FY 2006 REPORT TO CONGRESS

ON THE

MEDICAID INTEGRITY PROGRAM

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Introduction

On February 8, 2006, the Deficit Reduction Act of 2005 (DRA) was signed into law. With the passage of this legislation, specifically section 6034, Congress created the Medicaid Integrity Program (MIP) under Title XIX of the Social Security 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' responsibility and accountability to devise an effective national strategy to do so. Congress appropriated resources to the MIP 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. From these funds, the DRA required CMS to enter into contracts with Medicaid Integrity Contractors (MIC) to review provider actions, audit provider claims, identify overpayments, and conduct provider education. Also from these funds, CMS was required to increase its staffing by 100 full-time equivalent employees (FTE) "…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." Implicit in this second function is the provision by CMS of appropriate oversight of States' fraud and abuse efforts as well.

In addition to contracting with MICs and increasing staffing to provide support and assistance to States' fraud and abuse efforts, the statute enumerated two other major functions, as outlined below.

- CMS was required to establish a comprehensive plan for ensuring the integrity of the program by combating fraud, waste, and abuse for the five fiscal year period beginning with FY 2006. The legislation required CMS to consult with a number of organizational components in the development of the plan. After extensive consultation, the Comprehensive Medicaid Integrity Plan (CMIP) was developed and issued first to the appropriate Congressional committees and then publicly on July 18, 2006. (The CMIP document may be found at the CMS website – http://www.cms.hhs.gov/Deficit Reduction Act/02_CMIP.asp#TopOfPage.)

- Not later than 180 days after the end of each FY, beginning with FY 2006, CMS must submit a report to Congress that identifies: a) the use of the funds appropriated; and, b) the effectiveness of the use of these funds.

The principal purpose of this first report to Congress is to focus on the funds appropriated by Congress in establishing the Medicaid Integrity Program – both the use and effectiveness of those funds – and the activities undertaken to implement the program. This report covers activities and spending for slightly more than seven months due to the fact that the legislation was signed into law on February 8, 2006, just past the middle of FY 2006. With that in mind, approximately 57% of the $5 million allocated for FY 2006 was expended; on an annualized basis, this percentage was very much on target. The bulk of the expenditures were devoted to staffing and the procurement of strategic contracts to address the two major functional activities of the MIP, i.e., contracting with entities to conduct provider oversight and audits and providing effective support and assistance to States.

Virtually all of the activities undertaken in FY 2006 were developmental in nature and designed to provide a foundation, the building blocks, for a strong, effective, and sustainable program to combat fraud, waste, and abuse in the Medicaid program.

Use of Funds

FY 2006 expenditures during Phase One – Pre-Implementation Strategic Planning and Startup - totaled about $2.8 million. CMS did not expend the entire $5 million appropriation due to the condensed timeframe in the partial, first fiscal year of planning for the MIP.

Table 1: FY 2006 Spending – Medicaid Integrity Program

Budget Category	FY Budgeted Allocation by Category	FY Budgeted Allocation Spent	FY Budget Allocation Available	% Budgeted Allocation Spent
Staffing	$2,000,000	$404,644	$1,595,356	20%
Travel	$100,000	$51,632	$48,368	52%
Training	$5,000	$1,256	$3,744	25%
Admin/Supplies	$10,000	$3,914	$6,086	39%
MIP Contracts	$2,885,000	$2,384,038	$500,962	83%
TOTALS	$5,000,000	$2,845,484	$2,154,516	57%

Effectiveness of Funds

The effectiveness of the funds expended (Table 1) can be shown by tying their use to the purposes described in the various start up activities that are briefly summarized below. The following categories are examples of some of the more notable activities undertaken in FY 2006 in order to implement the Medicaid Integrity Program.

Formation of the Medicaid Integrity Group

With the February 2006 enactment of the DRA, the Department's initial and concerted efforts with the Medicaid integrity provisions were devoted to strategic planning and startup activities. A MIP Planning Group was promptly formed and charged with beginning the strategic planning process and developing a model organizational design for the MIP. This small staff began with a comprehensive analysis of the statutory requirements and then put these policy decisions into an operational design and implementation plan, which included the organizational framework for a new Medicaid Integrity Group (MIG) as well as a program plan with timelines and milestones in bringing the new MIG together. Fundamental to this plan was the vital need to bring leadership

on board early in the program. In April 2006, the MIP Planning Group submitted a reorganization proposal to CMS leadership that would establish a new MIG. Approval was granted in June 2006 and an interim director was appointed to head the new group. The MIG formally became a new group-level component housed in the Center for Medicaid and State Operations (CMSO). CMSO was designated because of its familiarity and experience with the Medicaid program. The newly formed MIG was charged with the implementation and ongoing management of the MIP.

The exact costs for forming the MIG cannot be broken down to a single line item. Rather, the various costs involved are attributable to a portion of each of the several categories depicted in Table 1. This is illustrated in the following examples.

- Of the $2 million allocated for staffing in FY 2006, $404,644 was originally spent for the eight key staff members of the initial MIP Planning Group who were integral to the MIP planning process.

- $51,632 in travel expenses were used to search out prospects for leadership positions in the new MIG and foster collaborative relationships among stakeholders, particularly, the States.

- $5,170 was spent on administrative activities, supplies, and training. These expenses were used to support the goals and objectives of MIP and included office supplies and printing.

Staffing and Organizational Resources

The organizational design and makeup of the new MIG reflect its focus on allocating resources to reduce program risk for fraud and abuse to the greatest extent possible. The organizational structure of the MIG is aimed at facilitating the two major business activities of the Medicaid Integrity Program, which are the audit program and State oversight and assistance. In June 2006, an organizational proposal was approved for the new program. Out of the 100 new personnel authorized, 20 FTEs were allocated to the Medicare Program Integrity Group to bring the Medi-Medi Program up to full operations nationally as well as to assist with the Payment Error Rate Measurement initiative and one FTE was allocated to the Office of the Acquisition and Grants Management to help with the overall contracting effort. The remaining 79 FTEs were devoted exclusively to the newly formed MIG. An acting director and management team were identified as well as three divisions that would operate under the MIG Director's Office:

- Division of Medicaid Integrity Contracting;

- Division of Field Operations; and

- Division of Fraud Research and Detection.

Hiring has commenced and the leadership search is ongoing. The MIG hiring plan is based upon incremental waves that will be completed by the end of FY 2007. To date, two Division

Directors have been hired (Division of Field Operations and the Division of Medicaid Integrity Contracting). In addition to the initial cadre of eight staff assigned to the MIP Planning Group, 14 additional staff-level positions have been hired as of this write-up, bringing the MIG's total staffing to 22. This includes filling four of the top seven MIG management positions. The FY 2006 staffing expenditures effectively laid the leadership groundwork for the MIG as well as the overall program.

The First Comprehensive Medicaid Integrity Plan

The DRA amended Title XIX of the Social Security Act to require the Department to develop a comprehensive plan for ensuring the integrity of the Medicaid program and to update it every 5 years. Accordingly, the MIG drafted and publicly released the initial Comprehensive Medicaid Integrity Plan (CMIP) in July 2006. As required by the DRA, the CMIP was developed after considerable consultation with the required stakeholders (DOJ, FBI, GAO, HHS OIG, and relevant State officials). Moreover, MIG staff also held discussions with the staffs of three Congressional committees, i.e., Senate Finance Committee, House Energy and Commerce Committee, and the Senate Committee on Homeland Security and Governmental Affairs, subcommittee on Federal Financial Management, Government Information and International Security. This first CMIP contained a 5-year startup and implementation plan that described the program design as well as the MIG's vision for the longer term.

As in the case of the formation of the MIG, it is not possible to isolate the individual costs involved in developing the CMIP. Again, the costs are a portion of each of the various groupings listed in the preceding spending table. For example, the MIP Planning Group staff wrote the CMIP, staff travel was involved in the extensive consultation and coordination process, and other attendant costs were associated with publishing the plan.

Consultation, Coordination, and Public Awareness

A major challenge in developing the CMIP was ensuring that this wide-ranging plan provided the required strategic direction for not only CMS and its contractors, but also for the States and our law-enforcement partners. Cooperation among Federal agencies, balancing responsibilities with the States, and communications with stakeholders were of paramount importance in designing the program plan and allocating resources. Facilitating this effort was CMS' ability to draw upon its experience in putting together a similar program integrity plan for Medicare in 1999. Certain concepts from this first program integrity plan served as a template for its efforts. For example, engaging the States and Federal partners to truly collaborate on the plan's development was integral to its success.

Upon issuance of the CMIP in July 2006, a number of briefings and "roll-outs" were conducted for a wide variety of interested parties, including national conference calls for members of the American Public Human Services Association (APHSA) as well as individual providers and provider groups. In furtherance of ongoing collaboration, standing meetings have been established with CMS' leadership in the Office of Financial Management's Program Integrity Group and HHS' Office of the General Counsel (OGC) and Office of the Inspector General (OIG). MIG management promoted public awareness by presenting information on the MIP on

more than 20 occasions, to audiences both large and small, as well as to national associations including the American Public Human Services Association, the National Association of State Medicaid Directors, and the National Association for Medicaid Program Integrity. It is difficult to specify with any precision the cost of crafting these relationships and rapport, which involve valuable staff time and travel, but which are of incalculable value in establishing an effective program. Additionally, training funds were also used to enable limited numbers of MIG staff to attend national conferences relating to issues of health care fraud and abuse.

Award of Strategic Contracts

In late FY 2006, two strategic contracts in support of the MIP were awarded. The allocation for these two contracts totaled $2,384,038 and represented 83% of the $2,885,000 level budgeted by CMS. These important contracts, dealing with Audit Program Development (APD) and State Program Integrity Assessment (SPIA), support the major functional responsibilities of the MIP (provider oversight/audit and support and assistance to the States).

- The APD contract meets the requirements of the DRA for conducting audits of claims and identifying overpayments by providing CMS with design and development recommendations for an audit system that incorporates the best approaches to review provider actions for which Medicaid State Plan payments are made. In addition, this contract provides CMS with provider education recommendations.

- The SPIA contract provides support and assistance to the States and CMS by developing an approach for collecting State program integrity profile data and performance measures. This involves conducting extensive research to establish a current program integrity baseline of the individual States and collective program integrity efforts. The SPIA system will be used to identify vulnerabilities as well as strengths in these program integrity efforts. This will facilitate CMS' efforts to identify areas to provide support and assistance to States and areas in which to develop best practices.

Guidance on DRA Sections 6031 and 6032

The amendments made by DRA Section 6031, captioned "Encouraging the Enactment of State False Claims Acts," and Section 6032, captioned "Employee Education about False Claims Recovery" each had an effective date of January 1, 2007. Through issuing a State Medicaid Director (SMD) letter encouraging States to enact legislation enacting State False Claims Acts, CMS provided formal guidance regarding section 6031 to the States, provider groups, and other interested parties. CMS also developed guidance regarding section 6032, issuing a separate SMD letter providing CMS' instructions to the States regarding applicable employers' obligations to educate employees and others about the Federal and any applicable State False Claims Acts. We have since followed this up with CMS' final guidance to the States on section 6032, which included an extensive compilation of questions and answers, along with a description of the federal False Claims Act provided by the U.S. Department of Justice. (The three SMD letters referenced above may be found at the CMS website - http://www.cms.hhs.gov/SMDL/SMD/list.asp – under the following subjects: State False Claims

Act; Employee Education about False Claims Recovery; and Final Guidance Regarding Employee Education for False Claims Recovery.)

Conclusion

The MIP represents an unprecedented effort to detect and prevent Medicaid program fraud and abuse. Together with our State and Federal stakeholders, we are taking unparalleled steps to assure the integrity of the program. Planning for and implementing the MIP provides CMS with a unique opportunity to strengthen its leadership of State and federal program integrity efforts. CMS welcomes both the challenges and opportunities presented by the DRA to improve Medicaid integrity. Furthermore, we are off to a good start in putting together a strong, viable, and sustainable program, and we are confident that we will have more good news to report next year.