THE MEDICAID INTEGRITY PROGRAM: FULL STEAM AHEAD

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While many providers are currently focused on the rollout of the Medicare Recovery Audit Contractor ("RAC") program, providers and their counsel should also be prepared for similar audits and increased enforcement activity as a result of the ongoing overhaul of the Medicaid fraud and abuse detection, enforcement and prevention program, now known as the Medicaid Integrity Program ("MIP").

History of the Medicaid Integrity Program

Historical Lack of Federal Oversight

Even though the federal share of Medicaid funds is generally greater than the state share,[1] the responsibility for Medicaid fraud enforcement has traditionally fallen predominately on the states. A study presented by the Government Accountability Office ("GAO") in June 2005 highlighted the lack of resources committed to oversight of the Medicaid program on a federal level.[2] The GAO reported that in fiscal year 2005, the Centers for Medicare and Medicaid Services' ("CMS") total staff resources allocated to overseeing and supporting the states' fraud and abuse efforts approximated 8.1 full-time equivalent ("FTE"s), including 3.6 FTEs at the national headquarters and only 4.5 FTEs to staff ten regional offices.[3]

The Deficit Reduction Act of 2005

Congress addressed the concerns related to lack of federal oversight and attention to Medicaid fraud and abuse detection and prevention in the Deficit Reduction Act of 2005 (the "DRA"), which was signed into law on February 8, 2006.

The mandate to create a comprehensive Medicaid Integrity Program ("MIP") within a five year timeframe was one component of Chapter Three of the DRA aimed at "eliminating fraud, waste, and abuse in Medicaid," which also included, among other provisions, incentives for the states to adopt false claims acts similar to the Federal False Claims Act[4] and required certain providers and entities receiving Medicaid funds to educate their employees on the Federal False Claims Act and its qui tam provisions.[5]

In order to implement the MIP, Congress appropriated $5 million in fiscal year 2006, $50 million for both fiscal years 2007 and 2008, and $75 million for each fiscal year thereafter.[6] The DRA also mandated CMS to hire contractors to perform review, auditing and education functions, as well as to employ 100 FTE employees[7] to provide support and assistance to the states, by providing, for example, the following services: identification of Medicaid data elements necessary for Medicaid fraud detection and research; development of algorithms to identify suspect Medicaid payments; development of a large scale data repository; creation of a national Medicaid provider enrollment system; and education of state employees.[8]

The MIP also requires increased funding to the Department of Health and Human Services Office of the Inspector General ("OIG") for Medicaid fraud and abuse control,[9] as well as expansion of the Medicare-Medicaid ("Medi-Medi") data match pilot program, a program established to identify potentially fraudulent billing patterns through the use of computer algorithms and to share this information between the federal programs.[10]

Structure of the Medicaid Integrity Program

Leadership

CMS decided to place the MIP under the jurisdiction of the Center for Medicaid & State Operations ("CMSO"), a division of CMS that is directly responsible for the financial management and oversight of the Medicaid program.[11] CMS chose CMSO because of CMSO's history of oversight of the Medicaid program as well as its oversight of the MIP's predecessor, the Medicaid Alliance for Program Safeguards ("MAPS").[12]

The Medicaid Integrity Group ("MIG") was created within CMSO to implement and manage the MIP,[13] specifically the two major business activities of the MIP, which are the audit program and state oversight and assistance.[14] The placement of the MIG under the CMSO gives the MIG "a seat at the table" with regard to Medicaid policy decisions that might impact the MIP's preventative efforts, which are also expected to yield a high return on investment.[15]

The MIG is further divided into three divisions:[16]

(1) The Division of Medicaid Integrity Contracting ("DMIC"), which is responsible for procuring and overseeing the Medicaid Integrity Contractors ("MIC"s);

(2) The Division of Fraud Research and Detection ("DFRD"), which is responsible for providing statistical and data support, identifying emerging fraud trends, and conducting special studies; and

(3) The Division of Field Operations ("DFO"), which is responsible for overseeing the state integrity programs in the form of technical assistance and fraud and abuse training.

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Medicaid Integrity Contractors ("MIC"s)

The DMIC is in the process of awarding three types of MIC contracts: Medicaid Integrity Review Contracts ("Review MIC"s), Medicaid Integrity Audit Contracts ("Audit MIC"s), and Medicaid Integrity Education Contracts ("Education MIC"s).[17]

Entities wishing to serve as MICs must first be awarded an umbrella contract. Once an umbrella contract has been awarded, the entity can bid on specific task orders through a competitive process, but recipients of umbrella awards are not guaranteed to receive a task order.[18] As of July 2009, the following Review MICs have been awarded umbrella contracts: ACS Healthcare Analytics, AdvanceMed Corporation, IMS Government Solutions, SafeGuard Services, and Thomson Reuters.[19] In April 2008, CMS awarded Thomson Reuters the first review task order for CMS Regions III and IV.[20] AdvanceMed has received task orders for four different regions: Regions V, VI, VII, and VIII.[21]

With regard to Audit MICs, the DMIC awarded umbrella contracts to Booz Allen Hamilton, Fox & Associates, IPRO, Health Management Solutions ("HMS") and Health Integrity, LLC. Task orders have been awarded to Booz Allen Hamilton for Regions III and IV and to HMS for Regions VI, VIII, IX, and X.[22] The DMIC expects to award the final two task orders for Audit MICs by the end of fiscal year 2009, i.e., September 30, 2009.[23]

Task orders will run for twelve month periods and can be renewed up to four times for additional twelve month periods at the option of the government. Thus, if all options are exercised a task order could last for up to five years.[24]

Audits began in September 2008[25] and as of July 2009, were taking place in 17 states, specifically those in Regions III, IV, VI, and VIII.[26] The next Regions slated to begin audits are Regions IX and X[27] and audits are expected to be underway in every state by the end of 2009.[28] Approximately 400-500 audits are currently in progress, in varying stages of the process, but less than 100 are complete.[29] Preliminary estimates based on test audits show a return on investment of 300 percent.[30]

Strategic Contractors

The MIG also contracted with "strategic contractors" to assist in the design and development of the two main MIP functions, i.e., (1) conducting audits and (2) supporting the states.

The Audit Program Development ("APD") contractor is responsible for designing and developing audit protocols, methodologies and standards for the MIP.[31] This contract was awarded to Catapult Consultants, a full-service financial and program management firm based in Arlington, Virginia and Strategic Management Systems, a health care management consulting firm based in Alexandria, Virginia.[32] As of June 2008, protocols had been developed by CMSO for individual fee-for-service providers, institutional providers, pharmacies and hospitals and nursing home cost reports.[33]

The MIG also contracted with a State Program Integrity Assessment ("SPIA") contractor in the early stages of the development process.[34] The SPIA assisted in the development of a baseline for state performance by collecting state program integrity data and statistics. This contract, which has been completed, was awarded to the Helix Group, a management consulting firm.[35]

Collaboration

The MIP was developed in consultation with various interested parties and law enforcement authorities, such as the OIG, the FBI, and the Department of Justice, as well as a host of other associations and groups associated with the Medicaid program.[36] The MIG has also stated an intent to collaborate with both the Medi-Medi program and the Payment Error Rate Measurement ("PERM") project.[37] As discussed previously, the Medi-Medi program focuses on the comparison of Medicare and Medicaid claims data to find patterns of fraud, since those who defraud Medicare are likely to defraud Medicaid and vice versa. The PERM project involves the audit of claims from the states on a rotating basis, first at a state level and then at the provider level to review for appropriateness. This information has been traditionally used to determine an error rate for each state[38] and will now also be used for future planning for the MIP.[39] The ability to utilize the data from these programs, as well as information obtained through consultation with the Office of Financial Management's ("OFM") Program Integrity Group,[40] is expected to strengthen the MIP program.[41]

The Audit Process

Selection of Providers

Review MICs will have the responsibility of reviewing and selecting providers for audit by utilizing algorithms developed by the DFRD to analyze electronic Medicaid claim data for aberrancies.[42] As has been the case historically, state agency officials may also identify providers to be audited.[43] The contractors will work with the states and law enforcement officials to ensure that they are not duplicating state audits or interfering with investigations.[44] The MICs are also expected to work with the RAC contractors to avoid over burdening providers with back-to-back audits.[45]

The initial intent of the MIP is to focus on the following provider types and services: nursing and personal care related to long term care facilities and home health agencies, provision of prescription drugs to beneficiaries, durable medical equipment ("DME") and other medical

supplies, as well as improper claims for hospitals and independent provider services to the MIP.[46] Of the providers that are currently under audit, 44 percent are hospitals, 29 percent are long term care providers, 21 percent are pharmacies and 6 percent are physicians and other providers.[47] Managed care entities may also be selected for audits but will initially be limited in scope because limited data is available.[48]

Unlike the Medicare RAC program, the MIP does not have restrictions on how far it can "look back" to identify overpayments. As a general rule, however, the MIP expects to follow state policies with regard to "look back" periods.[49]

Once providers have been selected, they will be referred to the Audit MICs who will be responsible for performing comprehensive and focused audits.[50]

Notification of Providers

Audit MICs will send selected providers a "notification letter" setting forth the records being requested from the provider.[51] Providers will be expected to provide requested records within a designated time frame not specified by regulation.[52] According to a CMS fact sheet, the Audit MIC will generally give providers at least two weeks to respond and may accommodate reasonable requests for extension.[53] During a recent Open Door Forum, CMS spokesmen indicated that longer time frames are being considered, especially where the request does not include key fields that are necessary for pulling medical records.[54] Providers will not be compensated for copying or shipping costs if records are requested by the MIC.[55]

The "notification letter" will also identify a primary point of contact at the Audit MIC where providers can direct specific questions about the audit process or the notification letter itself.[56] The Audit MICs will also contact providers to schedule an "Entrance Conference" during the early stages of the audit process.[57]

The Audit

Audit MICs may perform field or desk audits and are expected to exercise their professional judgment in determining which will be more efficient in any given situation.[58] In addition to having the authority to request records, the Audit MICs also have the authority to interview providers and their office staff, as well as enter the provider's facility.[59] Unlike the Medicare RAC contractors, the MICs do not have limitations on the number of records they can request. However, CMS spokesmen indicated that they are working with the MICs to develop protocols to first look at informal samples to determine whether true aberrancies exist before making voluminous requests.[60]

Audits will be conducted according to Generally Accepted Government Auditing Standards and in accordance with protocols developed by the Audit Program Development contractor with input and review by the OIG.[61] The intent of the protocols is to ensure that the audits are conducted in a uniform manner among the Audit MICs, which are each assigned to different regions, as discussed above.[62]

While the use of paid contractors is similar to the Medicare RAC program, the Audit MICs will not be paid on a contingency basis.[63]

Post-Audit

After completion of the audit, the Audit MIC is expected to prepare a draft audit report.[64] The report will be shared with the state Medicaid agency for review and comment, specifically to ensure that the state's Medicaid policies were appropriately interpreted by the MIC.[65] Next, the report will be shared with the provider who will have thirty days to comment and submit additional supporting information.[66] CMS will take these comments into consideration and will prepare a draft report, which will again be reviewed by the state for comment.[67] After taking the state's comments into consideration, the Audit MIC will submit a final report to the state.[68] There are currently no regulations governing this process and thus, no regulatory time frames within which these steps must occur. The process is laid out in "Standard Operating Procedures" which are internal documents and may be modified as deemed necessary, including based on provider input from open door forums.[69]

Once the final report is issued, provider appeals will be handled through the state appeals process, pursuant to state law, with support from the MIC.[70] Although it is beyond the scope of this article to comment on the various states' appeals processes, it is likely that state appellate processes will contain an opportunity for a hearing pursuant to the state administrative procedures act.

Audit MICs are also expected to make referrals to the OIG if fraudulent behavior is detected. The OIG, where deemed appropriate, may pass this information on to the state's Medicaid Fraud Control Unit.[71]

The Audit MICs are not responsible for collecting overpayments from providers. Rather, the federal government will collect its share directly from the states and the states will be responsible for recovering overpayments.[72] As with the RAC program, payments to providers may be suspended once overpayments are identified.[73]

The Educational Component

State Education

The MIG has been involved with the implementation of various educational initiatives to educate state Medicaid personnel to enhance fraud enforcement efforts. One such initiative was the creation of the Medicaid Integrity Institute ("MII"), which will provide a national training center and credentialing mechanism for state employees. The comprehensive program includes training on conducting fraud investigations, use of algorithms, fraud trend development and analysis, state of

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the art data mining tools, and training in health care billing codes.[74] Another educational initiative for state employees is the provision of Certified Professional Coder ("CPC") training for state program integrity staff personnel.[75]

Provider and Beneficiary Education

Education MIC task orders are expected to be awarded in September 2009.[76] These MICs will be responsible for educating Medicaid providers, beneficiaries, managed care entities and others on Medicaid program integrity and quality of care issues. Education will likely take the form of distribution of educational materials, classroom education and awareness campaigns.[77] The education will focus on risk areas identified through self-assessments, reviews and analyses conducted by the Audit and Review MICs as well as other sources, such as the OIG, the GAO, HHS, and state Medicaid Fraud Control Units.[78]

In order to educate the provider community about the MIP audit process, the MIG is in the process of hosting open door forums, posting FAQs and background papers to the CMS website and providing liaisons to speak with provider associations.[79]

Considerations for Providers and Counsel

Identification of Risk Areas

As with any third party payor audit, an effective compliance plan is the best defense. Because providers are chosen for audit based on the identification of aberrant billing practices, providers should perform a self-assessment or hire an independent auditor to determine whether their claims will be considered outliers. Some examples of aberrancies that have been identified by the MIG are: services after death, duplicate claims, unbundling, and outpatient claims during inpatient stay.[80]

A recent GAO report indicated that 90 percent of all Medicaid payment errors were related to insufficient or lack of documentation.[81] Thus, providers should expect documentation related to Medicaid services to be carefully scrutinized. Other sources of payment errors identified in the GAO report were pricing errors and payment of non-covered services.

Providers and their counsel should also keep a watchful eye on the educational campaigns and materials that are being provided by the Education MICs. Since the subject matter of these campaigns will be based, at least in part, on information gleaned from the Review and Audit MICs, it should give providers and their counsel some insight into the focus areas of the MIP.

Appeals Strategy

As discussed previously, the provider appeals process will vary according to state law.[82] In addition to the state appeals process, certain aspects of the MIP audit process offer valuable opportunities that may not have been previously available, depending on State law. First, the "entrance conference" may be an opportunity for the provider or entity to gain an understanding of why it was targeted by the Audit MIC. This may provide valuable insight into what the Audit MIC is looking for with regards to the records request and can help providers respond with all of the relevant information to aid the Audit MIC in its decision. The opportunity to comment on the audit report and submit additional information before finalization is another valuable opportunity for providers, that may not have been available during state initiated audits and is not available in Medicare RAC audits.

Since there may be early opportunities to impact the outcome of the audit, attorneys who represent affected providers should consider getting involved at the early stages of an audit, rather than waiting until the commencement of the formal state appeals process.

Conclusion

According to an April 2009 GAO report, the Medicaid program reported an estimated error rate of 10.5 percent resulting in a total improper payment estimate of $32.7 billion in FY 2008. Of this estimated $32.7 billion, $18.6 billion represents the federal share and $14.1 billion represents the state share, creating huge incentives for both the state and the federal government to attempt to recover these alleged "improper payments."[83] Because the estimated overpayments are even greater than those associated with the Medicare program, the MIP has the potential to have an even greater impact on the healthcare community than the RACs.[84]

While the MIP is still a work in progress, it has had very effective results already. As discussed previously, HHS has reported the return on investment for the MIP at 300 percent for fiscal year 2008. Although this figure was not calculated on a full year's worth of data, HHS predicts that the return on investment will be at least 100 percent.[85] In light of the large amount of funds being appropriated to the MIP, the return on the investment is significant and means that tens of millions of dollars of funds will be recovered from providers for the federal share as well as tens of millions of dollars for the state share.

Counsel for providers and other healthcare entities that could be targeted by the MICs should encourage clients to implement compliance programs, specifically looking at risk areas identified by the MIP. Counsel should also encourage clients to take advantage of the early opportunities to advocate and challenge the audit findings that are present in the MIP process.

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Endnotes

1 *See* FY 2009 Federal Medical Assistance Percentages, 72 Fed. Reg. 67304 (Nov. 28, 2007).

2 GAO Testimony Before the Committee on Finance, U.S. Senate, Medicaid Fraud and Abuse: CMS's Commitment to Helping States Safeguard Program Dollars is Limited, GAO-05-855T (June 28, 2005).

3 *Id.*

4 Deficit Reduction Act of 2005, Section 6031.

5 Deficit Reduction Act of 2005, Section 6032.

6 Deficit Reduction Act of 2005, Section 6034 (e)(1)

7 Deficit Reduction Act of 2005, Section 6034 (e)(3)

8 Secretary of Health and Human Services, Report to Congress on the Medicaid Integrity Program for Fiscal Year 2007.

9 Deficit Reduction Act of 2005, Section 6034(c)

10 Deficit Reduction Act of 2005, Section 6034(d)

11 Comprehensive Medicaid Integrity Plan, July 2006, p. 9.

12 *Id*. Note that although the MAPS was a federal program, as discussed above, the FTEs allocated to federal oversight at that time were miniscule and the primary role of the MAPS program was to review state Medicaid agencies' program integrity policies and compile them as a reference to the other states. For information on these reports, see http://www.cms.hhs.gov/FraudAbuseforProfs/03_MedicaidReports.asp.

13 Secretary of Health and Human Services, FY 2006 Report to Congress on the Medicaid Integrity Program.

14 *Id.*

15 Comprehensive Medicaid Integrity Plan, July 2006, p. 9.

16 Secretary of Health and Human Services, Report to Congress on the Medicaid Integrity Program for Fiscal Year 2007.

17 Comprehensive Medicaid Integrity Plan of the Medicaid Integrity Program FYs 2008-2012, June 2008.

18 July 14, 2009 telephone conference with Paul Miner, Deputy Director of MIG and Barbara Rufo, Director, Division of Medicaid Integrity Contracting.

19 *Id.*

20 *See* Slides from David Frank, Director of MIG's presentation The Medicaid Integrity Program, HCCA's 13th Annual Compliance Institute (April 28, 2009) *available at:* http://www.complianceinstitute.org/pastCIs/2009/PDFs2page/500s/503/503.pdf.

21 July 14, 2009 telephone conference with Paul Miner, Deputy Director of MIG, and Barbara Rufo, Director, Division of Medicaid Integrity Contracting. As of July 14, 2009, the DMIC was still in the process of awarding the final two task orders for Regions I, II, IX, and X.

22 Medicaid Integrity Program Provider Audit Fact Sheet, June 2009, available at http://www.cms.hhs.gov/FraudAbuseforProfs/Downloads/mipproviderauditfactsheet.pdf.

23 June 15, 2009 telephone conference with Paul Miner, Deputy Director of MIG, and Barbara Rufo, Director, Division of Medicaid Integrity Contracting.

24 July 14, 2009 telephone conference with Paul Miner, Deputy Director of MIG and Barbara Rufo, Director, Division of Medicaid Integrity Contracting.

25 Department of Health and Human Services, CMS, FY 2010 Justification of Estimates for Appropriations Committees available at http://www.cms.hhs.gov/PerformanceBudget/Downloads/CMSFY10CJ.pdf.

26 July 14, 2009 telephone conference with Paul Miner, Deputy Director of MIG and Barbara Rufo, Director, Division of Medicaid Integrity Contracting.

27 June 15, 2009 telephone conference with Paul Miner, Deputy Director of MIG, and Barbara Rufo, Director, Division of Medicaid Integrity Contracting.

28 *Id.* Region I includes CN, ME, MA, NH, RI, VT; Region II includes NJ, NY, PR, VI; Region III includes DC, DE, MD, PA, VA, and WV; Region IV includes AL, FL, GA, KY, MS, NC, SC, and TN; Region V includes IL, IN, MI, MN, OH, WI; Region VI includes AR, LA, NM, OK, TX; Region VII includes IA, KS, MO, NE; Region VIII includes CO, MT, ND, SD, UT, WY; Region IX includes AZ, CA, HI, NV, and Pacific Territories; Region X includes AK, ID, OR, WA.

29 July 14, 2009 telephone conference with Paul Miner, Deputy Director of MIG and Barbara Rufo, Director, Division of Medicaid Integrity Contracting.

30 GAO Report, Improper Payments: Progress Made but Challenges Remain in Estimating and Reducing Improper Payments, April 22, 2009, available at http://www.gao.gov/new.items/d09628t.pdf. Note that pursuant to July 14, 2009 telephone conference with Paul Miner, Deputy Director of MIG, Mr. Miner cautioned that these ROI statistics are based on very limited data and are likely based on less than 40 "test audits".

31 Comprehensive Medicaid Integrity Plan of the Medicaid Integrity Program FYs 2008-2012, June 2008.

32 Clifford Barnes and Elizabeth Murphy, Medicaid Health Plans of America, CMS Updates Medicaid Managed Care Plans and Other Entities on the Status of the New Medicaid Integrity Program, *available at* http://www.mhpa.org/_upload/DRA_Medicaid.pdf.

33 Comprehensive Medicaid Integrity Plan of the Medicaid Integrity Program FYs 2008-2012, June 2008.

34 July 14, 2009 telephone conference with Paul Miner, Deputy Director of MIG and Barbara Rufo, Director, Division of Medicaid Integrity Contracting.

35 Clifford Barnes and Elizabeth Murphy, Medicaid Health Plans of America, CMS Updates Medicaid Managed Care Plans and Other Entities on the Status of the New Medicaid Integrity Program, *available at* http://www.mhpa.org/_upload/DRA_Medicaid.pdf. *See also* Romero, "Deficit Reduction Act Gives Medicaid a Shot in the Arm", Healthcare Financial Management, June 2007, *available at:* http://findarticles.com/p/articles/mi_m3257/is_6_61/ai_n19311753/; Comprehensive Medicaid Integrity Plan of the Medicaid Integrity Program FYs 2006-2010, June 2006.

36 Comprehensive Medicaid Integrity Plan of the Medicaid Integrity Program FYs 2006-2010, June 2006. Additional interested parties include: the GAO, the National Association of State Medicaid Directors, the National Association of Surveillance and Utilization Review Officials, the Medicaid Fraud and Abuse Technical Advisory Group, and the National Association of Medicaid Fraud Control Units.

37 *Id.*

38 State error rates are calculated by dividing projected error payments (calculated through sampling) by projected payments and multiplying by 100. *See* http://www.cms.hhs.gov/PERM/Downloads/CalculatingStateErrorRates.pdf. State error rates are used in a two-stage sampling process to calculate the national error rate. See Medicaid Program and State Children's Health Insurance Program (SCHIP); Payment Error Rate Measure, 72 Fed. Reg. 50490 (August 31, 2007).

39 Comprehensive Medicaid Integrity Plan of the Medicaid Integrity Program FYs 2006-2010, June 2006.

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[40] Along with other responsibilities, the OFM is responsible for the fiscal integrity of all agency programs. It also works with the CMSO to develop Medicaid program integrity policy and monitor Medicaid program integrity activities. *See* http://www.cms.hhs.gov/CMSLeadership/15_Office_OFM.asp

[41] Comprehensive Medicaid Integrity Plan of the Medicaid Integrity Program FYs 2006-2010, June 2006.

[42] Medicaid Integrity Program Provider Audit Fact Sheet, June 2009, available at http://www.cms.hhs.gov/FraudAbuseforProfs/Downloads/mipproviderauditfactsheet.pdf; Report to Congress on the Medicaid Integrity Program for Fiscal Year 2007. As of July 2009, the DFRD had data for half of the states in its database and by the end of 2009 is expected to have data for all states. Jim Gorman, CMS, Special Open Door Forum: Medicaid Integrity Provider Audit Program, July 15, 2009.

[43] Medicaid Integrity Program Provider Audit Fact Sheet, June 2009, available at http://www.cms.hhs.gov/FraudAbuseforProfs/Downloads/mipproviderauditfactsheet.pdf.

[44] *Id.*

[45] Rob Miller, CMS, Special Open Door Forum: Medicaid Integrity Provider Audit Program, July 15, 2009.

[46] Comprehensive Medicaid Integrity Plan of the Medicaid Integrity Program FYs 2006-2010, June 2006.

[47] Rob Miller, CMS, July 15, 2009 Special Open Door Forum, Medicaid Integrity Provider Audit Program.

[48] Medicaid Integrity Program Provider Audit Fact Sheet, June 2009, available at http://www.cms.hhs.gov/FraudAbuseforProfs/Downloads/mipproviderauditfactsheet.pdf; Jim Gorman and Rob Miller, CMS, July 15, 2009 Special Open Door Forum, Medicaid Integrity Provider Audit Program.

[49] Rob Miller, CMS, July 15, 2009 Special Open Door Forum, Medicaid Integrity Provider Audit Program.

[50] Medicaid Integrity Program; Eligible Entity and Contracting Requirements for the Medicaid Integrity Audit Program, 73 Fed. Reg. 55765, 55766 (Sept. 26, 2008).

[51] Medicaid Integrity Program Provider Audit Fact Sheet, June 2009 *available at:* http://www.cms.hhs.gov/FraudAbuseforProfs/Downloads/mipproviderauditfactsheet.pdf.

[52] *Id.*

[53] *Id.*

[54] Rob Miller and Jim Gorman, CMS, July 15, 2009 Special Open Door Forum, Medicaid Integrity Provider Audit Program. For example, Mr. Miller discussed the fact that the data currently available to the MICs might not include medical record numbers or, in the case of pharmacies, prescription numbers. However, Mr. Gorman stated that the data is expected to continue to become more comprehensive in the next few years.

[55] Rob Miller and Jim Gorman, CMS, July 15, 2009 Special Open Door Forum, Medicaid Integrity Provider Audit Program.

[56] Medicaid Integrity Program Provider Audit Fact Sheet, June 2009 *available at:* http://www.cms.hhs.gov/FraudAbuseforProfs/Downloads/mipproviderauditfactsheet.pdf.

[57] *Id.*

[58] *Id. See also* Rob Miller, CMS, July 15, 2009 Special Open Door Forum, Medicaid Integrity Provider Audit Program.

[59] *Id.*

[60] Rob Miller, CMS, July 15, 2009 Special Open Door Forum, Medicaid Integrity Provider Audit Program.

[61] Report to Congress on the Medicaid Integrity Program for FY 2007, p. 9; Medicaid Integrity Program Provider Audit Fact Sheet, June 2009 *available at:* http://www.cms.hhs.gov/FraudAbuseforProfs/Downloads/mipproviderauditfactsheet.pdf.

[62] 73 Fed. Reg. at 55766 (Sept. 26, 2008).

[63] 73 Fed. Reg. at 55768 (Sept. 26, 2008).

[64] *Id.*

[65] *Id.* Rob Miller, CMS, July 15, 2009 Special Open Door Forum, Medicaid Integrity Provider Audit Program.

[66] Rob Miller, CMS, July 15, 2009 Special Open Door Forum, Medicaid Integrity Provider Audit Program.

[67] Medicaid Integrity Program Provider Audit Fact Sheet, June 2009 *available at:* http://www.cms.hhs.gov/FraudAbuseforProfs/Downloads/mipproviderauditfactsheet.pdf.

[68] *Id.*

[69] July 14, 2009 telephone conference with Paul Miner, Deputy Director of the MIG and Barbara Rufo, Director of Medicaid Integrity Contracting.

[70] *Id.*

[71] *See* Slides from David Frank, Director of MIG's presentation The Medicaid Integrity Program, HCCA's 13th Annual Compliance Institute (April 28, 2009) *available at:* http://www.compliance-institute.org/pastCIs/2009/PDFs2page/500s/503/503.pdf; *See also* 73 Fed. Reg. 55767 (Sept. 26, 2008). Note that the states' Medicaid Fraud Control Units are entities in state governments, annually certified by the U.S. Department of Health and Human Services, that administer statewide programs to investigate and prosecute healthcare providers who defraud the Medicaid program. *See* The National Association of Medicaid Fraud Control Units, http://www.namfcu.net/about-us/about-mfcu.

[72] 73 Fed. Reg. 55768 (Sept. 26, 2008).

[73] Comprehensive Medicaid Integrity Plan of the Medicaid Integrity Program FYs 2006-2010, June 2006, p. 15.

[74] Report to Congress on the Medicaid Integrity Program for FY 2007, p. 6.

[75] Report to Congress on the Medicaid Integrity Program for FY 2007, p. 10.

[76] July 14, 2009 telephone conference with Paul Miner, Deputy Director of MIG and Barbara Rufo, Director, Division of Medicaid Integrity Contracting. According to Ms. Rufo, umbrella contracts have been awarded to Information Experts and Strategic Health Solutions.

[77] MIC Education and Training Support Solicitation Number: RFP-CMS-2008-0021, *available at:* Fedbizopps.gov.

[78] *Id.*

[79] July 14, 2009 telephone conference with Paul Miner, Deputy Director of the MIG and Barbara Rufo, Director of Medicaid Integrity Contracting. Future educational and outreach information will be available at: http://www.cms.hhs.gov/MedicaidIntegrityProgram/

[80] *See* Slides from David Frank, Director of MIG's presentation The Medicaid Integrity Program, HCCA's 13th Annual Compliance Institute *available at:* http://www.compliance-institute.org/pastCIs/2009/PDFs2page/500s/503/503.pdf.

[81] GAO Report, Improper Payments: Progress Made but Challenges Remain in Estimating and Reducing Improper Payments, April 22, 2009. Available at: http://www.gao.gov/new.items/d09628t.pdf.

[82] For example, in Michigan, the appeals process for the adjustment or reduction of provider payments includes the right to a preliminary conference, a bureau conference and an administrative law judge hearing.

[83] GAO Report, Improper Payments: Progress Made but Challenges Remain in Estimating and Reducing Improper Payments, April 22, 2009, available at http://www.gao.gov/new.items/d09628t.pdf.

[84] *Id.* HHS reported improper payment amounts of $10.4 billion in Medicare Fee-for-Service and $6.8 billion in Medicare Advantage. Medicaid improper payments were estimated at $18.6 billion for the federal share.

[85] Department of Health and Human Services, CMS, FY 2010 Justification of Estimates for Appropriations Committees available at http://www.cms.hhs.gov/PerformanceBudget/Downloads/CMSFY10CJ.pdf.