid and OIG audit practices to identify current audit activities, States' perceived return on investment, States' levels of commitment to Medicaid audits, and potential best practices to incorporate into MIP; and
- Conducting a thorough literature review on Medicaid audit issues.

The State Program Integrity Assessment (SPIA) contractor will describe State agencies' efforts in combating fraud, waste, and abuse. This will include surveying the landscape, identifying State program integrity baselines, and recommending performance metrics and standards against which States' performance may be measured in the future. This contractor will also build a national database to store these metrics. The SPIA deliverables will include:

- Identifying baseline demographics to accurately depict the critical issues related to assessing State program integrity activities;
- Defining what CMS and States believe should be included under the umbrella of "program integrity;"
- Examining all aspects of developing a State-level program integrity effectiveness measurement system;
- Surveying the landscape of State Medicaid program integrity practices to identify current program integrity (PI) activities, States' perceived ROI, and States' levels of commitment to program integrity; and
- Conducting a thorough literature review on Medicaid program integrity issues.

Statutory & Regulatory Review

The legal and regulatory review process began with a comprehensive examination of both the law and legislative intent. It includes developing an understanding of how MIP will fit into the existing legal and regulatory scheme within CMS. Two experienced attorneys from the Office of General Counsel are working on behalf of MIP to conduct these reviews. Their initial efforts are expected to be completed by mid-summer 2006 with further review ongoing as dictated by their early efforts. It is fully expected that further consultation, particularly with State and Federal partners, will occur after the initial reviews are completed.

MIP's planning workgroup has the additional responsibility of implementing CMS' responsibilities for Sections 6031 and 6032 of Chapter 3, Title VI of the DRA. The specific statutory language for these sections can be found in Appendix A of this report.

Section 6031 creates an incentive for the State to receive an enhanced share in False Claims Act cases brought under a State law that meets the requirements of Section 6031.

It is the responsibility of the OIG, in consultation with the Department of Justice, to implement this provision. A State Medicaid Director letter encouraging States to pass such legislation is being developed for national distribution.

Section 6032 requires "any entity that receives or makes annual payments under the State plan of at least $5,000,000" to provide education to its employees and contractors on both the Federal and State False Claims Acts. CMS intends to issue guidance on this section after both legal review and consultation with partners.

Five Year Implementation Plan

As mandated by the DRA, CMSO has developed a five year plan to implement the Medicaid Integrity Program. The plan lays out how MIP will address five major functional areas in each of the next five fiscal years. Those areas are: a) Integrity Planning; b) Medicaid Integrity Contracting; c) Field Operations; d) Fraud Research & Detection; and e) Medicare Integrity Collaboration. Detailed activities for each of these major areas can be found in Appendix B of this report.

Program Integrity Literature Review

There is an extensive body of knowledge and experience related to maintaining the integrity of the Medicaid program. HHS OIG and the Government Accountability Office (GAO), as well as numerous State and private entities, have shed light on fraud, waste, and abuse since the inception of the program. The Medicaid Integrity Program is committed to conducting initial and ongoing literature reviews. This effort will be useful to both avoid "reinventing the wheel" and provide program integrity units throughout the country with a valuable resource for future anti-fraud efforts.

Strategies for Success

MIP implementation involves a number of strategies for success. Each major strategy is discussed in greater detail below.

Collaboration & Coordination

CMSO recognizes the need for a strong commitment to coordinate its activities with its internal and external partners in the fight against fraud, waste, and abuse. To that end, the Medicaid Integrity Program will ensure that its efforts are developed in collaboration with those of OFM's Program Integrity Group as well as State program integrity units and Federal and State law enforcement agencies. That commitment began with the extensive consultations that have already taken place and which will continue in the future.

This initial CMIP presents another expression of CMSO's pledge to cooperate with all those who are similarly committed to combating Medicaid fraud. That commitment will be reflected in the insights from MIP efforts that will be shared with the program integrity and law enforcement communities. Through the coordination of anti-fraud conferences and other training opportunities, CMSO will work diligently to fulfill the obligations of the Medicaid Integrity Program.

Finally, it will be essential that MIP work closely with States on all aspects of the audit program. States have traditionally been on the frontline of direct provider oversight. MIP's activities must complement their ongoing efforts.

Consultations with Interested Parties

CMS staff has formally consulted with all of the partners described earlier in this report. These meetings included representatives of the Department of Justice, the Federal Bureau of Investigation, the Office of Inspector General for the Department of Health and Human Services, the Government Accountability Office, the National Association of State Medicaid Directors, the National Association of Surveillance and Utilization Review Officials, the Medicaid Fraud and Abuse Technical Advisory Group, and the National Association of Medicaid Fraud Control Units. In addition, consultations were conducted with staff from the Senate Finance Committee, a subcommittee of the Senate Committee on Homeland Security and Governmental Affairs, and the House Energy and Commerce Committee.

Each of these meetings was fruitful and informed the development of the CMIP. MIP briefing staff made it clear that these meetings were the first of what are expected to be ongoing and not less than annual consultations with MIP's external partners.

Although not statutorily required, the planning group is also consulting with other HHS and CMS partners in the development of the CMIP. Those partners have included the Program Integrity Group and will include, in the near future, other components of the Office of Financial Management, the Office of Information Services, the Office of

Acquisitions and Grant Management, the Office of Strategic Operations and Regulatory Affairs, and HHS' Office of General Counsel. There has also been extensive collaboration with elements of MIP's parent organization, the Center for Medicaid & State Operations.

The planning group has also conducted or will be soon conducting consultations with CMS Regional Administrators, Deputy Regional Administrators, Associate Regional Administrators, and key representatives from the program integrity, financial management, and state representative areas of Medicaid and Medicare in CMS' regional offices. As of this report, a total of 15 briefings have been held since April 2006. Additional consultations will be conducted over the summer and early fall. The success of the Medicaid Integrity Program will depend to a great degree on building effective working relationships with all of these entities.

The initial consultations raised a number of themes as described below.

Collaboration. One of the most frequently voiced concerns was the importance of collaboration to the success of the Medicaid Integrity Program. The potential for creating conflicts with ongoing State provider audits or unintentionally impeding an active Federal or State fraud investigation underscored that message. Communication and coordination are essential. The Medicaid Integrity Program commits itself to achieving this goal.

Medi-Medi. In almost every session, questions were raised about MIP's relation to the Medi-Medi national expansion project. Matching Medicare and Medicaid claims data to find patterns of fraud, previously undetectable to the programs individually, is currently underway in nine states and in the planning stages in a tenth state. Medi-Medi has provided State and Federal law enforcement and program integrity units with dramatic insights into the overall practices of providers who are exploiting both programs. In 2001, CMS and California began the first project. Through FY 2005, Medi-Medi has resulted in the initiation of 335 investigations and 42 referrals to law enforcement. Fifteen million four hundred thousand dollars ($15.4 million) in overpayments have either been denied or identified. MIP may also strengthen its efforts by using both types of claims data to conduct more effective Medicaid audits.

PERM. The role of MIP vis-à-vis the Payment Error Rate Measurement (PERM) project was also raised in several meetings. OFM's Program Integrity Group is responsible for both Medi-Medi and PERM. Because of the importance of these projects to the overall integrity of the Medicaid program, 20 staff from MIP will be allocated to work directly on PERM and Medi-Medi under the direction of the Office of Financial Management.

PERM and Medi-Medi serve, each in their respective ways, to underscore the importance of collaboration. As each program evolves, their results will inform future planning for MIP. Similarly, the lessons learned through the Medicaid Integrity Program will offer valuable insights into the administration of PERM and Medi-Medi.

Liaison with Providers. During the consultations, more than one partner discussed the value of keeping the provider community informed about MIP. Providers not only have an interest in understanding the expectations espoused in the CMIP, but can also be a valuable ally in identifying potentially fraudulent practices in their respective industries, as well as serve as a source of intelligence of specific misconduct. Over the next several months, MIP intends to inform provider communities about the CMIP and learn more about their concerns as well.

Relationship between Oversight & Assistance. In one consultation, concern was expressed about the inherent conflict between oversight and technical assistance. The commenter believed that MIP would have to utilize separate staffs for these functions because it would otherwise be too confusing for the States. This is a legitimate concern. In the past, MAPS balanced its oversight and assistance roles by assigning staff from a separate geographic area to State program integrity reviews. This shielded regional office staff for that particular State from potential conflicts between oversight and support. MIP expects to use a similar model for future State program integrity reviews.

Targeting Programmatic Vulnerabilities

A key element of all of the consultations was the identification of those areas of the Medicaid program that are most vulnerable to fraud, waste, and abuse. For example, federal law enforcement officials suggested that MIP planning should include reviewing activities involving high expenditures for medical and other services that do not require prior authorization or a certificate of need. Medical suppliers represent another fraud-prone area.

CMSO has identified several specific issues that may be appropriate to address at the outset of the Medicaid Integrity Program. In drawing from its own experience and that of the OIG and the GAO, CMSO plans to initially focus on a number of areas. They include: a) nursing and personal care such as fraud related to long term care facilities and home health agencies; b) the provision of prescription drugs to beneficiaries and the underlying costs of those drugs as reported to the States; c) durable medical equipment and other medical suppliers; and d) improper claims for payment from hospitals and individual practitioners.

Over the next several months, MIP will develop a more detailed work plan to address these and other vulnerabilities. It is critical that all interested parties, not just those mandated by the DRA, have the opportunity to weigh in with their respective concerns. MIP will consult with OFM's Program Integrity Group on its experiences in the Medicare program. Common wisdom in health care fraud holds that a provider defrauding the Medicare program is also likely to be defrauding the Medicaid program.

There are many variations among the States' Medicaid programs. There are also varied fraud challenges around the country. CMSO will employ an evidence-based planning approach in identifying vulnerabilities. It will act in a deliberate manner and be alert to new schemes. . MIP's most important task in FY 2006 is to create an infrastructure that

cogently addresses the overall problems and develops a systematic approach to combating each of the most critical issues identified.

Balancing MIP's Roles

The duties of the Medicaid Integrity Contractors involve both oversight and education. Audits will be conducted and overpayments identified. Providers and other parties will also be educated on payment integrity and quality of care.

Similarly, CMSO will balance both oversight and education in its relationships with the States. Through program integrity training, best practices guidance and other forms of technical assistance, CMSO will provide value to State Medicaid agencies and program integrity units. By re-designing the State program integrity review process and learning more about the state of program integrity activities across the country, CMSO will provide effective oversight of these critical functions.

MIP will serve as a bully pulpit to encourage States and those who provide Medicaid services to enhance their program integrity activities. It will act as a regulator to enforce reasonable requirements. Through training, technical assistance and State oversight reviews, MIP will shine a powerful spotlight on any entity seeking inappropriate payment from the Medicaid program.

Suspending payments to suspect providers while simultaneously seeking recovery of identified overpayments will be integral to MIP's overall plan. MIP will make referrals on suspected fraudulent practices and providers to Federal and State law enforcement agencies. However, it is important that law enforcement referrals do not routinely result in a cessation of administrative sanctions taken against such providers. CMS has discussed these concerns with law enforcement and will consult on a case by case basis.

Learning from Experience

MIP will use the lessons it learns through its own experiences, and those of the States and others, to turn them into guidance and directives aimed at preventing future improper payments. Audit issues will take into account not only the potential value of individual provider overpayments but also the potential for prevention-oriented guidance to the States.

The experiences of the Medicaid Integrity Contractors and the field operations functions of the Medicaid Integrity Program will offer invaluable insights into future fraud prevention and cost savings strategies. MIP expects to identify significant overpayments through a carefully crafted audit program. However, those overpayments will likely be dwarfed by the potential savings from more global strategies developed from those audit experiences. Similarly, by identifying the States' best practices and vulnerabilities, CMSO will make recommendations and directives to the States to prevent future improper payments to providers.

Return on Investment

The DRA calls for the Medicaid Integrity Program to submit an annual report to Congress that documents the use and effectiveness of the funds appropriated to it. MIP will report on its activities and how it has calculated the return on investment related to both the prevention of inappropriate payments and the collection of identified overpayments. Support and assistance to the States will also be quantified.

It will be fairly straightforward to report on the actual monies directly recovered through the labors of the Medicaid Integrity Contractors. Calculating the cost savings or cost avoidance from MIP's other efforts will not be so simple. That methodology will be developed as part of the overall implementation of the program. It will, however, be a conservative and reasonable measure of the value of CMS' anti-fraud and abuse duties.

In addition, as part of the strategic contractor's work on the State program integrity assessment, the various cost savings methodologies used by the States will be examined. Over time, MIP will develop best practices guidance on reporting cost avoidance statistics for program integrity work.

The creation of the Medicaid Integrity Program offers another opportunity as well. MIP can identify key risks and implement appropriate internal controls to mitigate those risks. With thorough documentation and rigorous maintenance of those controls, the Medicaid Integrity Program will conform to the requirements of the Chief Financial Officer (CFO) Act.

Organizational Resources

In July 2006, CMS announced the creation of the Medicaid Integrity Group (MIG) within the Center for Medicaid & State Operations. In recognition of the critical nature of MIG's work, the Group Director reports directly to CMSO Director Dennis Smith.

The two major activities of the Medicaid Integrity Program are the audit program and State oversight and assistance. The organizational structure of the Medicaid Integrity Group is aimed at accomplishing both those activities in an efficient and effective manner.

Medicaid Integrity Group Director's Office

The Medicaid Integrity Group Director's office will serve as CMSO's primary point of contact on Medicaid fraud and abuse issues within CMS, with other partners, including law enforcement, and with the States. In particular, this team will work closely with CMSO and OFM leadership to ensure that MIG's efforts remain synchronized with all other Medicaid and Medicare integrity activities. The Group Director's office will promote the integrity of the Medicaid program through the audit and review of providers and others seeking payment under the Medicaid programs. It will coordinate the field activities of the group and convene national training conferences to promote the integrity of the Medicaid program. It will be responsible for the development and maintenance of the CMIP, MIP's annual report to Congress, and generally provide support to and direct the Medicaid anti-fraud activities of MIG staff.

Division of Medicaid Integrity Contracting

The Division of Medicaid Integrity Contracting (DMIC) will serve as the primary Agency focal point for procurement, functional administration, and oversight of all Medicaid Integrity Contractors. In that role, it will develop requests for proposals and serve as the home base for project officers (and potentially government task leaders) for contractors conducting the activities designated in the DRA. This will include: a) reviewing the action of providers and others seeking Medicaid payments; b) auditing their claims; c) identifying their overpayments; and d) educating providers and others on payment integrity and quality of care.

In preparation for and as part of the requests for proposal, DMIC will be responsible for developing and incorporating performance measurements for the MICs and using these standards to monitor their contractual performance. DMIC will also ensure the collection of overpayments identified by the MICs in coordination with CMSO, the Regional Offices, and the States.

Division of Fraud Research & Detection

The Division of Fraud Research & Detection (DFRD) will be charged with the responsibility for conducting state of the art data mining and analysis to identify

emerging trends in Medicaid fraud and abuse. It will also: a) provide statistical and data support to DMIC and DFO; b) conduct special program integrity studies as appropriate; c) assist in the development and delivery of program integrity training; d) identify appropriate performance measurements for State program integrity units; e) provide technical assistance to DMIC and the MICs in the execution of provider oversight activities; and f) provide support and assistance to States through oversight, training, best practices and other forms of technical assistance.

Division of Field Operations

The Division of Field Operations (DFO) will be the largest of MIG's components with staff divided among a division office and up to five teams whose staff will be strategically located throughout the country. While no decision has been made at this time, it is likely the teams will be headquartered in those areas commonly believed to be "fraud hot spots." They include Southern California, South Florida, the Gulf Coast, New England-New York-New Jersey and the Chicago-Detroit area.

The teams will be responsible for specific states and territories, covering the nation. Teams will be staffed with integrity specialists who will have the primary responsibility for carrying out MIG's obligation to provide "effective support and assistance to States to combat provider fraud and abuse."

That support and assistance will take several forms. CMSO will build on its experience in conducting 44 State program integrity reviews to strengthen its oversight of State efforts in this area. A more focused, outcome-oriented review guide will be developed in consultation with the States. In conjunction with DFRD and other CMS operating units, DFO will identify best practices guidance for States and offer other technical assistance such as training in key fraud and abuse areas of interest to the States. DFO will interact with Federal and State law enforcement agencies to help coordinate CMS' assistance in health care fraud investigations. In conjunction with other MIG divisions, DFO will also closely collaborate with the Program Integrity Group and Regional Office staffs on Medi-Medi and PERM.

Staffing

The 100 full time equivalent employees authorized by the DRA will be allocated among three operational areas within CMS: a) 79 staff assigned to the Medicaid Integrity Group; b) 20 staff assigned to OFM's Program Integrity Group; and c) one staff assigned to the Office of Acquisitions & Grant Management (OAGM). The 20 staff assigned to OFM will be assigned to duties directly related to Medicaid fraud and abuse through the nationally expanded Medi-Medi project or to conduct follow up reviews related to PERM. The one employee working with OAGM will be fully dedicated to supporting MIG's extensive responsibilities related to procurement of both developmental and operational contractors.

A variety of skill sets is being sought for MIP staff. These include contract and financial management, investigations, auditing, data mining and analysis, statistical sampling and research, and skilled medical professionals such as pharmacists and registered nurses.

Budget

Congress appropriated $5 million in start-up funding during FY 2006 and appropriated an additional $50 million beginning in each of fiscal years 2007 & 2008 and $75 million annually in FY 2009 and each year thereafter. The statute provides that these funds "remain available until expended."

The major expenditure categories for accomplishing the objectives of the MIP include contracting, staff salaries and associated costs, travel, training, equipment and supplies. These expenses will be allocated among three major components in the Medicaid Integrity Group including support and assistance to the States, Medicaid integrity contracting and fraud research and detection.

During Phase One of the implementation plan, which runs through the end of fiscal year 2006, a major obligation against the $5 million in start-up funding will be contracting expenses for the strategic contractors and for travel, training, equipment and supplies. Expenses for salaries and associated costs will increase as staff is hired in FY 2006 and FY 2007.

Category	**FY 2006**	**FY 2007**
Staff Salaries	$760,000	$12,000,000
Strategic and Support Contractors	$2,760,000	$1,200,000
Medicaid Integrity Contractors	$0	$35,000,000
Equipment, Supplies, Space, Hardware, Software	$1,180,000	$1,200,000
Travel, Training, Technical Assistance	$300,000	$600,000
Totals	**$5,000,000**	**$50,000,000**

Conclusion

The Comprehensive Medicaid Integrity Plan for the Medicaid Integrity Program is, and always will be, a work in progress as no five year plan will hold true for that length of time. The CMIP will be revised and re-published annually to take into account the evolving and elusive nature of fraud control.

The late Peter Drucker was once quoted as saying: "Plans are only good intentions unless they immediately degenerate into hard work." With the publication of this Comprehensive Medicaid Integrity Plan, CMS commits itself to the hard work of combating Medicaid fraud, waste, and abuse.

Appendix A - Medicaid Integrity Program Statutory Responsibilities

Sections 6031, 6032 and 6034 (Title VI, Subtitle A, Chapter 3) of the Deficit Reduction Act of 2005

SEC. 6031. ENCOURAGING THE ENACTMENT OF STATE FALSE CLAIMS ACTS.

(a) IN GENERAL.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by inserting after section 1908A the following:

''STATE FALSE CLAIMS ACT REQUIREMENTS FOR INCREASED STATE SHARE OF RECOVERIES

''SEC. 1909. (a) IN GENERAL.—Notwithstanding section 1905(b), if a State has in effect a law relating to false or fraudulent claims that meets the requirements of subsection (b), the Federal medical assistance percentage with respect to any amounts recovered under a State action brought under such law, shall be decreased by 10 percentage points.

''(b) REQUIREMENTS.—For purposes of subsection (a), the requirements of this subsection are that the Inspector General of the Department of Health and Human Services, in consultation with the Attorney General, determines that the State has in effect a law that meets the following requirements:

''(1) The law establishes liability to the State for false or fraudulent claims described in section 3729 of title 31, United States Code, with respect to any expenditure described in section 1903(a).

''(2) The law contains provisions that are at least as effective in rewarding and facilitating qui tam actions for false or fraudulent claims as those described in sections 3730 through 3732 of title 31, United States Code.

''(3) The law contains a requirement for filing an action under seal for 60 days with review by the State Attorney General.

''(4) The law contains a civil penalty that is not less than the amount of the civil penalty authorized under section 3729 of title 31, United States Code.

''(c) DEEMED COMPLIANCE.—A State that, as of January 1, 2007, has a law in effect that meets the requirements of subsection (b) shall be deemed to be in compliance with such requirements for so long as the law continues to meet such requirements.

''(d) NO PRECLUSION OF BROADER LAWS.—Nothing in this section shall be construed as prohibiting a State that has in effect a law that establishes liability to the State for false or fraudulent claims described in section 3729 of title 31, United States Code, with respect to programs in addition to the State program under this title, or with respect to expenditures in addition to expenditures described in section 1903(a), from being considered to be in compliance with the requirements of subsection (a) so long as the law meets such requirements.''.

(b) EFFECTIVE DATE.—Except as provided in section 6035(e), the amendments made by this section take effect on January 1, 2007.

SEC. 6032. EMPLOYEE EDUCATION ABOUT FALSE CLAIMS RECOVERY.

(a) IN GENERAL.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(1) in paragraph (66), by striking ‘‘and’’ at the end;

(2) in paragraph (67) by striking the period at the end and inserting ‘‘; and’’; and

(3) by inserting after paragraph (67) the following:

‘‘(68) provide that any entity that receives or makes annual payments under the State plan of at least $5,000,000, as a condition of receiving such payments, shall—

‘‘(A) establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1128B(f));

‘‘(B) include as part of such written policies, detailed provisions regarding the entity’s policies and procedures for detecting and preventing fraud, waste, and abuse; and

‘‘(C) include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of employees to be protected as whistleblowers, and the entity’s policies and procedures for detecting and preventing fraud, waste, and abuse.’’.

(b) EFFECTIVE DATE.—Except as provided in section 6035(e), the amendments made by subsection (a) take effect on January 1, 2007.

SEC. 6034. MEDICAID INTEGRITY PROGRAM.

(a) ESTABLISHMENT OF MEDICAID INTEGRITY PROGRAM.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended—

(1) by redesignating section 1936 as section 1937; and

(2) by inserting after section 1935 the following:

‘‘MEDICAID INTEGRITY PROGRAM

‘‘SEC. 1936. (a) IN GENERAL.—There is hereby established the Medicaid Integrity Program (in this section referred to as the ‘Program’) under which the Secretary

shall promote the integrity of the program under this title by entering into contracts in accordance with this section with eligible entities to carry out the activities described in subsection (b).

''(b) ACTIVITIES DESCRIBED.—Activities described in this subsection are as follows:

''(1) Review of the actions of individuals or entities furnishing items or services (whether on a fee-for-service, risk, or other basis) for which payment may be made under a State plan approved under this title (or under any waiver of such plan approved under section 1115) to determine whether fraud, waste, or abuse has occurred, is likely to occur, or whether such actions have any potential for resulting in an expenditure of funds under this title in a manner which is not intended under the provisions of this title.

''(2) Audit of claims for payment for items or services furnished, or administrative services rendered, under a State plan under this title, including—

''(A) cost reports;

''(B) consulting contracts; and

''(C) risk contracts under section 1903(m).

''(3) Identification of overpayments to individuals or entities receiving Federal funds under this title.

''(4) Education of providers of services, managed care entities, beneficiaries, and other individuals with respect to payment integrity and quality of care.

''(c) ELIGIBLE ENTITY AND CONTRACTING REQUIREMENTS.—

''(1) IN GENERAL.—An entity is eligible to enter into a contract under the Program to carry out any of the activities described in subsection (b) if the entity satisfies the requirements of paragraphs (2) and (3).

''(2) ELIGIBILITY REQUIREMENTS.—The requirements of this paragraph are the following:

''(A) The entity has demonstrated capability to carry out the activities described in subsection (b).

''(B) In carrying out such activities, the entity agrees to cooperate with the Inspector General of the Department of Health and Human Services, the Attorney General, and other law enforcement agencies, as appropriate, in the investigation and deterrence of fraud and abuse in relation to this title and in other cases arising out of such activities.

''(C) The entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement.

''(D) The entity meets such other requirements as the Secretary may impose.

''(3) CONTRACTING REQUIREMENTS.—The entity has contracted with the Secretary in accordance with such procedures as the Secretary shall by regulation establish, except that such procedures shall include the following:

''(A) Procedures for identifying, evaluating, and resolving organizational conflicts of interest that are generally applicable to Federal acquisition and procurement.

''(B) Competitive procedures to be used—

''(i) when entering into new contracts under this section;

''(ii) when entering into contracts that may result in the elimination of responsibilities under section 202(b) of the Health Insurance Portability and Accountability Act of 1996; and

''(iii) at any other time considered appropriate by the Secretary.

''(C) Procedures under which a contract under this section may be renewed without regard to any provision of law requiring competition if the contractor has met or exceeded the performance requirements established in the current contract. The Secretary may enter into such contracts without regard to final rules having been promulgated.

''(4) LIMITATION ON CONTRACTOR LIABILITY.—The Secretary shall by regulation provide for the limitation of a contractor's liability for actions taken to carry out a contract under the Program, and such regulation shall, to the extent the Secretary finds appropriate, employ the same or comparable standards and other substantive and procedural provisions as are contained in section 1157.

''(d) COMPREHENSIVE PLAN FOR PROGRAM INTEGRITY.—

''(1) 5-YEAR PLAN.—With respect to the 5-fiscal year period beginning with fiscal year 2006, and each such 5-fiscal year period that begins thereafter, the Secretary shall establish a comprehensive plan for ensuring the integrity of the program established under this title by combatting fraud, waste, and abuse.

''(2) CONSULTATION.—Each 5-fiscal year plan established under paragraph (1) shall be developed by the Secretary in consultation with the Attorney General, the Director of the Federal Bureau of Investigation, the Comptroller General of the United States, the Inspector General of the Department of Health and Human Services, and State officials with responsibility for controlling provider fraud and abuse under State plans under this title.

''(e) APPROPRIATION.—

''(1) IN GENERAL.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated to carry out the Medicaid Integrity Program under this section, without further appropriation—

''(A) for fiscal year 2006, $5,000,000;

''(B) for each of fiscal years 2007 and 2008, $50,000,000; and

''(C) for each fiscal year thereafter, $75,000,000.

''(2) AVAILABILITY.—Amounts appropriated pursuant to paragraph (1) shall remain available until expended.

''(3) INCREASE IN CMS STAFFING DEVOTED TO PROTECTING MEDICAID PROGRAM INTEGRITY.—From the amounts appropriated under paragraph (1), the Secretary shall increase by 100 the number of full-time equivalent employees whose duties consist solely of protecting the integrity of the Medicaid program established under this section by providing effective support and assistance to States to combat provider fraud and abuse.

''(4) ANNUAL REPORT.—Not later than 180 days after the end of each fiscal year (beginning with fiscal year 2006), the Secretary shall submit a report to Congress which identifies—

''(A) the use of funds appropriated pursuant to paragraph (1); and

''(B) the effectiveness of the use of such funds.''.

(b) STATE REQUIREMENT TO COOPERATE WITH INTEGRITY PROGRAM EFFORTS.—Section 1902(a) of such Act (42 U.S.C. 1396a(a)), as amended by section 6033(a), is amended—

(1) in paragraph (67), by striking ''and'' at the end;

(2) in paragraph (68), by striking the period at the end and inserting ''; and''; and

(3) by inserting after paragraph (68), the following:

''(69) provide that the State must comply with any requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program established under section 1936.''.

(c) INCREASED FUNDING FOR MEDICAID FRAUD AND ABUSE CONTROL ACTIVITIES.—

(1) IN GENERAL.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated to the Office of the Inspector General of the Department of Health and Human Services, without further appropriation, $25,000,000 for each of fiscal years 2006 through 2010, for activities of such Office with respect to the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(2) AVAILABILITY; AMOUNTS IN ADDITION TO OTHER AMOUNTS APPROPRIATED FOR SUCH ACTIVITIES.—Amounts appropriated pursuant to paragraph (1) shall—

(A) remain available until expended; and

(B) be in addition to any other amounts appropriated or made available to the Office of the Inspector General of the Department of Health and Human Services for activities of such Office with respect to the Medicaid program.

(3) ANNUAL REPORT.—Not later than 180 days after the end of each fiscal year (beginning with fiscal year 2006), the Inspector General of the Department of Health and Human Services shall submit a report to Congress which identifies—

(A) the use of funds appropriated pursuant to paragraph (1); and

(B) the effectiveness of the use of such funds.

(d) NATIONAL EXPANSION OF THE MEDICARE-MEDICAID (MEDIMEDI) DATA MATCH PILOT PROGRAM.—

(1) REQUIREMENT OF THE MEDICARE INTEGRITY PROGRAM.—Section 1893 of the Social Security Act (42 U.S.C. 1395ddd) is amended—

(A) in subsection (b), by adding at the end the following:

''(6) The Medicare-Medicaid Data Match Program in accordance with subsection (g).''; and

(B) by adding at the end the following:

''(g) MEDICARE-MEDICAID DATA MATCH PROGRAM.—

''(1) EXPANSION OF PROGRAM.—

''(A) IN GENERAL.—The Secretary shall enter into contracts with eligible entities for the purpose of ensuring that, beginning with 2006, the Medicare-Medicaid Data Match Program (commonly referred to as the 'Medi-Medi Program') is conducted with respect to the program established under this title and State Medicaid programs under title XIX for the purpose of—

''(i) identifying program vulnerabilities in the program established under this title and the Medicaid program established under title XIX through the use of computer algorithms to look for payment anomalies (including billing or billing patterns identified with respect to service, time, or patient that appear to be suspect or otherwise implausible);

''(ii) working with States, the Attorney General, and the Inspector General of the Department of Health and Human Services to coordinate appropriate actions to protect the Federal and State share of expenditures under the Medicaid program under title XIX, as well as the program established under this title; and

''(iii) increasing the effectiveness and efficiency of both such programs through cost avoidance, savings, and recoupments of fraudulent, wasteful, or abusive expenditures.

''(B) REPORTING REQUIREMENTS.—The Secretary shall make available in a timely manner any data and statistical information collected by the Medi-Medi Program to the Attorney General, the Director of the Federal Bureau of Investigation, the Inspector General of the Department of Health and Human Services, and the States (including a Medicaid fraud and abuse control unit described in section 1903(q)). Such information shall be disseminated no less frequently than quarterly.

''(2) LIMITED WAIVER AUTHORITY.—The Secretary shall waive only such requirements of this section and of titles XI and XIX as are necessary to carry out paragraph (1).''.

(2) FUNDING.—Section 1817(k)(4) of such Act (42 U.S.C. 1395i(k)(4)), as amended by section 5204 of this Act, is amended—

(A) in subparagraph (A), by striking ''subparagraph (B)'' and inserting ''subparagraphs (B), (C), and (D)''; and

(B) by adding at the end the following:

> ‘‘(D) EXPANSION OF THE MEDICARE-MEDICAID DATA MATCH PROGRAM.—The amount appropriated under subparagraph (A) for a fiscal year is further increased as follows for purposes of carrying out section 1893(b)(6) for the respective fiscal year:
>
> ‘‘(i) $12,000,000 for fiscal year 2006.
>
> ‘‘(ii) $24,000,000 for fiscal year 2007.
>
> ‘‘(iii) $36,000,000 for fiscal year 2008.
>
> ‘‘(iv) $48,000,000 for fiscal year 2009.
>
> ‘‘(v) $60,000,000 for fiscal year 2010 and each fiscal year thereafter.’’.

(e) DELAYED EFFECTIVE DATE FOR CHAPTER.—Except as otherwise provided in this chapter, in the case of a State plan under title XIX of the Social Security Act which the Secretary determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by a provision of this chapter, the State plan shall not be regarded as failing to comply with the requirements of such Act solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature.

Appendix B - MIP 5-Year Implementation Plan

FISCAL YEAR 2006 [DESIGNING INFRASTRUCTURE - $5 MILLION[2]]

- Integrity Planning (update annually)
    - Engage internal & external stakeholders
        - Internal: CMSO, OFM/PI Group, RO's, OL, OGC, OAGM, OIS, OSORA, OIG
        - External: DOJ, FBI, GAO, States, TAG
    - Conduct legislative & regulatory review
    - Promulgate new regulations as appropriate
    - Design & release Comprehensive Medicaid Integrity Plan (CMIP)
- Medicaid Integrity Contracting
    - Develop specifications and procure Audit Program Development contractor
- Field Operations
    - Re-engineer state oversight protocol
    - Develop state audit liaisons (ongoing)
    - Coordinate with Medicaid/Medicare FM operations (ongoing)
    - Support MIC procurement efforts (ongoing)
    - Serve on Medi-Medi steering committees (ongoing)
    - Coordinate with Medicaid F&A Tag (ongoing)
- Fraud Research & Detection
    - Develop specifications and procure State PI Assessment contractor
    - Provide statistical support for planning & implementation activities (ongoing)
    - Identify emerging fraud practices & trends (ongoing)
    - Conduct special studies as appropriate (ongoing)
    - Utilize skilled medical professionals for industry expertise (ongoing)
- Medicare Integrity Collaboration
    - Liaison with Medi-Medi expansion (ongoing)
        - Integrate MIP planning with M-M expansion planning
    - Coordinate PERM regional office activities
    - Liaison on law enforcement issues with Medicare PI which is CMS' national point of contact for law enforcement issues (ongoing)
    - Coordinate FR&D efforts with Medicare PI data analysis group
    - Liaison on long term contracting strategies (ongoing)

FISCAL YEAR 2007 [IMPLEMENTATION & PROCUREMENT - $50 MILLION]

- Integrity Planning
    - Draft and release mandatory annual report to Congress including ROI (ongoing)
    - Continue legislative & regulatory review (ongoing) - particular focus on potential role of SCHIP in MIP

[2] Amounts appropriated remain available until expended

- Medicaid Integrity Contracting
  - Develop SOWs/RFPs/budgets for four MIC activities
    - Based on Audit Program Development contractor & field operations staff input for reviews/audits/identification of overpayments contractor(s)
    - Based on fraud research & detection expertise for education of providers
  - Evaluate proposals; select and negotiate with contractors
  - Implement/oversee all four MIC activities
  - Initiate MIC reviews & audits
- Field Operations
  - Conduct state oversight reviews (ongoing)
  - Develop best practices (ongoing)
  - Convene national fraud conferences (ongoing)
  - Serve as MIC Co-GTLs (ongoing)
  - Coordinate audit collections (ongoing)
- Fraud Research & Detection
  - Collect & maintain state PI metrics including ROI (ongoing)
  - Develop state program integrity training curriculum (ongoing)
  - Serve as clearinghouse for MIC reports (ongoing)
- Medicare Integrity Collaboration
  - Consult with OFM on IDR development (ongoing)
    - Collaborate on "Joint PI Data" concept
  - Coordinate satellite office activities (ongoing)

FISCAL YEAR 2008 [OPERATIONAL - $50 MILLION]

- Integrity Planning
  - Engage internal/external stakeholders in CMIP review
  - Incorporate PERM findings
- Medicaid Integrity Contracting
  - Continue on all ongoing activities
  - Develop/implement MIC performance measurements & evaluate contractors
- Field Operations
  - Continue all ongoing activities
- Fraud Research & Detection
  - Continue all ongoing activities
- Medicare Integrity Collaboration
  - Continue all ongoing activities

FISCAL YEAR 2009 [FULLY FUNDED - $75 MILLION]

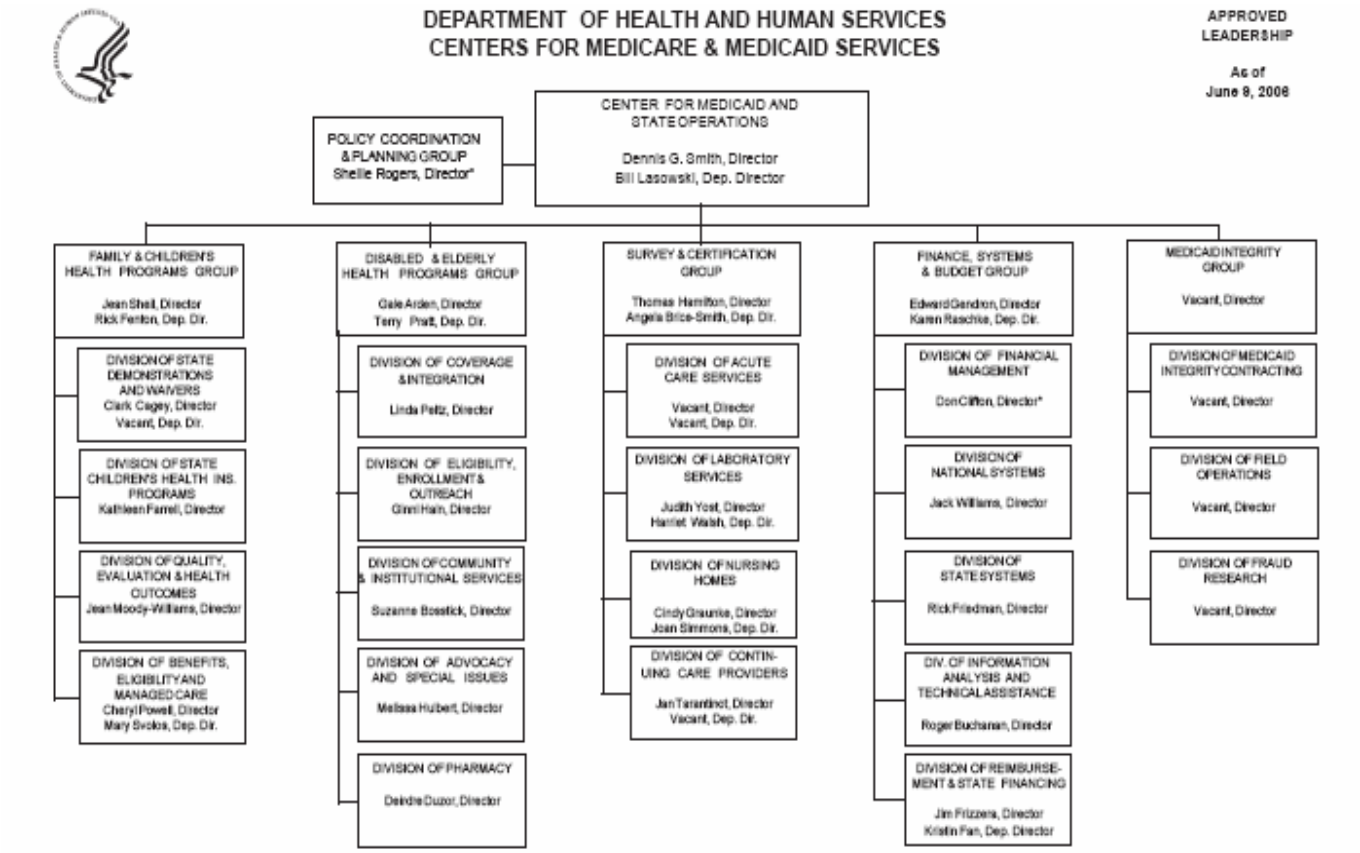
- Integrity Planning
  - Engage internal/external stakeholders in CMIP review
  - Incorporate PERM findings
- Medicaid Integrity Contracting

  - Continue on all ongoing activities with full funding
  - Revisit MIC strategies going forward
  - Develop/implement MIC performance measurements & evaluate contractors
- Field Operations
  - Continue all ongoing activities with full funding
- Fraud Research & Detection
  - Continue all ongoing activities with full funding
- Medicare Integrity Collaboration
  - Continue all ongoing activities

FISCAL YEAR 2010 [FULLY OPERATIONAL - $75 MILLION]

- Integrity Planning
  - Engage internal/external stakeholders in CMIP review
  - Incorporate PERM findings
- Medicaid Integrity Contracting
  - Continue on all ongoing activities with full funding
  - Implement revised MIC strategies developed in FY 2009
  - Develop/implement MIC performance measurements & evaluate contractors
- Field Operations
  - Continue all ongoing activities with full funding
- Fraud Research & Detection
  - Continue all ongoing activities with full funding
- Medicare Integrity Collaboration
  - Continue all ongoing activities

Appendix C - CMSO Organizational Chart



Appendix D - Medicaid Integrity Group Functional Statements

Date: June 9, 2006

Centers for Medicare & Medicaid Services
Office of the Administrator
Center for Medicaid & State Operations
Medicaid Integrity Group
(FASK)

- Serves as the primary point of contact for Medicaid & SCHIP fraud and abuse issues within CMS and with the States.

- Promotes the integrity of the Medicaid & SCHIP programs through the audit and review of providers and others seeking payment under the Medicaid & SCHIP programs.

- Develops and maintains a Comprehensive Plan for Program Integrity in consultation with internal and external partners.

- Provides support and assistance to States through oversight, training, best practices and other forms of technical assistance.

- Provides support to and directs the program integrity activities of CMS staff both in Central Office and in the field.

- Collaborates with the Program Integrity Group on common efforts to combat fraud and abuse in both the Medicaid & SCHIP and Medicare programs.

- Coordinates MIG activities with those of CMSO's Financial Management staff as well as the Regional Offices' State Representatives.

Date: June 9, 2006

Centers for Medicare & Medicaid Services
Office of the Administrator
Center for Medicaid & State Operations
Medicaid Integrity Group
Division of Medicaid Integrity Contracting
(FASK1)

• Serves as the primary Agency focal point for procurement, functional administration and oversight of all Medicaid Integrity Contractors (MIC).

• Develops statements of work and task orders for contractors conducting the following activities:

- Reviewing the action of providers and others seeking Medicaid payments
- Auditing their claims
- Identifying their overpayments
- Educating providers and others on payment integrity and quality of care

• Develops performance measurements for MICs and monitors their contractual performance.

• Coordinates the collection of overpayments identified by MICs with CMSO, the Regional Offices and the States.

Date: June 9, 2006

Centers for Medicare & Medicaid Services
Office of the Administrator
Center for Medicaid & State Operations
Medicaid Integrity Group
Division of Field Operations
(FASK2)

• Serves as CMS' primary point of contact with State program integrity units.

• Acts as CMS' primary liaison with APHSA's National Medicaid Fraud and Abuse Technical Advisory Group.

• Conducts Medicaid program integrity reviews and audits.

• Acts as primary Agency focal point for State provider audit issues.

• Identifies and disseminates best practices in Medicaid & SCHIP 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 MIG's interactions with CO/RO Medicaid Financial Management staff and NARs/State Representatives.

• Collaborates with internal and external partners in the development and execution of anti-fraud strategies and activities.

• Develops program integrity training curricula and conducts training.

• Supports DMIC through contract oversight in field offices.

Date: June 9, 2006

Centers for Medicare & Medicaid Services
Office of the Administrator
Center for Medicaid & State Operations
Medicaid Integrity Group
Division of Fraud Research and Detection
(FASK3)

• Provides statistical and data support to DMIC and DFO.

• Identifies emerging fraud 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 DMIC and the MICs in the execution of provider oversight activities.

• Provides support and assistance to States through oversight, training, best practices and other forms of technical assistance.

Appendix E - List of Acronyms

APD	Audit Program Development
APHSA	American Public Human Services Association
CFO	Chief Financial Officer
CMIP	Comprehensive Medicaid Integrity Plan
CMS	Centers for Medicare & Medicaid Services (HHS)
CMSO	Center for Medicaid & State Operations (CMS)
CO	Central Office (CMS)
Co-GTL	Co-Governmental Task Leader
DFO	Division of Field Operations (MIG/CMSO)
DFRD	Division of Fraud Research & Detection (MIG/CMSO)
DMIC	Division of Medicaid Integrity Contracting (MIG/CMSO)
DOJ	U.S. Department of Justice
DRA	Deficit Reduction Act of 2005
FBI	Federal Bureau of Investigations
FY	Fiscal Year
GAO	Government Accountability Office
HHS	U.S. Department of Health and Human Services
IDR	Integrated Data Repository
MAPS	Medicaid Alliance for Program Safeguards
MFCU	Medicaid Fraud Control Unit
MIC	Medicaid Integrity Contractors
MIG	Medicaid Integrity Group (CMS)
MIP	Medicaid Integrity Program
NAR	National Account Representative
OAGM	Office of Acquisitions & Grant Management (CMS)
OFM	Office of Financial Management (CMS)
OGC	Office of General Counsel (HHS)
OIG	Office of Inspector General (HHS)
OIS	Office of Information Services (CMS)
OL	Office of Legislation (CMS)
OSORA	Office of Strategic Operations & Regulatory Affairs (CMS)
PERM	Payment Error Rate Measurement project
PI	Program Integrity
RFP	Request For Procurement
RO	Regional Office (CMS)
ROI	Return on investment
SCHIP	State Children's Health Insurance Program
SOW	Statement of Work
SPIA	State Program Integrity Assessment
TAG	Technical Advisory Group