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

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

Dear Mr. President:

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

The Fiscal Year (FY) 2009 report to Congress on the MIP discusses our activities and accomplishments that best illustrate the effective use of the congressionally appropriated funds. In addition to the $75 million appropriated for the program in FY 2009, the Centers for Medicare & Medicaid Services (CMS) had approximately $11 million in carry-over funds from previous FY appropriations, for a total of $86 million available for spending in FY 2009. Of these funds, CMS expended or obligated a total of nearly $81 million. These funds were primarily used to support staffing, procure Medicaid integrity contractors to conduct provider reviews and audits, and enhance the MIP's data analysis and information technology capabilities.

We are proud to report that FY 2009 was a very productive year in moving this essential program forward and on schedule. Moreover, I am confident that sound judgment and prudence were central to our spending decisions.

Let me again state that HHS is grateful to Congress for the resources to take on this charge. Please accept this letter and report in response to the requirements of section 6034 of the DRA. I will also provide this report to the Speaker of the House of Representatives.

Sincerely,

Kathleen Sebelius

Enclosure

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

The Honorable Nancy Pelosi
Speaker of the House of Representatives
Washington, DC 20515

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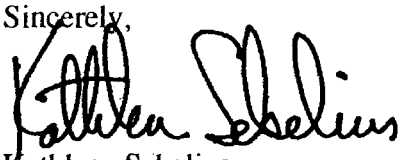

Kathleen Sebelius

Enclosure

Report to Congress

on the

Medicaid Integrity Program

For Fiscal Year 2009

Kathleen Sebelius
Secretary of Health and Human Services
2010

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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) 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. Appropriations for the MIP increase in stages from planning to startup to fully operational. As of FY 2009, MIP appropriations reached its maximum funding of $75 million.

On behalf of the Secretary, the Centers for Medicare & Medicaid Services (CMS)' Medicaid Integrity Group (MIG) implemented and now operates the MIP. CMS has two broad responsibilities under the MIP: (1) to hire contractors to review Medicaid provider activities, audit claims, identify overpayments, and educate providers and others on Medicaid program integrity issues and (2) to provide effective support and assistance to States in their efforts to combat Medicaid provider fraud, waste and abuse. 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 audits, State support, and education information below highlights the success the MIP has had in meeting its broad responsibilities.

Audit. FY 2009 marked the first full year of the national Medicaid provider audit program. Over the course of the year CMS awarded task orders for contractors to review provider claims, conduct provider audits and initiate the provider education activities required by section 1936 of the Act. At the end of FY 2009, over 600 audits were underway in close to half of the States and we had identified an estimated $8.5 million in final overpayments, through both direct provider audits and automated reviews of State claims.

State Support. To fulfill the requirement in section 1936 for providing support and assistance to State Medicaid program integrity efforts, the MIG completed 18 comprehensive State program integrity reviews, identifying problems that warranted improvement or correction in State operations. We also highlighted commendable practices. Moreover, the MIG responded to numerous State requests for technical support. For example, we provided staff for State Medicaid program integrity investigative projects that led to numerous provider billing suspensions and referrals to law enforcement. We hosted conference calls to discuss program integrity issues and best practices, and we issued guidance on policy/regulatory issues.

Data. The MIG continues to build on the data strategy and information technology infrastructure for the MIP through the MIG Data Engine. The MIG Data Engine is a secure, high technology, fully operational management information system that stores a subset of all state Medicaid data in a format that can make queries quickly to detect and report suspect Medicaid payments or answer general research questions. Analyses are being conducted in almost all the States and can now be completed in minutes compared to days. Over 100 algorithms have been developed and used to detect payment anomalies – one algorithm alone led to the recovery of over $5 million from a State. The MIG is also working with a number of States to conduct projects on cross-border, regional and national issues.

Education. In terms of education of State program integrity employees, the Medicaid Integrity Institute (MII) remains one of the MIG's most significant achievements. In its first two years of existence, the MII has offered numerous courses and provided training to almost 1,200 State employees at no charge to the States. These courses included orientation to Medicaid program integrity and its relation to State Medicaid programs, programs to enhance investigative and analytical skills to maximize program integrity efforts, and symposia 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 several intensive Certified Professional Coder training courses for State employees, including a comprehensive course on hospital inpatient facility services coding.

As illustrated above, CMS continues to effectively utilize its resources to combat Medicaid fraud, waste and abuse at the national level.

INTRODUCTION

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.

To establish such a national strategy, Section 1936 of the Act outlines activities the Secretary must meet to fulfill its responsibility to hire contractors 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 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 Medicaid Integrity Group (MIG), within CMS, was created by the Secretary to ensure that 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 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.

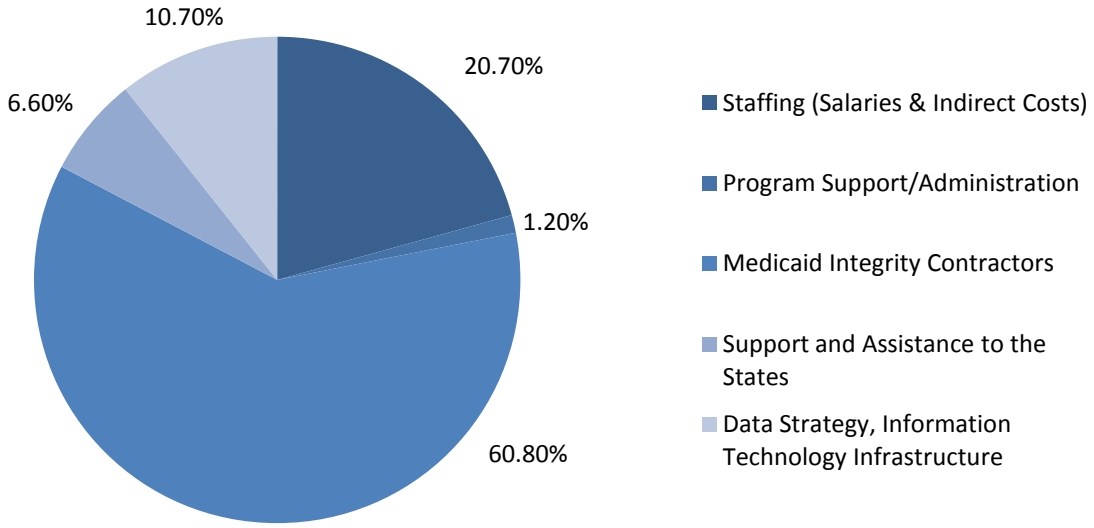
- The **Division of Field Operations (DFO)** conducts reviews of State program integrity operations and provides training and other forms of support and assistance to the State Medicaid agencies. DFO has field offices in New York, Atlanta, Dallas, Chicago, and San Francisco.

The complex nature of the 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 2009.

USE OF FUNDS

Congress appropriated $5 million in start-up funding for the MIP during FY 2006, an additional $50 million each year for FYs 2007 and 2008, and $75 million in FY 2009 and each year thereafter. In addition to the $75 million appropriated for the MIP in FY 2009, CMS had $11,150,358 in carry-over funds from previous fiscal year appropriations, for a total of $86,150,358 million available for spending in FY 2009. Of these funds, CMS expended or obligated a total of $80,738,206, leaving $5,412,152 of carry-over funds for FY 2010. Chart 1 summarizes the use of funds for the MIP during FY 2009.

Chart 1. FY 2009 Medicaid Integrity Program Expenditures



As illustrated in Chart 1, the bulk of the FY 2009 funds were used to procure MIC services, provide support and assistance to States, and enhance the MIP's data analysis and information technology capabilities.

STAFFING AND PROGRAM SUPPORT/ADMINISTRATION ($17,647,165)

Staffing (Salaries and Indirect Costs)

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

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

At the end of FY 2009, CMS had filled 94 of the 100 FTEs allocated for the MIP:

- 8 staff members were hired in the MIG during FY 2009, bringing the total MIG staff to 76 of the 79 allocated to the group.
- 16 of the 20 FTEs allocated to CMS' Office of Financial Management have been hired.
- Two staff have been hired by the Office of Acquisition and Grants Management. Although only one staff was allocated to OAGM, two staff have been hired to support the MIG's contracting activities.

In January 2008, CMS applied 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.

MEDICAID INTEGRITY CONTRACTORS ($49,101,519)

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 has awarded umbrella contracts to several contractors to perform these services. The three categories of MICs are Review of Provider MICs, Audit of Provider MICs, and Education MICs.

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.

The five Review MICs are:

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

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.

The five Audit MICs are:

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

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.

The two Education MICs are:

- Information Experts; and
- Strategic Health Solutions.

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 have been completed (or are in the process of concluding) in four States (Florida, Mississippi, Texas, and Washington) and the District of Columbia. At the end of FY 2009, preliminary findings from the test audits had identified approximately $13 million in overpayments and an additional $9,000 in State-imposed fines.

National Medicaid Integrity Audit Program

The national Medicaid provider audit program is now fully operational. In FY 2009, CMS awarded task orders for the Review of Provider and Audit MICs in the remaining CMS Regions (Tables 1 and 2). The Review of Provider MICs continue to run algorithms and conduct other data mining activities to help identify Medicaid providers with suspect billing patterns. Over

600 audits are underway in close to half of the States. At the end of the fiscal year, the Audit MICs had identified approximately $2 million in potential overpayments based on Audit MIC activity. MIG identified an additional $6.5 million in final overpayments, through both direct provider audits and automated reviews of State claims.

Table 1. Review of Provider MIC Task Order Status

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 2009
Regions V & VII (IL, IN, MI, MN, OH, WI, IA, KS, MO, NE)	AdvanceMed	May 2009
Regions I & II (CT, ME, MA, NH, RI, VT, NJ, NY, PR, US VI)	Thomson Reuters	August 2009
Regions VI & VIII (AR, LA, NM, OK, TX, CO, MT, ND, SD, UT, WY)	AdvanceMed	September 2009
Regions IX & X (Am. Samoa, AZ, CA, Guam, HI, NV, No. Mariana Is., AK, ID, OR, WA)	AdvanceMed	September 2009

Table 2. Audit MIC Task Order Status

CMS REGIONS	CONTRACTOR	AWARD DATE
Regions III &IV (DE, MD, PA, VA, DC, WV, AL, FL, GA, KY, MS, NC, SC, TN)	Booz Allen Hamilton Health Integrity (recompeted)	April 2008 September 2009
Regions IX & X (Am. Samoa, AZ, CA, Guam, HI, NV, No. Mariana Is., AK, ID, OR, WA)	HMS	May 2009
Regions I & II (CT, ME, MA, NH, RI, VT, NJ, NY, PR, US VI)	IPRO	July 2009
Regions V & VII (IL, IN, MI, MN, OH, WI, IA, KS, MO, NE)	Health Integrity	September 2009
Regions VI & VIII (AR, LA, NM, OK, TX, CO, MT, ND, SD, UT, WY)	HMS	September 2009

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

Table 3. Education MIC Task Order Status

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 2009
Develop educational curriculum via Web-based and traditional methods; educate Medicaid providers about Medicaid program integrity and quality of care	Strategic Health Solutions	September 2009

EFFECTIVE SUPPORT AND ASSISTANCE TO STATES ($5,332,892)

In addition to implementing key program integrity activities such as reviewing the claims of 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 as part of its critical support and assistance function. In addition, through program integrity training, best practices guidance, and other forms of technical assistance, the MIG augments the efforts of State Medicaid program integrity nationally.

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 2009, the MIG conducted 17 comprehensive State program integrity reviews in the following States and in the District of Columbia: Alabama, Arizona, California, Colorado, Florida, Kentucky, Louisiana, Massachusetts, Maryland, Maine, Mississippi, Nebraska, New Hampshire, New Jersey, Rhode Island, Washington, and West Virginia.

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; lack of written program integrity policies and 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 2009, the MII provided training to 739 State employees/officials from 49 States, the District of Columbia, and Puerto Rico, to include the following courses:

- Testifying and Report Writing Skills: hands-on instruction with an emphasis in deposition testimony. The skills and techniques taught are transferable and applicable to any forum where Medicaid program employees give sworn testimony, such as administrative hearings or trial.

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

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

- 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.

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

- 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.

- Investigation Data Collaboration: focuses on the collaborative acquisition, analysis and use of Medicaid data in the investigation process.

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

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

- Home Health and Durable Medical Equipment (DME) Symposium: a forum to exchange ideas, define concepts, and create best practice models utilized to identify fraud, waste, and abuse in the area of home health care and durable medical equipment.

In addition to these classes, MII staff conducted a Train-the-Trainer session for California Medicaid integrity staff. States have reported immediate value and benefit from the training provided by the MII.

In some States, it is the first time their staff have had certification in medical coding. Several State participants have been able to implement ideas gained from the training upon returning to their workplaces.

- *"I will be able to use the information on an everyday basis preparing & conducting my investigations."*
  (student on Basic Skills and Techniques in Medicaid Fraud Detection)

- *"To get all States together to hear the same message, to meet each other and share information, is very valuable. I think over the next few years the program integrity will be increased and the partnerships between the States and CMS will be stronger."*
  (student on Emerging Trends in Medicaid Symposium)

State Program Integrity Assessment (SPIA)

The State Program Integrity Assessment 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 2009, MIG completed the first national collection of SPIA data. Based on the self-reported data from the States, we now know that in FY 2007, close to 3,800 program integrity staff were employed by the States and a total of $181 million was expended on program integrity activities. There were 54,829 audits conducted resulting in the recovery of $594 million. Overall, States reported $1.3 billion in recoveries from all program integrity-related activities.

With this information, States and CMS can identify areas of opportunity to build on already effective practices and to identify areas for improvement. Individual State reports, a complete dataset, and a high-level executive summary of the FY 2007 results are available on the CMS website at http://www.cms.hhs.gov/FraudAbuseforProfs/11_SPIA.asp#TopOfPage.

Special Fraud Investigation Projects

In March 2009, MIG staff assisted the State of Florida Medicaid program integrity officials in an investigation of prescribing providers and recipients served by five specific home health agencies (HHAs). The multi-day investigation involved 82 prescribing physicians and 111 recipients. Two of the five HHAs were referred to the Florida Medicaid Fraud Control Unit; all five HHAs face State fines and were referred to Medicare for suspected fraudulent activities.

In September 2009, MIG staff assisted the State of Florida Medicaid program integrity officials in a second street-level investigation of HHAs' prescribing physicians. The multi-day investigation involved 70 prescribing provider interviews. Preliminary findings include: 20 percent of the physicians had expired drugs in stock, 6 percent of the physicians did not have the required documentation in patient files, 4 percent of the physicians were not located at the address listed in Florida's Medicaid Management Information System, and 2 percent of the physicians were missing entire patient records.

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, an approximately 14 percent reduction in total dollars spent on unskilled home health visits for Florida from 2007-2008.

Other Support and Assistance Activities

In FY 2009, MIG received 504 requests for technical assistance from 49 States, providers, advocates and others. The most common topics included the MIC Audit Program, policy/regulatory requirements on disclosures and other general topics, law enforcement, and fraud detection tools. 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 State Medicaid Director letter in January 2009 providing guidance to participating Medicaid providers in regards to screening their employees and contractors for excluded persons; and May 2009 issuance of the FY 2008 Program Integrity Review Annual Summary Report.

DATA STRATEGY, INFORMATION TECHNOLOGY INFRASTRUCTURE ($8,656,630)

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 of Provider 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 patterns.

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.

The MIG Data Engine became operational in January 2009. Data from all 50 States and the District of Columbia have been loaded into the system. There are currently approximately 300 users of the system, including analysts and auditors. The MIG began running analysis using the Data Engine for 40 States and expects to have the capability to run analysis for all 50 States by the end of calendar year 2009. Analyses that would previously take days, even weeks to run can now be completed in minutes. The MIG is working with nine States to conduct national projects with cross-bordering States. Examples of projects underway include an analysis of all the claims across the country submitted after a recipient's or provider's death and a comparative analysis between States to identify system problems and assist States with corrective actions. At the end of FY 2009, the MIG had run approximately 150 algorithms that have identified over 600 providers for audits. In one State, one algorithm alone has led to the recovery of an overpayment in excess of $5 million.

Medicaid and CHIP Business Information and Solutions Council (MACBIS)

The MACBIS was established as an internal CMS governance body to provide leadership and guidance in support of efforts toward 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. Committee and workgroup members meet bi-weekly and monthly. In FY 2009, MIG identified data elements from States' Medicaid Management Information Systems (MMIS) to supplement Medicaid Statistical Information System (MSIS) data for program integrity use. An evaluation of MSIS data to determine if the collection of the additional elements adds value to program integrity will be conducted under the governance of MACBIS to ensure alignment across the Agency's program integrity and program management functions.

Algorithm Development

The MIG has identified over 100 algorithms which have been run in 40 States. Through the use of these algorithms, MIG has detected millions of dollars in potential overpayments. The algorithms have also resulted in seven audits that are currently being conducted in States. We have also been able to refine the algorithms and advise States of vulnerabilities within their systems.

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 fourth Comprehensive Medicaid Integrity Plan, 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.

Outreach to Program Integrity Partners and Stakeholders

In July 2009, the MIG hosted a special Open Door Forum conference call attended by over 1,400 State provider associations and providers covering the Medicaid Integrity Audit Program. The MIG also hosted a similar national conference call in July 2009 for States-only through the Medicaid Fraud and Abuse Technical Advisory Group. In addition, the MIG has conducted presentations in-person and via webinar at multiple provider association meetings across the country including:

- CMS Region II National Medicare Training Program
- CMS Region IV Medicaid Financial Management Staff
- CMS Region V Long Term Care Provider Association, Home Health and Hospice Association meetings
- CMS Region VII Pharmacy Association and Hospital Association meetings
- American Health Care Association regional meetings
- American Hospital Association (AHA) – American Association of Hospital Accountants meeting
- Association of Inspectors General Fall Conference

- Health Care Compliance Association regional meetings

We plan to hold similar information sessions/Open Door Forums in FY 2010. In addition, the MIG has created several documents for outreach purposes, such as brochures on the MIP and the Medicaid Integrity Institute, a MIP Provider Audit Fact Sheet, MIP Provider Audit Frequently Asked Questions (FAQs), and a MIP A to Z document. These materials are available on the CMS website at http://www.cms.hhs.gov/ProviderAudits/.

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

The MIG occasionally provided statistical assistance to the 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 2009, the total length of criminal sentences issued was 430 months with a total recovery in civil cases of $78.3 million.

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 2009 marked another notable year of program accomplishments for the MIP. 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 Medicaid.