REPORT TO CONGRESS

ON THE

MEDICAID INTEGRITY PROGRAM

FOR FISCAL YEAR 2007

MICHAEL O. LEAVITT
SECRETARY OF HEALTH AND HUMAN SERVICES

2008

TABLE OF CONTENTS

BACKGROUND

On February 8, 2006 the Deficit Reduction Act (DRA) of 2005 was signed into law (P.L. 109-171). With the passage of this legislation, specifically section 6034, Congress created the Medicaid Integrity Program (MIP) under Title XIX of the Social Security Act (Act), which dramatically increased resources available to the Centers for Medicare & Medicaid Services (CMS) to combat Medicaid fraud, waste, and abuse, as well as CMS' charge to devise an effective national strategy to do so. Appropriations for the MIP increase in stages from planning to startup to fully operational as follows:

- $5 million in fiscal year (FY) 2006;
- $50 million in each of FYs 2007 and 2008; and
- $75 million in FY 2009 and each year thereafter.

The DRA requires CMS to enter into contracts with Medicaid Integrity Contractors (MICs) to review provider actions (Review of Providers MICs), audit provider claims and identify overpayments (Audit of Providers MICs), and conduct provider education (Education MICs). CMS was also required to increase its staffing by 100 full-time equivalent employees "…whose duties consist solely of protecting the integrity of the Medicaid program…by providing effective support and assistance to States to combat provider fraud and abuse."

In addition to contracting with MICs and increasing staffing to provide support and assistance to States, the statute also requires CMS to: 1) establish a comprehensive plan for ensuring the integrity of the Medicaid program for the five fiscal year period beginning with FY 2006 and for each such five fiscal year period that begins thereafter; and 2) submit an annual report to Congress that identifies a) the use of the funds appropriated for the MIP and b) the effectiveness of the use of these funds.

OVERVIEW

The Department's first report to Congress on the MIP covered an abbreviated eight-month time frame following mid-fiscal year enactment of the DRA in February 2006. This second annual report encompasses the first full fiscal-year of the MIP. While the first report to Congress centered on program and organizational planning, this second annual report discusses our program building and initial implementation activities. In short, FY 2007 was a very successful year for the new MIP and can best be described as a *building year* in terms of the following types of building-block activities:

1) building the organization;
2) building the program;
3) building and/or reinforcing relationships with strategic partners;

4) building opportunities for our two main lines of business operations, which are:
   - conducting Medicaid integrity audits and reviews through contractors and
   - providing effective support and assistance to the States' program integrity operations.

The building activities and infrastructure development undertaken in FY 2007 marked significant strides and the Medicaid Integrity Group (MIG) in CMS has made remarkable progress towards developing a strong, effective, and sustainable program to combat fraud, waste, and abuse in Medicaid. The organization now has all of its leadership positions filled and has hired approximately 75 percent of its staff. The services of a contractor have provided invaluable assistance in getting the program underway by helping to refine the procurement requirements for the MICs that will do the health care provider audits and reviews. The requests for proposals were issued, proposals have been received and reviewed, and negotiations are ongoing. We expect the first task orders for the MICs to be awarded in spring 2008. Moreover, we expect the Review MICs and Audit MICs to be conducting provider reviews and audits by summer 2008.

At the same time, not all of the activities of FY 2007 were restricted to development and building. For example, FY 2007 saw the initiation of the first operational activities of the MIP, such as test audits of providers in four States and comprehensive State program integrity reviews by MIG staff in another eight States.

USE OF FUNDS

For FY 2007, CMS had a total of $52.1 million available for the MIP. Of this total amount, $2.1 million represented carry-over funds from FY 2006 and $50 million was from the FY 2007 appropriation. The total amount expended or obligated in FY 2007 came to $50.7 million, which left only $1.5 million remaining. The following table summarizes the use of MIP funds.

Table: FY 2007 Spending Report – Medicaid Integrity Program

BUDGET CATEGORY	FY 2007 APPROPRIATION PLUS FY 2006 CARRYOVER SPENT OR OBLIGATED	FY 2007 BUDGET RESIDUAL CARRYOVER
• Staffing	$ 3,837,813	$ 662,187
• Administrative	$ 358,155	$ 141,845
• Program Support Contracts	$ 6,753,727	0
• Data Improvements and Technical Support	$ 4,941,174	$ 662,365
• Medicaid Integrity Contracts	n/a	n/a
• Support and Assistance to the States	$ 462,242	0
o One-Stop Shop Provider Enrollment	$26,922,740	0
o Medicaid Integrity Institute	$ 7,417,486	0
TOTALS	**$50,693,337**	**$1,466,397**

EFFECTIVENESS OF FUNDS

The effectiveness of the funds expended can be shown in this second year of the MIP by tying their use to the building blocks outlined earlier, which are: 1) the organization; 2) the program; 3) relationships with strategic partners; and 4) opportunities for our two main lines of business operations - Medicaid Integrity Contracting (through audits and reviews by the MICs) and State Program Integrity Operations (through support and assistance to the States). However, there are no clear ways to separate many of the activities into just a single grouping because many of the activities overlap with two or more categories. Nonetheless, the depictions in the discussions that follow are our best efforts to illustrate how the funds were spent effectively by capturing some of the notable building activities and accomplishments.

Building the Organization

The organizational design of the MIG reflects its focus on allocating resources to reduce program risk for fraud, waste, and abuse. Moreover, the organizational structure of the MIG is aimed at facilitating the two main business operations of the MIP, which are: 1) Medicaid Integrity Contracting and 2) State Program Integrity Operations.

- The approved structure for the new MIG includes three divisions operating under the leadership of a Group Director. All senior leadership positions for the MIG were in place by the end of FY 2007 and include: MIG Director, MIG Deputy Director, and a director for each of the three divisions.
    - Division of Medicaid Integrity Contracting, which is responsible for procurement and oversight of the MICs that conduct provider reviews and audits as well as education of providers and others.
    - Division of Fraud Research & Detection, which provides statistical and data support, identifies emerging fraud trends, and conducts special studies.
    - Division of Field Operations which conducts State program integrity oversight reviews and provides support in the form of technical assistance and fraud and abuse training to the States.
        - Field offices have been established in: New York, Atlanta, Dallas, Chicago, and San Francisco.
        - With the Division Director centrally located in Chicago, the MIG completed the field office management by hiring Deputy Directors on the east coast and west coast.
- As noted previously, the DRA authorized 100 new full-time employees whose duties are devoted to protecting the integrity of the Medicaid program. The hiring status of these new positions is as follows:
    - 41 new hires were brought on board in FY 2007, bringing the total MIG staff strength to 59 of the 79 allocated to MIG.
    - Filled 12 of 20 hired positions allocated to the CMS Office of Financial Management's Medicare Program Integrity Group to bring the Medicare-Medicaid Data Match Program (Medi-Medi) up to full operations nationally as well as to assist with the Medicaid Payment Error Rate Measurement (PERM) initiative.
    - In addition, one employee has been hired by the Office of Acquisition and Grants Management to help with the overall MIP contracting effort.

Building the Program

FY 2007 marked a series of program milestones and developments that laid the groundwork for building a strong, sustainable program. The MIG staff began laying the foundation for the work of the MICs through vastly improved data analysis capabilities that are crucial to the MIP's efforts to combat fraud, waste, and abuse. The MIG also implemented two exciting program initiatives that will contribute enormously to the MIP with immediate and long-term benefits. Moreover, these program-building achievements represent superlative efforts in providing support and assistance to the States' Medicaid program integrity operations.

Improved Data Analysis Capabilities:

- *Medicaid Data Elements* – Working with the CMS Office of Financial Management (OFM) Medicare Program Integrity Group, we are seeking to identify Medicaid data elements that are necessary for Medicaid fraud detection and research. These elements, we believe, will help form the basis for Medicaid program integrity efforts across CMS, including MIP, PERM, and Medi-Medi. In FY 2008, these elements will be tested to assess their usefulness in CMS program integrity efforts.
- *Identification of Suspect Payments* – Staff in the MIG's Division of Fraud Research & Detection have evaluated the Medicaid payment data that CMS currently collects and, working with the States, have been able to identify suspected overpayments and suspicious billing activity. To date, Division of Fraud Research & Detection staff have developed and run approximately 24 data algorithms (fraud detection computer programs) and have discovered millions of dollars in suspect Medicaid payments. In FY 2008, MIG will be working with the States and other components of CMS to validate these findings and recover associated overpayments.
- *MIG Data Repository* – The identification of data elements for fraud detection and the identification of suspect payments require a new, secure, national database of Medicaid claims data – a MIG Data Repository – with a high-end database structure, analytical tool set, and multi-site access. We have identified a cost-efficient solution that utilizes a Federally-funded, large scale data initiative. We have proposed that the MIG Data Repository be hosted at the University of California, San Diego Super Computer Center, which is part of a national super computer grid funded by the Federal government. The use of this Federal infrastructure will enable us to house and analyze the large volumes of Medicaid claims data at a low cost to CMS.

One-Stop Shop Provider Enrollment Initiative:
This initiative will enable the national Medicare provider enrollment system to include and process Medicaid provider enrollment information. The goal of this initiative is to strengthen the integrity of the Medicaid program through tighter, nationally consistent control of provider enrollment. The improved system will become a single "gateway" to both the Medicare and Medicaid programs.

- This will be accomplished through the construction and deployment of a secure, centralized management information system and common enrollment process that meets 100 percent of Medicare and Medicaid requirements. In addition to the creation of a common enrollment form for Medicare and Medicaid, the system will be designed to allow for supplementary, State-specific forms, for those States that want to collect additional data elements.
- The One-Stop Shop project is significant in that it is the first attempt to create a national system that addresses Medicaid provider enrollment at a national level, rather than the State-by-State approach that has been used since the program's inception. Medicaid currently utilizes more than 600 different provider enrollment forms in the States and territories. An analysis of these forms by a joint Medicare-Medicaid work group estimated that approximately 80-85 percent of the data elements contained in all these forms were common to the single national provider enrollment form used in Medicare.
- This creation of a national Medicaid provider enrollment system will benefit CMS, the States, as well as providers. Medicaid provider enrollment is a costly, labor-intensive, and convoluted process. The movement to a single national system will reduce costs and resource requirements for the States and ultimately for CMS. Although firm cost estimates are not yet available, CMS expects the savings to be significant.
- Moreover, the biggest benefit for the States will be access to provider data from Medicare and the other States (e.g., chain/ownership information, licensing information, censures, suspensions, terminations, and other provider activities). Access to data from these outside sources will greatly enhance States' front-end program integrity controls and enable them to more readily identify unscrupulous health care providers. Finally, providers will benefit from a joint Medicare-Medicaid provider enrollment system as they will only be required to fill out one enrollment form for both programs.

Medicaid Integrity Institute:

The second landmark initiative is the formation of a national Medicaid program integrity training center, named the Medicaid Integrity Institute (MII). The MII will provide first-class support and assistance to the States' program integrity operations by providing State employees a national training center and credentialing mechanism. The MII will raise standards, levels of performance, and professionalism for State program integrity staffs across the nation. A comprehensive program of course work encompassing all aspects of Medicaid program integrity will be developed, such as, fraud investigation, use of algorithms, fraud trend development and analysis, state of the art data mining tools, training in health care billing codes, among others. Over time, accreditation standards and credentialing benchmarks for overall State program integrity operations will be developed.

- The MII will utilize nationally recognized program integrity instructors to form the core of the faculty, including State program integrity administrators, Federal and State law enforcement officials, State auditors, and individuals from private companies, non-profit associations and foundations, and academia.
- The MII will offer, upon completion of course work, training certificates bearing specific designations, such as, Certified Program Integrity Fraud Examiner, Certified Program

Integrity Coding Auditor, Certified Program Integrity Data Mining Specialist, and others to be determined. It is envisioned that this credentialing by the MII will gain a national reputation and will be used as a standard for State staff hiring and promotions.

- To implement the MII, we have executed an interagency agreement with the Department of Justice (DOJ) to use its existing training facility located at the University of South Carolina. The National Advocacy Center (NAC), operated by the DOJ, was built to train Federal and State prosecutors in advocacy skills and management of legal operations. The NAC is an established training facility that houses expertise in substantive legal issues, training, and curriculum development, which makes it a natural fit to house the MII. Together with the infrastructure of the NAC, the MII will provide a unique opportunity for CMS to offer substantive training and support to the States in a tremendous learning environment and at a highly regarded Federal training facility with access to expertise in appropriate subject areas.
- We anticipate funding the MII for a five-year period. The MII presents a unique opportunity to create something that will have a major, long lasting impact on State program integrity standards and performance and to provide support and assistance to the States, as required by the DRA.

In addition to the major undertakings discussed, the MIG completed other projects in FY 2007 as outlined below:

- Published a second, updated Comprehensive Medicaid Integrity Plan (CMIP) in August 2007. The DRA requires the Department to develop a comprehensive plan for ensuring the integrity of the Medicaid program. Accordingly, the MIG drafted and released the initial CMIP in July 2006. The CMIP contains a five-year program implementation plan that describes the design and purpose of the MIP as well as CMS' vision for the longer term. Although only required to update this document every five years, the MIG plans to keep the document current by updating it more frequently. Consequently, the second CMIP was published in FY 2007. As required by the DRA, the CMIP was developed after consultation with other Federal and State officials.
- Issued guidance to States in the form of three State Medicaid Director letters. Two of these letters provided guidance regarding DRA Section 6032, "Employee Education About False Claims Recovery." The third letter provided guidance for States to implement the requirements for use of tamper-resistant prescription pads for Medicaid outpatient prescriptions, as mandated by section 7002(b) of the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act (UTRA) of 2007 (P.L. 110-28). In addition to publishing the letters, MIG staff held numerous question and answer sessions and conducted other outreach activities with the States and various provider and health care industry groups on the issues discussed in the letters.

Building Relationships

A major challenge for CMS in developing the new MIP was ensuring cooperation among Federal agencies and balancing Federal responsibilities with those of the States. The MIG facilitated these processes by building relationships and reinforcing those in existence through some of the following activities:

- Formed the MIP Advisory Committee to bring together more than 40 stakeholders from 16 States and three Federal agencies. The MIP Advisory Committee is a key component of CMS' strategy for implementing the MIP by collaborating with internal and external partners and stakeholders. CMS established the MIP Advisory Committee to provide input and feedback to the MIG in its development of our two main lines of business operations - Medicaid Integrity Contracting and State Program Integrity Operations. The committee members include program integrity representatives from 16 States, the Department's Office of Inspector General (HHS-OIG), the Federal Bureau of Investigation, CMS Regional Offices, and the CMS Office of Financial Management. Four subcommittees of the MIP Advisory Committee were formed to assist with the development of the following strategic plans: 1) return-on-investment strategy for the MIP; 2) audit strategy for the MICs; 3) State program integrity performance measures; and 4) audit protocols for managed care plans. We anticipate that other subcommittees could be formed, such as, managed care, Medicaid data, and data mining/algorithms.
    - The MIP Advisory Committee held two face-to-face meetings to date, initially during December 12-14, 2006 and a follow-up meeting during March 13-15, 2007. The December 2006 meeting focused on building a collaborative and productive partnership to provide consultation regarding: 1) how to define the scope of Medicaid program integrity under the MIP; 2) CMS' approach to provide support, assistance to, and assessment of State program integrity operations; and 3) CMS' approach to Medicaid integrity contracting. The March 2007 meeting was convened to provide updates on the status of the progress-to-date and draft recommendations for the Medicaid Integrity Audit Program and State Program Integrity Assessment efforts and to obtain input and feedback from the MIP Advisory Committee as the MIG moved forward in the development of these two programs.
- Made numerous presentations on the MIP and on the organizational structure of the MIG at various meetings and conferences, including:
    - National Association of State Medicaid Directors annual meeting,
    - National Association of Medicaid Program Integrity annual conference,
    - Association of Inspectors General annual meeting,
    - Multiple HHS/OIG conferences, and
    - National Association of State Human Services Finance Officers conference.
- Provided the logistical and financial support to the States to convene in June 2007 in the first face-to-face Medicaid Fraud and Abuse Technical Advisory Group meeting in years.

Building Opportunities for Our Two Main Lines of Business Operations

I. Medicaid Integrity Contracting (Provider Reviews, Audits, and Education)

Medicaid integrity contracting involves conducting provider reviews to detect potentially fraudulent and abusive billing; accomplishing follow-up through provider audits; identifying (and recovering) overpayments; and educating providers and other stakeholders on payment integrity and quality healthcare. We refer to this as one of our two main business lines and we have made specific progress in this area through: 1) developing comprehensive audit protocols, 2) conducting test audits, and 3) initiating steps to procure the MICs.

Audit Protocols:

- An "audit protocol" is a document that outlines the steps and procedures with sufficient specificity to be carried out such that a MIC would be able to conduct satisfactory provider reviews and audits based on the content of the audit protocol.
- The MIG entered into programmatic contract work with a contractor to develop a series of protocols for a payment integrity audit system. The major products being developed by the contractor are four protocols - one for each of the four activities required to be conducted by the MICs as described by section 6034 of the DRA, which include:
    1) reviewing the actions of individuals or entities furnishing items or services for which payment was made by Medicaid;
    2) conducting audits of claims for payments;
    3) identifying overpayments; and
    4) educating providers and others on payment integrity and quality of care.
- CMS requested the HHS-OIG's Office of Audit Services review the audit protocols to determine the completeness and adequacy of the audit steps contained in the documents. OIG staff performed a series of desk reviews for each of the following audit protocols:
    - Individual Practitioners - comprehensive and focused audits,
    - Other Fee-For-Service Providers - comprehensive and focused audits,
    - Pharmacy Providers - comprehensive and focused audits,
    - Institutional Providers - comprehensive and focused audits,
    - Nursing Home Providers - cost report audits,
    - Hospital Providers - cost report audits.

  The HHS-OIG staff used their experience and technical expertise to provide suggestions for improvements to the protocols, which were incorporated by the CMS contractor. Both CMS and the HHS-OIG believe the protocols provide a solid approach for use by the Audit of Providers MICs when they begin to conduct provider audits.

Test Audits:

- Test provider audits were conducted using the protocols developed in September 2007 in the following States: Washington, Texas, Mississippi, and Florida. The MIP Advisory Committee strongly encouraged the MIG to work with States and conduct test audits in

order to gain a better understanding of audit processes and procedures as well as to help MIG understand how these processes and procedures vary across States. Further, MIG wanted to find an approach to start conducting audits as a precursor to the MICs to test the venues of conducting these audits as well as to test the newly developed audit protocols. The contractor who developed the audit protocols will continue conducting test audits throughout FY 2008. The contractor will perform the audits in accordance with the protocols they developed and in strict compliance with all Federal and applicable State Medicaid guidelines, laws and regulations as well as Federal audit guidelines and standards. Furthermore, lessons learned from these audits will be used to improve the audit protocols being developed for the MICs. We expect to conduct as many as 40 of these test audits through FY 2008.

Procuring the MICs:

- The program achieved two major milestones regarding solid progression towards procuring the MICs. In FY 2007, CMS released the requests for proposal for both 1) the Review of Providers MICs and 2) the Audit of Providers MICs. The awards of the indefinite delivery and indefinite quantity contracts for the MICs were made in December 2007, and we anticipate the MICs to be conducting provider reviews and audits by spring 2008.

II. State Program Integrity Operations

Some of the most significant program strides in FY 2007 were directly related to providing support and assistance to the States to improve Medicaid program integrity operations at the State level. Described below are a few of the ways the MIG supported and assisted the States' program integrity operations in FY 2007:

- Procured a contractor to provide Certified Professional Coder training in health care procedures terminology for State program integrity staff personnel. This initiative was viewed by the States as vitally important since most did not have the resources to obtain this necessary training for their program integrity staff. This contract will promote best practices, knowledge, and understanding of medical coding as practiced by the American Academy of Professional Coders. Moreover, this specialized training will facilitate State program integrity staffs in conducting provider reviews and audits.
- Conducted site visits with nine States slated for the State Program Integrity Assessment (SPIA) project. The SPIA project is a major activity to support MIG's efforts in providing effective support and assistance to, as well as assessment of, State Medicaid program integrity activities. Through the SPIA effort, CMS will identify current Medicaid program integrity information for each State by collecting qualitative outcomes and quantitative data measures of each State's activities, developing profiles for each State based on the data, determining areas to provide States with technical support and assistance, and using the data to develop performance measures to assess States' performance in an ongoing manner.

- In early 2007, CMS conducted a pilot case study to aid in the design and development of an approach to the national SPIA system. The nine States that volunteered to participate in the SPIA pilot were California, Florida, Louisiana, Maryland, Minnesota, Pennsylvania, Texas, Washington, and Wisconsin. The pilot involved three types of data collection: administrative document review; a Web-based data collection survey; and site visit interviews. The data types were analyzed and synthesized to address common themes across the case study States. The information was then used to develop recommendations on what data can and/or should be collected on a national level to develop the State profiles and performance measures. MIG modified the tools used in the pilot case study and developed a standardized data collection instrument to be used for the national SPIA data collection system. The first national SPIA survey will be collected in FY 2008.

- Developed a comprehensive guide and set of protocols for conducting State program integrity reviews to evaluate a State's fraud and abuse control procedures. Moreover, MIG staff refined this guide and protocols by testing them during an initial series of program integrity reviews in eight pilot States. In each of these State program integrity reviews, the principal method for gathering information is through interviews with State staff. The field work includes a review of the suspected fraud and abuse cases opened, closed, and referred to the State's Medicaid Fraud Control Unit (MFCU) over the past three years by the State's program integrity unit. This type of in-depth review requires interviews and discussions with the State's Medicaid program integrity unit staff and the MFCU staff. In addition, other State staff might be interviewed as necessary as well as contractors whose duties impact the State's Medicaid program integrity function, such as fiscal agents for the State's automated claims and payment systems.
  - The purpose of the State program integrity reviews are threefold:
    1) determine whether a State's program integrity policies and procedures comply with Federal requirements;
    2) determine whether a State's program integrity function is effective at identifying, prosecuting, and preventing Medicaid fraud and abuse; and
    3) determine how the State identifies, receives, and processes information about potential fraud and abuse involving Medicaid providers.
  - The overall intent of the State program integrity reviews is to assess how a State carries out its fraud and abuse control procedures and related processes and to propose recommended improvements for conducting these activities. In addition, through the State program integrity review process, the MIG staff will begin the compilation of best practices observed throughout the States. The MIG plans to eventually develop a best practices compendium to share with all of the States.
  - MIG staff completed eight pilot, comprehensive State program integrity reviews during FY 2007 in the following States: Connecticut, Michigan, Nevada, Arkansas, Virginia, Delaware, Missouri, and Oregon.
  - The MIG notified an additional 17 States of their selection for comprehensive State program integrity reviews in FY 2008.

Other CMS Activities to Improve Medicaid Financing Accountability and Integrity

In addition to the above DRA-funded MIP initiatives to combat fraud, waste, and abuse in the Medicaid program, CMS continues other activities to improve its effectiveness in identifying and addressing Medicaid financial issues. Actions taken by CMS this past year continue to strengthen fiscal accountability in the Medicaid program by ensuring that Medicaid funds are only used to provide allowable Medicaid services to eligible Medicaid individuals. In addition, based upon prior Government Accountability Office (GAO) recommendations, CMS has instituted numerous changes to the handling of its internal Medicaid financial management processes that GAO has acknowledged have improved the handling of Medicaid financial issues at the Federal level (GAO report GAO-06-705).

CMS has been able to monitor and validate the effectiveness of its actions through the success in the State Plan Amendment (SPA) review process and consolidation of reimbursement and financing policies. Since August 2003, we have reviewed over 1,700 SPAs that involve health care provider Medicaid reimbursement. About 10 percent of these have been disapproved or withdrawn by the State because of potential improper financing. We worked with 30 States to remove improper Medicaid financing practices with only three States still challenging the statutory and regulatory requirements regarding State financing of their share of Medicaid program costs. For those three States, CMS took appropriate action by either the denial of Medicaid reimbursement SPAs and/or disallowances of claims for Federal financial participation (FFP). In March 2007, the GAO issued a final report (MEDICAID FINANCING: Federal Oversight Initiative is Consistent with Medicaid Payment Principles but Needs Greater Transparency GAO-07-214) in which GAO acknowledged significant fiscal oversight efforts on the part of CMS under the SPA review initiative.

Building upon these activities, CMS undertook an ambitious regulatory agenda to further strengthen the financial accountability of the Medicaid program. As a result, the following regulatory publications were issued during 2007:

- After publication of the proposed rule in January, on May 29, 2007, CMS placed a final rule with comment period, CMS-2258-FC (Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provision to Ensure the Integrity of Federal-State Financial Partnership), 72 FR 29748, on display at the Federal Register to clarify the appropriate Medicaid State financing sources, including the use of intergovernmental transfers and certified public expenditures. The final rule limits government health care providers to 100 percent of the costs they incur for services to Medicaid beneficiaries. The final rule also reaffirms the retention of payment requirements to ensure that all health care providers retain the entire Medicaid payment to which they are entitled. These provisions were intended to remove incentives for States to manipulate reimbursement and financing of their Medicaid programs. However, the U.S. Troop

Readiness, Veteran's Care, Katrina Recovery, and Iraq Accountability Appropriations Act, 2007 (UTRA, P.L. 110-28) prohibits implementation of the rule through May 25, 2008.

- After publication of the proposed rule in March 2007, CMS published a final rule on February 22, 2008, CMS-2275-F (Medicaid Program; Health Care-Related Taxes), 73 FR 9685, in the Federal Register to implement Congress' direction regarding the allowable amount States can collect from health care related taxes. The final rule also clarifies the standard for determining the existence of a hold harmless arrangement.
- On May 23, 2007, CMS issued a proposed rule, CMS-2279-P (Medicaid Program; Graduate Medical Education), 72 FR 28930, to make Medicaid graduate medical education (GME) payments and costs ineligible for FFP. Specifically, the proposed rule would no longer allow States to include GME as a payment under the Medicaid State plan or as an allowable cost in determining Medicaid payments. Medicaid is authorized to pay for medical assistance services and section 1905 of the Act describes the services eligible for the FFP under an approved Medicaid State Plan. GME is not included as a service eligible for FFP. UTRA also prohibits promulgation or implementation of a rule relating to GME through May 25, 2008.
- After publication of a proposed rule in September 2007, CMS published a final regulation on December 28, 2007, CMS-2287-F (Medicaid Program; Elimination of Reimbursement Under Medicaid for School Administration Expenditures and Costs Related to Transportation of School-Age Children Between Home and School), 72 FR 73635, stipulating that Federal Medicaid payments will no longer be available for: administrative activities performed by school employees or contractors, or anyone under the control of a public or private educational institution; or transportation from home to school and back for school-aged children with an Individualized Education Program (IEP) or an Individualized Family Services Plan (IFSP), established pursuant to the Individuals with Disabilities Education Act (IDEA). The Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173) imposes a moratorium on the final rule until June 30, 2008.
- On September 28, 2007 CMS published in the Federal Register a proposed rule, CMS-2213-P (Medicaid Program; Clarification of Outpatient Clinic and Hospital Facility Services Definition and Upper Payment Limit), 72 FR 55158, to clearly define the scope of Medicaid outpatient hospital services and provide guidance on the upper payment limit requirements for those services.

Finally, as part of its day to day operations in 2007, CMS reviewed approximately 423 Medicaid reimbursement SPAs, of which 237 were approved. In addition, CMS issued 43 disallowances challenging approximately $358 million in FFP and processed over 120 deferrals questioning over $600 million in FFP.

CONCLUSION

Section 6034 of the DRA provided the resources to establish the MIP, the first national strategy in the more than 40-year history of the Medicaid program to prevent and detect fraud and abuse. CMS is strengthening its leadership and coordination of State and Federal efforts by assembling a program that will improve compliance and quality of care while promoting the fiscal integrity of Medicaid. FY 2007 was a highly successful building year for the MIP.

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MAY 16 2008

The Honorable Richard B. Cheney
President of the Senate
Washington, D.C. 20510

Dear Mr. President:

I am respectfully submitting this letter and the enclosed report in response to the requirements of Section 1936 of the Social Security Act, as added by section 6034 of the Deficit Reduction Act (DRA) of 2005. This legislative provision established the Medicaid Integrity Program and required the Department to report on the program regarding the use and effectiveness of funds.

This second annual report covers the Medicaid Integrity Program expenditures made during FY 2007. While last year's report focused entirely on program planning, this report discusses our program building and initial implementation activities. The Congress appropriated $50 million in FY 2007 for the new program to build up to full implementation by FY 2009, when appropriations will increase to $75 million per year. In FY 2007, the Centers for Medicare & Medicaid Services (CMS) had $52.1 million available for the program coming from the FY 2007 appropriation funding plus $2.1 million in FY 2006 carry-over funds. Of this total available, CMS expended $50.7 million. These funds were used for program building and infrastructure as well as some initial implementation activities. We are proud to report that FY 2007 was a very productive year in moving this essential program forward and on schedule. Moreover, I am confident that sound judgment and prudence were central to our spending decisions.

Let me again state that the Department is grateful to Congress for the resources to take on this charge. Please accept this letter and report in response to the requirements added by section 6034 of the DRA of 2005. I am also sending identical copies to the Speaker of the House of Representatives.

Sincerely,

Michael O. Leavitt

Enclosure

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MAY 16 2008

The Honorable Nancy Pelosi
Speaker of the House of Representatives
Washington, D.C. 20515

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Enclosure