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CMS LAUNCHES COMPREHENSIVE EFFORT TO COMBAT MEDICAID FRAUD AND ABUSE *Unprecedented Effort to Halt Diversion of Critical Funds*

In an effort to halt theft, inappropriate use and simple mistakes that drain critical Medicaid program dollars, CMS today launched an unprecedented effort to detect and prevent program fraud and abuse, announced Mark B. McClellan, M.D., Ph.D., administrator of the Centers for Medicare & Medicaid Services (CMS).

“A comprehensive and systematic approach to combating the misuse of taxpayer funds is key to helping lower health care costs for Medicaid beneficiaries,” Dr. McClellan said. “The program we are initiating today builds upon expanded activities to combat fraud in the Medicare program that have proven successful in the past few years, as well as recent congressional action on our request for additional funding to protect the Medicaid program. These strategies will yield significant Medicaid savings to help sustain the program.”

The new Medicaid Integrity Program (MIP) was created by the Deficit Reduction Act of 2005 with funds that will rise from \$5 million in 2007 to \$75 million by fiscal year 2009 and each year thereafter. Congress specifically required the use of contractors to review the actions of those seeking payment from Medicaid, conduct audits, identify overpayments and educate providers and others on program integrity and quality of care. Congress also mandated that the agency devote at least 100 full-time staff to the project which will also be in collaboration with state Medicaid officials.

The new MIP will be based on four key principles:

- National leadership in Medicaid program integrity;
- Accountability for the program’s own activities and those of its contractors and the states;
- Collaboration with internal and external partners and stakeholders; and,
- Flexibility to address the ever-changing nature of Medicaid fraud.

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The MIP will employ several major strategies including:

- Collaboration and coordination with internal and external partners.
- Consultation with interested parties in the development of the comprehensive Medicaid integrity plan.
- Targeting vulnerabilities to the Medicaid program.
- Balancing MIP roles:
 - Between providing training and technical assistance to states while also conducting oversight of their activities; and,
 - Between supporting criminal investigations of suspect providers while concurrently seeking administrative sanctions
- Employing lessons learned in developing guidance and directives aimed at fraud prevention; and,
- Developing effective return on investment strategies.

“Together with our state partners, we are implementing unprecedented steps to assure that Medicaid funds do not support criminal activities within the system,” said Dr. McClellan. “With rising health care costs, Medicaid funds are needed more than ever to care for the 55 million vulnerable Americans who depend upon it for their healthcare.”

The dynamic nature of fraud makes it essential that we coordinate closely both within our two programs and with our strategic partners across the country if we are to succeed,” Dr. McClellan said. “We have made a very strong start today that demonstrates we are absolutely committed to this effort.”

The MIP will also closely coordinate with the Medicare Program Integrity group on projects such as Medi-Medi, a pilot project to share data to detect improper billing and utilization patterns and the Payment Error Rate Measurement Program, which is designed to calculate Medicaid payment error rates.

The Medicaid program, which provides health coverage for 55 million Americans, is jointly funded by states and the federal government and total expenditures are expected to exceed \$300 billion in fiscal year 2006.

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