Comprehensive Medicaid Integrity Plan of the Medicaid Integrity Program

FYs 2008–2012

June 2008

Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations
Medicaid Integrity Group

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EXECUTIVE SUMMARY

Section 6034 of the Deficit Reduction Act of 2005 (DRA) established the Medicaid Integrity Program in section 1936 of the Social Security Act (Public Law 109-171). The legislation directed the Secretary of the United States Department of Health and Human Services (HHS) to establish a 5-year comprehensive plan to combat fraud, waste, and abuse in the Medicaid program, beginning in fiscal year (FY) 2006. The first Comprehensive Medicaid Integrity Plan (CMIP) covering FYs 2006 to 2010 was released in July 2006; the second, covering FYs 2007-2011, was released in October 2007. This revised plan reflects changes since the October 2007 plan was released.

The Centers for Medicare & Medicaid Services (CMS), Medicaid Integrity Group (MIG) is responsible for implementing the Medicaid Integrity Program. During FY 2008, the MIG will focus on the following tasks: planning and program management, communication and collaboration, ensuring accountability, information management and research, Medicaid Integrity contracting, and State program integrity operations.

Specific activities for FY 2008 include:

- Filling the remaining MIG staff vacancies and training staff on Medicaid program integrity and fraud, waste, and abuse issues;
- Issuing guidance to support and assist CMS and the States in improving overall program integrity effectiveness;
- Continuing communication and collaboration with internal and external stakeholders of the Medicaid Integrity Program;
- Developing performance measures to assess State Medicaid integrity programs;
- Publishing the second annual Medicaid Integrity Program Report to Congress;
- Developing a strategy to report on return on investment and effective use of funds;
- Overseeing the development of the "One-Stop-Shop" provider enrollment system;
- Conducting a national baseline information collection and assessment of State Medicaid integrity activities;
- Developing an information management system for the Medicaid Integrity Program;
- Developing data mining approaches and tools for fraud research and detection activities;
- Conducting test audits of Medicaid providers in order to develop effective, efficient audit protocols;
- Awarding the first round of Medicaid Integrity contracts to audit and review Medicaid providers, identify overpayments, and provide education on payment integrity and quality of care issues;
- Conducting oversight reviews of and providing technical support and assistance to State Medicaid integrity programs;
- Developing program integrity training curricula and establishing a national Medicaid Integrity Institute to promote the study of Medicaid program integrity issues; and
- Identifying and disseminating best practices in Medicaid program integrity efforts to States and other program integrity partners.

By the end of FY 2008, the MIG intends to have an array of tools and best practices with which to promote Medicaid program integrity and combat fraud, waste, and abuse.

INTRODUCTION

The CMS, through the MIG, is charged with the implementation and management of the Medicaid Integrity Program, as mandated in section 1936 of the Social Security Act (the Act) and enacted as part of the DRA[1]. The CMIP is an integral requirement of the Medicaid Integrity Program. The Act requires that a comprehensive plan be developed in consultation with a collective group of stakeholders including the Secretary of HHS, the United States Attorney General, the Director of the Federal Bureau of Investigation (FBI), the Comptroller General of the United States, the Inspector General of HHS (OIG), and State officials with responsibility for controlling provider fraud and abuse under Medicaid.

As a result of a host of planning efforts, including extensive consultations with key and mandated stakeholders, CMS is pleased to present this third CMIP, covering FYs 2008 through 2012. The plan is organized into three sections:

- **Section I: Background.** Provides an overview of legislation that created the Medicaid Integrity Program, the purpose of the program, and the organizational structure and responsibilities of the MIG.

- **Section II: FY 2008 Activities.** Provides an overview of the activities for FY 2008 based on the four core business processes and two main business operations of the MIG. NOTE: the text boxes throughout this section provide additional information on the details of the activities.

- **Section III: Overview of FYs 2008 – 2012 Planned Activities.** Provides an overview of the FY 2008 activities and planned activities for the next consecutive four Federal fiscal years.

In addition, a list of acronyms used throughout the plan is provided as an appendix.

[1] The Medicaid Integrity Program statutory responsibilities can be found at http://www.ssa.gov/OP_Home/ssact/title19/1936.htm

I. BACKGROUND

The Deficit Reduction Act of 2005 – Increased Resources for Medicaid Program Integrity
On February 8, 2006, President George W. Bush signed the DRA. Section 6034 of the DRA established the Medicaid Integrity Program at section 1936 of the Act. The Act increased federal resources to help CMS in its efforts to prevent, detect, and reduce fraud, waste, and abuse in the $300 billion per year Medicaid program. Specifically, section 1936 of the Act provided CMS with resources to establish the Medicaid Integrity Program, CMS' first national strategy to detect and prevent Medicaid fraud and abuse. The statute also provides CMS with the authority to hire 100 full-time equivalent employees to provide support to States and appropriated $5 million in funding during FY 2006, $50 million in FYs 2007 and 2008, and $75 million in FY 2009, and each year thereafter. The statute states that these funds "remain available until expended."

The Medicaid Integrity Program – What It Is
The Medicaid Integrity Program offers a unique opportunity to prevent, identify, and recover inappropriate Medicaid payments. It also supports the efforts of State Medicaid agencies through a combination of oversight and technical assistance. Although individual States work to ensure the integrity of their respective Medicaid programs, the Medicaid Integrity Program provides CMS with the ability to more directly ensure the accuracy of Medicaid payments and to deter those who would exploit the program.

The Medicaid Integrity Group – Who We Are
In July 2006, CMS announced the creation of the MIG within the Center for Medicaid and State Operations (CMSO). The organizational structure of the MIG is aimed at accomplishing the requirements for the Medicaid Integrity Program in an efficient and effective manner.

- **Office of the Group Director:** serves as the primary point of contact on Medicaid fraud, waste, and abuse issues within CMS and with other partners, including law enforcement and the States; oversees the development and publication of the CMIP and annual report to Congress; and directs the activities of MIG staff, including its three divisions;
- **Division of Medicaid Integrity Contracting:** responsible for the procurement and oversight of Medicaid Integrity contracts to conduct reviews, provider audits, and provide education, as well as other program support contracts (e.g., conference planning, training, data support) as needed;
- **Division of Field Operations:** conducts State Medicaid program integrity reviews, and provides support in the form of technical assistance and training to States; and
- **Division of Fraud Research and Detection:** provides statistical and data support for MIG activities, including those of its contractors, identifies emerging fraud trends, and conducts special studies as appropriate.

The Medicaid Integrity Group – What We Do

The primary goals of the MIG are to:

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

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

The **Core Business Processes** are:

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

The **Main Business Operations** are:

- Medicaid Integrity Contracting: procuring and managing contracts for Medicaid Integrity contractors and other Medicaid Integrity Program projects; and

- State Program Integrity Operations: providing effective support and assistance to States to improve Medicaid program integrity activities, and conducting reviews of State Medicaid integrity programs.

The MIG's goals, core business processes, and main business operations align with the following CMS Strategic Action Plan Objectives for 2006 - 2009:

- Skilled, Committed, and Highly-motivated Workforce;
- Accurate and Predictable Payments; and
- Collaborative Partnerships.

The next section elaborates on the FY 2008 activities for each core business process and main business operation.

II. FISCAL YEAR 2008 ACTIVITIES

PLANNING AND PROGRAM MANAGEMENT

Staffing

- Hire remaining 18 of the 79 MIG staff allocation. The majority of the sixty-one staff as of April 2008 was hired in FY 2007.
- Coordinate with CMS' Office of Financial Management (OFM) regarding hiring of the remaining 12 staff of the 20 allocated to OFM's Program Integrity Group.
- Provide basic training for all MIG Division of Field Operations staff on critical topics, including, but not limited to, health care fraud, State program integrity operations, and Medicaid program integrity reviews.

The 100 full-time-equivalent employees authorized by the DRA will be allocated among three operational components within CMS:

a) 79 staff assigned to MIG;
b) 20 staff assigned to OFM's Program Integrity Group; and
c) One staff person assigned to the Office of Acquisitions & Grant Management.

Training

- Completed the initial MIG staff training in January 2008.
- Conduct workforce analysis.
- Reassess the need for additional/ongoing MIG staff training.

The MIG is committed to recruiting and maintaining adequate staff to perform the duties necessary to combat Medicaid fraud, waste, and abuse. A Training Coordinator was hired in October 2007 to oversee the training activities for the group.

Regulatory, Legal Developments

- Published Notice of Proposed Rulemaking for Eligible Entity and Contracting Requirements provisions under sections 1936(c)(2) and (c)(3) of the Act in November 2007.
- Published final rule for Limitation on Contractor Liability provisions under section 1936(c)(4) of the Act in November 2007.
- Collaborate with States to develop processes and procedures to address the recoupment of overpayments identified by Medicaid Integrity contractor audits.

The Secretary is mandated to promulgate regulations on the limitations of contractor liability and the requirements for Medicaid Integrity contractors (MICs). The MIC audits will be conducted in accordance with Federal laws and regulations and may result in the discovery of overpayments for which a State will be required to reimburse the Federal share. The MIG will seek input from States to develop processes and procedures to address the recoupment of overpayments identified by the MICs.

COMMUNICATION AND COLLABORATION

Comprehensive Medicaid Integrity Plan

- Develop in consultation with mandated stakeholders.
- Develop and adhere to a schedule that aims to publish the CMIP close to the beginning of each Federal fiscal year.

Medicaid Integrity Program Advisory Committee

- Continue to work with subcommittees of the Medicaid Integrity Program Advisory Committee on strategies related to measuring return on investment and developing State performance measures.
- Establish a new subcommittee to address issues pertaining to managed care and program integrity.

In FY 2006, MIG established the Medicaid Integrity Program Advisory Committee to provide input and consultation on the development of its approaches to State program integrity operations and Medicaid Integrity contracting. The committee members include program integrity representatives from 16 States, the FBI, OIG, CMS' Regional Offices, and OFM. CMS plans to continue its collaboration with the committee through informal mechanisms as needed. To date, four subcommittees of the Advisory Committee have been formed:

1) To assist with the development of a return-on-investment strategy for the MIP;
2) To assist with the development of the audit strategy for the Medicaid Integrity contractors;
3) To assist in the development of State-level performance measures; and
4) To assist in the development of audit protocols for managed care providers.

Other External Communication

- Attend regular meetings with law enforcement at the management and staff levels.
- Continue collaboration with law enforcement to develop a standard fraud referral process and identify circumstances under which MIG will provide data support.
- Continue outreach via participation in Open Door Forums/audio conferences and presentations on the Medicaid Integrity Program.
- Continue to conduct presentations on the Medicaid Integrity Program at regional OIG conferences, industry meetings, and other venues.
- Update Medicaid Integrity Program Communications Plan.

The MIG has made a significant investment on a number of joint, collaborative initiatives with other CMS components. In addition, MIG continues to engage in ongoing communication and collaboration with its program integrity partners and stakeholders. Objectives of the Medicaid Integrity Program Communications Plan include:

- Provide stakeholders and other interested parties with updates on the status of the program and maintain an open line of communication;
- Educate stakeholders and interested parties about the significance of the program and its impact on Medicaid program integrity;
- Solicit feedback on ways that CMS can enhance its Medicaid program integrity efforts and improve the work of the MIG; and
- Provide the public with communication channels to inform CMS of cases of Medicaid fraud, waste, and abuse.

Internal Collaboration

- Continue ongoing collaboration and communication with CMSO and Medicare program integrity components.
- Conduct regular standing meetings with other CMS and HHS components on program integrity issues.
- Continue collaboration on joint initiatives with other CMS components and program integrity partners (e.g., One-Stop-Shop provider enrollment system, National Integrated Data Repository).

ENSURING ACCOUNTABILITY

Release annual Report to Congress

Section 1936(e)(4) of the Act outlines the requirements related to the Annual Report to Congress. The Act requires that the Secretary of HHS submit a report annually, 180 days after the end of the fiscal year, beginning with fiscal year 2006. The report is to identify the use of funds appropriated and the effectiveness of the use of such funds.

Return on Investment

- Collect data on FY 2008 MIG costs and recoveries to calculate return on investment.
- Collect data on other FY 2008 Medicaid Integrity Program costs to determine effective use of funds.

In addition to the annual Report to Congress, MIG is statutorily required to report return on investment for the Government Performance Results Act and the Office of Management and Budget Program Assessment Rating Tool.

INFORMATION MANAGEMENT AND RESEARCH

"One-Stop-Shop" Provider Enrollment System

- Continue ongoing oversight and administration of the system in collaboration with CMS components.
- Finalize joint and State-specific enrollment forms.
- Create requirements and design for system life cycle development.
- Provide infrastructure support.
- Organize listening sessions for States to provide input on the development of the system.

The "One-Stop-Shop" Provider Enrollment System is a comprehensive strategy that, for the first time, addresses provider enrollment as a national issue and impacts the "front-end" of the process (i.e., stronger controls during initial enrollment) and post-payment activities. In collaboration with Medicare program components within CMS, MIG will oversee the development and implementation of the "One-Stop-Shop," a secure, centralized provider enrollment system to meet 100% of Medicare and Medicaid requirements.

National Integrated Data Repository (IDR)

- Explore existing CMS applications and identify the data files, elements, and analysis tools needed to establish a national data repository that will modernize access to and integration of program integrity and beneficiary, provider and claims data.
- Continue to consult with OFM and CMS' Office of Information Services on the IDR development.

State Program Integrity Assessment (SPIA) Profiles

- Conduct first national collection of the SPIA, including baseline data for an initial set of State program integrity performance measures.
- Refine data collection instrument and performance measures based on assessment of first national data collection.

The MIG developed the State Program Integrity Assessment to provide a mechanism to collect State Medicaid program integrity data, develop profiles for each State based on these data, determine areas to provide States with technical support and assistance, and use the data to develop performance measures to assess States' performance in an ongoing manner. The profiles will include:
- Descriptive information on States' program integrity activities;
- States' medical and administrative Medicaid expenditures and program integrity recovery data; and
- States' accounting of Medicaid integrity return on investment.

Data mining and fraud and abuse research

- Build fraud and abuse research team to include researchers, statisticians, analysts, clinical/medical personnel, and technical advisors.
- Establish procedures and protocols for fraud and abuse detection and identification of overpayments (i.e., algorithms, queries, models).
- Identify and test analysis tools (e.g., Medicaid Statistical Information System) to conduct data mining and fraud and abuse research.
- Pilot test fraud algorithms with volunteer States.
- Develop fraud and abuse library to identify best practices.

Information Management System

- Develop modules for and begin utilizing the Medicaid Integrity Program Information Management System.
- Identify application for and support development of Audit Case Management and Scheduling System.
- Identify application for and implement Contractor Cost and Performance Tracking System.

The Medicaid Integrity Program Information Management System will provide a mechanism to organize, store, analyze, and disseminate a broad spectrum of information, data, and reports in support of the Medicaid Integrity Program. The MIG will use the system to share reports and best practices with internal and external partners; house performance, compliance, and audit data that can be viewed and analyzed within the system; and collect administrative and program management data.

MEDICAID INTEGRITY CONTRACTING

Medicaid Integrity Audit Program Development

- Initiate development of audit protocols for managed care.

In FY 2006, MIG awarded a contract to provide technical support for the design and development of the Medicaid Integrity Audit Program. Audit protocols have been developed for the following provider types:

- Individual fee-for-service practitioners;
- Institutional providers;
- Pharmacies; and
- Hospitals and nursing home cost reports.

Test Audits

- Complete 40 test provider audits in four states.
- Conduct lessons learned sessions with States to review the test audit process and make recommendations for the final audit protocols.
- Use lessons learned to inform implementation of Medicaid Integrity contractors (i.e., the Review, Audit, and Education contractors).

To gain a better understanding of audit processes and procedures and variation across States, MIG will conduct test audits prior to the implementation of the Medicaid Integrity contractors. The test audits will be performed in accordance with Federal and State Medicaid guidelines, laws and regulations and the Yellow Book Audit standards. Forty test audits of Medicaid providers will be conducted through FY 2008 in the following States: Washington, Texas, Mississippi, and Florida.

Medicaid Integrity Review Contracts

- Awarded umbrella contracts in December 2007.
- Award task order contracts in Spring 2008.
- Begin review activities in Spring 2008.

Medicaid Integrity Audit Contracts

- Awarded umbrella contracts in December 2007.
- Award task order contracts in Spring 2008.
- Begin provider audits in Spring 2008.

Medicaid Integrity Education Contracts

- Award umbrella contracts in July 2008.
- Award task order contracts in September 2008.

As required by section 1936 of the Act, the activities of the Medicaid Integrity contractors will include the:

- Review of the actions of individuals or entities furnishing items or services under Medicaid;
- Audit of claims for payment of these items or services and identification of overpayments to individuals or entities receiving Federal Medicaid funds; and
- Education of providers of services, managed care entities, beneficiaries, and other individuals on payment integrity and quality of care

STATE PROGRAM INTEGRITY OPERATIONS

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

State Program Integrity Reviews

- Conduct annual comprehensive program integrity reviews of one-third of the States.
- Follow-up on corrective action plans resulting from reviews that identify compliance issues.
- Conduct focused reviews on specific issues as appropriate and needed.

Medicaid Integrity Institute

- Identify immediate State Medicaid program integrity training needs.
- Develop core training curriculum for immediate needs.
- Pilot test core training curriculum.
- Identify national program integrity training needs.

In establishing the Medicaid Integrity Institute, MIG will develop a comprehensive program of course work encompassing all aspects of Medicaid program integrity. Over time, accreditation standards for overall State program integrity operations will be developed. The Medicaid Integrity Institute will utilize nationally recognized trainers from a variety of settings. The core faculty will include State Medicaid program administrators, Federal and State law enforcement, consultants from private associations and foundations, and mainstream academia

Other Activities to Provide Support and Assistance to States

- Issue guidance on excluded provider checks for States and providers by way of State Medicaid Director Letter.
- Convene Fraud and Abuse Technical Advisory Group annual meeting.
- Support State attendance at program integrity-related conferences and events.
- Provide logistical and personnel support to special State Medicaid program integrity.
- Conduct Current Procedural Terminology (CPT) coding certification training for two program integrity staff employees from every State, the District of Columbia, and Puerto Rico.
- Identify and disseminate State program integrity best practices.

The CMS has been providing various forms of technical assistance and support to States since the mid-1990s, including hosting regional and national conferences and meetings to provide States and other stakeholders with a venue for learning and interaction. The MIG intends to continue these types of activities under the Medicaid Integrity Program. Other activities include issuing guidance on Medicaid program integrity regulations and policies; coordinating training for State program integrity units to improve their abilities to prevent and earlier detect fraud, waste and abuse; identifying State program integrity best practices; and assigning Medicaid Integrity Specialists in the MIG's Division of Field Operations to specific States as technical assistance liaisons.

BUDGET

Congress appropriated $5 million in funding during FY 2006, $50 million in each of FYs 2007 and 2008, and $75 million in FY 2009 and each year thereafter. The statute provides that these funds "remain available until expended." As such, approximately $1.57 million of unobligated FY 2007 funds was carried forward from the FY 2007 appropriation.

The major expenditure categories for FY 2008 are: staffing; administrative costs; technical assistance and support to States; Medicaid Integrity contracts, and data improvements/technical support.

The following table illustrates the estimated spending for each major expenditure category.

CATEGORY	ESTIMATED SPENDING*
STAFFING	$10,000,000
ADMINISTRATIVE COSTS (e.g., equipment, supplies, etc.)	$2,000,000
SUPPORT CONTRACTS	$5,000,000
SUPPORT & TECHNICAL ASSISTANCE TO STATES	$5,000,000
MEDICAID INTEGRITY CONTRACTS	$20,000,000
DATA IMPROVEMENTS/TECHNICAL SUPPORT	$9,573,423
TOTAL	**$51,573,423**

***As of April 2008

III. OVERVIEW OF FYS 2008 - 2012 PLANNED ACTIVITIES

The following tables illustrate the planned activities for FY 2008 – 2012 in each of the MIG's core business processes and main business operations. NOTE: An "X" in the column indicates that the activity is planned for the fiscal year.

A. Planning and Program Management

Planned Activities	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Organizational & Staff Planning					
Hire remaining staff	X				
Complete initial MIG staff training	X				
Reassess need for additional/ongoing MIG staff training	X	X	X	X	X
Reassess Strategic Plan and MIG Framework		X		X	
Continue regulatory review	X	X	X	X	X
Develop rules and legislative proposals					
Publish final rules for Limitation on Contractor Liability provisions	X				
Publish Notice of Proposed Rule Making for Contracting Requirements provisions	X				
Develop forward-thinking legislative proposals	X	X	X	X	X

B. Communication and Collaboration

Planned Activities	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Internal Collaboration					
Coordinate field office activities	X	X	X	X	X
Coordinate and regularly meet with CMSO components	X	X	X	X	X
Coordinate and regularly meet with other CMS components, OIG, and OGC	X	X	X	X	X
External Consultations					
Develop CMIP in consultation with mandated stakeholders	X	X	X	X	X
Continue ongoing work with Medicaid Integrity Program Advisory Committee	X	X	X	X	X
Attend regular meetings with law enforcement and continue ongoing collaboration on fraud referral process and other issues	X	X	X	X	X
External Communication					
Publish CMIP	X	X	X	X	X
Participate in Open Door Forums/audio conferences and conduct presentations on MIG activities	X	X	X	X	X
Update Medicaid Integrity Program Communications Plan	X	X	X	X	X

C. Information Management and Research

Planned Activities	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Develop "One-Stop-Shop" Provider Enrollment System					
Continue ongoing collaboration with CMS components on the administration of the system with (e.g., life cycle development, infrastructure support)	X	X	X	X	X
Finalize joint and State-specific enrollment forms	X				
Organize listening sessions for States	X				
Develop National Integrated Data Repository (IDR)					
Conduct needs assessment and evaluation of existing applications	X				
Develop specifications for system and identify modifications needed to existing applications	X	X			
Continue consultation with CMS components on IDR development	X	X	X	X	X
Establish fraud and abuse research team					
Hire researchers, analysts, clinical/medical personnel, technical advisors, and support staff	X				
Refine research team and identify training and tools needed for ongoing fraud & abuse research and detection		X	X	X	X
Conduct data mining and fraud & abuse research					
Develop procedures and protocols for fraud and abuse research and detection	X	X	X	X	X
Develop queries, algorithms, and models to detect fraud and abuse and identify overpayments	X	X	X	X	X
Develop mechanisms and reports to validate methods and provide technical assistance to the States and Medicaid Integrity contractors	X	X	X	X	X
Develop fraud and abuse library to identify best practices	X	X	X	X	X
Develop information management system					
Develop specifications for system and identify applications needed to store program management data and reports	X				
Maintain information in system and refine as needed		X	X	X	X
Develop audit tracking system					
Develop specifications and identify application for system	X				
Maintain information in system and refine as needed		X	X	X	X

D. Ensuring Accountability

Planned Activities	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Continue to refine strategy for measuring return on investment	X				
Release annual Report to Congress	X	X	X	X	X

E. Medicaid Integrity Contracting

Planned Activities	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Support Contracts					
Conduct post-award contracting activities of support contracts	X	X	X	X	X
Conduct post-award contracting activities of procurement actions to assist in developing approach to data mining activities	X	X			
Continue to conduct test audits of Medicaid providers in the development of and refinement of audit protocols	X				
Conduct pre-award contract activities for other support contracts as needed		X	X	X	X
Medicaid Integrity Contracts					
Continue to develop Statements of Work/Requests For Proposals/budgets for MIC activities	X	X			
Award umbrella contracts for MICs	X				
Evaluate and negotiate proposals for MIC task order activities with bidders	X	X	X	X	X
Award MIC task orders	X	X	X	X	X
Conduct post-award activities for MIC contracts and task orders	X	X	X	X	
Issue contract modifications for revised MIC strategies		X	X	X	
Develop procurement strategies for next round of MICs				X	

F. State Program Integrity Operations

Planned Activities	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Provide support and assistance to States					
Continue to develop standard operating procedures	X				
Conduct training at Medicaid Integrity Institute	X	X	X	X	X
Identify and disseminate best practices	X	X	X	X	X
Coordinate Fraud and Abuse Technical Advisory Group annual meeting	X	X	X	X	X
Conduct oversight of State program integrity activities					
Update review protocol for State program integrity reviews	X				
Conduct State oversight reviews	X	X	X	X	X
Coordinate audit collections		X	X	X	X

APPENDIX A. LIST OF ACRONYMS

CMIP	Comprehensive Medicaid Integrity Plan
CMS	Centers for Medicare & Medicaid Services
CMSO	Center for Medicaid and State Operations
CPT	Current Procedural Terminology
DRA	Deficit Reduction Act of 2005
FBI	Federal Bureau of Investigation
FY	Fiscal Year
HHS	United States Department of Health and Human Services
IDR	Integrated Data Repository
MIC	Medicaid Integrity Contractor
MIG	Medicaid Integrity Group
OFM	Office of Financial Management
OGC	HHS, Office of the General Counsel
OIG	HHS, Office of Inspector General