CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-15 Medicaid Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12925	**Date: October 30, 2024**
	Change Request 13720

Transmittal 12871 issued October 11, 2024, is being rescinded and replaced by Transmittal 12925, dated October 30, 2024, to remove Business Requirements 13720.14 and 13720.15 as well as any IOM reference to section 3.4 Lead Vetting. All other information remains the same.

SUBJECT: Updates of Chapter 1, Chapter 2, Chapter 3, Chapter 4, and Appendices in Publication (Pub.) 100-15, Including Auditing of Program Integrity Activities in Managed Care Plans

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update sections within Chapter 1, Chapter 2, Chapter 3, Chapter 4, and Appendices in Pub. 100-15. The updates in this CR include, but are not limited to, Unified Program Integrity Contractor (UPIC) auditing of program integrity activities in Managed Care Plans, guidance regarding support to states on appeals, guidance regarding proactive project development, and various other minor updates to Pub 100-15.

This update does not affect the provider and/or beneficiary populations. Rather, this update is solely related to contractor technical processes and procedures. All updates ensure our contractors have the most recent guidance. This CR does not require Provider Education.

EFFECTIVE DATE: November 14, 2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: November 14, 2024

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	1/1.1/Basis of Authority – Statutory/Regulatory Citation
R	1/1.2/Background
R	1/1.3/Definitions
R	2/2.0/State Collaboration Purpose
R	2/2.1/2.1.1/Implementation Process and Timeline
R	2/2.1/2.1.2/Initial State Collaboration Meeting
R	2/2.1/2.1.3/Information Exchange Agreement (IEA)
R	2/2.1/2.1.4/Joint Operating Agreement (JOA)
R	2/2.1/2.1.5/Program-Level Training and Information Sharing
R	2/2.2/Ongoing Collaboration with States
R	2/2.2/2.2.1/Program Management Meetings or Monthly Collaboration Meetings
N	2/2.3/Support to States on Appeals
R	3/3.0/Overview
R	3/3.1/Medicaid Data for Use by UPICs
R	3/3.2/Proactive Project Development
R	3/3.3/Lead Screening
R	3/3.5/Investigations/Audits
R	3/3.7/Extrapolation
R	3/3.8/Look Back Period
R	3/3.9/Medical Review for Program Integrity Purposes
R	3/3.11/Working with Law Enforcement: Requests for Assistance and Requests for Information
R	3/3.12/Auditing Program Integrity Activities in Managed Care Plans
R	3/3.12/3.12.1/Scope of Managed Care Plan Project
R	3/3.12/3.12.2/Review of Managed Care Plans' Compliance Efforts
R	3/3.12/3.12.3/Review of Paid Claims
N	3/3.12/3.12.4/Review of Denied Claims and Denied Prior Authorizations
N	3/3.12/3.12.5/Review of Provider Network Adequacy
N	3/3.12/3.12.6/Review of Preventive Services
R	4/4.1/Documentation of Investigations/Audits and Medical Review Findings
R	4/4.3/4.3.1/Calculation of Federal Financial Participation (FFP) Based on State's Date of Expenditure

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	4/4.9/Immediate Advisements
R	4/4.10/Fraud Referrals
R	Appendices/Appendix D

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-15	Transmittal: 12925	Date: October 30, 2024	Change Request: 13720

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This update does not affect the provider and/or beneficiary populations. Rather, this update is solely related to contractor technical processes and procedures. All updates ensure our contractors have the most recent guidance. This CR does not require Provider Education.

II. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to update sections in Chapters 1, 2, 3, 4, and Appendices in Pub. 100-15. Specifically, guidance in Chapter 2 is being added regarding UPIC support to states for appeals. The guidance in Chapter 3 is being revised to add detailed processes related to the auditing of program integrity activities in Managed Care Plans. The updates in the remaining chapters are minor and primarily for purposes of re-wording, structure, and additional clarification.

B. Policy:

This CR does not involve any legislative or regulatory policies.

III. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
13720.1	The Unified Program Integrity Contractor (UPIC) shall investigate allegations of fraud made by beneficiaries,									UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	providers/suppliers, Centers for Medicare and Medicaid Services (CMS), Health & Human Services Office of Inspector General (HHS-OIG), social media and other sources.									
13720.2	The UPIC shall refer cases that aligns with the Medicaid Major Case Coordination process to the HHS-OIG/Office of Investigations (OI) for consideration of civil and criminal prosecution and/or application of administrative sanctions.									UPICs
13720.3	The UPIC shall define dollars at risk as referenced in Section 1.3 Definitions of Publication (Pub.) 100-15.									UPICs
13720.4	The UPIC shall be advised that activities associated with an investigation/audit may include post-payment reviews of claims/claim lines.									UPICs
13720.5	The UPIC's investigative plan shall include total dollars at risk for the scheme or code and sample dollars at risk for the actual claims/claim lines to be reviewed.									UPICs
13720.6	The UPIC shall be advised that the Initial Findings Report (IFR) shall detail the timeframe and summary of the initial findings from the claims/claim lines review, along with any other findings discovered during the investigation.									UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
13720.7	The UPIC shall be advised that the Final Findings Report (FFR) shall provides details on the time period of the review, findings discovered during the investigation, summary of the claims/claim lines review findings, total computable overpayment, and the total federal financial participation overpayment.									UPICs
13720.8	The UPIC shall be advised that reliable evidence includes recommendations for suspension by HHS-OIG/OI, Federal Bureau of Investigations (FBI), Assistant U.S. Attorneys (AUSAs), or CMS, based on their finding that the provider has already received overpayments and continued payments should be made only after a determination that continued payment is appropriate.									UPICs
13720.9	The UPIC shall coordinate data exchanges with their states according to the decision tree referenced in Section 2.1.3 - Information Exchange Agreement (IEA) of Pub. 100.15.									UPICs
13720.9.1	The UPIC shall use the decision tree if/when they begin working with a state.									UPICs
13720.10	The UPIC shall support the states on appeals related to the UPIC's investigations/audits as outlined in the Task Order Statement of Work and Section 4.4 – State Appeal Process of Pub. 100-15 as									UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	part of the collaboration with State Medicaid Agencies (SMAs).									
13720.11	The UPIC shall be responsible for collaborating with SMAs in their respective jurisdiction to develop processes for investigating Medicaid fraud, waste, and abuse issues.									UPICs
13720.12	The UPIC shall following steps 1-5 of the process as outlined in Section 3.2 - Proactive Project Development of Pub. 100-15 to demonstrate the proactive project development workflow.									UPICs
13720.13	The UPIC shall, when necessary, verify a provider's enrollment status, which would include verifying provider's eligibility through the Adverse Action Report generated by the Data Exchange System (DEX) to the Tibco Managed File Transfer (MFT) Server.									UPICs
13720.13.1	The UPIC shall be advised that the Adverse Action Report contains information related to whether the provider has been terminated for cause from Medicare or a state Medicaid program and is ineligible for enrollment in Medicaid per 42 CFR 455.416(c).									UPICs
13720.13.2	The UPIC shall be advised that the Adverse Action Report contains information related to whether the provider has been excluded									UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	and is listed on the HHS-OIG's List of Excluded Individuals and Entities.									
13720.14	This business requirement has been deleted.									UPICs
13720.15	This business requirement has been deleted.									UPICs
13720.16	The UPIC shall, when necessary, perform a Medical Review (MR) probe to validate the data analysis or allegation by selecting a small representative sample of claims/claim lines before deploying significant MR resources to examine claims/claim lines identified as potentially fraudulent.									UPICs
13720.16.1	The UPIC shall be advised that the general recommendation for a provider/supplier-specific probe sample is 20-40 claims/claim lines.									UPICs
13720.17	The UPIC shall have specific review parameters and guidelines established for the identified claims/claim lines.									UPICs
13720.17.1	The UPIC shall be advised that each claim/claim line shall be evaluated using the same review guidelines.									UPICs
13720.17.2	The UPIC shall be advised that the claim/claim line and the medical record shall be linked by patient name, applicable Medicaid identification number, diagnosis, Medicaid claim number, and procedure when providing feedback to the SMA regarding the									UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	review outcome.									
13720.18	The UPIC shall be advised that additional requirements and guidance related to Requests for Information (RFIs) and Requests for Assistance (RFAs) can be found in the Task Order Statement of Work, along with the Medicare Program Integrity Manual (PIM) guidelines at section 4.8 – Requests for Information from Outside Organizations.									UPICs
13720.19	The UPIC shall be advised that a CMS representative will contact the HHS-OIG to explore the feasibility of other data search and/or production options if the estimated level of effort to fulfill any one request is likely to meet or exceed 40 hours.									UPICs
13720.20	The UPIC shall follow the guidance as outlined in sections 3.12, 3.12.1, 3.12.2, 3.12.3, 3.12.4, 3.12.5, and 3.12.6 of Pub. 100-15 when auditing program integrity activities in managed care plans.									UPICs
13720.21	The UPIC shall be advised that the working paper file contains evidence accumulated throughout the investigation/audit to support the work performed, the results of the investigation/audit, including adjustments made, and all findings made by the reviewer.									UPICs
13720.22	The UPIC shall ensure that the calculations for each									UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	claim/claim line are accurate for each fiscal year.									
13720.23	The UPIC shall follow the Medicare PIM guidelines at 4.9.1 - Immediate Advisements to the HHS-OIG/OI and notify the SMA of such advisements when they are assisting the state with a Medicaid investigation/audit.									UPICs
13720.24	The UPIC shall be advised that HHS-OIG may coordinate a preliminary review of the Medicaid UPIC case with the state's Medicaid Fraud Control Unit (MFCU) to determine if they are interested in a case.									UPICs
13720.25	The UPIC shall be advised that CMS/Center for Program Integrity (CPI) will record the primary and secondary actions identified during the Medicaid Major Case Coordination (MCC) meeting to be resolved as case decisions in Unified Case Management (UCM) system.									UPICs
13720.26	The UPIC shall continue with the IFR/FFR if an overpayment has been identified for cases declined by Law Enforcement (LE).									UPICs
13720.26.1	The UPIC shall refer the case to the state for any administrative actions the state finds necessary and close the case within seven (7) calendar days of the Medicaid MCC if no overpayment was identified.									UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
13720.27	The UPIC shall utilize the Medicaid Major Case Coordination Pre/Post Meeting Report – Work Details Executive Summary Tip Sheet as referenced in Appendix D of Pub. 100-15.									UPICs

IV. PROVIDER EDUCATION

None

Impacted Contractors: None

V. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

VI. CONTACTS

Pre-Implementation Contact(s): Jesse Havens, 410-786-6566 or jesse.havens@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VII. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

MEDICAID PROGRAM INTEGRITY MANUAL
CHAPTER 1 – **Authority, Background, and Definitions**

Table of Contents
(Rev. 12925; Issued:10-30-24)

Transmittals for Chapter 1

1.1 - Basis of Authority – Statutory/Regulatory Citation

(Rev. 12925; Issued: 10-30-24; Effective: 11-14-24; Implementation: 11-14-24)

A. Provisions for the Work of the Unified Program Integrity Contractors

Section 1936 of the Social Security Act (the Act), established by the Deficit Reduction Act of 2005, is the statutory authority under which the Unified Program Integrity Contractors (UPICs) operate their Medicaid functions.

Section 1936(a) of the Act provides that the Secretary must enter into contracts with eligible entities to conduct certain activities specified at section 1936(b) of the Act.

Section 1936(b) of the Act provides that eligible entities under contract with the Centers for Medicare & Medicaid Services (CMS) will provide the following activities:

(1) Review the actions of individuals or entities furnishing items or services (whether fee-for-service, risk, or other basis) under a State plan or any waiver to determine whether fraud, waste, or abuse has occurred; is likely to occur; or whether such actions have any potential for resulting in an expenditure of funds which is not intended.

(2) Audit of claims for payment for items or services furnished, or administrative services rendered, under a State plan, including (A) cost reports; (B) consulting contracts; and (C) risk contracts under section 1903(m).

(3) Identification of overpayments to individuals or entities receiving federal funds under this title.

(4) Education or training, as the Secretary may establish, of certain individuals and entities with respect to payment integrity and quality of care.

Additionally, Section 6402 of the Patient Protection and Affordable Care Act (Affordable Care Act) provides guidance related to the Medicaid integrity program; health care fraud oversight and guidance; suspension of Medicaid payments pending investigation of credible allegations of fraud; and the increased funding associated with targeting and preventing Medicaid fraud, waste, and abuse.

Lastly, Section 6506 of the Affordable Care Act provides guidance related to Medicaid overpayment recoupment and federal repayment.

B. Provisions for State Collaboration with the Unified Program Integrity Contractors

Section 1902(a)(69) of the Act entitled, “State Requirement to Cooperate with Integrity Program Efforts” requires that the Medicaid State plan “provide that the State must comply with any requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program established under section 1936.”

C. Provisions for the Medicare-Medicaid Data Match Program (Medi-Medi Program)

Section 1893(g) of the Act established the Medicare-Medicaid Data Match Program, which stipulated that:

(1) Expansion of program.—

(A) In general.—The Secretary shall enter into contracts with eligible entities or otherwise for the purpose of ensuring that, beginning with 2006, the Medicare-Medicaid Data Match Program (commonly referred to as the “Medi-Medi Program”) is conducted with respect to the program established under this title and State Medicaid programs under title XIX for the purpose of—

(i) identifying program vulnerabilities in the program established under this title and the Medicaid program established under title XIX through the use of computer algorithms to review claims data to look for payment anomalies (including billing or billing patterns identified with respect to provider, service, time, or patient that appear to be suspect or otherwise implausible);

(ii) working with States, the Attorney General, and the Inspector General of the Department of Health and Human Services to coordinate appropriate actions to investigate and recover amounts with respect to suspect claims to protect the Federal and State share of expenditures under the Medicaid program under title XIX, as well as the program established under this title;

(iii) increasing the effectiveness and efficiency of both such programs through cost avoidance, savings, and recoupments of fraudulent, wasteful, or abusive expenditures; and

(iv) furthering the Secretary's design, development, installation, or enhancement of an automated data system architecture—

(I) to collect, integrate, and assess data for purposes of program integrity, program oversight, and administration, including the Medi-Medi Program; and

(II) that improves the coordination of requests for data from States.

(B) Reporting requirements.—The Secretary shall make available in a timely manner any data and statistical information collected by the Medi-Medi Program to the Attorney General, the Director of the Federal Bureau of Investigation, the Inspector General of the Department of Health and Human Services, and the States (including a Medicaid fraud and abuse control unit described in section 1903(q)). Such information shall be disseminated no less frequently than quarterly.

(2) Limited waiver authority. The Secretary shall waive only such requirements of this section and of titles XI and XIX as are necessary to carry out paragraph (1).

(3) Incentives for states. The Secretary shall study and, as appropriate, may specify incentives for States to work with the Secretary for the purposes described in paragraph (1)(A)(ii). The application of the previous sentence may include use of the waiver authority described in paragraph (2).

1.2 - BACKGROUND

(Rev. 12925; Issued: 10-30-24; Effective: 11-14-24; Implementation: 11-14-24)

The UPICs are contracted entities with CMS that conduct investigations/audits (which may be referred to as "reviews" by certain state Medicaid agencies) of providers' billing in an effort to reduce fraud, waste, and abuse in both the Medicare and Medicaid programs. The UPICs operate in geographic areas or "jurisdictions" defined by individual Task Orders.

The UPICs perform numerous functions to detect, prevent, and deter specific risks and broader vulnerabilities to the integrity of the Medicare and Medicaid programs including, but not limited to:

- Proactively identify potential fraud, waste, and abuse that exist within its service area and take appropriate action on each case.

- Investigate allegations of fraud made by beneficiaries, providers/suppliers, CMS, Health & Human Services Office of Inspector General (*HHS*-OIG), social media and other sources.

- Jointly operate with other entities through agreements in the analysis of data, medical review and/or other specialty areas.

- Explore all available sources of leads, including, but not limited to, state Medicaid agencies (SMAs), law enforcement, CMS' Center for Program Integrity or its Regional Offices, social media, and the contractor's own data mining.

- Refer and/or recommend appropriate Medicaid administrative actions to the SMAs based on investigative/audit findings including, but not limited to: overpayments, payment suspensions, terminations, referrals to licensing boards, etc.

- Refer cases that aligns with the Medicaid Major Case Coordination process to the *HHS*-OIG/Office of Investigations (OI) for consideration of civil and criminal prosecution and/or application of administrative sanctions.

- Partner with state Medicaid Program Integrity Units to perform the above activities for Medicaid investigations/audits.

- Work closely with CMS on joint projects, investigations/audits, and other proactive, anti-fraud activities.

The UPICs utilize a variety of techniques to address any potentially fraudulent, wasteful, or abusive billing practices based on the various leads they receive. The UPICs integrate the program integrity functions for investigations/audits across Medicare and Medicaid and assure that CMS's national priorities for both Medicare and Medicaid are executed and supported at the state level or within the UPIC jurisdiction.

1.3 - Definitions

(Rev. 12925; Issued: 10-30-24; Effective: 11-14-24; Implementation: 11-14-24)

The following definitions provide additional context for the UPICs to reference while collaborating with SMAs. However, CMS recognizes that each SMA may use other terms and definitions than those noted below. The UPIC shall consult with each SMA to determine the appropriate terms and definitions to utilize during the collaboration. In addition, the UPICs may refer to Exhibit 1 of the Medicare PIM for further definitions.

Abuse - Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

Case - A case is a work product that the UPIC opens as an investigation/audit after screening and vetting of a potential lead.

Closing Summary – The Closing Summary is completed when an investigation/audit reveals that there are low/no findings (LNF) to pursue or the investigation/audit is being closed for other reasons, e.g., discontinued by the SMA and no overpayment was identified that would normally trigger an Initial Findings Report (IFR). The UPICs shall use the "Closing Summary" template found at Appendix B to summarize the investigation/audit.

Dollars at Risk – For Medicaid leads and investigations, dollars at risk will be identified at two levels:

1. **Total dollars at risk** include only the dollars for the service code/scheme that are outliers on any specific data algorithm, and which will be the focus of the investigation/audit. This amount is

required when submitting a potential lead to CMS for review/approval and for pre-vetting with CMS and vetting with the SMA.

2. **Sample dollars at risk** are those dollars associated with the sample to be selected for review. When extrapolation is not being used, and the focus of the investigation/audit is identifying an overpayment (unlike an opioid project, which may focus more on quality of care or prescribing behavior), the sample dollars at risk must meet the $50,000 threshold for a Medicaid investigation/audit. This amount is required in the Investigative Plan of Action for review/approval by CMS and the SMA.

Fraud – Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Investigation/Audit – An investigation/audit is the formal review of suspicious aberrancies in a provider's submitted Medicaid claims to establish evidence that potential fraudulent activities or other improper payments have occurred. The UPIC shall focus its investigation/audit in an effort to establish the facts and the magnitude of the alleged fraud, waste, or abuse and take any appropriate action to protect Medicaid dollars.

Generally, the activities associated with an investigation/audit may include, but are not limited to:

- Interviews of recipients or providers,
- Documentation requests to providers in the form of questionnaires, attestations, request for medical records, Managed Care Plan (MCP) contracts and contract deliverables, etc.
- Post-payment reviews of claims*/claim lines*,
- Auditing for third party liability as well as usual and customary charges,
- Identifying overpayment determinations,
- Making referrals to the SMA for potential administrative actions, such as payment suspension or termination actions, and
- Making referrals to law enforcement agencies for possible fraudulent activity.

Investigative Plan of Action (IPA) – The Investigation Plan of Action (or Audit Test Plan) outlines the plan of action for conducting the investigation/audit of a provider. The plan shall include the steps and timeframes necessary to meet investigative objectives. Please refer to the TO SOW at 4.4.1.

The Investigative Plan should include, at a minimum, the following elements:

- Provider Name
- Provider NPI
- Provider Medicaid Number, if different from NPI
- Provider Address
- Provider Type
- Service codes and/or scheme being investigated
- Dollars-at-risk for the scheme or service codes in question (not total dollars paid for all services during the time period):
    - Total dollars at risk for the scheme or code and
    - Sample dollars at risk for the actual claims/claim lines to be reviewed
- Time period being reviewed
- Proposed action steps and estimated time to complete each step. (NOTE: Action steps need to include frequency of communication with the SMA.)
- Size of sample (i.e., number of claims/claim lines) to be reviewed and whether extrapolation will be used

Lead ("Initiation of an Issue") - A lead is some indication that points toward a suspected instance of fraud, waste, or abuse. A lead can come in the form of either proactive or reactive efforts, typically through complaints, data analysis, SMAs, newspaper articles, anonymous tips, or some other channel.

Medicaid - The Medicaid program was established under title XIX of the Social Security Act. The program is a joint federal-state funded health insurance program that is the primary source of medical assistance for millions of low-income, disabled, and elderly Americans. The federal government establishes minimum requirements for the program, and states design, implement, administer, and oversee their own Medicaid programs. In general, states pay for the health benefits provided, and the federal government, in turn, matches qualified state expenditures based on the Federal Medical Assistance Percentage (FMAP), which can be no lower than 50 percent.

All states participate in the Medicaid program, and as a requirement for receipt of federal matching, payments must cover individuals who meet certain minimum financial eligibility standards. Additionally, the states must cover certain medical services, such as physician, hospital, and nursing home care, and are provided the flexibility to offer a large number of optional benefits to beneficiaries. States also have the option to expand their Medicaid programs to cover additional beneficiaries who have income above the minimum financial threshold, up to statutory limits on income levels. State governments have a great deal of programmatic flexibility within which to tailor their Medicaid programs to their unique political, budgetary, and economic environments.

Medicaid Initial Findings Report – The Medicaid Initial Findings Report (IFR), is a summary of findings resulting from a UPIC investigation/audit of a Medicaid provider. The IFR will detail the timeframe and summary of the initial findings from the claims*/claim lines* review, along with any other findings discovered during the investigation.

Medicaid Final Findings Report – The Medicaid Final Findings Report (FFR) is a final summary of the findings resulting from a UPIC investigation/audit of a Medicaid provider when an overpayment has been identified and is being referred to the SMA for recovery. In addition, the FFR may include areas where provider education is recommended. The FFR is developed after CMS, the SMA, and the provider have fully reviewed the IFR, and the provider has had an opportunity to provide any rebuttal records to the initial findings, when applicable to the type of investigation/audit being conducted. Although the FFR is created by the UPIC, CMS is responsible for sending the FFR to the SMA. The FFR provides details on the time period of the review, findings discovered during the investigation, summary of the claims*/claim lines* review findings, total computable overpayment, and the total federal financial participation overpayment. As part of the FFR, there is a transmittal letter attached to the report which contains details associated with the federal requirement for the state to remit the federal share of the overpayment to CMS within one year from the date of the letter.

Medicaid Major Case Coordination – The Medicaid Major Case Coordination (Medicaid MCC) is a collaborative meeting held with SMA staff, law enforcement (LE), the respective UPIC, and CMS whenever the UPIC has identified a potential case warranting a fraud referral to LE. It provides the opportunity for all entities to jointly discuss details of the investigation, determine whether LE will accept the referral, discuss any necessary administrative actions to be taken, and determine next steps following the MCC.

Medical Review - A medical review is a formal review of medical records by qualified UPIC personnel to determine if the documentation in the medical record supports what was billed by the provider and paid for by the Medicaid and/or Medicare programs. The process is used as part of an investigation/audit to determine potential fraud, waste, or abuse.

Overpayment – Overpayment means the amount paid by a Medicaid agency to a provider which is in excess of the amount that is allowable for services furnished under section 1902 of the Act and which is required to be refunded under section 1903 of the Act.

Referral - A referral is the formal presentation of an issue to the SMA or law enforcement, or the receipt of a potential fraud lead from an SMA or another source.

Reliable Information - Reliable information includes credible allegations, oral or written, and/or other material facts that would likely cause a non-interested third party to think that there is a reasonable basis for believing that a certain set of facts exists, for example, that claims are or were false or were submitted for non-covered or miscoded services.

Reliable information of fraud exists if the following elements are found:

- **The allegation is made by a credible person or source.** The source is knowledgeable and, in a position, to know. The source experienced or learned of the alleged act firsthand, i.e., saw it, heard it, read it. The source is more credible if the source has nothing to gain by not being truthful. The source is competent, e.g., a beneficiary may not always be a credible source in stating that services received were not medically necessary. An employee of a provider who holds a key management position and who continues to work for the provider is often a highly credible source. The friend of a beneficiary who heard that the provider is defrauding Medicare may not be a particularly credible source.

- **The information is material.** The information supports the allegation that fraud has been committed by making it more plausible, reasonable, and probable (e.g., instructions handwritten by the provider delineating how to falsify claim forms).

- **The act alleged is not likely the result of an accident or honest mistake**. For example, the provider was already educated on the proper way to complete the form, or the provider should know that billing for a service not performed is inappropriate, or claims are submitted the same way over a period of time by different employees.

Reliable evidence includes, but is not limited to, the following:

- Documented allegations from credible sources that items or services were not furnished or received as billed.
- Billing patterns so aberrant from the norm that they bring into question the correctness of the payments made or about to be made.
- Data analysis that shows the provider's utilization to be well above that of its peers without any apparent legitimate rationale for this.
- Statements by beneficiaries and/or their families attesting to the provider's fraudulent behavior.
- Corroboration from provider employees (official and unofficial whistle blowers).
- Other sources, such as prepayment and postpayment review of medical records.
- Recommendations for suspension by *HHS*-OIG/OI, FBI, Assistant U.S. Attorneys (AUSAs), or CMS, based on their finding that the provider has already received overpayments and continued payments should be made only after a determination that continued payment is appropriate.

Screening - Screening is the initial step in the review of a lead to determine whether further investigation/audit is warranted based on the potential for fraud, waste, or abuse. Screening shall be completed within 45 calendar days after receipt of the lead.

Activities that the UPIC may perform in relation to the screening process include, but are not limited to:

- Verification of provider’s enrollment status
- Data analysis
- Contact with the complainant, when the lead source is a complaint
- Beneficiary interviews
- Site verification to validate the provider’s/supplier’s practice location
- Review of state policy and regulations

State Medicaid Agency (SMA) — This is the single state agency administering or supervising the administration of a state Medicaid plan. Each SMA establishes and administers their own Medicaid programs; they determine the type, amount, duration, and scope of benefits within broad federal guidelines.

Vetting - Vetting is the process of determining whether a provider, who has been selected for an investigation/audit, is clear to pursue. All leads and any new subjects that the UPIC determines warrants further investigation/audit are vetted through CMS and the SMA for approval before transitioning to an investigation/audit. Determinations are based on any ongoing law enforcement activity and/or current SMA activity with the provider.

MEDICAID PROGRAM INTEGRITY MANUAL
CHAPTER 2 – Collaboration with States

Table of Contents
(Rev. 12925; Issued:10-30-24)

Transmittals for Chapter 2

2.0 - State Collaboration Purpose

(Rev. 12925; Issued: 10-30-24; Effective: 11-14-24; Implementation: 11-14-24)

The purpose of collaboration between the state Medicaid agency (SMA) and the UPIC is to identify state priorities, specialty areas of analytical and investigative interest, clarification of state policy, and to ensure there is no duplication of efforts.

All leads and any new providers that the UPIC determines warrant further investigation shall be vetted concurrently through the SMA and CMS for approval before transitioning to an investigation. The UPIC shall provide the state a list of potential investigations generated by the data analysis, complaints, referrals, etc. If the state is conducting an audit or investigation of the same provider for similar Medicaid issues, CMS may cancel or postpone the UPIC investigation of the provider. Through this information exchange, CMS avoids duplicating the efforts of other Medicaid audits and investigations.

Collaboration between the SMA and the UPIC may differ from state to state. While some states may prefer the term "investigation," other states may prefer the term "audit" or "review." State preference in regards to the review of Medicaid claims shall be discussed at the onset of the collaboration, and continue throughout the investigative and/or audit process.

The scope and execution of program integrity activities varies by state. CMS recognizes that states have different structures and that the program lead from each state may be located in different areas of the state organizational structure. If the program integrity function exists outside of a single state agency, CMS will encourage both the single state agency and the program integrity staff to collaborate on program activities. State entities that may be involved in the program integrity oversight includes the SMAs, Medicaid fiscal agents, Medicaid Fraud Control Units (MFCUs), State Attorneys General offices, and other agencies with program integrity missions, such as Medicaid Inspector General and State Comptroller offices.

States are critical partners in stewardship of the public trust and are strongly committed to ensuring the accuracy of Medicaid payments and detection/prevention of fraud, waste, and abuse. States are required to establish and maintain program integrity activities, which meet federal requirements, and which coordinate with federal program integrity efforts.

2.1.1 - Implementation Process and Timeline

(Rev. 12925; Issued: 10-30-24; Effective: 11-14-24; Implementation: 11-14-24)

The first step in establishing an effective program is developing a partnership between CMS, the UPIC, and the relevant SMA. Step 2 is to document the state preferred, and CMS agreed upon, process for conducting investigations in that state via a Joint Operating Agreement (JOA). JOAs will be initiated between each state partner and shall only be viable for the state as set forth in the JOA. However, with the consensus of all participating states, the UPIC may initiate jurisdictional program integrity projects to detect fraud schemes across at least two neighboring SMAs.

Several activities must occur during implementation. Some activities may occur simultaneously, while other activities must occur consecutively. The list below summarizes the steps the UPIC will take when initiating collaboration with a state.

a) Convene the Initial State Collaboration Meeting

b) Maintain Information Exchange Agreement, if required

c) Develop the Joint Operating Agreement

d) Provide initial cross-training

e) Begin document sharing

f) Establish exchange of other sources of Medicaid data, as needed

2.1.2 - Initial State Collaboration Meeting

(Rev. 12925; Issued: 10-30-24; Effective: 11-14-24; Implementation: 11-14-24)

The UPIC shall convene separate Initial State Collaboration Meetings for each state program and, as applicable, jurisdictional programs. These initial meetings differ from kickoff meetings, as kickoff meetings are between CMS and the UPIC for the purposes of discussing the new contract. The Initial State Collaboration meetings include SMAs.

a. Timing

The Initial State Collaboration Meeting shall be held no later than 30 calendar days after the beginning of the implementation phase of the contract or after the SMA agrees to collaboration.

b. Meeting Location

The Initial State Collaboration Meeting shall be held in-person at the SMA, if possible. If space is not available at the state agency, the meeting shall be held at a location agreed upon between the UPIC and the SMA program lead. In addition, if face-to-face contact is prohibited for public health reasons, other telephonic communication, such as Zoom, may be utilized.

c. Attendees

The UPIC Program Director, or designee, shall invite appropriate individuals to attend the Initial State Collaboration Meeting. At a minimum, the attendees of the initial meeting will include the following:

- State Medicaid program integrity unit lead(s),
- UPIC Medicaid Operations Lead,
- CMS CORs and BFLs, and
- CMS One PI, CPI/DASG and Office of Technical Solutions representatives. (It is expected that the discussion at the initial meeting will include technical issues such as connectivity; therefore, individuals with the appropriate technical knowledge should be included in the meeting.)

d. Meeting Agenda and Other Materials

The UPIC shall prepare all materials for the Initial State Collaboration Meeting and provide copies to all attendees, including the JOA.

Prior to the meeting, the UPIC should prepare and distribute a meeting agenda to all participants. The meeting agenda should, at a minimum, include the items identified in Table 2.A. for discussion. At the conclusion of the meeting, specific decisions regarding implementation and operation of the program should be made.

Table 2.A: Decision/Discussion Points for the Initial State Collaboration Meeting

Agenda Item	Decisions/Discussion Points
Joint Operating Agreement	• Discuss the purpose of the JOA. • Discuss procedure for state-level review of the JOA. • Plan a separate meeting, via conference call or in person, between the SMA, and the UPIC to discuss each section of the JOA that is not addressed in the Initial State Collaboration Meeting.
Data sources	• Provide an overview of the sources of Medicare and Medicaid data. • Clarify the state-level of access to matched data that is allowed. • Discuss the source and structure of Medicaid data. • Discuss documentation sharing related to data sources.
Data connectivity and transmission	• Provide the options for the state to provide Medicaid data to CMS via the UPIC. • Make a preliminary decision on the best method for providing Medicaid data. • Notify the SMA on how it will request and access matched data. The states are prohibited from provider data for Medicare only providers.
Training and information sharing	• Discuss the importance of training early in the program and provide options for initial, formal cross-training. • Make a preliminary decision regarding the format and timing of the cross-training.

e. Meeting Minutes

The UPIC shall submit a draft of the meeting minutes to the CMS COR, BFL, and the SMA program lead for review and approval. The UPIC shall submit the final meeting minutes to CMS after incorporating comments from meeting participants. Meeting minutes should conclude "action items" to identify deliverables that were agreed upon for the next meeting. Upon CMS approval, the UPIC shall distribute final meeting minutes to all meeting participants.

2.1.3 - Information Exchange Agreement (IEA)

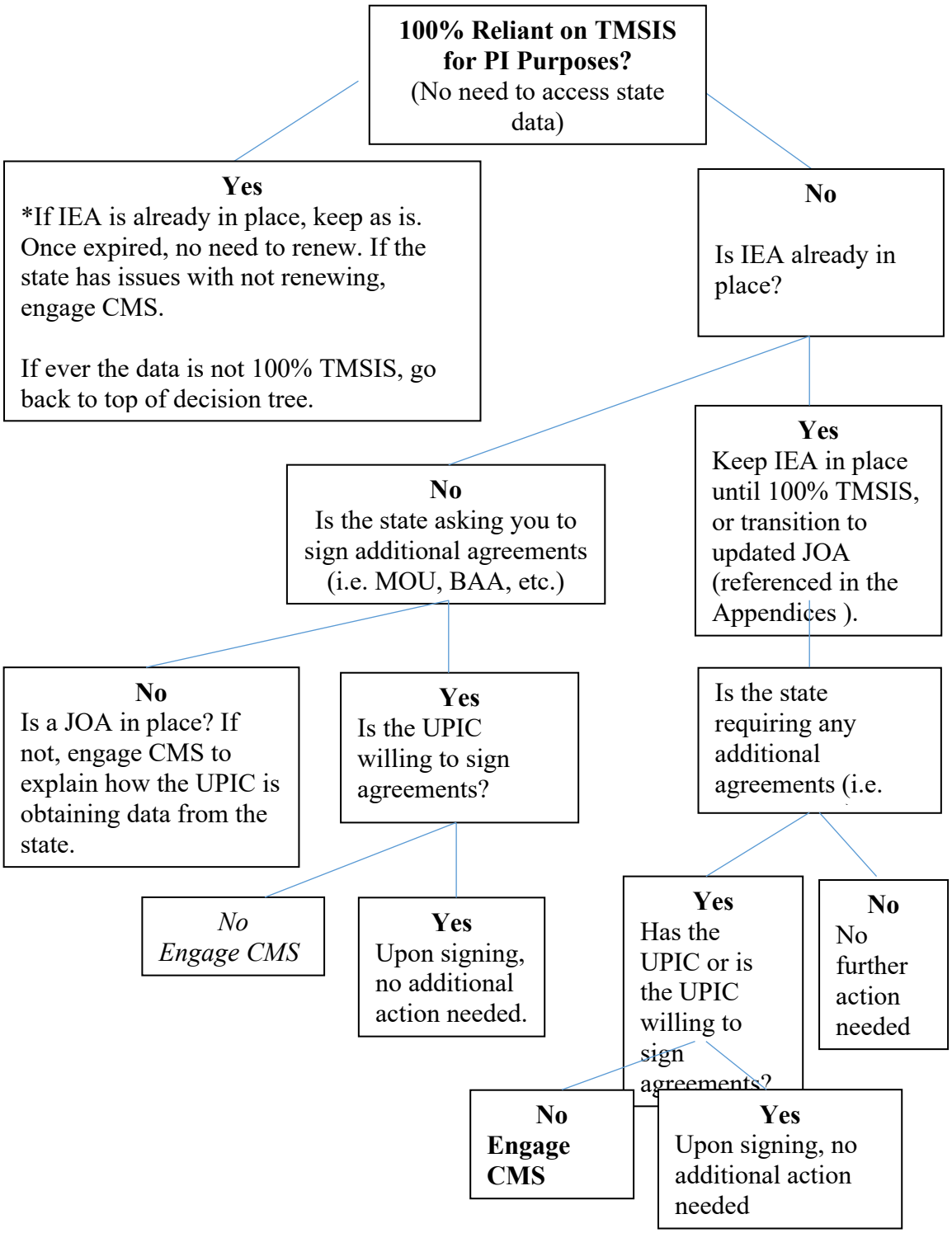
(Rev. 12925; Issued: 10-30-24; Effective: 11-14-24; Implementation: 11-14-24)

When a state chooses to partner with the UPIC, a JOA between the state and UPIC is required. However, in various states (as referenced in the decision tree below), an Information Exchange Agreement may remain in place until expiration or renewal as needed. If the SMA request that the IEA be renewed, the current version of the IEA can be found in the Appendices.

A. IEA Decision Tree

The UPICs shall coordinate data exchanges with their states according to the *decision tree* below.

If you are working with the state, use this decision tree. If not, use the *decision tree* if/when you begin working with the state.



2.1.4 - Joint Operating Agreement (JOA)

(Rev. 12925; Issued: 10-30-24; Effective: 11-14-24; Implementation: 11-14-24)

a. Purpose of the JOA

In general, much of the UPICs' activities are governed by CMS' Task Order Statement of Work (TO SOW), the Medicaid PIM, and the Medicare PIM. However, the SMA is not governed by the PIM. The JOA is an agreement between the SMA and the UPIC that establishes guidelines, duties, and shared expectations of how each will conduct business with the other. The JOA will include any agreement between the SMA and the UPIC on program implementation and operation that is not specified in this manual or the TO SOW. CMS also has a role in mediating any disputes that may arise between the SMA and the UPIC during the creation of the JOA, and it will provide technical guidance regarding the JOA.

The template for the JOA can be found at Appendix J..

b. JOA Template and Instructions for Customizing the JOA

The UPIC shall customize the JOA template with input from the SMA. The template is a guide and includes suggested language, which may be changed pending the agreement of the UPIC and the SMA. SMAs are encouraged to participate in other implementation activities while awaiting the review and execution of the JOA. However, it is at the discretion of the SMA whether to participate in other implementation activities while awaiting the JOA. It is a best practice for the SMA to sign the JOA as soon as possible as the JOA clarifies the working relationship between the SMA and the UPIC.

The following provides a summary for each section of the JOA:

Section 1. Introduction

This section describes the purpose of the coordination and the JOA. It also describes how the JOA should be maintained and updated.

Section 2. Implementation

This section describes the overall implementation process and each party's responsibilities.

Section 3. Dispute Resolution

This section describes how disagreements between the UPIC and the SMA will be resolved. It is recommended that disagreements be brought to the attention of the COR/BFL team for assistance.

Section 4. Communications Plan

This section outlines the requirements for establishing points of contact at the UPIC and SMA, regular meetings, and work groups. The UPIC and the SMA should establish points of contact to clarify communications between organizations. The JOA template suggests the creation of "leads" in the areas of the overall project, IT, data analysis, and investigations. The UPIC and SMA, as applicable, should revise and add to these roles as appropriate.

Section 5. Training and Information Sharing

In this section, the UPIC and the SMA acknowledge that each party will provide training to the other party and share information with each other as needed. The way in which training shall be provided should also be described in this section.

Section 6. Connectivity and Data Sharing, if applicable

This section outlines how the UPIC and the SMA will work together to share the necessary data. Due to the nature of this content, section 6.5 Security shall not be edited and/or revised by either the SMA or the UPIC.

Section 7. Data Analysis

This section describes the development of a Data Analysis Project Management Strategy and the process for prioritizing projects and sharing results.

Section 8. Investigations and Referrals

This section describes the investigation and referral processes for joint investigations. The JOA clarifies the rules outside of the PIM to which the UPIC and the SMA must adhere. It provides a forum through which the partners can agree on how to work together on joint investigations.

c. Process for Executing the Initial JOA

The UPIC and the SMA shall discuss the timeline and contents of the JOA during the Initial State Collaboration Meeting. Based on the results of this meeting, the UPIC shall customize the JOA template (Appendix J) collaboratively with the SMA and submit to CMS for approval. CMS will provide technical assistance on the customization as needed. If, after reasonable efforts by the UPIC, there are issues that the SMA and the UPIC cannot agree upon, either of the parties may notify CMS. CMS will coordinate resolutions of the disputes so that the implementation process is not delayed.

The UPIC and the SMA should agree to the content of the JOA, as it details how the partners will work together. The JOA is not a contract. Therefore, the SMA is not required to provide signatures for the JOA. In place of signing the JOA, the SMA can inform the UPIC through an e-mail or formal letter that the JOA accurately reflects how the parties will work together to implement and operate the coordinated efforts.

The UPIC shall distribute a copy of the final JOA to the SMA. The SMA lead should disseminate the final JOA within the agency.

d. Annual Review of the JOA

The UPIC and the SMA should review and revise the JOA at least annually. The revised JOA should be approved by the UPIC and the SMA and be submitted to CMS by the UPIC.

e. Other Revisions to the JOA

The UPIC and the SMA may revise the JOA on an as-needed basis, as long as the changes are agreed upon by both parties in accordance with a process that both parties establish during implementation.

2.1.5 - Program-Level Training and Information Sharing

(Rev. 12925; Issued: 10-30-24; Effective: 11-14-24; Implementation: 11-14-24)

The success of the collaborative efforts in Medicaid program integrity depends on effective communication, information sharing, and training among partners. This section focuses on the training and information sharing opportunities and requirements within state and regional program integrity efforts.

Below are the responsibilities of the UPIC in regards to training and information sharing:

- Provide data and policy background information about Medicare to the SMA.
- Provide project-specific information about Medicare data and policies to the SMA.
- Provide subject-matter experts to the SMA as needed.
- Share customized documents that guide the implementation and operation of each state's program.
- Share educational materials and maintain key documents that explain the agency's program and operational environment.

2.2 - Ongoing Collaboration with States

(Rev. 12925; Issued: 10-30-24; Effective: 11-14-24; Implementation: 11-14-24)

Once the UPIC has established a working relationship with the SMA, the UPIC will need to continue ongoing communication and collaboration. This ongoing collaboration will be conducted via the Program Management Meeting or Monthly Collaboration Meeting.

2.2.1 - Program Management Meetings or Monthly Collaboration Meetings

(Rev. 12925; Issued: 10-30-24; Effective: 11-14-24; Implementation: 11-14-24)

UPICs shall facilitate additional program management meetings with CMS and the SMAs. The purpose of these meetings is to discuss the program's progress, identify issues and resolutions, and discuss the planned activities for the following month.

In the implementation phase, these meetings have various names including case coordination meetings or executive meetings. During the Initial State Collaboration Meeting, the partners will discuss the timing and purpose of the project management meetings, which shall be facilitated by the UPIC.

a. Timing

The UPIC shall convene the project management meetings on an agreed upon recurring basis, based on the availability of the COR/BFL and SMA program lead. CMS recommends these meetings be held on a monthly basis.

The CMS, the UPIC, and the SMA must have regularly scheduled standing meetings to discuss ongoing issues and to make sure that all members of the team are fully informed on all issues.

b. Agenda

The UPIC shall provide a draft agenda to the attendees prior to each meeting. The agenda should contain, at a minimum, the following areas for discussion:

- Status of current workload,
- Development of new Proactive Data Projects,
- Data analytic findings,
- Administrative actions,
- State Issues/recommendations, and
- CPI Feedback/Input.

The CMS COR/BFL and the SMA program lead may provide comments on the agenda. The UPIC shall incorporate requested changes to the agenda and provide a final agenda prior to the meeting.

c. Meeting Location

The meetings will be held virtually via conference call or video conference. The UPIC is encouraged to use web-based technology that allows participants to share and view common applications, such as PowerPoint, live during the meeting.

d. Attendees

The UPIC shall invite the following individuals to the project management meetings or monthly collaboration meetings:

- SMA Program Integrity Director or Inspector General, or designee
- UPIC Medicaid Operations Lead or designee
- UPIC Data Analyst or Manager
- CMS COR/BFL.

The attendees may bring additional individuals to the meeting. The attendees should inform the UPIC in advance who will be joining the meeting.

e. Meeting Minutes

The UPIC shall be responsible for drafting the meeting minutes and be willing to make appropriate changes as requested by either CMS or the SMA.

2.3 – Support to States on Appeals

(Rev. 12925; Issued: 10-30-24; Effective: 11-14-24; Implementation: 11-14-24)

As part of the collaboration with SMAs, the UPICs will support the states on appeals related to the UPIC's investigations/audits as outlined in the TO SOW and with this manual at 4.4 – State Appeal Process.

MEDICAID PROGRAM INTEGRITY MANUAL
CHAPTER 3 – **Medicaid Investigations & Audits**

Table of Contents
(Rev. 12925; Issued: 10-30-24)

Transmittals for Chapter 3

3.0 - Overview

(Rev. 12925; Issued: 10-30-24; Effective: 11-14-24; Implementation: 11-14-24)

The UPICs shall be responsible for collaborating with *State Medicaid Agencies (*SMAs*)* in their respective jurisdiction to develop processes for investigating Medicaid fraud, waste, and abuse issues. The UPIC may be requested to provide the complete spectrum of investigative and audit services for a state or selected activity that augments programmatic reviews conducted by states regarding Medicaid including, but not limited to, identifying leads, conducting investigations, and referring cases to law enforcement.

The SMAs have established processes for investigating potentially fraudulent activities. The UPIC shall work with SMA to develop a state preferred, and CMS approved, process to perform Medicaid investigations and/or audits. Therefore, it is essential that the state and the UPIC work cooperatively to understand both parties' requirements. The UPIC shall establish ongoing meetings with SMAs (as referenced in Chapter 2 of this manual) to discuss vulnerabilities, update the status of existing investigations and referrals, and resolve any issues that may arise during ongoing investigations.

3.1 - Medicaid Data for Use by UPICs

(Rev. 12925; Issued: 10-30-24; Effective: 11-14-24; Implementation: 11-14-24)

Transformed Medicaid Statistical Informational System (T-MSIS) data is the system of record for Medicaid. CMS has now made T-MSIS data from all states and territories available in OnePI Business Intelligence tools. The UPICs may now access all OnePI Business Intelligence tools, such as BusinessObjects and SAS, for all T-MSIS data. The UPICs shall use T-MSIS data to the fullest extent for every state.

The purpose and uses of T-MSIS data are published in the T-MSIS System of Records Notices (SORN) (https://www.federalregister.gov/documents/2019/02/06/2019-01157/privacy-act-of-1974-system-of-records), of which became effective March 18, 2019. CMS has authorized UPICs to use T-MSIS data to the fullest extent for every state for UPIC related activities.

The UPIC is not to replicate or confirm findings from T-MSIS with data from state source data warehouses, unless observed or noted data quality issues cast doubt on the results. If data quality issues necessitate additional data, the UPIC may supplement data as needed with prior approval from the BFL and COR. Supplemental data includes data obtained from state source data warehouses or data obtained directly from Managed Care Plans. In addition, for any newly identified data issues in T-MSIS, the UPIC shall submit a ticket to CMS as directed in earlier guidance.

3.2 - Proactive Project Development

(Rev. 12925; Issued: 10-30-24; Effective: 11-14-24; Implementation: 11-14-24)

Through ongoing collaboration with each state, the UPIC shall discuss areas of interest and convey CMS' priorities related to Medicaid fraud, waste, and abuse for purposes of potential investigations. As outlined in the UPIC statement of work, the UPIC shall be flexible and shall have the capability to adapt to the changing landscape of fraud, waste, and abuse in their jurisdiction. The UPIC shall keep CMS and the state informed as to the highest investigative priorities in such a way as to assure that CMS and the state always has a full understanding of the UPIC's highest priorities and supports State PI efforts.

Once an investigative area of interest is identified, the UPIC shall access the applicable Medicaid claims data for analysis through the CMS/CPI Integrated Data Repository (IDR).

Concurrently, the UPIC shall conduct state policy research and communicate with the appropriate state policy experts. Once the policies have been researched and clarified, the UPIC will conduct an analysis of the applicable data. The UPICs shall develop proactive, innovative and robust analytic tools for investigations that commence with an exposure (i.e. Medicaid dollars-at-risk associated with the specific scheme/allegation) greater than $50,000 total computable. If a state is interested in pursuing an audit where

exposure does not reach the $50,000 threshold, UPICs shall ensure that the exposure is greater than the total cost of the audit. In these instances, the UPICs should consult with their Medicaid BFLs/CORs prior to lead screening to discuss the value of proceeding and document the reason for proceeding in the UCM case record. The threshold would not apply to cases where fraud is suspected.

Upon review of the data, clarification of policy interpretation, and agreement by the state on the focus of the investigation, the UPIC will identify those "targets" or "potential leads" that meet the criteria of the project and submit those potential leads to the Medicaid BFL for review/approval. When submitting a potential lead to CMS, the UPIC will submit the total dollars at risk for the allegation to be investigated. The dollars at risk do not include the total amount billed by the provider for all services. The dollars at risk will only include the dollars for the service code(s) that are outliers on any specific data algorithm or analysis, and which will be the focus of the investigation/audit. Once approved, those leads will then be screened in accordance with Section 3.3 of this manual. *In lieu of a workflow diagram, please see the step-by-step process below to demonstrate this workflow.*

Step 1: UPIC conducts proactive data study as a PDP/Data Project Record (DPR) in UCM.
Step 2: UPIC identifies potential targets it would like to pursue that are outliers on the data study and which meet or exceed the $50,000 threshold. It is understood that there may be numerous outliers in a large state, and the UPIC may choose to pursue only a portion of them at any one time. The DPR may remain open as it continues to generate leads, with the data being refreshed as needed, or at least every 30 days per the Medicare PIM. 4.12.1. [The $50,000 threshold may not be applicable to certain projects such as opioid prescribing.]
Step 3: UPIC submits the potential provider targets to Medicaid BFL (copy COR) with the total dollars at risk for the scheme.
Step 4: BFL approves or declines potential targets.
Step 5: For those targets which were approved, the UPIC will open a CSE in UCM within seven (7) calendar days of approval by the BFL and begin the screening process.

3.3 - Lead Screening

(Rev. 12925; Issued: 10-30-24; Effective: 11-14-24; Implementation: 11-14-24)

Screening is the initial step in the review of a lead to determine whether further investigation/audit is warranted based on the potential for fraud, waste, or abuse. In addition to the guidance listed below, please refer to the Medicare PIM at Section 4.5 – Screening Leads if further guidance is needed.

The UPIC may identify leads through any number of sources:

a. Data Analysis: Discussions should take place between all stakeholders about data project analyses to facilitate the detection and prevention of fraud, waste, and abuse. In addition, the progress of data projects and/or investigations shall be communicated to partners on an ongoing basis through informal communications between the UPIC and the stakeholders. Prioritization is critical to ensure that resources are devoted to projects that are high priority to all the stakeholders including CMS, state Medicaid officials, and local law enforcement.

b. State Identified Leads: The SMA may provide leads to the UPIC that result from data analytics, tips, or any other source.

c. Medicare-related Leads: The UPIC may identify a lead resulting from work conducted in Medicare fraud, waste, and abuse.

d. Law Enforcement: The UPIC may receive Medicaid-related leads from law enforcement entities and/or through the HHS-OIG hotline.

e. CMS Identified Leads: These may include special projects (Moratorium, etc.), complaints from beneficiaries or their families via CMS regional offices, or inquiries from the CMS Administrator

through SWIFT.

f. General Leads: The UPIC may receive or identify Medicaid-related leads from any source not identified above. These could include tips, newspaper, or internet articles.

g. Suspected Beneficiary Harm: CMS has a zero tolerance for beneficiary harm issues. When there is any indication that beneficiary harm may exists when investigating a lead, complaint, project, etc., the UPIC shall immediately contact the SMA and BFL with its preliminary findings. These allegations will be handled on a case-by-case basis dependent upon the severity of the potential patient harm.

Screening shall be completed within 45 calendar days after receipt of the lead.

If the lead resulted from data analysis conducted by the UPIC, the receipt of the lead shall be the date the lead was referred from the UPIC data analysis department to its investigation or screening unit. For a new lead that is identified from an active or current UPIC investigation, the receipt of the lead shall be the date the new lead was identified by the UPIC investigator.

Activities that the UPIC may perform in relation to the screening process include, but are not limited to:

- Verification of provider's enrollment status*, which would include verifying provider's eligibility through the Adverse Action Report generated by the Data Exchange System (DEX) to the TIBCO MFT Server. This report contains information related to:*
  - *Whether the provider has been terminated for cause from Medicare or a state Medicaid program and is ineligible for enrollment in Medicaid per 42 CFR 455.416(c).*
  - *Whether the provider has been excluded and is listed on the HHS-OIG's List of Excluded Individuals and Entities.*
- Data analysis.
- Contact with the complainant when the lead source is a complaint.
- Beneficiary interviews.
- Site verification to validate the provider's/supplier's practice location, and
- Review of state policy and regulations.

Any screening activities shall not involve contact with the subject provider/supplier during this stage. If the lead involves potential patient harm, the UPIC shall immediately notify CMS within two (2) business days.

After completing its screening, the UPIC shall close the lead if it does not appear to be related to fraud, waste, or abuse. If the screening determines that further investigation is warranted, the UPIC will move forward with submitting the lead to vetting with CMS and the SMA. (See Section 3.*4*)

At a minimum, the UPIC shall document the following information in its case file regarding the lead screening:

- The date the lead was received and closed.
- Lead source (e.g., PDP/DPR, SMA, beneficiary, LE, etc.).
- Record the name and telephone number of the individual (or organization), if applicable, that provided the information concerning the alleged fraud or abuse.
- Indicate the provider's/supplier's name, address, and ID number.
- Start and end date of the screening.
- Description of the actions/activities performed.
- Start and end date of each action/activity.
- A brief description of the action taken to close the lead (e.g., reviewed records and substantiated amounts billed). Ensure that sufficient information is provided to understand the reason for the closeout.

- The number of leads received to date regarding this provider/supplier, including the present lead. This information is useful in identifying providers/suppliers that are involved in an undue number of complaints.
- Any documentation associated with the UPIC's activities (i.e., referrals to other entities).

Additionally, if the screening process exceeds 45 calendar days, the UPIC shall document the reasons, circumstances, dates, and actions associated with the delay in UCM and to its COR and BFL within its monthly reporting in CMS ARTS.

3.5 - Investigations/Audits

(Rev. 12925; Issued: 10-30-24; Effective: 11-14-24; Implementation: 11-14-24)

An investigation/audit is the formal review of suspicious aberrancies in a provider's submitted Medicaid claims to establish evidence that potentially fraudulent activities or other improper payments have occurred. The UPIC shall focus its investigation/audit in an effort to establish the facts and the magnitude of the alleged fraud, waste, or abuse and take any appropriate action to protect Medicaid dollars.

The investigative/audit process may differ by each SMA; therefore, the UPIC shall coordinate and confirm the use of its investigative approach with the SMA at the onset of the collaboration. This may include determining how joint investigations will be conducted. It is important that the two parties discuss the process early.

The UPIC shall document the final investigative plan of action and share with the CMS Medicaid BFL for review and approval prior to sharing with the SMA for final approval.

The UPIC, SMA, and CMS shall determine the level of effort required by the UPIC in support of an investigation. CMS shall make the final approval or disapproval of any investigative strategy.

Activities that the UPIC may perform in relation to the investigative process include, but are not limited to:

- Contact with the provider via telephone or on-site visit;
- Beneficiary/Recipient interviews;
- Interviews of employees or associates of the provider;
- Medical record requests and reviews; and
- Recommendation of administrative actions.

If additional guidance is needed, the UPIC shall consult with the Medicaid BFL on potential investigative strategies. If the SMA determines it would like the UPIC to utilize an audit and/or a financial accounting approach, the UPIC shall follow the guidance established by the SMA (i.e., Generally Accepted Government Auditing Standards) during an investigation.

Throughout the course of any investigation, CMS may request the UPIC to cease all activity associated with an open investigation and allow CMS to review the current status of the investigation. During this time, the UPIC shall take no action, including, but not limited to, investigative and administrative actions, unless otherwise directed by CMS. Upon receiving CMS's request to review the investigation, the UPIC shall document in UCM the reason for ceasing investigative activities at that time. After CMS has conducted its review, CMS will provide the UPIC with a determination. If the UPIC is instructed by CMS to close the investigation without further action, the UPIC shall do so within two (2) business days. If the UPIC is instructed to continue its investigation, it shall proceed with the appropriate investigative and administrative actions. The UPIC shall discuss any questions regarding the decision with its COR and BFL.

In order to process investigations/audits in a timely manner, UPICs are expected to reach a decision on the ongoing status of a case within 180 days from the Medicaid Investigation Start Date. This would mean:

a) Determining whether there are low/no findings to pursue and submitting a request to close the investigation/audit to CMS; or
b) Determining there is sufficient evidence that warrants a law enforcement referral and initiating the referral process by completing the Major Case Coordination (MCC) Pre/Post Meeting Report - Work Details (hereon referred to as the Executive Summary) and submitting to CMS; or,
c) Identifying potential Medicaid overpayments and submitting an Initial Findings Report (IFR) to the SMA.

The UPIC shall not wait 180 days to request a discontinuance and closure of an investigation/audit due to low/no findings, begin making an LE referral, or begin developing the IFR. Action shall be taken once the investigation/audit has revealed what decision is needed. Please refer to Chapter 4 "Reporting Investigational Findings and Making Referrals" for more details on Close-Out Letters, LE referrals, and developing the IFR.

In addition, for any of these scenarios, vulnerabilities may be identified in the SMA's policies or processes that may warrant submitting the Vulnerability Template. Please refer to Chapter 4.11 of the Medicaid PIM on "Reporting State Vulnerabilities."

It is understood that investigations/audits may also be closed after an IFR has been issued to the SMA and/or the provider, and the findings have been changed due to the SMA's or the provider's feedback. Similarly, referrals to law enforcement may result in cases being returned to the UPIC with nothing to pursue. In these circumstances, closures following an IFR to the SMA/Provider or LE Referral would not be subject to the 180-day time frame.

3.7 - Extrapolation

(Rev. 12925; Issued: 10-30-24; Effective: 11-14-24; Implementation: 11-14-24)

While UPICs have the ability to extrapolate, they must first determine if each state allows for the use of extrapolation. Even if state law allows for extrapolation, based on the focus of the investigation, extrapolation may not be appropriate. For investigations where extrapolation can be used, the UPIC shall seek agreement from the SMA on the use of extrapolation and the parameters for applying extrapolation. The UPIC shall defer to the state's policies on extrapolation, when applied. Each UPIC and state will continuously coordinate to determine the most efficient way to sample the claims universe and apply it to the investigation.

In addition, the UPIC may need to consult with its BFL on the appropriate use of extrapolation. The use of extrapolation may be dependent on the provider's previous history with the SMA or other Medicaid contractors. When applicable, this information should be provided to the BFL in order to make a determination.

3.8 - Look Back Period

(Rev. 12925; Issued: 10-30-24; Effective: 11-14-24; Implementation: 11-14-24)

The UPIC shall defer to the state's look-back period for purposes of conducting an audit or investigation. If the SMA's look-back period exceeds five years, the UPIC shall consult with the COR and BFL on the appropriate review timeframe.

3.9 - Medical Review for Program Integrity Purposes

(Rev. 12925; Issued: 10-30-24; Effective: 11-14-24; Implementation: 11-14-24)

Medical Review (MR) for program integrity purposes is one of the parallel strategies of the UPIC to encourage the early detection of fraud, waste, and abuse. The primary task of the UPIC is to identify suspected fraud, develop cases thoroughly and in a timely manner, and take immediate action to ensure that improper payments of Medicaid monies are identified. For this reason, the UPIC and the state must collaborate early in the development of the investigative process to ensure the UPIC is following the

necessary state policies/guidelines, the policy/guidelines are interpreted accurately, and that grounds for potential appeals are taken into consideration. If the SMA prefers that the UPIC utilizes an audit protocol (i.e., Generally Accepted Government Auditing Standards), the UPIC shall follow those established protocols. Additionally, the UPIC and SMA staff shall coordinate and communicate throughout the course of the investigation/audit to prevent inappropriate duplication of review activities.

Typically, the focus of program integrity MR includes, but is not limited to:

- Possible falsification or other evidence of alteration of medical record documentation including, but not limited to: obliterated sections, missing pages, inserted pages, white out, and excessive late entries (i.e., information documented numerous days after the actual service was performed);
- Evidence that the service billed for was actually provided and/or provided as billed; and
- Patterns and trends that may indicate potential fraud, waste, and abuse.

It is essential that the MR is integrated early in the investigative plan of action to facilitate the timeliness of the investigative process. Before deploying significant MR resources to examine claims/*claim lines* identified as potentially fraudulent, the UPIC may perform a MR probe to validate the data analysis or allegation by selecting a small representative sample of claims/*claim lines*. The general recommendation for a provider/supplier-specific probe sample is 20-40 claims/*claim lines*. This sample size should be sufficient to determine the need for additional post-payment MR actions. MR resources shall be used efficiently and not cause a delay in the investigative process. In addition, development of an investigation shall continue while the contractor is awaiting the results of the MR.

The UPIC shall follow Medicare PIM Chapter 3.3.1.1 - Medical Record Review, all other applicable chapters of the PIM, and any applicable state specific medical review requirements, where applicable, unless otherwise instructed in this chapter and/or in its Task Order Statement of Work (TO SOW). If there is a discrepancy between the methodologies outlined between the state and Medicaid PIM, the UPIC shall consult with its COR and BFL for guidance.

1. The UPIC shall maintain current references to support MR determinations. The review staff shall be familiar with the below references and be able to track requirements in the internal review guidelines back to the statute or manual. References include, but are not limited to:

    - State statutes, administrative code, and/or specific state Medicaid policies and guidance;
    - Code of Federal Regulations;
    - CMS guidance; and
    - Internal review guidelines (sometimes defined as desktop procedures).

2. The UPIC shall have specific review parameters and guidelines established for the identified claims/*claim lines*. Each claim/*claim line* shall be evaluated using the same review guidelines. The claim/*claim line* and the medical record shall be linked by patient name, applicable Medicaid ID, diagnosis, Medicaid claim number, and procedure when providing feedback to the SMA regarding the review outcome.

3. The UPIC shall evaluate if the provider specialty is reasonable for the procedure(s) being reviewed. For example, chiropractors should not bill for cardiac care, podiatrists for dermatological procedures, and ophthalmologists for foot care.

4. The UPIC shall evaluate and determine if there is evidence in the medical record that the service submitted was actually provided, and if so, if the service was medically reasonable and necessary. The UPIC shall also verify diagnosis and match to age, gender, and procedure.

5. The UPIC shall determine if patterns and/or trends exist in the medical record that may indicate potential fraud, waste, abuse or demonstrate potential patient harm.

6. The UPIC shall evaluate the medical record for evidence of alterations including, but not limited to, obliterated sections, missing pages, inserted pages, white out, and excessive late entries. The UPIC shall not consider undated or unsigned entries handwritten in the margin of a document. These entries shall be excluded from consideration when performing medical review.

7. The UPIC shall adjust payment for the service, in part or in whole, depending upon the service under review, when medical records/documentation do not support services billed by the provider/supplier.

8. The UPIC shall thoroughly document the rationale utilized to make the MR decision.

9. The UPIC shall coordinate with the SMA to validate the review, in order to ensure the necessary state policies/guidelines were referenced and interpreted accurately.

10. The UPIC shall follow the guidance provided in Chapter 4 of this manual on documenting medical review findings.

3.11 - Working with Law Enforcement: Requests for Assistance and Requests for Information

(Rev. 12925; Issued: 10-30-24; Effective: 11-14-24; Implementation: 11-14-24)

On occasion, law enforcement agencies may request assistance from the UPIC in conducting an investigation or may request information to assist in carrying out an investigation. These are referred to, respectively, as Request for Assistance (RFA) and Request for Information (RFI).

An RFA is commonly submitted to the UPIC to request clinical expertise that the law enforcement agency may be lacking. This may be in the form of a medical review of clinical records. In these circumstances, the UPIC does not engage the provider directly. Instead, the law enforcement agency obtains the medical records (often through a subpoena) and provides the records to the UPIC for the clinical review. The UPIC will not share findings from the medical review with the provider as in other investigations/ audits for the SMA. Instead, the findings are shared directly with the law enforcement agency to help support their investigation. In these circumstances, no contact is to be made with the provider unless the law enforcement agency permits it. The SMA may be notified, if law enforcement is in agreement, so that the SMA may take any administrative actions that may be needed.

For an RFI, a law enforcement agency may request specific information, usually in the form of data, regarding a specific provider.

Additional *requirements and* guidance related to *RFIs and RFAs* can be found in the *Task Order Statement of Work, along* with the Medicare PIM guidelines at 4.8 – Requests for Information from Outside Organizations.

The CMS has established a level of effort limit of 40 hours for any individual request for support RFIs and RFAs. If the estimated level of effort to fulfill any one request is likely to meet or exceed this figure, the UPIC shall contact its COR for approval to proceed. A CMS representative will contact the *HHS*-OIG to explore the feasibility of other data search and/or production options. The UPIC shall obtain approval from the COR regarding requests started by the UPIC that it subsequently anticipates will exceed that 40-hour level of effort. The UPIC shall not exceed the 40-hour level of effort until it receives COR approval.

Additionally, if an outside organization (including a law enforcement agency) is requesting only Medicaid claims data, the UPIC shall refer the requestor to the SMA to have the request fulfilled. However, if an outside organization is requesting Medicaid claims data, in addition to Medicare and/or Medicare/Medicaid crossover claims data, the UPIC can fulfill the request. However, the UPIC shall notify and gain approval by the SMA prior to releasing the Medicaid claims data.

3.12 - Auditing Program Integrity Activities in Managed Care Plans

(Rev. 12925; Issued: 10-30-24; Effective: 11-14-24; Implementation: 11-14-24)

The Center for Program Integrity (CPI) has developed an audit strategy to address Medicaid managed care utilizing the resources of the Unified Program Integrity Contractors (UPICs). This strategy and the resulting investigative/audit work will help drive CPI's efforts related to Medicaid managed care program integrity oversight.

These audits will focus solely on the program integrity efforts of the state's managed care plans (MCPs) and will not include other administrative operations such as calculating medical loss ratios.

For FFY 2024, the strategy is being revised and expanded to capture quality issues that may impact beneficiaries' access to care that include reviewing the adequacy of the MCP's provider network to meet beneficiaries' needs, and the timeliness of receiving medically necessary preventive services.

The strategy will provide greater insight into program integrity oversight and fraud, waste, and abuse risks in Medicaid managed care by identifying:

- Weaknesses in a state's processes for monitoring and/or overseeing the MCPs' PI activities.
- Dollars at risk in the managed care program due to lack of proper oversight.
- Potential overpayments in capitation *payments to MCPs.*
- Potential overpayments to network providers due to *lack of* oversight.
- *Inappropriate denials of claims for services rendered.*
- *Inappropriate denial of services, prescriptions, or equipment being sought under prior authorization.*
- *Inadequate provider networks to meet beneficiaries' needs.*
- *Shortcomings in the provision of preventive services for children, adults, and pregnant/post-partum females.*

*Previously t*he audits/investigations *were conducted in* four components in two stages. *The audits/investigations will now be conducted as one project and captured in a single IFR and FFR for each MCP.* For some components of the review, the report may only identify non-monetary findings, which reflect deficiencies in program integrity activities. For other components, there may be an identified overpayment or dollars at risk due to the program deficiency. Additional direction regarding this process shall be provided by CMS.

The time frame for this project is being modified to allow additional time to reach the IFR. The UPICs will have 210 days to submit the IFR to the SMA. The time frame for traditional work will remain at 180 days. All other time frames for investigation/audit work will apply. As usual, any delays outside of the control of the UPIC shall be documented in the CSE record in UCM.

Due to the expansion and scope of the project, which includes numerous data analytics, the UPICs will collaborate with CMS/CPI's Program Integrity Modeling and Analytics Support Contractors (PIMASCs) for much of the work. The UPICs will be responsible for reviewing state contracts and policies for the needed information and communicating the data needs to the PIMASCs. In addition, the UPIC's role will be essential in working with the PIMASCs to create valid models and review the data once it is received to ensure that the UPIC has the necessary data to continue its audit of the plan.

3.12.1 – *Scope of Managed Care Plan Project*

(Rev. 12925; Issued: 10-30-24; Effective: 11-14-24; Implementation: 11-14-24)

For states *having* 10 or fewer MCPs, all MCPs will be reviewed, unless otherwise directed by CMS. In states *having* more than 10 MCPs, a sample of 10 MCPs will be selected, unless otherwise directed by CMS. A lead (CSE) will be opened in UCM on each MCP selected.

The project will have five different sections addressing both program integrity oversight by the MCPs, along with quality of access to care for beneficiaries. The five sections include:

a) *Review of Managed Care Plans' Compliance Efforts*
b) *Review of Paid Claims to Network Providers*
c) *Review of Denied Claims and Denied Prior Authorizations*
d) *Review of Provider Network Adequacy*
e) *Review of Preventive Services*

3.12.2 – Review of *Managed Care Plans' Compliance Efforts*

(Rev. 12925; Issued: 10-30-24; Effective: 11-14-24; Implementation: 11-14-24)

This section will include a review of the activities that the MCPs engage in to protect the Medicaid program. This may include, but is not limited to data analytics, cost avoidance measures, investigative procedures, and analysis of payments made to the plans and/or providers.

3.12.3 – Review of *Paid Claims*

(Rev. 12925; Issued: 10-30-24; Effective: 11-14-24; Implementation: 11-14-24)

In this section of the MCP audit, the UPIC will audit a broad sample of claims paid by the MCP to its network providers for the past two (2) federal fiscal years. The sample will focus on areas identified as high priorities for CMS and which are frequently reviewed by program integrity groups. This stage will aid in determining if program integrity efforts are sufficient or should be increased. Additional direction regarding this process shall be provided by CMS.

For this section, the MCP remains the primary subject in UCM, and the selected providers for review will be secondary subjects. If, while reviewing the provider's records, the UPIC finds evidence of questionable billing that is outside the scope of the current audit, the UPIC shall open a separate lead on the provider as part of the UPIC's traditional work.

3.12.4 - Review of Denied Claims and Denied Prior Authorizations

(Rev. 12925; Issued: 10-30-24; Effective: 11-14-24; Implementation: 11-14-24)

In this section, the UPIC will separately analyze the denied claims and denied prior authorizations of services and prescriptions for the past two (2) federal fiscal years to determine if any patterns exist that may be indicative of underutilization of services and/or avoiding payment for high-dollar services, prescriptions, or items.

For this section, the MCP will remain the primary subject. The providers, whose records will be requested from the MCP to support/refute the denial, will be secondary subjects and vetted accordingly. If, while reviewing the provider's records, the UPIC finds evidence of questionable billing that is outside the scope of the current audit, the UPIC shall open a separate lead on the provider as part of the UPIC's traditional work.

3.12.5 – Review of Provider Network Adequacy

(Rev. 12925; Issued: 10-30-24; Effective: 11-14-24; Implementation: 11-14-24)

The UPIC will review the state's contracts with their MCPs in accordance with the federal regulations and evaluate the adequacy of the MCPs' provider networks, and accuracy of provider network disclosures, to ensure beneficiaries have access to needed health care.

For this component, the UPIC, working collaboratively with the PIMASCs, will evaluate the MCP's compliance with state and federal requirements for provider network adequacy. The UPIC shall become familiar with the federal regulations for Medicaid Managed Care network adequacy standards at 42 CFR § 438.68.

3.12.6 – Review of Preventive Services
(Rev. 12925; Issued: 10-30-24; Effective: 11-14-24; Implementation: 11-14-24)

This component will evaluate the frequency and scope of delivery of routine preventive services at medically recommended intervals. The data will be reviewed separately for three categories of preventive services:

a) *Children/youth under the age of 21.*
b) *Adults, general health care.*
c) *Pregnant and post-partum women, and newborns, including prenatal, postpartum, and neonatal care.*

The UPIC will review the state's contract for coverage of required preventive services for these three categories. If the information is not specifically outlined in the state's contract or elsewhere within state policy, the UPIC will follow the basic guidelines as provided by CMS for assessing preventive services. Where state contract may conflict with the CMS-provided guidelines, the UPIC will follow the state contract.

The PIMASCs will collect demographic data, e.g. age, race/ethnicity, sex, and zip code, for all three categories of preventive services, as well as the demographics data for total enrolled beneficiaries of the MCP. The PIMASCs will provide the raw data results and analyses to the UPIC for inclusion in the findings reports.

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Chapter 4 - Reporting Investigational Findings and Making Referrals

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4.1 - Documentation of Investigations/Audits and Medical Review Findings

(Rev. 12925; Issued: 10-30-24; Effective: 11-14-24; Implementation: 11-14-24)

All investigations/audits and medical review findings must be supported by adequate documentation. Adequate documentation consists of documents obtained by the investigator during the course of the investigation or medical review and should be part of the investigation/audit working file. The working paper file contains evidence accumulated throughout the investigation/audit to support the work performed, the results of the investigation/audit, including adjustments made, and all *findings* made by the reviewer. All documents and working papers shall be uploaded to UCM.

Examples of documents are:

1. Copies of federal and/or state policies and regulations.
2. Copies of medical/financial records to support the finding.
3. Copies of state generated remittance advices which support the claim payment or credit adjustment.
4. Correspondence, such as Provider Notification Letters and Record Request Letters/Lists.
5. Investigator's notes regarding the investigation.
6. Miscellaneous memoranda that pertain to the investigation.

4.3.1 - Calculation of Federal Financial Participation (FFP) Based on State's Date of Expenditure

(Rev. 12925; Issued: 10-30-24; Effective: 11-14-24; Implementation: 11-14-24)

The UPIC shall calculate the FFP amount for each discrepant claim line identified based on the Federal Medical Assistance Percentage (FMAP) in place at the time of the state Medicaid agency's date of expenditure (i.e., the date the state Medicaid agency paid the applicable claim). The total overpayment amount shall be entered into Appendix A of the FFR. The UPIC shall comply with the following directions when preparing FFRs for all assigned Medicaid investigations.

- The UPIC shall add columns to Appendix A identifying the "Federal Share Percentage" and "Federal Share Amount" for each Fiscal Year (FY) and FY Quarter identified per discrepant claim.
- The UPIC shall add a column to Appendix A identifying the date of expenditure, in addition to the date of service.
- The UPIC shall use the appropriate "Federal Share Percentage" for FY and Quarter.
- The UPIC shall add a column to Appendix A identifying the "Federal Share Total."
- The UPIC shall sum total the "Federal Share Total" column at the bottom of the Appendix A.

(Example)

Federal Share % (FY15)	Federal Share % (FY16)	Federal Share Amount (FY15)	Federal Share Amount (FY16)	Federal Share Total
%	%	$	$	$
			Total	$

In calculation of the FFP, the UPIC shall consult the Federal Register for the applicable FMAP rate and shall monitor any changes to the FMAP as published in the Federal Register on an ongoing basis. The relevant FMAP table can be found quickly and directly by searching the internet for "Federal Register FMAP rates for FY [year]." The Federal Register displays adjustments to the FMAP for states and territories

periodically based on legislation, (i.e., the American Recovery and Reinvestment Act (2009) increased the FMAP for certain claims for services on or after October 1, 2008. In addition, The Patient Protection and Affordable Care Act (2010) allowed states to file a State Plan Amendment (SPA) to expand Medicaid to cover additional populations. The federal government financed the costs of these newly eligible beneficiaries at a different rate than those who were previously eligible.).

The UPIC shall ensure that the calculations for each claim/*claim line* are accurate for each FY. If, as a result of an appeal, the overpayment needs to be recalculated, the UPIC shall follow the methodology used in the original overpayment calculation.

4.9 - Immediate Advisements

(Rev. 12925; Issued: 10-30-24; Effective: 11-14-24; Implementation: 11-14-24)

The UPIC shall follow the Medicare PIM guidelines at 4.9.1 - Immediate Advisements to the *HHS*-OIG/OI and notify the SMA of such advisements when they are assisting the state with a Medicaid investigation/audit.

4.10 - Fraud Referrals

(Rev. 12925; Issued: 10-30-24; Effective: 11-14-24; Implementation: 11-14-24)

Throughout the course of a Medicaid investigation/audit, should the UPIC identify potential Medicaid fraud, the UPIC shall discuss the matter with the COR/BFL to determine if a referral to LE is warranted. If CMS agrees that a referral to LE is appropriate, the process for initiating and scheduling a Medicaid Major Case Coordination Meeting (Medicaid MCC) shall begin. The Medicaid MCC Meeting is an opportunity for UPICs to discuss their proposed Medicaid fraud referrals with CMS, the SMA, and LE. The goal is to collaborate with all of the key decision makers, provide guidance on each proposed LE referral, and identify any proposed secondary actions.

Note: All UPIC referrals of potential fraud shall be reviewed by the Department of Health and Human Services – Office of Inspector General (HHS-OIG) for determination and coordination with the state's MFCU. State referrals of potential fraud will continue to follow state policy and be coordinated with the state's MFCU.

The UPIC does not need the SMA's approval for a LE referral but shall communicate with the state that suspected fraud has been identified and is being referred through CMS to HHS-OIG.

<u>Steps Before the Medicaid MCC Meeting:</u>

The UPIC shall finalize the MCC Pre/Post Meeting Report - Work Details (hereon referred to as the Executive Summary) within seven (7) calendar days. The UPIC shall notify CMS once these actions are complete. CMS will submit the Executive Summary to HHS-OIG for review of the possible referral. Then, the following processes will take place:

- HHS-OIG *may* coordinate a preliminary review of the Medicaid UPIC case with the state's Medicaid Fraud Control Unit (MFCU) to determine if they are interested in the case.
- HHS-OIG will communicate the results of the preliminary review to CMS.

This initial review does not constitute the formal referral to law enforcement, and is, instead, a summary of the information for law enforcement to consider whether a formal referral is warranted and a Medicaid MCC Meeting needs to be held to collaborate with all parties.

CMS will coordinate a Medicaid MCC meeting and assure participants include at a minimum: CMS/CPI, HHS-OIG's Office of Investigations (HHS-OIG/OI), the state's MFCU, UPIC, and applicable SMA

Program Integrity Unit staff. CMS will be responsible for scheduling the appointment at the agreed-upon time by all participants. CMS will also be responsible for establishing the agenda for the meeting.

Note: Attendance is optional for LE agencies if the cases are declined prior to the Medicaid MCC, and the case being presented is only subject to state administrative actions.

The UPIC shall ensure all revisions and updates to the case are completed in the UCM three (3) days prior to the scheduled Medicaid MCC.

Steps During the Medicaid MCC Meeting:

The UPIC shall prepare and follow the guidance set forth in the Medicaid Executive Summary Tip Sheet (see Appendices to this manual) when presenting investigations/ audits at the Medicaid MCC.

The CMS/CPI will record the primary and secondary actions identified during the Medicaid MCC *to be resolved as case decisions in UCM (NexGen).*

Steps After the Medicaid MCC Meeting:

Following the Medicaid MCC Meeting, when applicable, the UPIC shall submit a formal referral to the appropriate LE within seven (7) calendar days, unless otherwise advised by CMS. Referrals shall include all applicable information that the UPIC has obtained through its investigation/audit at the time of the referral. The UPIC shall utilize the "LE Referral Template" available in CMS IOM 100-08: Exhibit 16.1. Once the referral package is complete, the UPIC shall submit the referral to LE and copy CMS and the SMA Program Integrity Unit point-of-contact. Upon submission of the referral to HHS-OIG/OI and/or MFCU, the UPIC shall request written and/or email confirmation from the respective law enforcement partner acknowledging receipt of the referral. The UPIC shall update UCM with the date the referral was sent, the name of the agent acknowledging receipt of the referral, and the date of receipt. In the event that written confirmation is not received, the UPIC shall notify CMS. Additionally, the UPIC shall refrain from implementing any additional administrative actions against the provider/supplier without CMS approval. If the UPIC has any questions related to LE referrals, the UPIC shall coordinate with CMS.

UPICs will need to verify all action items discussed during a Medicaid MCC in UCM. The UPIC is responsible for the updating the completion of action items identified during a Medicaid MCC.

Regarding cases declined by LE, the UPIC *shall continue with the IFR/FFR if an overpayment has been identified. If no overpayment was identified, the UPICs shall refer the case to the state for any administrative actions the state finds necessary and close the case within seven (7) calendar days of the Medicaid MCC*.

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Appendix D

Medicaid Major Case Coordination Pre/Post Meeting Report – Work Details Executive Summary Tip Sheet

(Rev. 12925; Issued: 10-30-24; Effective: 11-14-24; Implementation: 11-14-24)

The Executive Summary is a free text field that the UPIC should populate to convey important information about the investigation. The information in this field should be a high-level summary of the relevant activities that have occurred during the investigation as well as any pertinent linkages and should be updated frequently. The UCM Medicaid MCC Executive Summary Tip Sheet mirrors the type of information provided in the Medicare MCC Executive Summary.

Items to Include in the Executive Summary
Allegation
A summary of the findings related to the allegation.
Background of the Investigation
Source of Data
A summary of key data findings.
A summary of investigative findings.
Detail associated with linked referring providers and/or linkages that would be of value to CMS, LE, and stakeholders.
Zone Restriction (ZR) information to include current and past ZR information.
A summary of the linkages to other investigations or suspect providers (including linkages to other UPIC/I-MEDIC investigations).
A summary of the ownership to include linkages to other entities that are of importance.
Billing company/management company information, e.g. name, etc.
Current and previous investigation information to include the date and the decisions made and the reasons why this is being presented or re-presented at the MMCC, when applicable.
Previous medical review information to include a high-level summary of the denials, denial rates, and denial reasons (identify if any of the denials were technical in nature). A summary describing if these denials are related to the same issues that are currently being investigated.
A summary of any education that was issued to the provider (including education provided by the State Medicaid Agency), including the dates the education was issued. This would include any letters that outlined corrective actions to the provider.
State Policy References
Medicare Exposure
MCO/FFS Exposure
PDMP Review (if Opioid)
Patient Harm Assessment
Dollars at Risk
Identified *Medicaid* Overpayment *Amount*
UPIC Point of Contact*, including e-mail*
Note: *State Administration Actions are the responsibility of the state once the case is referred from the UPIC to the state or when the case was closed after it was a LE referral. Updating State Administrative Actions and outcomes in UCM is highly recommended.*