# Annual Report to Congress

# on the

## Medicaid Integrity Program

**Center for Program Integrity**
**Centers for Medicare & Medicaid Services**

**For Fiscal Year 2010**

**Kathleen Sebelius**
**Secretary of Health and Human Services**
**2011**

# Table of Contents

# Executive Summary

On February 8, 2006, the Deficit Reduction Act (DRA) of 2005 was signed into law (P.L. 109-171) and created the Medicaid Integrity Program (MIP) under Section 1936 of the Social Security Act (the Act). Section 1936 of the Act dramatically increased resources available to the Secretary of Health and Human Services (HHS) to devise an effective national strategy to combat Medicaid provider fraud, waste, and abuse.

On behalf of the Secretary, the Centers for Medicare & Medicaid Services' (CMS) Center for Program Integrity Medicaid Integrity Group (MIG), implemented and now operates the MIP. CMS has two broad responsibilities under the MIP. The first responsibility is to hire contractors to review Medicaid provider activities, audit claims, identify overpayments, and educate providers and others on Medicaid program integrity issues. The second responsibility is to provide effective support and assistance to states in their efforts to combat Medicaid provider fraud, waste, and abuse. Under the DRA, within 180 days of the end of the fiscal year, the Secretary is required to report to Congress the use of funds appropriated to the MIP and the effectiveness with which these funds were used.

Under the leadership of the MIG, CMS continues to make significant progress in developing a strong, effective, and sustainable program to combat Medicaid provider fraud, waste, and abuse. The information below on Audit, State Support, Data Analytics, and Education activities highlights the success the MIP has had in meeting its broad responsibilities.

**Audit -** Fiscal Year (FY) 2010 marked the second full year of the national Medicaid provider audit program. CMS awarded task orders in all regions for contractors to review provider claims, conduct provider audits, and initiate the provider education activities required by Section 1936 of the Act. Through the end of FY 2010, 947 audits were underway in 45 of the states and MIG efforts identified an estimated $10.7 million in overpayments, through both direct provider audits and automated reviews of state claims.

**State Support -** Section 1936 of the Act required MIG to provide support and assistance to state Medicaid program integrity efforts. To fulfill this requirement, the MIG completed 17 comprehensive state program integrity reviews, identifying problems that warranted improvement or correction in state operations and assisted states in their efforts to remedy these issues. The MIG also highlighted commendable practices. Moreover, the MIG responded to numerous state requests for technical support. For example, the MIG provided staff to state Medicaid program integrity investigative projects. The MIG also hosted conference calls to discuss program integrity issues and best practices and issued guidance on policy and regulatory issues. The CMS' goal is for one state's best practice to become all states' common practice. Providing states with a compendium of program integrity activity and benchmarks for easy reference adds value to our collective effort to improve the overall integrity of the Medicaid program.

**Data Analytics -** The MIG continues to build on the data strategy and information technology infrastructure of the MIP. The MIG created and now operates a data analysis management

information system. This system is able to capture and store a subset of state Medicaid data translated into a format that can be used to detect and report suspect Medicaid payments or answer general research questions. The system is used in support of the MIG's responsibility for reviewing payments made to Medicaid providers to identify overpayments. Analyses are underway in almost all states. Over 328 algorithms have been developed and used to detect payment anomalies. The application of these algorithms has resulted in audit targets and data models. The MIG continues to work with many states to conduct projects on cross-border, regional, and national issues.

**Education -** For the continuing education of state program integrity employees, the Medicaid Integrity Institute (MII) remains one of the MIG's most significant achievements. In its three years of existence, the MII offered numerous courses and trained over 1,600 state employees at no cost to the states. Courses have included: an orientation to Medicaid program integrity; programs to enhance investigative and analytical skills to maximize program integrity efforts; and a symposium to exchange ideas, create best practice models, and identify emerging fraud trends. States continue to report immediate value and benefit from the training offered at the MII. The MIG also sponsored intensive Certified Professional Coder training courses and provided training to more than 200 additional state employees. Furthermore, FY 2010 marked the first full year contractors were in place to develop materials to conduct provider education and training on payment integrity, utilization, and quality of care issues and to highlight the prevention of fraud, waste, and abuse in the Medicaid program.

In March 2010 the Patient Protection and Affordable Care Act (Affordable Care Act) was passed. Provisions in this act have expanded the role of MIP with regard to federal and state program integrity activities and efforts. The Affordable Care Act has also provided new tools to detect, deter, and remedy fraud, abuse and waste in the Medicaid program. Among these are:

- the formation of State Medicaid Recovery Audit Contractors (RACs);
- the ability to suspend payments more quickly when fraudulent activity is suspected;
- more effective screening measures to prevent fraudulent providers from enrolling in the Medicaid program; and
- streamlined procedures to terminate providers from the Medicaid and CHIP programs when they have been terminated by Medicare or the Medicaid or CHIP program in another state.

As MIG works toward full implementation of the provisions of the Affordable Care Act the effectiveness of Medicaid program integrity will improve and result in reduced improper payments from the Medicaid program.

# Introduction

The President is committed to streamlining the efficiency of government programs through a more proactive accounting of improper payments in major programs and services. The Medicaid program under Title XIX of the Social Security Act (the Act) is included in this initiative and represents a critical component of our nation's safety net for those vulnerable individuals in our society. Despite the many uninsured and underinsured persons in our nation the Medicaid program, by its existence, has prevented that number from being much higher. Because the Medicaid program is a large, nationwide effort to provide medical coverage to 47 million vulnerable children and adults it can be a target for those who would abuse or defraud a health care program for personal financial gain. The Medicaid program is not unique in this case, fraud, waste, and abuse represent a persistent, pervasive threat to the fiscal integrity of all health care delivery and payment mechanisms whether it is Medicare, Medicaid, or private insurance.

Recognizing this growing trend, Congress passed the Deficit Reduction Act (DRA) of 2005 (P.L. 109-171) in February 2006. The DRA created the Medicaid Integrity Program (MIP) under Section 1936 of the Act, the first nationwide effort at the federal level to combat fraud, waste, and abuse in the Medicaid program. The Medicaid Integrity Group (MIG) is tasked to implement this effort. The MIP is but one component in the overall effort to ensure Medicaid program integrity. The CMS works with partner agencies at the federal, state, and local levels to proactively confront those individuals and organizations that would abuse or defraud the Medicaid program.

In March 2010, the President signed the Patient Protection and Affordable Care Act (the Affordable Care Act). This act included many program integrity provisions that strengthened the efforts authorized by the DRA. Several of these provisions were based on ideas generated by state Medicaid operations and enforcement agencies. The Affordable Care Act also incorporated many initiatives from the President's Executive Order 13520, *Reducing Improper Payments*, signed in November 2009. In April 2010, the Center for Program Integrity (CPI) was created to combine the fraud, waste, and abuse detection and enforcement efforts in the Medicare, Medicaid, and CHIP programs. The CPI consolidates the health care fraud, waste, and abuse efforts at CMS strengthening a concerted, unified initiative to combat this problem nationwide.

Prior to passage of the DRA the federal Medicaid PI effort consisted of fewer than 6 full-time equivalent (FTE) employees and negligible funding. Section 1936 of the Act dramatically increased resources available to the Secretary of the Department of Health and Human Services (HHS) to devise an effective national strategy to combat Medicaid provider fraud, waste, and abuse. To establish this national strategy, Section 1936 of the Act outlines activities the Secretary must meet to fulfill her responsibility to promote Medicaid program integrity. Specifically, the Secretary must enter into contracts with eligible entities to perform four activities:

(1) the review of Medicaid provider actions to detect fraud or potential fraud;
(2) the auditing of Medicaid provider claims;
(3) the identification of overpayments; and

(4) the education of providers and others on payment integrity and quality of care issues.

The contractors that perform these activities are known as Medicaid Integrity Contractors (MICs). The statute also requires that the Secretary increase staffing for the Centers for Medicare & Medicaid Services (CMS) by 100 FTE 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."

Before detailing the implementation of section 1936, an overview of CMS' program integrity organizational structure, including some recent restructuring that has enhanced our program integrity capabilities is appropriate.

## The Center for Program Integrity

In April 2010, the Center for Program Integrity (CPI) was formed within CMS. This newly-established Center brought together the oversight of Medicare Program Integrity and Medicaid Program Integrity, in order to leverage resources and techniques for overall program improvement. CPI's overarching goal is to protect the trust funds and other public resources against losses from fraud and other improper payments; and to improve the integrity of the health care system. CPI established five strategic goals for its mission:

1. Prevent Fraud: CPI will prevent, detect, and resolve fraud, abuse, waste, and errors by expanding the breadth of the PI strategy beyond post-payment recoveries to preventing improper payments and resolving problems as they occur.

2. Focus on Risk: CPI will focus on risk and reward compliance by targeting initiatives that identify bad actors while reducing the burden on legitimate providers and suppliers.

3. Innovate: CPI will innovate by using advanced technology and data analysis and apply best practices from the private sector.

4. Be Transparent and Accountable: CPI will be transparent and accountable to its stakeholders by sharing performance metrics on key program integrity activities.

5. Foster Public-Private Partnerships: CPI will foster public-private partnerships and provide a forum for external and internal stakeholders to accelerate positive change.

Centralizing CMS' program integrity functions focuses efforts to attain the mission and goals of CMS and CPI through cross-training, information sharing, and development of best practices in program integrity activities.

## The Medicaid Integrity Group

The Medicaid Integrity Group (MIG), now within CPI, was created by the Secretary to ensure the functions required by Section 1936 of the Act are carried out. The organizational structure of the MIG is designed to accomplish the requirements for the MIP in an efficient manner, while effectively allocating resources to reduce program risk for Medicaid provider fraud, waste, and abuse. The MIG consists of four divisions, which operate under the leadership of the Office of the Group Director.

- The **Division of Medicaid Integrity Contracting (DMIC)** helps procure and oversee the MICs that conduct provider reviews and audits, and that furnish provider education.

- The **Division of Fraud Research & Detection (DFRD)** identifies potential payment errors and trends through the analysis of Medicaid data and conducts studies to support the activities of the MICs and the state Medicaid program integrity offices.

- The **Division of Field Operations (DFO)** reviews state program integrity operations, provides training, and other forms of support and assistance to the state Medicaid agencies (including CMS and state audit coordination). DFO has field offices in New York, Atlanta, Dallas, Chicago, and San Francisco.

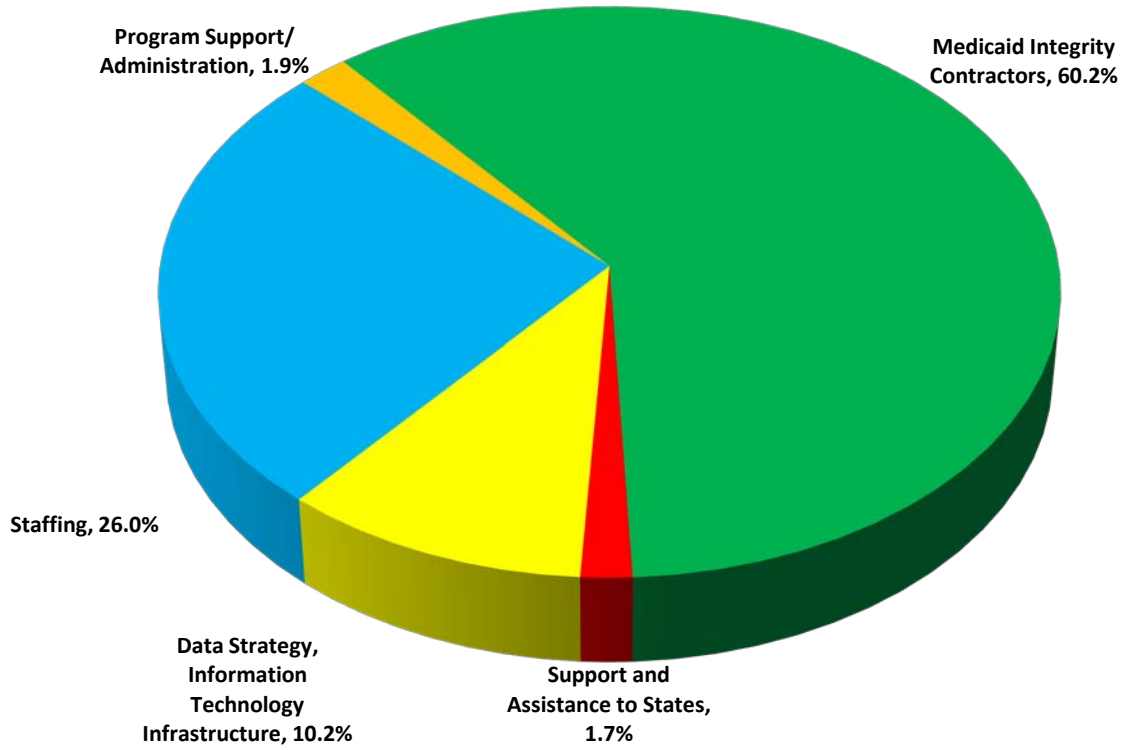
- The **Division of Audits & Accountability (DAA)** promotes collaborative liaisons with internal and external stakeholders of the MIP to ensure operational and administrative excellence of the program.

## Use of Funds

Under the DRA, Congress appropriated funds for the MIP beginning in FY 2006 and authorized these funds to remain available until expended. During FY 2009, this funding reached its maximum level of $75 million. In addition to the $75 million appropriated for the MIP in FY 2010, CMS allotted $5,412,152 in carry-over funds from previous fiscal year appropriations, for a total of $80,412,152 available for spending in FY 2010. Of these funds, CMS expended or obligated a total of $69,869,564, leaving $10,542,588 of carry-over funds for FY 2011. It is important to note that although not all funds appropriated for FY 2010 were expended, many factors make continued funding at this level along with carry-forward funding critical. The full-time equivalent positions (FTEs) were at 83% of mandated levels; fully staffed, MIG's expenditures would have increased by approximately $4 million during FY 2010. This would have resulted in approximately $73.9 million spent (instead of $69.9 million) during the year. The $1.1 million difference from the annual appropriation of $75 million will be obligated to mandated contract activity as it phases from start-up activities to full operational status in the future.

The chart below summarizes the use of funds for the MIP during FY 2010 and a narrative description of this information is provided on the pages that follow.

**FY 2010 Medicaid Integrity Program Expenditures**



## Staffing and Program Support/Administration ($19,536,524)

### Staffing (Salaries and Indirect Costs)

The 100 FTE employees authorized by the DRA are allocated between two operational components within CMS. At the end of FY 2010, CMS filled 83 of the 100 FTEs allocated for the MIP, 81 in the MIG and 2 in OAGM. The MIG continues to recruit and engage staff to address the evolving environment in Medicaid program integrity.

The indirect cost associated with these FTEs consists of staff support, budget, accounting, IT, procurement, and regulation development. The other indirect operating expenses include rent, utilities, guard services, furniture, human resources, and telecommunications.

## Medicaid Integrity Contractors ($42,044,669)

Section 1936 of the Act specifically requires the use of MICs to review the actions of Medicaid providers, audit providers' claims, identify overpayments, and educate providers and others on Medicaid program integrity issues. CMS completed the solicitation process in 2009, and evaluated potential contractors for eligibility to perform program integrity functions for the Medicaid program. The selected contractors were awarded umbrella contracts that qualified them to compete for specific task orders. Umbrella contracts are also referred to as IDIQs which means "indefinite delivery, indefinite quantity" and provides MIG the flexibility to identify tasks as needed, amongst the selected pool of prequalified contractors. For each new task order, MIG specifies the scope of work and the timeframe in which the work must be completed. The three categories of MICs are: Review of Provider MICs, Audit of Provider and Identification of Overpayment MICs, and Education MICs.

### Review of Provider MICs ("Review MICs")

The duties of the Review MICs are to:

- Design and apply algorithms and data models to analyze Medicaid claims data to identify aberrant claims and potential billing vulnerabilities; and
- Provide leads to Audit MICs of providers to be audited.

The five Review MICs are:

- ACS Healthcare Analytics, Inc.
- AdvanceMed Corporation
- IMS Government Solutions
- Safeguard Services, LLC
- Thomson Reuters

## Audit of Provider and Identification of Overpayment MICs ("Audit MICs")

The duties of the Audit MICs are to:

- Conduct post-payment audits of all types of Medicaid providers; and
- Where appropriate, advise states of overpayments made to these providers.

The five Audit MICs are:

- Booz Allen Hamilton
- Fox Systems, Inc.
- Health Integrity, LLC
- Health Management Systems (HMS)
- Island Peer Review Organization (IPRO)

### Education MICs

The duties of the Education MICs are to:

- Develop training materials to conduct provider education and training on payment integrity and quality of care issues; and
- Highlight the value of education in preventing fraud and abuse in the Medicaid program.

The two Education MICs are:

- Information Experts
- Strategic Health Solutions

The Review MICs apply algorithms and data models to claims data to identify anomalies. The results from these analyses identify providers with a propensity to abuse or defraud the Medicaid program. These providers are targeted by MIG for audit and are assigned to the Audit MIC with responsibility for the geographic area in which the provider practices. The results of the audit program are briefly described below and on the next page.

### MIP Test Audits

To gain a better understanding of audit processes and procedures, as well as variation across states, MIG initiated test audits prior to the implementation of the national Medicaid provider audit program. Test audits were conducted in four states (Florida, Mississippi, Texas, and Washington) and the District of Columbia. The test audits were performed by Catapult Consultants, LLC, and the test audit phase concluded in 2010. The final test audit reports identified $8.4 million in overpayments and an additional $9,000 in state-imposed fines through the end of FY 2010. MIG awarded an additional contract to provide states hearing and appeal assistance when faced with legal challenges to the collection of the identified overpayments.

## National Medicaid Integrity Audit Program

The national Medicaid provider audit program is now fully implemented. In FY 2010, CMS awarded task orders for the Review MICs and Audit MICs in the remaining CMS Regions (Tables 1 and 2). The Review MICs continue to run algorithms and conduct other data mining activities to help identify Medicaid providers with suspect billing patterns. As of September 30, 2010, the Audit MICs had identified a cumulative amount of approximately $10.7 million in potential overpayments. At the end of FY 2010, 947 audits were underway in 45 of the states.

**Table 1 - Review MIC Task Order Status 1**

| CMS Regions | Contractor | Award Date |
|---|---|---|
| Regions III &IV (DE, MD, PA, VA, DC, WV, AL, FL, GA, KY, MS, NC, SC, TN) | Thomson Reuters | April 2010 |
| Regions V & VII (IL, IN, MI, MN, OH, WI, IA, KS, MO, NE) | AdvanceMed | May 2010 |
| Regions I & II (CT, ME, MA, NH, RI, VT, NJ, NY, Puerto Rico, U.S. Virgin Islands) | Thomson Reuters | August 2010 |
| Regions VI & VIII (AR, LA, NM, OK, TX, CO, MT, ND, SD, UT, WY) | AdvanceMed | September 2010 |
| Regions IX & X (American Samoa, AZ, CA, Guam, HI, NV, Northern Mariana Islands, AK, ID, OR, WA) | AdvanceMed | September 2010 |

**Table 2 - Audit MIC Task Order Status 1**

| CMS Regions | Contractor | Award Date |
|---|---|---|
| Region III & IV (original) (DE, MD, PA, VA, DC, WV, AL, FL, GA, KY, MS, NC, SC, TN) | Booz Allen Hamilton | April 2010 |
| Region III & IV (re-competed) (DE, MD, PA, VA, DC, WV, AL, FL, GA, KY, MS, NC, SC, TN) | Health Integrity | September 2010 |
| Regions V & VII (re-competed) (IL, IN, MI, MN, OH, WI, IA, KS, MO, NE) | Health Integrity | September 2010 |
| Regions I & II (CT, ME, MA, NH, RI, VT, NJ, NY, Puerto Rico, U.S. Virgin Islands) | IPRO | July 2010 |
| Regions VI & VIII (AR, LA, NM, OK, TX, CO, MT, ND, SD, UT, WY) | HMS | September 2010 |
| Regions IX & X (American Samoa, AZ, CA, Guam, HI, NV, Northern Mariana Islands, AK, ID, OR, WA) | HMS | May 2010 |
| Test Audits Hearing & Appeals Support | Catapult | April 2010 |

### Education Program

Task orders for the Education MICs have also been awarded to initiate the development of fraud, waste, and abuse training materials; and an educational curriculum on program integrity and quality of care (Table 3).

**Table 3 - Education MIC Task Order Statu 1**

| TASK ORDER OVERVIEW | CONTRACTOR | AWARD DATE |
|---|---|---|
| Conduct gap analysis of existing education and training efforts; develop fraud, waste, and abuse training materials; educate Medicaid providers about appropriate and accurate billing for services | Strategic Health Solutions | August 2010 |
| Develop educational curriculum via Web-based and traditional methods; educate Medicaid providers about Medicaid program integrity and quality of care | Strategic Health Solutions | September 2010 |

MIG has a dedicated division, the Division of Medicaid Integrity Contracting (DMIC), that provides contract management and oversight of the MICs. DMIC monitors contractor performance, provides technical direction, and works closely with the MIG business owners to ensure the contractor is complying with the terms and conditions of the contract. DMIC conducts annual performance assessments and makes a recommendation to the Fee Determining Official on all award fee contracts as a result of performance.

## Effective Support and Assistance to States ($1,187,729)

Section 1936 of the Act requires CMS to provide effective support and assistance to states concerning provider fraud, waste, and abuse. MIG provides effective oversight through its annual state program integrity reviews and related activities, described more fully below. As part of its critical support and assistance function, the MIG offers program integrity training and best practices guidance to the states. MIG's participation in joint Federal-State field projects related to vulnerable programs, such as home health and DME, and other forms of technical assistance augments the efforts of state Medicaid program integrity nationally.

### State Program Integrity Reviews

The MIG conducts triennial comprehensive reviews of each state's program integrity activities. One third of the states are reviewed on an annual basis. Through the reviews, CMS assesses the effectiveness of the state's program integrity efforts and determines whether the state's policies and procedures comply with federal regulations. In addition, the MIG uses the reviews to identify and disseminate best practices. The review areas include: provider enrollment, provider disclosures, program integrity, managed care operations, and the interaction between the state's Medicaid agency and its Medicaid Fraud Control Unit. The MIG also conducts follow-up reviews to evaluate the success of the state's corrective actions.

In FY 2010, the MIG conducted 17 comprehensive state program integrity reviews in the following states: Alaska, Arkansas, Connecticut, Delaware, Hawaii, Indiana, Iowa, Kansas, Michigan, Missouri, Montana, Nevada, New York, Ohio, Oregon, Texas, and Virginia. As of the end of FY 2010, all states have been reviewed by the MIG, and 10 states (Arkansas, Connecticut, Delaware, Iowa, Michigan, Missouri, Nevada, Oregon, Texas, and Virginia) were reviewed twice. The start of the second comprehensive review cycle provided the MIG with the opportunity to make onsite assessments of the states' corrective actions, compare previous findings to current findings, and make an assessment of the states' progress in combating fraud, waste, and abuse.

The most common findings and vulnerabilities identified in the reviews to date include:

Findings:

- failure to collect required ownership, control, and criminal conviction disclosures
- failure to require the disclosure of business transaction information
- failure to report adverse actions states had taken on providers to the HHS Office of Inspector General (OIG)

Vulnerabilities:

- inadequate protections in the managed care provider enrollment process
- lack of exclusion checking at the time of initial provider enrollment and thereafter
- lack of written program integrity policies and procedures
- inadequate oversight of Medicaid managed care organizations

States responded positively to the reviews, indicating that they would correct the areas of non-compliance and program vulnerabilities identified in the reviews.

The MIG's Program Integrity Review Annual Summary report includes a compendium of data collected from comprehensive integrity reviews that have had final reports issued during the calendar year. The report includes information about effective practices, areas of vulnerability, and areas of regulatory non-compliance. The MIG publishes this report annually in May as part of its statutory obligation to provide effective support and assistance to the states. Annual reports can be found on the CMS website at:
http://www.cms.gov/FraudAbuseforProfs/05_StateProgramIntegrityReviews.asp

### Medicaid Integrity Institute (MII)

In September 2007, the MIG established the MII, the first national Medicaid program integrity training program. CMS executed an interagency agreement with the U.S. Department of Justice, in order to house the MII at the National Advocacy Center, located at the University of South Carolina. The MII provides a unique opportunity for CMS to offer substantive training, technical assistance, and support to states in a structured learning environment. Over time, the MII intends to create a credentialing process to elevate the professional qualifications of state Medicaid program integrity employees.

In FY 2010, the MII provided training to 590 state employees/officials from 49 states and the District of Columbia. The training in FY 2010 included the following courses:

- Evaluation and Management Boot Camp: an intensive two-day course geared toward both coding and auditing professionals, to show how to evaluate documentation in accordance with national and local guidelines with a strong emphasis on interpreting rules accurately; and how to maximize audits.

- Basic and Specialized Skills and Techniques in Medicaid Fraud Detection: a program to enhance the fundamental investigatory and analytical skills of state Medicaid employees to maximize the effectiveness of program integrity efforts.

- Program Integrity Fundamentals: an orientation to Medicaid program integrity and how it relates to state Medicaid programs.

- Data Expert Symposium: a program which brought together state Medicaid data experts to exchange ideas, define concepts, and create best practice models to identify fraud, waste, and abuse.

- Emerging Trends in Medicaid: a course to facilitate collaboration and discussion of emerging issues that currently have, or will have, a significant impact on program integrity functions in the future.

- CPT (Current Procedural Terminology) Coding Boot Camp: a comprehensive, five-day course designed to teach the fundamentals of medical coding, assist in preparation for national certification, and provide the framework for applying coding principles in a real-world environment.

- Emerging Trends in Managed Care: a course to facilitate collaboration and discussion of emerging managed care trends with the goals of enhancing efforts to detect health care fraud, waste, and abuse in the managed care environment.

- Emerging Trends in Pharmacy: a forum to exchange ideas, define concepts, and create best practice models to identify fraud, waste, and abuse in the area of pharmacy.

- CPT Coding Inpatient/Diagnosis-Related Group (DRG) Boot Camp: a comprehensive five-day course on coding and DRG assignment for hospital inpatient facility services.

- Investigation Data Collaboration: Acquisition, Analysis, and Use: a course focused on the collaborative acquisition, analysis, and use of Medicaid data in the investigation process.

- ICD-10 Basics Boot Camp: an intensive two-day course which introduced the fundamentals of ICD-10 coding, the differences between ICD-9 and ICD-10 codes, and major changes to official coding guidelines.

- Home Health and Durable Medical Equipment Symposium: a forum to exchange ideas, define concepts, and create best practice models for identifying fraud, waste, and abuse in the areas of home health care and durable medical equipment.

The MII CPT coding classes provided staff in some states with their first opportunity to acquire formal certification in medical coding. State participants have been able to implement ideas gained from the training upon returning to their workplaces.

As a result of several MII courses, state staff from across the country have the opportunity to engage in productive dialogue about the challenges they face combating fraud, waste, and abuse issues unique to their state Medicaid programs. This interaction permits participants to share their success stories, to learn from other's successes, to give their Medicaid programs a wider range of perspectives on available policy options, and to help identify problem providers who attempt to migrate from one state Medicaid program to another.

*"The ability to mingle with fellow peers who are from all 50 states gave me a much stronger feeling of unity and purpose. By working together I feel that we can make a difference in our fight against fraud, waste, and abuse."*

Student commenting on Emerging Trends in Managed Care

*"There were so many new and useful algorithms presented by not only the presenters, but also the participants. I have shared these ideas and concepts with our SURS [Surveillance Utilization Review Subsystem] unit who also agree with the wide variety of areas to explore."*

Student commenting on Data Expert Symposium

## State Program Integrity Assessment (SPIA)

The SPIA is an annual activity 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 develop measures to assess states' performance in an ongoing manner. SPIA represents the first national baseline collection of data on state Medicaid integrity activities for the purposes of program evaluation and technical assistance support. Through SPIA, the states and CMS will be able to gauge their collective progress in improving the overall integrity of the Medicaid program.

In FY 2010, the MIG completed the second national collection of SPIA data representing FY 2008 activity. The self-reported data collection from the states revealed in FY 2008, more than 4,100 program integrity FTEs were employed by the states and a total of $346.2 million was expended on program integrity activities. This represents an 8.8% increase in staff and a 91.2% increase in funding dedicated to Medicaid program integrity activities from FY 2007, the base year for SPIA. States reported that they conducted 106,139 audits resulting in the recovery of $737 million. This 92.2% increase in audits performed resulted in a 23.9% increase in recoveries from audits and an additional 54% increase in overpayments identified by audits.

Overall, in FY 2008, states reported $1.7 billion in recoveries from all program integrity-related activities[1], an increase of 27.4% from FY 2007 levels. These data indicate the increased focus on program integrity activities encouraged by the DRA and, which when further supplemented by the Affordable Care Act, along with increased resources with which to pursue these activities, have and will continue to result in increased savings to the Medicaid program and the health care resources of the several states. Individual state reports, a complete dataset, and a high-level executive summary of the FY 2007 and FY 2008 results are available on the CMS website at http://www.cms.hhs.gov/FraudAbuseforProfs/11_SPIA.asp.

At the end of FY 2010, plans were underway to gather SPIA data for a third consecutive year. As this data becomes available, and as future collections are conducted, statistical trends and indicators should emerge to enable MIG to refine its approach to program integrity activities and to provide the states with information they can use to become more effective in their program integrity efforts.

**Special Fraud Investigation Projects**

In February 2010, the MIG staff assisted State of Florida Medicaid program integrity officials in an investigation of high prescribing providers for six specific home health agencies (HHAs). The multi-day investigation involved visits to 96 high prescribing physicians. Of the 96 providers contacted, 74 received sanctions, including $26,500 in fines. Six of the providers were placed on mandatory prepayment review, one was referred to CMS, and 35 were referred to the Florida Department of Health.

In October 2010, the MIG staff assisted Florida Medicaid program integrity officials in a second street-level investigation of HHA prescribing physicians. This multi-day investigation involved interviews with the 60 top home health service prescribers in the Miami Dade County area. As part of the investigation, six review teams looked for documentation of home health services—including prescriptions and signed and dated Plans of Care (POC)—to ensure that providers were in compliance with recent Florida legislation authorizing stricter oversight of HHAs and prescribing providers. Although information on sanctions resulting from this investigation is not yet available, a significant number of administrative actions are anticipated because the team found numerous instances of missing POCs, un-signed or undated POCs, expired medications, and lack of evidence of calibrations for diagnostic equipment.

Florida has not yet calculated cost avoidance for the above 2010 investigations. However, in two similar projects, conducted in FY 2008, the State of Florida estimated that providers submitted $8.5 million less in Medicaid billings after the projects, compared to similar time periods before the projects. This decrease represents approximately 14 percent reduction in total dollars spent on unskilled home health visits for Florida between FY 2007 and FY 2008.

[1] Program integrity-related activities include desk audits, field audits, investigations, data mining, provider enrollment activities, provider education and communication, and managed care oversight.

### Other Support and Assistance Activities

In FY 2010, the MIG completed 420 requests for technical assistance from 43 states and numerous other providers and stakeholders. The other stakeholders included CMS contractors, the Department of Justice and U.S. Attorneys' Offices, the Federal Bureau of Investigation, the HHS OIG, State Medicaid Fraud Control Units, and other HHS agencies. The most common topics included requests for statistical assistance related to criminal and civil court actions, policy/regulatory requirements governing disclosures, provider exclusions and enrollment, the MIC Audit Program, specific fraud referrals, and other general topics.

Other examples of assistance provided to the states by the MIG included: hosting regional State Program Integrity Director conference calls to discuss program integrity issues and best practices, issuing a best practices document on the collection of disclosures in provider enrollment in September 2010, helping develop a State Medicaid Director Letter (issued in July 2010) on the return of federal share of overpayments under the Affordable Care Act, and planning an Open Door Forum on MIC Audits to be held early in FY 2011. These new activities conducted pursuant to the Affordable Care Act are described in more detail later in this report. In May 2010, MIG also issued its FY 2009 Program Integrity Review Annual Summary Report. This report summarizes the results of previous comprehensive program integrity reviews and includes best practices, regulatory findings and programmatic vulnerabilities. The CMS' goal is for one state's best practice to become all states' common practice. Providing states with a compendium of program integrity activity and benchmarks for easy reference adds value to our collective effort to improve the overall integrity of the Medicaid program.

## Data Strategy, Information Technology Infrastructure ($7,100,642)

The MIG's fraud research and detection activities focus on the use of state Medicaid claims and statistical data to identify potential high-risk areas for overpayments. Using data analytics, the MIG provides valuable input to the Review MICs which, in turn, use the algorithms and other data-mining techniques to help identify providers with billing patterns that may warrant audits by the Audit MICs. The MIG continues to refine and expand its data analytics capacity and capabilities.

### Information Technology Infrastructure[2]

In April 2008, MIG began developing its information technology infrastructure comprised of a central data repository and analytical tools, which are key components of the MIP's data strategy. Prior to the development of the system, there was no analytical database of Medicaid claims to be used for program integrity purposes. The system is presently hosted at a federally-funded, national super computer network known as Teragrid.

The system became operational in January 2009. Data from all 50 states and the District of Columbia is available in the system for MIG to conduct analyses. The U.S. territories that participate in the Medicaid program do not have data systems in place to conduct similar

[2] The Information Technology Infrastructure was previously referred to as the MIG Data Engine.

analyses. Currently, there are approximately 300 users of the system, including analysts and auditors. The MIG is working with over 20 states to conduct regional and national analytics and audit projects. Examples of projects underway include analysis and model development for home health services and long-term care services.

The MIG uses defined methods to identify potential fraud, waste, or abuse payments. Methods include using algorithms, a rule based technique, to compare claims data and state policy to identify potential overpayments. An additional method—modeling—uses statistical techniques to identify providers who received payment on potentially fraudulent, wasteful, or abusive claims that may warrant further investigation.

Data utilized for Medicaid fraud detection comes from the Medicaid Statistical Information System (MSIS). MSIS consists of eligibility and claims program data submitted from states to CMS. The five files, submitted quarterly, include one file which contains eligibility and demographic characteristics for each person enrolled in Medicaid at any time during the quarter and four separate files of claims adjudicated for payment during the quarter for long term care services, prescription drugs, inpatient hospital stays and all other types of services. The state-submitted data include over 40 million eligibility records and over 2 billion claims records per year.

At the end of FY 2010, the MIG ran approximately 328 state specific Statistical Analysis System (SAS) algorithms that identified over 1,600 providers for audits. The algorithms were developed over the course of three years and cover the following services: dental, durable medical equipment, inpatient hospitals, lab and X-Ray, nursing facilities, outpatient hospitals, physicians, prescription drugs, and psychiatric care. Algorithms can be applied to claims from across the nation.

### Algorithm Development

The algorithm development process begins with the identification and analysis of an algorithm concept. This activity includes four steps: (1) proposing new concepts for fraud identification, (2) validating the proposed concept, (3) prioritizing the concept, and (4) issuing technical specifications for the concept. The factors used to consider a new concept for fraud identification include: past experience, referrals from authoritative sources (e.g., Review MICs, Audit MICs, HHS OIG, or DOJ), state collaborations, CMS fraud, waste, and abuse crossover issues, and mass media news sources. The analysis and development of new concepts for fraud identification is based on the availability and quality of data, industry trends, and proof-of-concept data mining and analytical results. A new concept will be evaluated by the MIG to determine whether it overlaps or complements existing analysis, the level of effort involved in developing the new concept, and the relevance to the Medicaid program on a national level.

Validated new concepts are prioritized based on criteria including: public risk, potential return-on-investment, complexity, legal defensibility, data availability, and analysis limitations. A technical specification describing the algorithm and its selection logic and analytical results is developed and summarized in a Draft Results Report. The algorithm and its results are reviewed through an independent peer review process, which provides a detailed analysis of the data,

coding, and test results. A Final Findings Report is developed to document the specifics of the algorithm and any extraneous considerations identified during the development process.

Algorithms developed generally fall into three different categories: overpayment, metric, and model. Overpayment algorithms apply logic to calculate overpayments and are used to identify providers suspected of overpayments at a volume for which it is cost effective to conduct an audit to recover overpayments. Metric algorithms derive values for comparison of utilizations among providers. No overpayment amount is calculated by metric algorithms. Algorithm models look at a number of indicators and produce a composite ranking based on combination of the indicators. An algorithm model calculates the potential Medicaid amount at risk, instead of overpayment.

## Medicaid and CHIP Business Information and Solutions Council (MACBIS)

The MACBIS was established as an internal CMS governance body to provide leadership and guidance for a more robust and comprehensive information management strategy for Medicaid, the Children's Health Insurance Program (CHIP) and state health programs. The council's strategy includes: (1) promoting consistent leadership on key challenges facing state health programs, (2) improving the efficiency and effectiveness of federal/state partnership, (3) making data on Medicaid, CHIP and state health programs more widely available to stakeholders, and (4) reducing duplicative efforts within CMS and minimizing the burden on states.

The primary responsibilities of the MACBIS include: data planning (e.g. identifying inventory data needs and performing gap analysis), governing ongoing projects, outreach and education, and information product development. This effort is led by CMS' Center for Medicaid, CHIP, and Survey & Certification, and MIG is a key participant. Committee and workgroup members meet bi-weekly and monthly. The MACBIS is leading a series of projects, which will lead to the development and deployment of enterprise wide improvements in data quality and availability for Medicaid program administration, program oversight, and program integrity. These projects include efforts to reduce time from state submission of MSIS data to data availability; automation of program data; improvements in encounter data reporting; and automation, standardization, and other improvements in MSIS data submissions. As these efforts mature, MIG, along with other CMS and state users, will be able to take advantage of CMS' technical infrastructure and business intelligence tools for program integrity oversight, including analytics, algorithms, and queries.

# Communication, Collaboration, and Transparency

The MIG is committed to coordinating its activities with internal and external partners in order to combat provider fraud, waste, and abuse. The MIG continues to ensure that its efforts are developed in collaboration with other federal program integrity partners as well as with state program integrity units and federal and state law enforcement agencies.

## Comprehensive Medicaid Integrity Plan

CMS last issued its Comprehensive Medicaid Integrity Plan (CMIP), covering FYs 2009–2013, in July 2009. The plan was developed in consultation with various stakeholders, including the United States Attorney General, the Director of the Federal Bureau of Investigation, the Comptroller General of the United States, the Inspector General of HHS, and state Medicaid program integrity officials. It includes information on the MIG's planned activities for the five-year period in the areas of planning and program management, ensuring accountability, communication/collaboration, information management and research, Medicaid integrity contracting, and state program integrity operations.

The next release is anticipated in the summer of 2011, covering the FYs 2012–2016. It is important to note that although the DRA requires the CMIP be revised every five years, CMS has reviewed and updated the five year plan annually. With passage of the Affordable Care Act, the advent of the new Center for Program Integrity, and the development of the CPI strategic plan, MIG has foregone the annual update and issuance of the CMIP for the FYs 2010–2014 and FYs 2011–2015, in order to include these recent developments in the next issuance.

## Outreach to Program Integrity Partners and Stakeholders

The MIG has conducted 23 presentations in-person and via webinar at multiple provider association meetings across the country including:

- CMS Bi-Regional (Regions I and II) Managed Care Compliance Conference
- CMS Region III State Medical Societies meeting
- CMS Region V Hospital Association meeting
- CMS Region VII Hospital Association meeting
- CMS Region VIII Health Finance Management Association meeting
- A2HA (South Carolina - American Hospital Association)
- American Health Care Association regional meeting
- Association of Inspectors General Fall Conference
- Behavioral Health Technical Advisory Group (TAG)
- Community Behavioral Health of Maryland
- Georgia Hospital Association meeting
- Health Care Compliance Association regional meetings
- Managed Care Technical Advisory Group (TAG)
- National Association of Medicaid Program Integrity (NAMPI)

- Nebraska Provider Association meeting
- Ohio Health Care Association
- Oklahoma Legislature
- U.S. Virgin Islands Health Symposium

In addition to in-person and webinar meetings, MIG also conducts the following routine conference calls:

- Quarterly (or more often) conference calls with PI Directors in each region
- Monthly calls with the Medicaid Fraud and Abuse Technical Advisory Group (TAG)
- Monthly calls with the Program Integrity (PI) Directors of small states to discuss unique PI issues

In early 2010, President Obama announced a nationwide series of regional fraud prevention summits, as part of a multi-faceted effort to crack down on health care fraud, inclusive of the Medicaid program. The National summit held in Washington, DC, in January 2010, and the regional fraud summits in FY 2010 (Miami-July 2010 and Los Angeles-August 2010) have brought together a wide array of federal, state, and local partners, beneficiaries, providers, and other interested parties to discuss innovative ways to eliminate fraud within the U.S. health care system. The MIG staff have participated in these summits. The MIG will send staff to the additional summits scheduled for FY 2011 and plans to have its education contractor supply Medicaid fraud and abuse educational materials at these meetings.

Information on the Medicaid Integrity Program is available on the CMS website at www.cms.gov/MedicaidIntegrityProgram/.

Statistical Support to the United States Department of Justice (DOJ)

In addition to the algorithm development, the MIG occasionally provides statistical assistance to U.S. Attorney's Offices around the country. As a result of this support, a number of criminal and civil health care fraud cases have been resolved, yielding large settlements and restitution orders. In FY 2010, 591 months of criminal sentences were issued with a total recovery in civil cases of over $103 million.

# New Initiatives to Improve the Financial Accountability and Integrity of the Medicaid Program

## The Patient Protection and Affordable Care Act of 2010

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act), which strengthens the focus on the integrity of Medicare, Medicaid, and CHIP. Subtitles E, F, and G, under Title VI of this Act further define and greatly expand the role of program integrity activities in the Medicaid program. The formation of CPI allows for a centralized approach that enables CMS to pursue a more strategic and coordinated set of anti-fraud policies, as well as collaborate on anti-fraud initiatives with law enforcement partners (including OIG, the Department of Justice (DOJ), and State Medicaid Fraud Control Units). In addition, the Affordable Care Act allows CMS to jointly develop many Medicare, Medicaid, and CHIP anti-fraud policies. The new integrated operation of program integrity activities ensures better consistency in CMS' approach to fraud prevention.

In FY 2010, the MIG, in collaboration with states and other federal partners, including CMS' Center for Medicaid, CHIP, Survey & Certification, began implementing certain program integrity provisions of the Affordable Care Act that will help Medicare, Medicaid and CHIP do less "pay-and-chase" of fraudulent health care claims and undertake more proactive fraud prevention. MIG has sought to align program integrity policies and activities, where effective, across Medicare, Medicaid and CHIP. MIG is focused on tailoring its actions toward the areas where improper payments are likely the greatest. For example, MIG is leading policy development for Medicaid and CHIP with regard to the following areas:

(1) Enhanced provider screening and enrollment requirements to keep fraudulent providers out of the program (Section 6401)—A final rule (CMS-6028-FC) was displayed in the Federal Register on February 2, 2011.
(2) Termination of provider participation in Medicaid and CHIP upon termination from Medicare or another state's Medicaid program or CHIP (Section 6501) —A final rule (CMS-6028-FC) was displayed in the Federal Register on February 2, 2011.
(3) Suspension of payments pending an investigation of a credible allegation of fraud (Section 6402) —CMS issued an Informational Bulletin and a list of Frequently Asked Questions on March 25, 2011.
(4) State Medicaid Recovery Audit Contractor (RAC) programs (Section 6411) —A State Medicaid Director Letter was issued on October 1, 2010.
(5) Provider disclosure of current or previous affiliation with another questionable or excluded provider (Section 6401)—CMS is developing a rule on this provision.[3]

The MIG laid the groundwork in FY 2010 for extensive support and assistance to states in the implementation of these provisions. This support includes guidance in the form of State Medicaid Directors' Letters, informational bulletins, and frequently asked questions (FAQs)

[3] Because the Affordable Care Act was passed during FY 2010, some of the CMS efforts reported here reflect work that occurred in both FY 2010 and FY 2011.

documents. CMS also enhanced its website to promote transparency among stakeholders regarding implementation.

## Executive Order 13520: Reducing Improper Payments

On November 20, 2009, the President issued *"Executive Order 13520, Reducing Improper Payments."* The goal of this order is limit improper payments while ensuring that those who are eligible for government assistance continue to have access to these programs. The Executive Order focuses on broad categories of action including boosting transparency, holding agencies accountable, and creating strong compliance incentives.

Under the Executive Order, agencies with high-priority programs, such as Medicaid and CHIP, are required to establish annual or semi-annual measurements for reducing improper payments. Medicaid and CHIP already report an annual error rate through the Payment Error Rate Measurement (PERM). Because Medicaid has the PERM measure established, the Executive Order required that Medicaid report a supplemental measure. In May 2010, CMS and several states in Regions III (Mid-Atlantic) and IV (Southeast) launched the first National Supplemental Measurement Project focusing on over-prescribing of certain drugs.

The MIG continues to work with states to refine existing measures and to define new measurements that accurately reflect performance and improvement in reducing improper payments. These include those areas historically known to be vulnerable to improper payments such as inpatient hospitals, home health agencies, long-term care providers, and prescription drugs. The goal is to develop protocols to evaluate state PERM corrective action plans and measure the progress of states and CMS to reduce improper payments. The MIG anticipates publishing the result of this project by the end of calendar year 2011.

## CMS Action to Address Risk Concerns Raised by the Government Accountability Office (GAO)

In its High-Risk Series Reports, GAO designated Medicaid as a high-risk program partly due to concerns about the adequacy of fiscal oversight, which is necessary to prevent inappropriate program spending. One area of concern raised by GAO is that of improper payments to Medicaid providers. The report disclosed that CMS estimated $22.5 billion in overpayments based on error rates developed from the triennial review of 17 states' Medicaid programs.[4] The report further states that CMS has already taken some steps to address improper payments. It acknowledges CMS' guidance to states with regard to the Recovery Audit Contractor (RAC) Program and the implementation of standard prepayment edits for Medicaid claims in all states. The GAO recognized CMS' attention to program integrity through its mention that the MIG was elevated and incorporated into the agency's overall program integrity effort.[5]

The MIG continues to work to address the concerns raised by GAO and to reduce the risk of improper payments due to vulnerabilities in the Medicaid program. CMS' commitment to reducing improper payments to maintain and improve the fiscal soundness of federal and state

[4] February 2011, GAO Report to Congressional Committees, High-Risk Series, An Update, p. 161.
[5] Ibid., p. 162

health care dollars is demonstrated by: the review and audit activities conducted by MIG under the DRA; the establishment of the RAC program; and collaborative efforts with the states.

## Improving the Medicaid Integrity Program

### Redesign of the National Audit Program

In an effort to enhance MIG programs and assist the states with their PI priorities, collaborative projects have been initiated for CMS to work directly with states. These projects allowed for greater coordination of data, policies, and audit measures. In these efforts, the states and MIG agree on various audit issues to review and, in some cases, with states providing the data to be used during the review. This gives the MIG audit contractors more timely and complete Medicaid payment data to identify potential fraud, abuse, and recoupable overpayments. In addition, the collaboration project enables states to augment their own resources through the MIG audit contractors and to address audit targets that they may not be able to initiate due to lack of staff. It also provides data analytic support for states that do not have that capability.

During FY 2010, the MIG launched collaboration projects with the following states: Arkansas, California, Connecticut, Maryland, Ohio, and Texas. The MIG audit contractors have completed audits of hospice and pharmacy providers in these states. The MIG also has initiated a collaboration effort with the States of Alaska, Idaho, Louisiana, Oregon, Pennsylvania, Utah and Washington. These activities are ongoing and results have not been finalized.

### Demonstrations to Enhance State Program Integrity Efforts

Historically, states have been prohibited by regulation from receiving Federal Financial Participation (FFP) for data mining efforts undertaken by their Medicaid Fraud Control Units (MFCUs). Data mining is a technique applied to information stored electronically that identifies aberrancies in utilization and billing practices. Data mining uses statistical modeling, intelligent technologies, and other algorithms and data analysis techniques to achieve these findings. On July 15, 2010 HHS approved an amendment to the State of Florida's demonstration waiver under Section 1115 of the Act to permit FFP for MFCU data mining in the state. This was the first such waiver specific to program integrity activity ever granted.

The CMS will monitor this activity in future years and work with the state and HHS-OIG to evaluate the success of this project and to measure the savings generated to the Medicaid program.

### Program Integrity Support & Assistance

In addition to ongoing methods of providing technical assistance and support, such as the SPIA surveys and state program integrity reviews, the MIG has begun to support states and other stakeholders in additional ways. These include the following initiatives:

- Development of a fraud awareness training program for state surveyors.

- Research into the billing records of community mental health centers (CMHCs) in selected states with the greatest CMHC concentration. CMHCs are a Medicare provider type with a track record of fraud and abuse. Because an Affordable Care Act provision requires the population served by CMHCs in the future to be at least 40 percent non-Medicare, the MIG has concerns that these facilities may undertake a push to expand into Medicaid. We are working with states to help ensure that questionable providers are either not admitted into the Medicaid program or subject to appropriate levels of scrutiny.

- Designation of a DFO State Liaison for each state. The State Liaison functions as the first source of information for the state. The relationship between the State Liaison and the state fosters open communication between MIG and the state and allows the state to request technical assistance when needed. The State Liaison plays a key role in reviewing state corrective action plans from program integrity reviews.

- Designation of DFO Audit Liaisons for each of the five task orders nationwide. The Audit Liaison serves a crucial function of coordinating efforts with states, developing new collaboratives and serving as audit subject matter experts for the National Audit Program. The Audit Liaisons serve as points of contact that can assist states in getting answers when questions and information needs arise, and in supporting their work with the MICs.

- Development of protocols for evaluating state PERM corrective action plans (CAPs), and incorporating the CAPs into the comprehensive state program integrity reviews or as specifically designed focused reviews in FY 2011.[6] This is being done in consultation with the Office of Financial Management's Division of Error Rate Measurement.

- Evaluation of state fraud and abuse detection systems as a part of the certification or recertification process for State Medicaid Management Information Systems (MMIS). States must go through a rigorous federal approval process in order to get their system certified for enhanced Federal Financial Participation. This is being done in consultation with the Division of State Systems (DSS) in the Center for Medicaid, CHIP, and Survey & Certification (CMCS).

- Development of multi-component teams (MIG, CMCS, and Regional Offices) that will monitor Medicaid provider compliance with the Health Information Technology for Economic and Clinical Health Act (HITECH) requirements for receiving subsidies for the adoption and meaningful use of electronic health record systems.

- Share with the OIG responses and supporting documentation that field staff receive from state managed care programs in the course of conducting comprehensive program integrity reviews. This will leverage resources and reduce the burden of information requests on state

[6] Focused program integrity reviews examine a narrow area of program interest or concern. They review the activities of up to nine states. An example is the review CMS is currently completing on the effectiveness of its fraud referral performance standards.

Medicaid agencies. The MIG and OIG are currently exploring ways of expanding this information-sharing to all segments of the program integrity review process. One specific example is the CMS effort to develop a national State policy database for use by all claims review entities, including MIG and the PERM program.

- Award two task orders to an Education MIC (Strategic Health Services, LLC), which is working with a wide variety of stakeholders to enhance awareness of Medicaid fraud, waste and abuse among providers, recipients, managed care organizations, and others. The contractor has undertaken a gap analysis to identify areas where information about fraud, abuse, and payment integrity issues is lacking. Working with the MIG, it has identified 14 priority areas to be addressed with new outreach and training materials. In developing materials on the priority areas, the contractor will draw on the expertise of stakeholders from state Medicaid agencies, law enforcement agencies, provider and advocacy organizations, and other relevant groups.

- Establishment of a National Medicaid Fraud Alert System in FY 2010 to quickly and effectively disseminate information, as appropriate, to federal and state partners as well as stakeholders in program integrity. The first alert was issued shortly after the start of FY 2011.

- Establishment of a secure website to allow states to communicate and exchange sensitive information confidentially.

# Conclusion

Section 6034 of the DRA provided the resources to establish the MIP, the first national strategy to detect and prevent provider fraud, waste, and abuse in the history of the Medicaid program. FY 2010 marked another notable year of program accomplishments for the MIP. Program Integrity provisions in the Affordable Care Act have fortified the tools and resources available to MIG in the DRA. The MIG continues to strengthen its leadership and coordination of state and federal efforts to improve compliance with the law while promoting the fiscal integrity of the Medicaid program.