THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON. D.C. ZOZOl

JUN 23 2009

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

Dear Madam Speaker:

I am respectfully submitting this letter and the enclosed report in response to the requirements added by section 6034 of the Deficit Reduction Act of 2005. This provision established the Medicaid Integrity Program under section 1936 of the Social Security Act and required the Secretary of Health and Human Services (HHS) to report on the use of the funds appropriated for the program and the effectiveness of the use of such funds.

The FY 2008 Report to Congress on the Medicaid Integrity Program discusses our activities and accomplishments that best illustrate the effective use of these funds. In addition to the $50 million appropriated for the program in FY 2008, the Centers for Medicare & Medicaid Services (CMS) had approximately $1.8 million in carry-over funds from previous fiscal year appropriations, for a total of $51.8 million available for spending in FY 2008. Of these funds, CMS expended or obligated a total of nearly $45.5 million. These funds were primarily used to support staffing, procure essential contractors to conduct provider reviews and audits, and enhance the Medicaid Integrity Program's data analysis and information technology capabilities.

We are proud to report that FY 2008 was a very productive year in moving this essential program forward and on schedule. Let me again state that HHS is grateful to Congress for the resources to take on this charge. I am also sending a copy to this Report to the President of the Senate.

Sincerely,

Kathleen Sebelius

Enclosure

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

JUN 23 2009

The Honorable Joseph R. Biden, Jr.
President of the Senate
Washington, D.C. 20510

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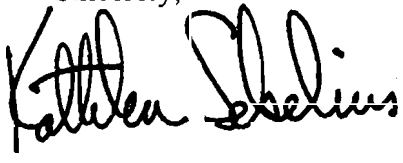

Kathleen Sebelius

Enclosure

Report to Congress

on the

Medicaid Integrity Program

For Fiscal Year 2008

Kathleen Sebelius
Secretary of Health and Human Services
2009

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EXECUTIVE SUMMARY

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) through section 1936 of the Social Security Act (the "Act"). Section 1936 of the Act dramatically increased resources available to the Centers for Medicare & Medicaid Services (CMS) to combat Medicaid provider fraud, waste, and abuse and to devise an effective national strategy to do so. Appropriations for the MIP increase in stages from planning to startup to fully operational, specifically:

- $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.

Under the leadership of the Medicaid Integrity Group (MIG) within the Center for Medicaid and State Operations, CMS continues to make significant progress in developing a strong, effective, and sustainable program to combat Medicaid provider fraud, waste, and abuse.

The MIG made significant strides in FY 2008 in implementing the national Medicaid provider audit program envisioned by the Congress in the DRA. In December 2007, CMS awarded umbrella contracts to several contractors to audit provider claims and identify overpayments. Task orders were issued later in the fiscal year for contractors to conduct provider audits in four of the 10 CMS regions. Moreover, at the end of the fiscal year, CMS awarded an umbrella contract to two contractors to carry out the provider education activities required by section 1936 of the Act.

To fulfill the requirement in section 1936 for providing support and assistance to State Medicaid program integrity efforts, the MIG completed 19 comprehensive State program integrity reviews, identifying problems that warranted improvement or correction in State operations and also highlighting commendable practices. Moreover, the MIG responded to numerous State questions or other requests for Medicaid program integrity assistance, such as staff for State Medicaid program integrity investigative projects that led to numerous provider billing suspensions and referrals to law enforcement.

The capstone of MIG's efforts to provide support and assistance to States was the launch of the Medicaid Integrity Institute, a national training venue for State Medicaid program integrity employees and officials. Several courses were offered throughout the year, including a national conference for State program integrity directors, a basic fraud investigations course to enhance the investigative skills of State Medicaid employees, and a data analysis symposium for Medicaid data experts. The MIG also sponsored several intensive Certified Professional Coder training courses for State employees, two of which were held at the Medicaid Integrity Institute. Altogether, over 400 State program integrity employees were trained during the year, with plans to train an additional 750 students in FY 2009.

In addition, the MIG built a data strategy and information technology infrastructure for the MIP. In FY 2008, the MIG developed the first national Medicaid claims database. Known as the MIG Data Engine, the database, located at a Federally-funded, national super computer network, initially will allow storage of up to 25 terabytes of Medicaid claims and related data. The MIG Data Engine will be accessed by MIG and its contractors to help identify aberrant billing patterns and support the audits of MIG's provider audit contractors. MIG also participated in the development of the design of the Unified Provider Enrollment Project, a common provider enrollment system for Medicaid and Medicare.

INTRODUCTION

Section 1936 of the Act requires the Secretary of Health and Human Services (HHS) to 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 CMS 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."

The organizational structure of the MIG is designed to accomplish the requirements for the Medicaid Integrity Program in an efficient manner, while effectively allocating resources to reduce program risk for provider fraud, waste, and abuse. The MIG consists of three divisions operating 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 will furnish provider education.
- The **Division of Fraud Research & Detection (DFRD)** identifies fraud trends through 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)** conducts reviews of State program integrity operations and provides training and other forms of support and assistance to the State Medicaid agencies. DFO has field offices in New York, Atlanta, Dallas, Chicago, and San Francisco.

The complex nature of Medicaid program integrity makes it challenging to separate many of the MIP's overlapping activities into single line items and categories for reporting on expenditures and accomplishments. Nonetheless, the following represent activities that best illustrate the effective use of congressionally appropriated MIP funds during FY 2008.

USE OF FUNDS

Congress appropriated $5 million in start-up funding for the Medicaid Integrity Program during FY 2006 and an additional $50 million each year for FYs 2007 and 2008. In addition to the $50 million appropriated for the MIP in FY 2008, CMS had $1,885,806 in carry-over funds from previous fiscal year appropriations, for a total of $51,885,806 million available for spending in FY 2008. Of these funds, CMS expended or obligated a total of $40,837,918, leaving $11,047,888 of carry-over funds for FY 2009. Table 1 summarizes the use of funds for the MIP during FY 2008.

Table 1: FY 2008 Medicaid Integrity Program Spending

BUDGET CATEGORY	FY 2008 OBLIGATED FUNDS	FY 2007 OBLIGATED FUNDS EXPENDED IN FY 2008	TOTAL FY 2008 EXPENDITURES
Staffing (Salaries & Indirect Costs)	$12,781,719		$12,781,719
Program Support/Administration	$1,511,090		$1,511,090
Medicaid Integrity Contractors	$20,510,469		$20,510,469
Support and Assistance to the States			$4,651,922
Medicaid Integrity Institute		*$884,463*	
Unified Provider Enrollment Project		*$3,767,459*	
Data Strategy, Information Technology Infrastructure	$6,034,639		$6,034,639
TOTALS	**$40,837,918**	***$4,651,922***	**$45,489,839**

As illustrated in Table 1, the bulk of the FY 2008 funds were used to support staffing and/or administration, procure MIC services, and enhance the MIP's data analysis and information technology capabilities. In FY 2007, MIG made a significant investment in two major initiatives to provide effective support and assistance to States, namely, the Medicaid Integrity Institute and the One-Stop Shop Provider Enrollment System (now known as the Unified Provider Enrollment Project). The funds for these initiatives were obligated in FY 2007; however, a portion of the funds was not expended until FY 2008.

STAFFING AND PROGRAM SUPPORT/ADMINISTRATION ($14,292,809)

Staffing (Salaries and Indirect Costs)

The 100 FTE employees authorized by the DRA are allocated among three operational components within CMS:

a) 79 staff assigned to the MIG;
b) 20 staff assigned to the CMS, Office of Financial Management's Medicare Program Integrity Group for the Medicare-Medicaid Data Match Program (Medi-Medi) and Medicaid Payment Error Rate Measurement (PERM) initiatives; and
c) One staff assigned to the Office of Acquisitions & Grant Management to assist with the overall MIP contracting. efforts.

At the end of FY 2008, CMS had filled 84 of the 100 FTEs allocated for the MIP:

- 40 staff members were hired in the MIG during FY 2008, bringing the total MIG staff to 68 of the 79 allocated to the group.
- 15 of the 20 FTEs allocated to the CMS, Office of Financial Management's Medicare Program Integrity Group have been hired.
- One staff person has been hired by the Office of Acquisition and Grants Management.

In January 2008, CMS approved a new methodology to allocate the Agency's indirect costs to specially funded programs within CMS. These indirect costs include staff support, such as budget, accounting, IT, procurement, regulations, and indirect operating expenses, such as rent, utilities, guard services, furniture, human resources, and telecommunications. Prior to FY 2008, MIG paid a flat percentage of its payroll for indirect costs. The new methodology, which utilizes MIG's payroll as a percentage of Agency payroll to calculate the portion of indirect costs charged to MIG, has resulted in a significant increase in MIG's indirect costs payments (Table 2).

Table 2: MIG Indirect Cost Allocation

FISCAL YEAR	TOTAL INDIRECT COSTS	PERCENTAGE OF MIG PAYROLL
FY 2007	$1,154,028	43%
FY 2008	$5,067,591	66%
FY 2009	$8,123,053*	70%*

*estimated

Staff Training

In January 2008, the Division of Field Operations held its first basic training. The training included presentations on a variety of topics, such as State program integrity operations, State Medicaid Agency operations, Medicaid program basics, and fraud investigation techniques. In addition, the staff was given in-depth training on the State Program Integrity Review process, an integral aspect of the division's work. Additional training was conducted in September 2008, focusing on the protocols and reporting for the comprehensive State Program Integrity Reviews, State technical assistance responsibilities, the role of the Medicaid Fraud Control Units (MFCUs), and the process by which fraud referrals are transmitted from State program integrity units to the MFCUs. Also, DFO staff participated in short-term internships at various States. During these internships, DFO staff observed daily State program integrity operations. This experience will help DFO staff members in their future interactions with State program integrity staff.

MEDICAID INTEGRITY CONTRACTORS ($20,510,469)

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.

Specifically, three types of MICs will perform the following activities:

1) Review of Provider MICs (Review MICs):

- Analyze Medicaid claims data to identify aberrant claims and potential billing vulnerabilities; and
- Provide leads to Audit MICs of providers to be audited; and

2) Audit of Provider and Identification of Overpayment MICs (Audit MICs):

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

3) Education MICs:

- 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.

In December 2007, CMS awarded an umbrella contract to five companies to serve as the first Review of Provider MICs and an additional five companies to serve as the first Audit MICs.

The Review MICs are:	The Audit MICs are:
AdvanceMed Corporation	Booz Allen Hamilton
ACS Healthcare Analytics, Inc.	Fox & Associates
Thomson Reuters	Island Peer Review Organization
SafeGuard Services, LLC	Health Management Systems, Inc.
IMS Government Solutions	Health Integrity, LLC.

In September 2008, CMS awarded the umbrella contract in the Education MIC procurement to Strategic Health Solutions, LLC and Information Experts, Inc.

MIP Regulations

Section 1936 of the Act requires the Secretary of HHS to promulgate regulations on contractor liability limitations and basic contracting eligibility requirements concerning the MICs. CMS published the final rule on the Limitation on Contractor Liability in the Federal Register on November 30, 2007 (72 Fed. Reg. 67653). The final rule for the Eligible Entity and Contracting Requirements for the Medicaid Integrity Audit Program was published in the Federal Register on September 26, 2008 (73 Fed. Reg. 55765). The publication of these two regulations is an important milestone for the MIP.

Launch of the National Medicaid Integrity Audit Program

In April 2008, CMS awarded the first task order for the Review MIC services to Thomson Reuters. Beginning in summer 2008, Thomson Reuters began running algorithms and conducting other data-mining in order to help identify Medicaid providers with suspect billing patterns. The same month, CMS awarded the first Audit MIC task order to Booz Allen Hamilton. The first Review MIC and Audit MIC task orders encompass CMS Regions III and IV. Provider audits began in Florida and South Carolina at the end of FY 2008; audits in other jurisdictions began in FY 2009.

CMS' Region III includes Delaware, Maryland, Pennsylvania, Virginia, West Virginia, and the District of Columbia. Region IV includes Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee.

In September 2008, CMS awarded the second Review MIC task order to AdvanceMed Corporation. The same month, CMS awarded the second Audit MIC task order to Health Management Systems. The task orders will encompass CMS Regions VI and VIII. Provider audits in these regions began in FY 2009.

CMS Region VI includes Arkansas, Louisiana, New Mexico, Oklahoma, and Texas. Region VIII includes Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming.

MIP Test Audits

The MIG worked to finalize provider test audits that had begun in FY 2007. These test audits were done for the MIG to be able to critique its provider audit processes and finalize protocols concerning the upcoming audits by the Audit MICs. At the end of FY 2008, preliminary findings from the test audits had identified approximately $8 million in overpayments.

EFFECTIVE SUPPORT AND ASSISTANCE TO STATES ($4,651,922)

In addition to implementing key program integrity activities such as reviewing Medicaid providers and identifying overpayments, section 1936 of the Act requires CMS to provide effective support and assistance to States concerning provider fraud, waste, and abuse. Through its annual State program integrity reviews and related activities, the MIG provides effective oversight of its critical support and assistance function. In addition, through program integrity training, best practices guidance, and other forms of technical assistance, the MIG bolsters State Medicaid program integrity.

State Program Integrity Reviews

Every three years, the MIG conducts a comprehensive management review of each State's Medicaid program integrity procedures and processes. 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 2008, the MIG conducted 19 comprehensive State program integrity reviews in the following States: Georgia, Illinois, Idaho, Iowa, Minnesota, New Mexico, North Carolina, North Dakota, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Wisconsin, Wyoming, and the Territory of Puerto Rico. The most common findings and vulnerabilities identified in the reviews include:

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

- Vulnerabilities: inadequate protections in the provider enrollment process; lack of exclusion checking after initial enrollment; undocumented program integrity procedures; failure to disenroll inactive providers; inadequate oversight of Medicaid managed care organizations; and ineffective relationships with the States' Medicaid Fraud Control Units.

All States responded positively to the reviews, indicating that they would correct the regulatory findings identified in the reviews.

Medicaid Integrity Institute

In September 2007, the MIG established the Medicaid Integrity Institute (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. In time, the MII intends to create a credentialing process to elevate the professional qualifications of State Medicaid program integrity employees.

In FY 2008, the MII provided training to 417 State employees/officials from 49 States, the District of Columbia, and Puerto Rico, including the following courses:

- What Every Program Integrity Director Needs to Know: reviewed the roles and responsibilities of State Medicaid program integrity directors, including understanding program integrity requirements, communicating with stakeholders, and using program integrity best practices.

- Basic Investigations Skills: covered fundamental investigative skills needed by Medicaid program integrity employees.

- Data Analysis Symposium: assembled State Medicaid data experts to exchange ideas and create best practices for the use of data mining and other information technology supported tools to help identify and reduce Medicaid fraud and waste.

- Faculty Development Seminar: reviewed teaching-learning objectives, strategies, methods, styles, and peer review critiquing processes that have proven reliable in adult/professional learning environments.

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

States have reported immediate value and benefit from the training provided. In some States, it is the first time their staff have had certification in medical coding. Of the 52 students who attended the CPT training at the MII in FY 2008, 22 students (42 %) passed the certification exam. Almost all State participants have been able to implement ideas gained from the training upon returning to their workplaces.

- *"The educational sessions were extremely informative and they covered a wide range of necessary topics."* (Michigan student on Basic Investigations)
- *"I wanted to thank you for all your support during the Coder's boot camp. It was a great learning experience; the interaction with other State employees was invaluable."* (New Jersey student on CPT Coding)
- *"Feedback on all the courses has been very positive. Everyone I have talked with about the MII has enjoyed their experience there." (*Wisconsin student on PI Directors Conference)

State Program Integrity Assessment

The State Program Integrity Assessment is intended to be an annual activity to collect State Medicaid program integrity data, develop program integrity 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. The profiles will include:

- Descriptive information on States' program integrity activities;
- States' medical and administrative Medicaid expenditures and program integrity recovery data; and
- States' accounting of Medicaid integrity return on investment.

As required by the Paperwork Reduction Act of 1995, the CMS-MIG obtained approval from the Office of Management and Budget for the national data collection effort. Data collection for the baseline assessment began in August 2008.

Tamper-Resistant Prescription Requirement

Section 1903(i)(23) of the Social Security Act, added by section 7002(b) of the U.S. Troop Readiness, Veterans' Health Care, Katrina Recovery, and Iraq Accountability Appropriations Act, 2007 (P.L. 110-28) that was signed into law on May 25, 2007, required that written prescriptions for covered outpatient drugs that are paid for by Medicaid be executed on tamper-resistant pads. The MIG was responsible for oversight of CMS' efforts to assure that States implemented the law in an efficient and safe manner.

In the period between this provision's enactment and the final implementation deadline, the MIG, working with CMS' Office of External Affairs, engaged in a wide variety of outreach efforts to ensure that all stakeholders, including State Medicaid agencies, pharmacy associations, and associations representing various physicians and other prescribers, provided input into the development of the CMS guidelines.

In August 2007, CMS issued guidance advising States that the use of tamper-resistant prescriptions could take place over two stages, with the final deadline for implementation occurring on October 1, 2008. MIG helped ensure that the guidance was issued in a timely fashion to allow States sufficient time to educate their providers on how to bring themselves into compliance with the law, and followed up that guidance with Frequently Asked Questions, as well as technical assistance that continued through 2008. Congress facilitated the implementation effort by adopting, in section 5 of the TMA, Abstinence Education, and QI Programs Extension At of 2007 (P.L. 110-90), a six-month delay in the implementation requirement. MIG also provided support to a variety of prescriber and pharmacist organizations' outreach efforts to assist their members with the transition to tamper-resistant

prescriptions. A measure of the success of these efforts is that when the October 1, 2008 final deadline for satisfying the obligations of the law arrived, all States were in full compliance, complaints from pharmacists and prescribers were minimal, and there were no reports of any Medicaid recipient being unable to obtain needed medication.

Performance Standard for Fraud Referrals

In January 2007, the Department's Office of Inspector General (OIG) issued a report on "Suspected Medicaid Fraud Referrals" (OIG-07-04-00181) made by State Medicaid program integrity units to the MFCUs. The OIG recommended that CMS commit to developing performance standards related to the State program integrity units' activities in this area.

In September 2008, MIG issued guidance entitled "Performance Standard for Referrals of Suspected Fraud from a Single State Agency to a Medicaid Fraud Control Unit." The performance standard was developed to provide State program integrity units with a clear understanding of how to comply with requirements for making referrals of fraud to MFCUs. In concert with the release of the performance standard, MIG issued a second guidance document, "Best Practices for Medicaid Program Integrity Units' Interactions with Medicaid Fraud Control Units." This document advises State program integrity units of the circumstances under which they should refer cases to their MFCUs, and provides guidance for interactions between State program integrity units and their MFCUs, with specific examples of actions taken by States that have created well-functioning and committed partnerships between the two entities.

Special Fraud Investigation Projects

In October 2007, MIG staff assisted State of Florida Medicaid program integrity officials in an investigation of forged prescriptions for, and the non-delivery of, nebulizers in Miami-Dade County. The several-day investigation involved more than 700 interviews. At least 40 matters were referred to the Florida MFCU for investigation of possible criminal activity. Based on the success of the initial investigation, in January 2008, MIG assisted Florida Medicaid officials in an investigation of home health agencies that were suspected of upcoding the billing of services and colluding with prescribing physicians and others to bill for services that were not medically necessary or were not rendered. Two home health agencies, numerous home health aides, and eight physicians were referred to the MFCU for investigation of possible crimes.

Later in FY 2008, MIG staff assisted the State of California Department of Health Care Services in an investigation of certain providers in the West Hollywood part of Los Angeles County. Multiple State and Federal agencies participated in this matter. The investigation resulted in the temporary suspension of 20 providers and over 30 recommendations for provider sanctions. In addition, there was nearly a $1.6 million reduction in Medicaid payments to the providers in the first month after the investigation.

Other Support and Assistance Activities

In FY 2008, MIG received 157 requests for technical assistance, including 90 requests from 44 different States. The most common topics included fraud referrals, billing concerns, provider exclusions, and policy clarifications on program integrity regulations. Other examples of assistance rendered by the MIG included: hosting regional State Program Integrity Director conference calls to discuss program integrity issues and best practices; issuing a State Medicaid Director letter in April 2008 regarding States' cooperation requirements under MIP; and issuing a State Medicaid Director Letter in June 2008 providing guidance to States on checking for excluded providers.

DATA STRATEGY, INFORMATION TECHNOLOGY INFRASTRUCTURE ($6,034,639)

The MIG continues to lay the groundwork for a national Medicaid provider audit program through establishing critical data analysis infrastructure. 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 computer algorithms, 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. This data-driven approach for identifying potential overpayments ensures that MIG and its contractors focus on those providers with truly aberrant billing.

MIG Data Engine

In April 2008, MIG began developing the MIG Data Engine, a central component of the MIP's data strategy and information technology infrastructure. Prior to the development of the data engine, there was no analytical database of Medicaid claims to be used for program integrity purposes. The data engine is presently hosted at a Federally-funded, national super computer network, collectively known as Teragrid. The initial database can hold approximately 25 terabytes of data and can expand to six times that size in the next few years.

Uniform Provider Enrollment Project (UPEP)

In collaboration with CMS' Medicare program integrity unit, MIG has provided oversight on the development and implementation of a secure, centralized provider enrollment system designed to meet Medicare and Medicaid requirements. The Uniform Provider Enrollment Project (UPEP) is a comprehensive strategy that addresses provider enrollment as a national issue and impacts the "front-end" of the process (i.e., provider enrollment). The concept design for the system has been completed, including a common data capture Web-based application, a transmission of data to either or both Medicare and Medicaid provider enrollment systems, a prototype of a common State provider enrollment system, and an all-States common provider file. The objective is to improve program integrity by increasing the level of scrutiny given to prospective Medicaid providers.

UPEP will benefit States by providing 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 controls and enable them to more readily identify unscrupulous health care providers.

COMMUNICATION AND COLLABORATION

The MIG recognizes the need for a commitment to coordinate its activities with its internal and external partners to combat provider fraud, waste, and abuse. We continue to ensure that our 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

The CMS issued its third annual Comprehensive Medicaid Integrity Plan, covering FYs 2008 – 2012, in June 2008. 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.

Outreach to Program Integrity Partners and Stakeholders

The success of the MIP's provider audit program relies in part on CMS' ability to partner with the States and gain their support for, and cooperation with, the provider audits that will be conducted in their States. In collaboration with CMS' Office of External Affairs' Intergovernmental Relations Group, the MIG provided briefings to State officials (e.g., State legislature, Governor's office, Medicaid agency, Program Integrity, and Medicaid Fraud Control Unit staff). In addition, MIG hosted a conference call in collaboration with the National Governor's Association and the National Conference for State Legislatures to discuss the audit program with State legislative officials in CMS' Regions III and IV. The MIG also hosted a similar national conference call for the Medicaid Fraud and Abuse Technical Advisory Group.

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

MIG occasionally provided statistical assistance to U.S. Attorneys' 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.

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 detect and prevent provider fraud, waste, and abuse. FY 2008 marked an impressive year of program accomplishments for the MIP. The MIG is strengthening its leadership and coordination of State and Federal efforts by assembling a program that will improve compliance with the law while promoting the fiscal integrity of Medicaid.