CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-15 Medicaid Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 11948	**Date: April 13, 2023**
	Change Request 13141

SUBJECT: Updates of Publication (Pub.) 100-15, Including Revisions to Chapters 1 and 2, and the Addition of Chapters 3, 4, 5, and Appendices

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update Chapters 1 and 2 in Pub. 100-15 and add Chapters 3, 4, 5, and Appendices. The CR is an overall update of IOM 100-15, to include all background, current direction, processes, procedures, and relevant documents as it relates to the Unified Program Integrity Contractor (UPIC) Medicaid investigations and audits.

EFFECTIVE DATE: May 15, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: May 15, 2023

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/Chapter Title
R	1/Table of Contents
R	1/1.1/Basis of Authority – Statutory/Regulatory Citations
R	1/1.2/Background
R	1/1.3/Definitions
D	1/1.4/State Collaboration Purpose
D	1/1.5/Complaint and Lead Screening
D	1/1.6/Vetting Process
D	1/1.7/Investigation Review Process
D	1/1.7/1.7.1/Initiation of an Investigation
D	1/1.7/1.7.2/Release of Medicaid Data to UPIC
D	1/1.7/1.7.3/Extrapolation
D	1/1.7/1.7.4/Look Back Period
D	1/1.7/1.7.5/Medical Review for Program Integrity Purposes
D	1/1.7/1.7.6/Request of Medical Records
D	1/1.7/1.7.7/Review of Medical Records
D	1/1.7/1.7.8/Completion of a Medical Records Review
D	1/1.8/Overpayment Assessment
D	1/1.9/Documentation of Investigation and Medical Review Findings
D	1/1.10/Overpayment Resolution Process
D	1/1.10/1.10.1/Calculation of FFP Based on State's Date of Expenditure
D	1/1.11/State Appeal Process
D	1/1.12/Close-Out Letters
D	1/1.13/Medicaid Settlement Negotiations
D	1/1.14/Requests for Information
D	1/1.15/Medicaid Payment Suspensions
D	1/1.16/Pre-Payment Medical Review
D	1/1.17/Revocations and Terminations
D	1/1.18/Immediate Advisements
D	1/1.19/Fraud Referrals

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
D	1/1.20/Unified Case Management (UCM) System Entries
D	1/1.20/1.20.1/Background
D	1/1.20/1.20.2/Entry Requirements for Leads
D	1/1.20/1.20.3/Entry Requirements for Investigations
D	1/1.20/1.20.4/Duplicate Entries
D	1/1.20/1.20.5/Deleting Entries in UCM
D	1/1.20/1.20.6/UCM Helpdesk
R	2/Chapter Title
R	2/Table of Contents
N	2/2.0/State Collaboration Purpose
N	2/2.1/Implementing Collaboration with States
N	2/2.1/2.1.1/Implementation Process and Timeline
N	2/2.1/2.1.2/Initial State Collaboration Meeting
N	2/2.1/2.1.3/Information Exchange Agreement (IEA)
N	2/2.1/2.1.4/Joint Operating Agreement (JOA)
N	2/2.1/2.1.5/Program-Level Training and Information Sharing
N	2/2.1/2.1.6/Initial Formal Cross-Training
N	2/2.2/Ongoing Collaboration with States
N	2/2.2/2.2.1/Program Management Meetings or Monthly Collaboration Meetings
R	3/Chapter Title
R	3/Table of Contents
N	3/3.0/Overview
N	3/3.1/Medicaid Data for Use by UPICs
N	3/3.2/Proactive Project Development
N	3/3.3/Lead Screening
N	3/3.4/Vetting Process
N	3/3.5/Investigations/Audits
N	3/3.6/Prioritization
N	3/3.7/Extrapolation
N	3/3.8/Look Back Period

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N	3/3.9/Medical Review for Program Integrity Purposes
N	3/3.10/Request for Medical Records
N	3/3.11/Working with Law Enforcement – Requests for Assistance and Requests for Information
N	3/3.12/Auditing Program Integrity Activities in Managed Care Plans
N	3/3.12/3.12.1/Stage 1 - Auditing Program Activities in Managed Care Plans
N	3/3.12/3.12.2/Stage 2.A. – Review of Paid Claims
N	3/3.12/3.12.3/Stage 2.B. – Review of Denied Services/Prescriptions
N	4/Chapter Title
N	4/Table of Contents
N	4/4.1/Documentation of Investigations/Audits and Medical Review Findings
N	4/4.2/Overpayment Assessment
N	4/4.2/4.2.1/Overpayment Assessed from Medical Review
N	4/4.2/4.2.2/Overpayment Assed Solely by Data Analysis
N	4/4.3/Overpayment Resolution Process
N	4/4.3/4.3.1/Calculation of Federal Financial Participation (FFP) Based on State's Date of Expenditure
N	4/4.4/State Appeal Process
N	4/4.5/Close-Out Letters
N	4/4.6/Medicaid Settlement Negotiations
N	4/4.7/Medicaid Payment Suspensions
N	4/4.8/Terminations
N	4/4.9/Immediate Advisements
N	4/4.10/Fraud Referrals
N	4/4.11/Reporting State Vulnerabilities
N	5/Chapter Title
N	5/Table of Contents
N	5/5.0/Purpose
N	5/5.1/Background
N	5/5.2/Entry Requirements for Investigations

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N	5/5.3/Creating Overpayment (OPT) Records
N	5/5.4/Mandatory Fields in UCM for Medicaid
N	Appendices/Chapter Title
N	Appendices/Table of Contents
N	Appendices/Appendix A/Close-Out Letter Sample
N	Appendices/Appendix B/Closing Summary Template
N	Appendices/Appendix C/Desk or Field Audit Notification Letter Sample
N	Appendices/Appendix D/Medicaid Major Case Coordination Pre/Post Meeting Report – Work Details Executive Summary Tip Sheet
N	Appendices/Appendix E/Final Findings Report – State Transmittal Letter Template Sample
N	Appendices/Appendix F/Final Findings Report – State Transmittal Letter Template for FFS with No MCO Recoupment
N	Appendices/Appendix G/Final Findings Report – State Transmittal Letter Template for No MCO Recoupment
N	Appendices/Appendix H/Final Findings Report Addendum – State Transmittal Letter Sample
N	Appendices/Appendix I/Information Exchange Agreement (IEA)
N	Appendices/Appendix J/Joint Operating Agreement (JOA)
N	Appendices/Appendix K/Medicaid Program Integrity Manual Acronyms
N	Appendices/Appendix L/State Collaboration Vetting Form Sample
N	Appendices/Appendix M/Vulnerability Template

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: 11948	Date: April 13, 2023	Change Request: 13141

SUBJECT: Updates of Publication (Pub.) 100-15, Including Revisions to Chapters 1 and 2, and the Addition of Chapters 3, 4, 5, and Appendices

EFFECTIVE DATE: May 15, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: May 15, 2023

I. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to update Chapters 1 and 2 in Pub. 100-15 and add Chapters 3, 4, 5, and Appendices. As the Unified Program Integrity Contractor's (UPIC) processes and procedures have evolved, the Center for Program Integrity (CPI) has determined that a major update to Pub. 100-15 is warranted in order to capture all current UPIC Medicaid direction. The revised Pub. 100-15 will now consist of 5 chapters and an appendices section, of which will provide detailed information regarding program background, state collaboration, investigation and audit processes, administrative actions, and Unified Contractor Management system direction as it relates to tracking of the workload.

B. Policy: This CR does not involve any legislative or regulatory policies.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13141.1	The Unified Program Integrity Contractor (UPIC) shall be advised that Internet Only Manual (IOM), Publication (Pub.) 100-15 has been reorganized and expanded in its entirety.									UPICs
13141.2	The UPIC shall be advised that the title Chapter 1 of Pub. 100-15 has been revised to “Authority, Background, and Definitions.”									UPICs
13141.3	The UPIC shall be advised that the Basis of Authority—Statutory/Regulatory Citations in section 1.1 of Chapter 1 of Pub. 100-15 has been revised and expanded.									UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13141.4	The UPIC shall be advised that the Background has been revised and expanded in section 1.2 of Chapter 1 of Pub. 100-15.									UPICs
13141.5	The UPIC shall be advised that the Definitions in section 1.3 in Chapter 1 of Pub. 100-15 have been revised and expanded.									UPICs
13141.6	The UPIC shall be advised that Chapter 2 of Pub. 100-15 has been replaced with new information and retitled "Collaboration with States."									UPICs
13141.7	The UPIC shall be advised of the purpose for state collaboration in section 2.0 in Chapter 2 of Pub. 100-15.									UPICs
13141.8	The UPIC shall follow the guidance at section 2.1 in Chapter 2 of Pub. 100-15 for implementing collaboration with the states.									UPICs
13141.9	The UPIC shall follow the guidance at section 2.2 in Chapter 2 of Pub. 100-15 for conducting ongoing collaboration with the states once collaboration has been implemented.									UPICs
13141.10	The UPIC shall be advised that Chapter 3 of Pub. 100-15 is a new Chapter on "Medicaid Investigations and Audits."									UPICs
13141.11	The UPIC shall be advised of the overview of the UPIC investigations and audits with the states at section 3.0 in Chapter 3 of Pub. 100-15.									UPICs
13141.12	The UPIC shall follow the guidance at section 3.1 of Chapter 3 of Pub. 100-15 for the Medicaid data to be used while conducting investigations and audits.									UPICs
13141.13	The UPIC shall follow the guidance at section 3.2 of Chapter 3 of Pub. 100-15 for developing projects from proactive data analysis.									UPICs
13141.14	The UPIC shall follow the guidance at section 3.3 in Chapter 3 of Pub. 100-15 when screening leads.									UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13141.15	The UPIC shall follow the guidance at section 3.4 in Chapter 3 of Pub. 100-15 for vetting leads that warrant further investigation or audit.									UPICs
13141.16	The UPIC shall follow the guidance at section 3.5 in Chapter 3 of Pub. 100-15 when conducting investigations or audits									UPICs
13141.17	The UPIC shall follow the guidance at section 3.6 in Chapter 3 of Pub. 100-15 for prioritizing workload.									UPICs
13141.18	The UPIC shall follow the guidance at section 3.7 in Chapter 3 of Pub. 100-15 when extrapolating findings in an investigation or audit.									UPICs
13141.19	The UPIC shall follow the guidance at section 3.8 in Chapter 3 of Pub. 100-15 when determining the look back period of an investigation or audit.									UPICs
13141.20	The UPIC shall follow the guidance at section 3.9 in Chapter 3 of Pub. 100-15 when conducting medical reviews for program integrity purposes during an investigation or audit.									UPICs
13141.21	The UPIC shall follow the guidance at section 3.10 in Chapter 3 of Pub. 100-15 when requesting medical records from a provider.									UPICs
13141.22	The UPIC shall follow the guidance at section 3.11 in Chapter 3 of Pub. 100-15 when receiving requests for assistance or requests for information from law enforcement.									UPICs
13141.23	The UPIC shall follow the guidance at section 3.12 in Chapter 3 of Pub. 100-15 when conducting audits of program integrity activities in managed care plans.									UPICs
13141.24	The UPIC shall be advised that Chapter 4 of Pub. 100-15 is a new Chapter on “Reporting Investigational Findings and Making Referrals.”									UPICs
13141.25	The UPIC shall follow the guidance at section 4.1 in									UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Chapter 4 of Pub. 100-15 on documenting the findings of investigations/audits and medical reviews.									
13141.26	The UPIC shall follow the guidance at section 4.2 in Chapter 4 of Pub. 100-15 on assessing the overpayment from either a medical review or solely by data analysis.									UPICs
13141.27	The UPIC shall follow the guidance at section 4.3 in Chapter 4 of Pub. 100-15 on creating and processing the Initial Findings Report and the Final Findings Report.									UPICs
13141.28	The UPIC shall follow the guidance at section 4.4 in Chapter 4 of Pub. 100-15 to provide support and assistance to the state during the appeal process.									UPICs
13141.29	The UPIC shall follow the guidance at section 4.5 in Chapter 4 of Pub. 100-15 on issuing a close-out letter to providers when an investigation/audit is discontinued or the findings are insufficient to pursue.									UPICs
13141.30	The UPIC shall follow the guidance at section 4.6 in Chapter 4 of Pub. 100-15 regarding its role in any Medicaid settlement negotiations.									UPICs
13141.31	The UPIC shall be advised of its role in implementing a Medicaid payment suspension at section 4.7 in Chapter 4 of Pub. 100-15.									UPICs
13141.32	The UPIC shall follow the guidance at section 4.8 in Chapter 4 of Pub. 100-15 for notifying the states of a provider's potential termination.									UPICs
13141.33	The UPIC shall follow the guidance at section 4.9 in Chapter 4 of Pub. 100-15 when submitting an Immediate Advisement to law enforcement.									UPICs
13141.34	The UPIC shall follow the guidance at section 4.10 in Chapter 4 of Pub. 100-15 when submitting a possible fraud referral to law enforcement and participating in the Medicaid Major Case Coordination process.									UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13141.35	The UPIC shall follow the guidance at section 4.11 in Chapter 4 of Pub. 100-15 when reporting a vulnerability in a state's policies that leave the Medicaid program at risk for fraud, waste, and abuse.									UPICs
13141.36	The UPIC shall be advised that Chapter 5 of Pub. 100-15 is a new Chapter on Medicaid-specific requirements for the Unified Case Management (UCM) system.									UPICs
13141.37	The UPIC shall be advised of the purpose of Chapter 5 at section 5.0 in Chapter 5 of Pub. 100-15.									UPICs
13141.38	The UPIC shall be advised of the background of UCM at section 5.1 in Chapter 5 of Pub. 100-15.									UPICs
13141.39	The UPIC shall follow the guidance at section 5.2 in Chapter 5 of Pub. 100-15 for entering information on investigations or audits into UCM.									UPICs
13141.40	The UPIC shall follow the guidance at section 5.3 in Chapter 5 of Pub. 100-15 for creating an Overpayment Record when an overpayment has been identified in the investigation or audit.									UPICs
13141.41	The UPIC shall be advised at section 5.4 in Chapter 5 of Pub. 100-15 regarding select fields in UCM that are required for Medicaid investigations or audits.									UPICs
13141.42	The UPIC shall be advised that a new section has been developed for templates, worksheets, and resource information at the Appendices in Pub. 100-15.									UPICs
13141.43	The UPIC shall use the sample letter found at Appendix A in the Appendices of Pub. 100-15 to issue a close-out letter to providers when an investigation/audit is discontinued or the findings are insufficient to pursue.									UPICs
13141.44	The UPIC shall use the template found at Appendix B in the Appendices of Pub. 100-15 to compile a closing summary on investigations or audits that are discontinued or there is little to no overpayment to									UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	pursue.									
13141.45	The UPIC shall use the sample letter found at Appendix C in the Appendices of Pub. 100-15 to notify providers of a desk or field audit.									UPICs
13141.46	The UPIC shall follow the tip sheet at Appendix D in the Appendices of Pub. 100-15 when developing the Executive Summary for a law enforcement referral.									UPICs
13141.47	The UPIC shall use the transmittal letter template at Appendix E in the Appendices of Pub. 100-15 when attached to a report of findings that are related to fee-for-service claims only.									UPICs
13141.48	The UPIC shall use the transmittal letter template at Appendix F in the Appendices of Pub. 100-15 when attached to a report of findings that include both FFS and managed care (MC) claims, but the MC claims are not recoupable in the state.									UPICs
13141.49	The UPIC shall use the transmittal letter template at Appendix G in the Appendices of Pub. 100-15 when attached to a report of findings that include only MC claims, and the claims are recoupable in the state.									UPICs
13141.50	The UPIC shall use the transmittal letter template at Appendix H in the Appendices of Pub. 100-15 when the final findings report has been amended and an addendum to the report is being issued to the state.									UPICs
13141.51	The UPIC shall use the Information Exchange Agreement template at Appendix I in the Appendices of Pub. 100-15 when such agreement is required with the state.									UPICs
13141.52	The UPIC shall use the template at Appendix J of the Appendices of Pub. 100-15 when developing a joint operating agreement with the state.									UPICs
13141.53	The UPIC shall be advised that common acronyms utilized in the manual can be found on Appendix K in the Appendices of Pub. 100-15.									UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13141.54	The UPIC shall use the sample form at Appendix L in the Appendices of Pub. 100-15 when submitting leads to the state for vetting.									UPICs
13141.55	The UPIC shall use the template at Appendix M in the Appendices of Pub. 100-15 when reporting a vulnerability found in a state's policies that leave the Medicaid program at risk for fraud, waste, and abuse.									UPICs

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. 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

V. 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).

VI. 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. 11948; Issued:04-13-23)

Transmittals for Chapter 1

1.1 - Basis of Authority – Statutory/Regulatory Citations

(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

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. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

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 (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*;
- *R*efer 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 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*; and

- 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. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

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.*

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:

- *I*nterviews of recipients or providers,
- *D*ocumentation requests *to providers in the form of* questionnaires, attestations, *request for medical records*, *Managed Care Plan (MCP) contracts and contract deliverables,* etc.
- *P*ost-payment *reviews of claims*,
- *A*uditing 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 the time period)*
- *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.)*

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 review*, along with any other findings discovered during the investigation.*

Medicaid Final Findings Report – *The Medicaid Final Findings Report (FFR) is a final s*ummary 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 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* detail*s* 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 first hand, 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 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. 11948; Issued:04-13-23)

Transmittals for *Chapter 2*

2.0 - State Collaboration Purpose

(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

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 - Implementing Collaboration with States
(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

The success of the UPICs is dependent on the collaboration of all parties involved, i.e. CMS, SMA, and the UPIC. This section will outline some of the steps necessary for implementing collaboration with the states in order for the UPIC to begin program integrity activities in their jurisdiction.

2.1.1 - Implementation Process and Timeline
(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

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. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

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.*

Agenda Item	*Decisions/Discussion Points*
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.

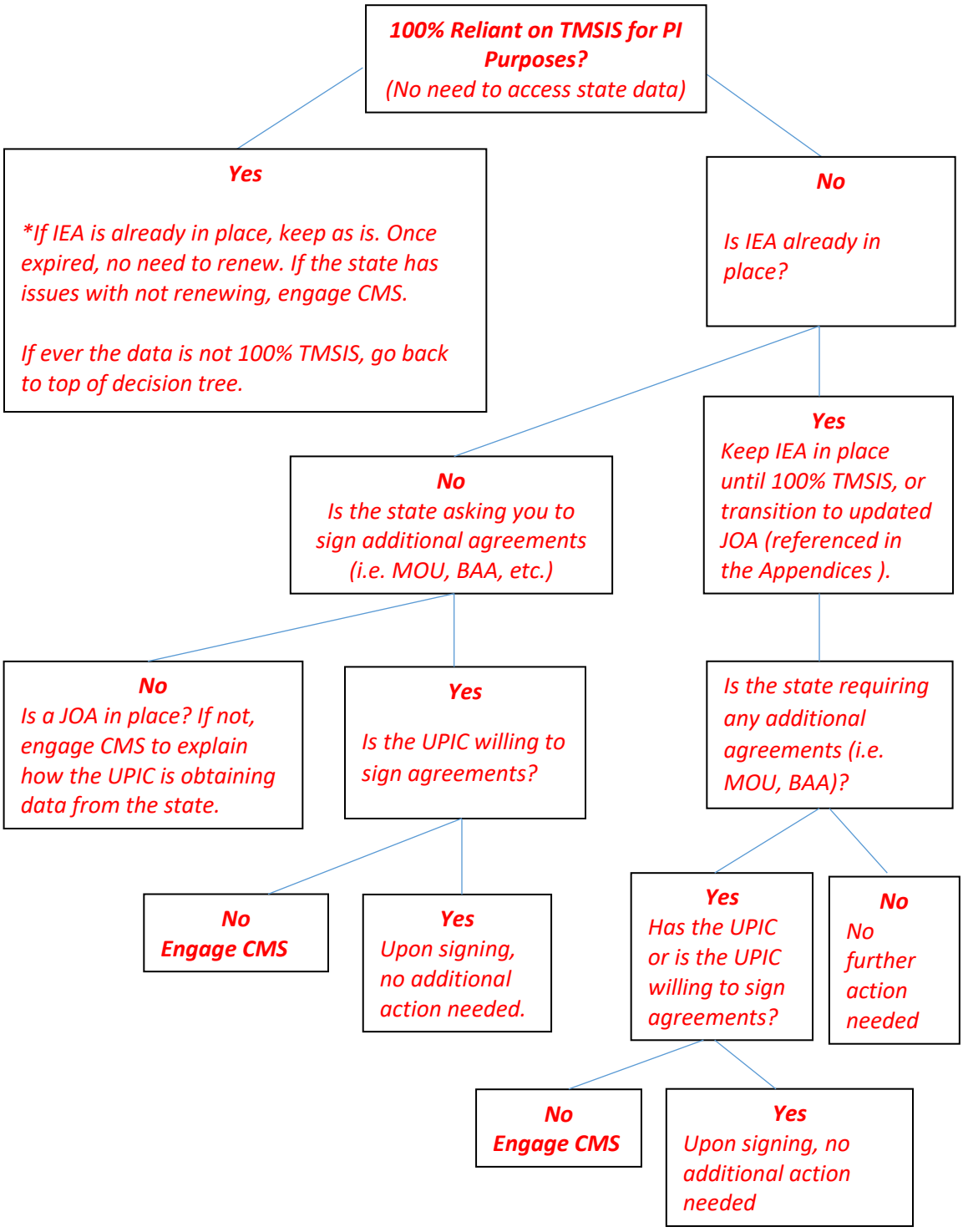
2.1.3 - Information Exchange Agreement (IEA)
(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

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 flowchart below.

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



2.1.4 - Joint Operating Agreement (JOA)

(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

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. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

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.*

2.1.6 - Initial Formal Cross-Training

(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

During the implementation of a new state or regional program, partners are encouraged to participate in an initial, broad-level training session that outlines the major data elements and the policies and procedures of both Medicare and Medicaid. This event will serve to build a foundation of understanding between partners providing a general idea of how each program works.

The UPIC shall provide Medicare training to the SMA staff, if requested, and the SMA is encouraged to provide reciprocal training on Medicaid. This initial training will be discussed at the Initial State Collaboration Meeting and will be coordinated between the UPIC Manager and the SMA program leads. Together, the UPIC Manager and the SMA program lead will decide on the appropriate location, format, and dates for training.

Should the SMA decline to participate in or provide cross-training, the UPIC Manager shall inform the CMS COR/BFL. The UPIC shall organize all formal training events upon the request of the SMA program lead.

a. Attendees

The SMA, the UPIC and One PI representatives (for discussions on data, connectivity and access) shall attend the initial training session.

b. Format

Outside of a Public Health Emergency (PHE), it is recommended that the initial training session occur in person. Virtual training may be used in lieu of in-person training for the convenience of all parties. Options for the format include multiple sessions of training spread out over a period of time or a multi-day retreat. For follow-up sessions, virtual training is recommended. The UPIC Manager and the SMA will determine which format is most appropriate.

c. Location and Logistics

For in-person training, the initial training should be held at the SMA if there is conference space available. If there is no conference space available, the UPIC shall arrange for a site that is acceptable to the SMA program lead.

d. Content

Training should be focused on two main components—policy and data. The SMA and the UPIC Medicaid Operations Lead shall work together to determine the agenda items for training.

The CMS COR/BFL will provide the UPIC with a presentation that gives an overview of national Medicare policy for use in the training session. However, the UPIC may produce a custom presentation tailored to the needs of the program, as appropriate. The UPIC will also encourage the SMA to provide materials for training which are customized or from existing training efforts.

The data portion of the training should include guidance on how the data systems are established and updated.

2.2 - Ongoing Collaboration with States

(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

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. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

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.

Medicaid Program Integrity Manual

Chapter 3 - Medicaid Investigations & Audits

Table of Contents
(Rev. 11948; Issued:04-13-23)

Transmittals for Chapter 3

3.0 - Overview
(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

The UPICs shall be responsible for collaborating with 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. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

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. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

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 "leads" that meet the criteria of the project. Those leads will then be screened in accordance with Section 3.3 of this manual.

3.3 - Lead Screening

(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

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.

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

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

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

d. *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.*

e. *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.*

f. *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;*
- *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 3.2.)

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; and*
- *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.

3.4 - Vetting Process

(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

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. Prior to submitting to CMS and SMA for vetting, the UPIC will submit the proposed lead to the Medicaid BFL for review and approval. This is to ensure that projects of the highest priority are being addressed by the UPIC, and resources are being properly allocated.

When vetting with CMS, the UPICs shall follow the Medicare PIM 4.6 - Vetting Leads with CMS.

When vetting with the SMA, the UPIC will submit an initial referral form to the SMA (Appendix L). The SMA's acceptance or declination of the proposed investigation shall be clearly documented on such form and shall be uploaded into the Document section of UCM by the UPIC. In addition, the UPIC shall indicate in the "State Involvement" tab the date vetting was sent to the SMA, the date the response was received, and the state's response.

If the SMA declines pursuing the provider/scheme (for example, the SMA has already investigated the provider or scheme and had no findings), then the proposed investigation shall be closed. However, leads should not be closed due to delays in the state's response to vetting. Instead, the UPIC shall document any delays in the vetting process in UCM. If the SMA declines a potential investigation that the UPIC believes is a major risk to the applicable state Medicaid program, the UPIC will communicate this to the CMS COR/BFL team.

3.5 - Investigations/Audits

(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

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.

3.6 - Prioritization

(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

As Congress has appropriated limited resources to CMS for the audit and investigation of Medicaid providers through the UPICs across five jurisdictions, prioritization of the investigation workload is critical to ensure that the resources available are devoted primarily to high-priority investigations. UPICs shall ensure that resources are used appropriately and to the maximum impact of protecting the integrity of the Medicaid program.

The UPIC shall follow the requirements in its UPIC SOW for prioritizing leads and will include consideration of CMS priority areas, along with the SMA's areas of concern. The UPIC Medicaid Operations Lead shall prioritize work coming into the UPIC to ensure that investigations with the greatest program impact and/or urgency are given the highest priority. The UPIC shall prioritize all work on an ongoing basis as new work is received or developed. With the limited resources allocated for Medicaid investigations, the UPICs primary focus should be on high risk (potential patient abuse or harm) and high dollar exposure investigations/audits. The CMS priority areas will be communicated in writing to the UPICs and may change as the fraud, waste, and abuse environment changes. In turn, UPICs will need to adjust their workload to accommodate the changing environment.

In addition, UPICs shall share CMS' priorities with SMAs to solicit interest from the state on other possible projects.

The UPIC shall contact its Contracting Officer's Representative (COR) and Medicaid BFL if there are any questions or concerns about prioritization of workload.

3.7 - Extrapolation

(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

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. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

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. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

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 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. The general recommendation for a provider/supplier-specific probe sample is 20-40 claims. 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. Each claim shall be evaluated using the same review guidelines. The claim 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.*

3.10 - Request for Medical Records

(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

At the beginning of any review, the UPIC sends the provider a record request letter, which includes a request for specific Medicaid medical records (Appendix C). The UPIC shall collaborate with the SMA to determine if additional steps are required and/or if state approval is required prior to sending record requests to the provider. Typically, the UPIC will allow the provider 30 days to produce the records, with a permissible 15-day extension if requested by the provider, unless otherwise specified by the SMA or CMS. If no records are received within the specified timeframe and the provider has made no reasonable attempt to provide the requested records, the UPIC shall coordinate with CMS and the state to determine if the full overpayment should be recouped due to non-response.

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

(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

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 guidance related to Requests for Information can be found in 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 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. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

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.

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 rates, and*
- *Potential overpayments to network providers due to improper oversight.*

The audits/investigations will include four components in two stages. An IFR and FFR will be created after each stage. 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.

3.12.1 - Stage 1 - Auditing Program Integrity Activities in Managed Care Plans

(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

Scope of audit for Stage 1: For states with 10 or less MCPs, all MCPs will be reviewed, unless otherwise directed by CMS. In states with 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.

In Stage 1, the UPIC will review a list of contract deliverables and program integrity activities, as directed by CMS. The review will look at timeliness and completion of deliverables, along with 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, and investigative procedures.

3.12.2 - Stage 2.A. – Review of Paid Claims

(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

Stage 2 of the MCP audit will include auditing services or claims paid by the MCP to its providers, along with reviewing denied claims or prior authorizations for services and/or prescriptions.

Scope of Stage 2: The UPIC, in collaboration with CMS and the SMA, will identify one or more MCPs from Stage 1 that warrant further review of their program integrity oversight of network providers.

In Stage 2.A., the UPIC will audit a broad sample of claims paid by the MCP to its network providers. 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.

3.12.3 - Stage 2.B. - Review of Denied Services/ Prescriptions

(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

In Stage 2.B., the UPIC will analyze the denied claims and denied prior authorizations of services and prescriptions/orders for the past 12 months to determine if any patterns exist that may be indicative of underutilization of services and/or avoiding paying for high-dollar services, prescriptions, or items.

Scope of Stage 2.B.: The same MCP(s) reviewed in Stage 2.A will be reviewed in 2.B. For this stage, the MCP will remain the primary subject. The providers whose records will be requested to support/refute the denial will not be considered secondary subjects, as it is the MCP who is being reviewed. If, while reviewing the provider's records, the UPIC finds evidence of questionable billing, the UPIC shall open a separate lead on the provider.

Medicaid Program Integrity Manual

Chapter 4 - Reporting Investigational Findings and Making Referrals

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(Rev. 11948; Issued:04-13-23)

Transmittals for Chapter 4

4.1 - Documentation of Investigations/Audits and Medical Review Findings

(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

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 assumptions 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; and*
6. *Miscellaneous memoranda that pertain to the investigation.*

4.2 - Overpayment Assessment-Reserve for future use

(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

4.2.1 - Overpayment Assessed from Medical Review

(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

When assessing potential Medicaid overpayments, the UPIC shall ensure the necessary state law and/or SMA overpayment methodologies and requirements are followed at all times. Upon completion of the medical review, the UPIC determines if there is a potential overpayment.

4.2.2 - Overpayment Assessed Solely by Data Analysis

(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

In certain instances, in collaboration with the SMA, the UPIC may identify overpayments based solely on data analysis. In these instances, the UPIC shall collaborate with the state to validate the analysis and to ensure the policy interpretation is accurate. Additionally, the UPIC shall coordinate with each individual SMA and the COR/BFL team to determine a state specific dollar threshold for action on overpayments based

solely on data analysis. Data driven overpayments that meet the dollar threshold, once reviewed and approved by CMS, shall be vetted in accordance with Chapter 3.3 of this manual prior to submitting the overpayment to the SMA by CMS through a Final Findings Report (FFR). All data analysis identified overpayments that fall below the state specified threshold will be sent to the SMA by the UPIC to take whatever action they deem necessary (i.e., collection of overpayments, identification of program vulnerabilities, necessary policy updates, automated edits, etc.).

4.3 - Overpayment Resolution Process

(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

Upon identification of an overpayment based on a Medicaid investigation/audit, an Initial Findings Reports (IFR) is sent to the Medicaid BFL for review and approval. Once the BFL has approved the IFR, the UPIC will send the IFR to the SMA within 180 days of the Medicaid Investigation Start Date for review and comments for 30 calendar days. The 180-day time frame is based on normal progression of the investigation/audit with no cause for delay or circumstances outside UPIC control, unless otherwise specified by CMS. All delays shall be documented in the Unified Case Management (UCM) system. If the state disagrees with the findings of the UPIC, which results in monetary changes to the Appendix A, the UPIC will revise the IFR and incorporate any other grammatical or narrative corrections identified by the state. If the state's comments speak to the body of the report and are primarily grammatical or corrections to cited regulations, terminology, etc., the document will remain an IFR, and the UPIC will make any necessary corrections.

The revised IFR (RIFR), or original IFR if the state review did not necessitate a revision, may then be transmitted by the UPIC to the provider for review and comments for 30 calendar days, if required by the SMA. The Medicaid BFL and the UPIC will review the provider's responses, if any, to determine if adjustments to the findings are necessary. If so, the UPIC will make the subsequent revisions and the RIFR is sent to the state, this time with a 15-day review and comment period. CMS, the UPIC, and, if necessary, the state reconcile any issues with the RIFR, after which the UPIC produces an FFR and completes the FFR – State Transmittal Letter and submits both to CMS for approval within 13 months of the Medicaid Investigation Start Date. The 13-month time frame is based on normal progression of the investigation/audit with no cause for delay or circumstances outside UPIC control, unless otherwise specified by CMS. All delays shall be documented in the Unified Case Management (UCM) system. CMS, upon approving the FFR, sends the FFR and State Transmittal Letter to the state. The FFR – State Transmittal Letter (Appendix E) can be found in the Appendices. Versions of the State Transmittal Letter are available for FFS and/or managed care investigations/audits, where the managed care overpayments can be recouped (Appendix E); FFS and managed care investigations/ audits when the managed care overpayments are not recoupable, but the FFS are (Appendix F); and managed care-only investigations/audits when there are only managed care overpayments that are not recoupable (Appendix G). The FFR identifies the total overpayment amount paid to the provider and specifies the

amount of Federal Financial Participation (FFP) that the state must return to CMS. It is the state's responsibility to adjudicate the review findings with the provider. The state has one year from the date the overpayment is identified to recover or attempt to recover the overpayment from the provider before the federal share must be refunded to CMS. Under CMS's regulations, the date of discovery of overpayments begins on the date that CMS first notifies the SMA in writing of the overpayment and specifies a dollar amount subject to recovery. (See 42 C.F.R. § 433.316).

Sometimes a 100% overpayment is identified because the provider or supplier does not provide the contractor with the required medical record documentation to conduct a post-payment medical review. A 100% overpayment means that all the claims in the contractor's selected sample are considered to be improperly billed and paid based on the documentation received (or lack thereof). Therefore, they are fully denied through post-payment review. In these instances, the UPIC shall consult with its BFL and SMA on any potential 100% overpayment determinations prior to initiation of state overpayment reporting actions or notice to the provider/supplier. If approved, the UPIC shall coordinate the overpayment reporting actions with the SMA. If denied, the UPIC shall follow the instructions provided by its Medicaid BFL.

In certain instances, the SMA may require an update to the FFR, based on updated analysis by the state, issues identified within the referenced policy, etc. In these instances, the UPIC shall notify CMS of the discrepancies and discuss a proposed resolution. If it is determined that an update to the FFR is necessary, CMS and the UPIC shall collaborate to draft an FFR Addendum, along with the FFR Addendum – State Transmittal Letter (Appendix H), which CMS shall submit to the SMA upon completion. The UPIC will edit the OPT financial information in UCM on the original OPT record and upload the FFR Addendum.

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

(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

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 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.

4.4 - State Appeal Process

(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

The CMS does not dictate the process by which UPIC Medicaid review findings are appealed. Rather, appeal processes are determined by each state and are subject to the state's Medicaid program requirements.

It is the responsibility of the SMAs to defend review findings in an administrative appeal or judicial proceeding, although the UPIC may provide testimonial support and other assistance to the state to defend the review findings throughout administrative or judicial proceedings.

It is recommended that the UPIC review each SMA's appeal process during the onset of any proposed investigation, so they understand the level of support needed and can plan appropriately should the SMA require support during the appellate process.

The UPIC should alert the Medicaid BFL/COR to any situation where a state indicates a

reluctance to defend FFR findings in an appeal.

4.5 - Close-Out Letters

(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

If the provider has been notified to begin an investigation/audit and the Medicaid investigation/audit is later discontinued for reasons other than identification of an overpayment, or if the findings are insufficient to pursue, a close out letter will be issued to the provider. The close-out letter provides notification to the provider that the review has concluded and no further action on the part of the provider is necessary. The UPIC is responsible for obtaining approval from CMS prior to issuing a close-out letter. Upon approval, the UPIC sends the close-out letter to the provider in question, sends a copy to the state, and uploads a copy to UCM. A sample of the "Close-Out Letter" can be found at Appendix A.

In addition, the UPIC will complete a summary of the investigation that is submitted to the SMA along with the letter to the provider, and a copy is uploaded to UCM. This summary is not sent to the provider. The "Closing Summary" template can be found at Appendix B.

4.6 - Medicaid Settlement Negotiations

(Rev.) (Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

Overpayment settlement negotiations are a function of the SMA. If the SMA and provider agree to a negotiated settlement, the SMA is still required to remit payment for the full FFP referred by CMS, in accordance with 42 CFR Part 433 Subpart F.

The UPIC shall not participate in any discussions or review of the negotiated overpayment since this is the responsibility of the SMA.

4.7 - Medicaid Payment Suspensions

(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

Implementation of Medicaid payment suspensions is an SMA function and should be in accordance with 42 C.F.R. § 455.23. Although UPICs may recommend the implementation of a Medicaid payment suspension based on a credible allegation of fraud, it is at the state's discretion to take the appropriate action.

4.8 - Terminations

(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

If the UPIC identifies potential grounds for Medicaid termination, the UPIC shall notify the SMA so it can review the facts and consider the appropriate action.

4.9 - Immediate Advisements

(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

The UPIC shall follow the Medicare PIM guidelines at 4.9.1 - Immediate Advisements to the 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. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

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 will 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.

If either the HHS-OIG or MFCU is interested in the case, 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 designate no more than two individuals to present cases 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 Fraud and Investigations Group (FIG) Business Owner/Subject Matter Expert for UCM will record the discussion and primary and secondary actions identified during the Medicaid MCC and submit updates to the UCM for the MCC Pre/Post Report.

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.

In regards to cases declined by LE, the UPIC shall update UCM with the declination and notify CMS and the SMA within two (2) business days in order to move forward with any approved secondary administrative actions. The UPIC will coordinate with the SMA in implementing any secondary administrative actions.

4.11 - Reporting State Vulnerabilities

(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

During the course of project development and/or investigational/audit activities, the UPIC may become aware of vulnerabilities in a state's policies that leave the Medicaid program at risk for fraud, waste, or abuse. In these circumstances, the UPIC will follow the Medicare PIM Guidelines at 4.13 – Vulnerabilities for reporting the information to the COR and BFL, along with completing the Vulnerability Template (required elements are described in the Medicare PIM at 4.13), which is then submitted to the Vulnerability Mailbox at CPIVulnerabilityIntake@cms.hhs.gov. It is understood that not all aspects of the Vulnerability Template may be relevant to the Medicaid program or the SMA. In these circumstances, the UPIC shall complete the Template to the best of their knowledge and may indicate "Not Applicable or N/A" for those elements that may not be relevant to Medicaid. A copy of the Vulnerability Template may be found at Appendix M.

In addition, a copy of the vulnerability report shall be submitted to the respective SMA for their review and shall be presented on a regularly scheduled monthly collaboration call. The minutes of the meeting shall reflect the presentation/discussion of the vulnerability.

Medicaid Program Integrity Manual

Chapter 5 - Unified Case Management System

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(Rev.11948; Issued:04-13-23)

5.0 - Purpose
(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

For this Chapter, the Medicaid PIM defers to the UPIC Task Order Statement of Work, supplemental guidance provided by CMS, and the Medicare PIM at section 4.12 for most information on the use of UCM by the UPICs.

However, in some instances, there is specific guidance unique to the Medicaid environment and working with state Medicaid agencies (SMAs) that is being maintained in this manual at this time. Below are sections that include guidance that is unique to Medicaid investigations/audits. The associated section in the Medicare PIM is also cited, when applicable.

5.1 - Background
(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

The UCM is a nationwide database that UPICs use to enter and update Medicare and Medicaid fraud, waste, and abuse leads, investigations, administrative actions, and referrals initiated by the UPICs.

The UCM shall also capture the UPIC's work related to administrative actions like post-payment reviews, pre-payment reviews, overpayments, etc., as well as referrals to other entities (SMAs, law enforcement, etc.). The UCM also has monitoring and reporting capabilities which facilitate oversight of the UPICs' workloads.

5.2 - Entry Requirements for Investigations
(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

For most of this information, please defer to section 4.12.2 of the Medicare PIM titled, "Initial Entry and Update Requirements for UPIC Leads and Investigations."

Guidance unique to Medicaid:

Investigative activities, such as on-site visits, interviews, etc. shall be captured in the "Plan of Action" section of UCM.

The UPIC shall take all appropriate administrative actions in accordance with this manual and in conjunction with the SMA.

5.3 - Creating Overpayment (OPT) Records
(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

Upon identification of an overpayment based on a Medicaid investigation/audit, the UPIC shall spawn an overpayment (OPT) record in UCM from the CSE associated with the investigation/audit. The UPIC shall refer to the UCM User Manual for opening OPT

records.

For investigations/audits of managed care network providers, where the provider is enrolled in multiple managed care organizations (MCOs), an OPT record will be opened for each MCO where the provider is enrolled, unless directed otherwise by the SMA.

In circumstances where the provider is being investigated/audited for both fee-for-service (FFS) claims and is enrolled in managed care, a separate OPT record will be opened for the FFS portion of the investigation/audit, along with the OPTs for each MCO, unless directed otherwise by the SMA.

For the "Overpayment Financials" section of the OPT record, the 'Original Overpayment Amount' will be the amount in the IFR that goes to the SMA and may include any revisions in the overpayment amount based on the CMS review. Whenever the overpayment is revised—either due to the state's review or the provider's review—the UPIC shall update the financial section of the OPT record with the revised amounts in the 'Revised Overpayment Amount' column and include the date of the revision in the 'Determination Date' column.

For the 'Federal Share Amount' of the "Overpayment Financials" section, the federal share will only be calculated for the FFR and will be entered prior to submitting the FFR to CMS. The amount will be the calculated federal share of the final revised amount (if revised) from the IFR that is listed in the FFR. If the FFR is later revised and the overpayment changes, the 'Revised Overpayment Amount' will be revised using the procedures above, and the federal share will be recalculated, and the amount will be entered in the 'Revised Federal Share' column.

For an FFR Addendum that has occurred after the FFR is issued to the SMA, the UPIC will update the financial amount by editing the original OPT record.

5.4 - Mandatory Fields in UCM for Medicaid

(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

There are some fields in UCM which are mandatory for investigations/audits that have a "Program Type" of 'Medicaid.' Currently, these include the fields listed below, although this list may change as needs arise. Please refer to the UCM User Manual and Release Notes for all changes and updates.

Mandatory Fields for the Case (CSE) Record:

1) *Fraud Case Summary Section*
   a) *Case Close Reason (if closed as a lead)*
   b) *Medicaid/Medi-Medi Case Close Reasons (when closed as an investigation)*

2) *Plan of Actions Section*
   a) *Any activities planned for the investigation shall be captured here. This may*

or may not include interviews with beneficiaries, providers, employees, etc.; on-site reviews; medical reviews, etc.

3) *General Tab*
   a) *Program Type*
   b) *Data Source of Lead*
   c) *Stage Agency*

4) *Allegations Tab*
   a) *Provider Type (formerly Service Type)*
   b) *Medicaid Dollars at Risk:*
      i. *FFS*
      ii. *MCO*

5) *State Involvement Tab*
   a) *Date Lead Vetted with State*
   b) *State Response Date*
   c) *State Response Status*

Medicaid Program Integrity Manual

Appendices

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Transmittals for Appendices

Appendix A

Close-Out Letter Sample

(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

Date

Provider Name Attn:
Provider Address

Provider Number:
NPI Number:

Dear PROVIDER NAME:

UPIC NAME has conducted an audit on behalf of the Centers for Medicare & Medicaid Services (CMS), Medicaid Integrity Program. This audit examined claims for AUDIT ISSUE for the time period DATE through DATE.

Based upon this audit, CMS has determined no further review is necessary at this time. You should retain the records pertaining to the items and services that were the subject of this audit in accordance with applicable state and federal law (including Section 1902(a)(4) of the Social Security Act and 42 CFR 431.17). You are advised that all the claims that were the subject of this audit may be re-audited or reinvestigated at a future date by the state of STATE NAME, CMS, or other state or federal agencies or authorities.

Appendix B

Closing Summary Template

(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

Medicaid Investigation/Audit Closing Summary		
Unified Program Integrity Contractor	*Self-explanatory*	
Jurisdiction	*Self-explanatory*	
UPIC Internal Tracking ID	*Self-explanatory*	
UCM ID	*Self-explanatory*	
Investigation/Audit Dates	*Opened:*	*Closed:*
State Medicaid Agency	*Self-explanatory*	
Provider Type	*Self-explanatory*	
Provider Name *Provider list attachment permissible*	*Self-explanatory*	
Provider NPI	*Self-explanatory*	
Description of Audit		
In this space, provide a general summary of the investigation, to include any associated allegations.		
Investigation/Audit Lead Source(s)		
In this space, provide a description of the source that prompted the opening of this investigation. Examples may be OIG, State, CPI, FPS Alert, HFPP, etc.		
Data Source		
In this space, provide a description of the data sources used during the investigation/audit. Examples may include but is not limited to TMSIS, MMIS, HFPP, State, PDMP, FQHCs, etc.		
Closure Reason		
Self-explanatory		
Next Steps		
In this space, provide a description of the next steps that may include but is not limited to referrals, 6 month look back, MFCU, education, etc.		

Additional Notes & Documentation
In this space, please provide any additional information and/or description of additional documents to be attached to this form. Examples may include separate list of related providers that could not fit in the provided fields above, provider address, citation of rules/regulations, etc.

Appendix C

Desk or Field Audit Notification Letter Sample

(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

Date

Provider Name Attn:
Provider Address:
Provider Number:
NPI Number:

Dear PROVIDER NAME:

This is to inform you that you or your facility has been selected for an audit of claims billed to Medicaid with dates of services from DATE through DATE. The objective of our audit is to determine whether the claims for services were billed and paid in accordance with applicable federal and state Medicaid laws, regulations, and policies.

Section 6034 of the Deficit Reduction Act of 2005 (DRA) established the Medicaid Integrity Program, through which the Centers for Medicare & Medicaid Services (CMS) shall conduct reviews and audits of claims submitted by Medicaid providers. As a Medicaid provider and a recipient of funds under the state Medicaid program, you are subject to these reviews and audits. The DRA authorizes CMS to utilize contractors, including UPIC NAME, to conduct such reviews and audits.

In accordance with the DRA and other applicable federal laws, you are required to provide CMS and its contractor, UPIC NAME, with timely, unrestricted access to all documents and records that relate in any way to Medicaid claims and payments.

THE FOLLOWING LANGUAGE IS RELATED TO A DESK AUDIT:

To facilitate the audit, we are requesting that all documentation related to the listed claim lines on the enclosed claims listing be assembled and provided to UPIC NAME. We have included a list of types of documentation that may be required to support the claims billed. The documents must be legible and arranged in an orderly manner. Be aware that this list is not all inclusive and that UPIC NAME may request additional documentation necessary to conduct and complete its audit. The requested information should be forwarded to UPIC NAME at the following address <u>within 30 business days</u> from receipt of this letter.

UPIC NAME
ATTN

ADDRESS

THE FOLLOWING LANGUAGE IS RELATED TO A FIELD AUDIT:

An auditor from UPIC NAME, will be contacting you in the near future to schedule an entrance conference and discuss the audit process, which will include an on-site visit. Upon arrival at the on-site visit, UPIC NAME, will conduct an entrance conference, and will need adequate workspace to conduct the audit.
During the entrance conference, UPIC NAME, will request an overview of your organization, including your Medicaid claims submission process, any policies and procedures related to this process, and an organizational chart.

To facilitate the audit, we are requesting that certain information shown in the enclosed document be assembled and provided to UPIC NAME, at the entrance conference.

The documents must be legible and arranged in an orderly manner. This list is not all inclusive, and UPIC NAME may request additional documentation necessary to conduct and complete the audit.

Any applicable state sanctions may be imposed against you if you fail to provide the information that is requested. Depending on the laws in your state, sanctions may include, but not be limited to, vendor hold and/or exclusion from participation as a provider in the state Medicaid program, until the matter is resolved. Additionally, payments for services for which you fail to produce records to UPIC NAME will be recovered from you.

Appendix D

Medicaid Major Case Coordination Pre/Post Meeting Report – Work Details
Executive Summary Tip Sheet
(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

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
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 Overpayment
UPIC Point of Contact
Note: Though identifiable State Administrative Actions are premature for the Executive Summary, the determination of all Administrative Actions identified during the Medicaid MCC should be followed up for completeness and captured in UCM.

Appendix E

Final Findings Report - State Transmittal Letter Template Sample

(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

<Date>

<Name of State Medicaid Director>, <Title>
<Address>
<City, State, Zip Code>

Dear < Mr. /Ms. State Medicaid Director Last Name>:

Enclosed is the final findings report for <provider name>, state Medicaid provider #<number>/NPI #<number>. The investigation was conducted by <name of UPIC>, on behalf of the Centers for Medicare & Medicaid Services (CMS), and concerned Medicaid claims paid to <provider name>. The investigation encompassed the Medicaid claims <<, associated with the managed care organization <MCO name>,> for services provided during the period of <date audit period started > through <date audit period ended >.

<Name of state> is responsible for initiating the state recovery process and furnishing the final findings report to the provider. CMS will not send a copy of the final findings report to the provider. The final findings report identifies <$0,000.00> total computable, (<$0,000.00> FFP) in unallowable claims paid to <provider name>. In accordance with §1903(d)(2)(C) of the Social Security Act, <name of state> has one (1) year from the date of this letter to recover or attempt to recover the overpayment from the provider before the Federal share must be refunded to CMS. Any amounts actually collected prior to the expiration of the one year time limit, however, remain due on the CMS-64 form for the quarter in which collection is actually made (see http://www.cms.gov/smdl/downloads/SMD10014.pdf).

Please report on Line 9C1, Recoveries: Fraud, Waste and Abuse Efforts, in the amount of <$0,000.00> total computable (<$0,000.00> FFP) using feeder Form CMS-64.9C1, Line 5, CMS Medicaid Integrity Contractors (MICs).

If you have any questions regarding this final findings report, please contact me by telephone at (312) 353-2990 or by e-mail at Elizabeth.Lindner@cms.hhs.gov.

Sincerely,

Elizabeth Lindner, Director
Division of Field Operations - North

cc: *<Name of State PI Director>, <State> PI Director*
<UPIC contact>
Robert Lane, CMS Division of Financial Operations, FMG, CMCS
Leticia Barraza, CMS Division of Financial Operations, FMG, CMCS
Dorothy Ferguson, CMS Division of Financial Operations, FMG, CMCS

Appendix F

Final Findings Report – State Transmittal Letter Template for FFS with No MCO Recoupment

(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

<Date>

<Name of State Medicaid Director>, <Title>
<Address>
<City, State, Zip Code>

Dear < Mr. /Ms. State Medicaid Director Last Name>:

Enclosed is the final findings report for <provider name>, state Medicaid provider #<number>/NPI #<number>. The investigation was conducted by <name of UPIC>, on behalf of the Centers for Medicare & Medicaid Services (CMS), and concerned Medicaid claims paid to <provider name>. The investigation encompassed both Medicaid fee-for-service and managed care claims, associated with the managed care organization <MCO name>, for services provided during the period of <date audit period started > through <date audit period ended >.

The report identified a fee-for-service overpayment of <$0,000.00> total computable (<$0,000.00> FFP) that should be recovered by the state. The report also identified <$0,000.00> as overpayments paid by the managed care organizations; those should be handled in accordance with the state's managed care contract and the requirements of 42 CFR 438.608(d).

<Name of state> is responsible for initiating the state recovery process and furnishing the final findings report to the provider. CMS will not send a copy of the final findings report to the provider. In accordance with §1903(d)(2)(C) of the Social Security Act, <name of state>has one (1) year from the date of this letter to recover or attempt to recover the overpayment from the provider before the Federal share must be refunded to CMS. Any amounts actually collected prior to the expiration of the one year time limit, however, are due on the CMS-64 form for the quarter in which collection is actually made (see http://www.cms.gov/smdl/downloads/SMD10014.pdf).

Please report on Line 9C1, Recoveries: Fraud, Waste and Abuse Efforts, the total computable amount of <$0,000.00 amount state can recover only> (<$0,000.00 amount state can recover only> FFP). This amount should first be entered on feeder Form CMS-64.9C1, Line 5, CMS Medicaid Integrity Contractors (MICs).

If you have any questions regarding this final findings report, please contact me by telephone at (312) 353-2990 or by e-mail at Elizabeth.Lindner@cms.hhs.gov.

Sincerely,

Elizabeth Lindner, Director
Division of Field Operations - North
Investigations and Audits Group

cc: <Name of State PI Director>, <State> PI Director
<UPIC contact>
Robert Lane, CMS Division of Financial Operations, FMG, CMCS
Leticia Barraza, CMS Division of Financial Operations, FMG, CMCS
Dorothy Ferguson, CMS Division of Financial Operations, FMG, CMCS

Appendix G

Final Findings Report – State Transmittal Letter Template with No MCO Recoupment

(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

<Date>

<Name of State Medicaid Director>, <Title>
<Address>
<City, State, Zip Code>

Dear < Mr. /Ms. State Medicaid Director Last Name>:

Enclosed is the final findings report for <provider name>, state Medicaid provider #<number>/NPI #<number>. The investigation was conducted by <name of UPIC>, on behalf of the Centers for Medicare & Medicaid Services (CMS), and concerned Medicaid claims paid to <provider name>. The investigation encompassed Medicaid claims associated with the managed care organization <MCO name> for services provided during the period of <date audit period started > through <date audit period ended >.

The report identified <$0,000.00> in overpayments paid by <MCO name> to the provider. This overpayment should be handled in accordance with the state's managed care contract and the requirements of 42 CFR 438.608(d). <State> is responsible for furnishing the final findings report to the provider. CMS will not send a copy of the final findings report to the provider.

If you have any questions regarding this final findings report, please contact me by telephone at (312) 353-2990 or by e-mail at Elizabeth.Lindner@cms.hhs.gov.

Sincerely,

Elizabeth Lindner, Director
Division of Field Operations - North

cc: <Name of State PI Director>, <State> PI Director
<UPIC contact>
Robert Lane, CMS Division of Financial Operations, FMG, CMCS
Leticia Barraza, CMS Division of Financial Operations, FMG, CMCS

Dorothy Ferguson, CMS Division of Financial Operations, FMG, CMCS

Appendix H

Final Findings Report Addendum – State Transmittal Letter Sample

(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

<Date>

<Name of State Medicaid Director>, <Title>
<State Medicaid PI Dept. Name
<Address>
<City, State, Zip Code>

Dear < Mr. /Ms. State Medicaid Director Last Name>:

On <date FFR issued>, the Centers for Medicare & Medicaid Services (CMS) issued a final findings report for <provider name>, State Medicaid provider #<number>/NPI #<number>. The investigation was conducted by <name of UPIC> on behalf of CMS and encompassed the Medicaid claims<<,associated with the managed care organization <MCO name>,>> for services provided during the period of <date audit period started > through <date audit period ended >.

Subsequent to the issuance of the final findings report, issues relating <brief description of discrepancies identified> were discovered. Consequently, the overpayment amount on <Appendix or Attachment name >has been revised, resulting in the identified overpayment changing from <$0,000.00> to <$0,000.00>. The Federal share has changed from <$0,000.00> to <$0,000.00>.

The remainder of the above referenced final findings report shall remain unchanged and shall continue in full force and effect.

Sincerely,

Elizabeth Lindner, Director
Division of Field Operations - North

cc: <Name of State PI Director>, <State> PI Director
<UPIC contact>
Robert Lane, CMS Division of Financial Operations, FMG, CMCS
Leticia Barraza, CMS Division of Financial Operations, FMG, CMCS
Dorothy Ferguson, CMS Division of Financial Operations, FMG, CMCS

Appendix I

Information Exchange Agreement (IEA)

(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

INFORMATION EXCHANGE AGREEMENT
BETWEEN

THE CENTERS FOR MEDICARE & MEDICAID SERVICES
AND

PARTICIPATING STATE MEDICAID AGENCIES
FOR

THE DISCLOSURE OF MEDICARE AND MEDICAID INFORMATION

CMS Information Exchange No. 2017-17

Effective:	
Expiration:	

I. PURPOSE, LEGAL AUTHORITY, AND DEFINITIONS

A. Purpose

The purpose of this Agreement is to establish the conditions, safeguards, and procedures under which the Centers for Medicare & Medicaid Services (CMS) will conduct an information exchange program with participating State Medicaid Agencies (SMA) that will match and study claims, billing, and eligibility information to detect suspected instances of programmatic fraud, waste and abuse (FW&A). To support the health oversight activities of CMS, CMS and the SMA and/or its contractor(s) will provide CMS and/or its contractor (hereinafter referred to as the "Custodian") with Medicare and Medicaid records pertaining to eligibility, claims, and billing information, which CMS and/or the Custodian will match.

Utilizing fraud detection software, the information will then be used to identify patternsof aberrant practices and abnormal patterns requiring further investigation. Aberrant practices and abnormal patterns identified in this matching program that constitute FW&A will involve individuals who are practitioners, providers and suppliers of services, Medicare beneficiaries, Medicaid recipients, and other individuals whose information may be maintained in the records.

Furthermore, § 6034(g) (1) (B) of the Deficit Reduction Act (DRA), Public Law (Pub.

L.aw)109-171; 42 United States Code (U.S.C.) § 1395ddd (g)(1)(B) provides for the disclosure of certain information that will be derived from these CMS health oversight activities to "States (including a Medicaid Fraud Control Unit (MFCU) described in § 1903(q))" of the Social Security Act (the Act). The SMA will therefore receive information from CMS for use in their own FW&A programs.

B. Legal Authority

This IEA is executed to comply with the Privacy Act of 1974 (Title 5 U.S.C. § 552a), as amended, and the Office of Management and Budget (OMB) Circular A-130, titled "Managing Information as a Strategic Resource" at 81 Federal Register (FR) 49689 (July 28, 2016).

This Agreement provides for information exchange of matched data that is fully consistent with the authority of the Secretary of the Department of Health and Human Services (HHS) (the Secretary). Sections 1816 and 1842 of the Act permits the Secretaryto make audits of the records of providers as necessary to ensure that proper payments aremade, to assist in the application of safeguards against unnecessary utilization of servicesfurnished by providers of services and other persons to individuals entitled to benefits, and to perform other functions as are necessary (Pub. L. 108-173 § 911, amending Title XVIII, § 1874A (42 U.S.C. § 1395kk-1).

Section 1857 of the Act provides that the Secretary, or any person or organization designated by the Secretary shall have the right to "inspect or otherwise evaluate (i) the quality, appropriateness, and timeliness of services performed under the contract" (42 U.S.C. § 1395w-27(d) (2) (A)); and "audit and inspect any books and records of [a Medicare Advantage] organization that pertain to services performed or determinations of amounts payable under the contract" (42 U.S.C. § 1395w-27(d) (2) (B)).

Furthermore, § 6402 (b) of the Affordable Care Act, which amended Title XVIII § 1860D-15(f)(2) of the Act, permits the use of Part D data "by officers, employees, and contractors of HHS for the purposes of, and to the extent necessary in conducting oversight, evaluation, and enforcement."

Additionally, § 1874(b) of the Act authorizes the Secretary to "contract with any person, agency, or institution to secure on a reimbursable basis such special data, actuarial information, and other information as may be necessary in the carrying out of his functions under Subchapter XVIII" (42 U.S.C. § 1395kk (b)).

Section 1893 of the Act establishes the Medicare Integrity Program (MIP), under which the Secretary may contract with eligible entities to conduct a variety of program safeguard activities, including fraud review employing equipment and software technologies that surpass existing capabilities (42 U.S.C. § 1395ddd)). These entities arecalled Unified Program Integrity Contractors (UPIC) and Medicare Drug Integrity Contractors (MEDIC).

Pursuant to the applicable state statutes and guidelines for the participating SMA charged

with the administration of the Medicaid program, disclosure of the Medicaid data pursuant to this Agreement is for purposes directly connected with the administration of the Medicaid program, in compliance with 42 Code of Federal Regulations (CFR) §§ 431.300 through 431.307. Those purposes include the detection, prosecution, and deterrence of FW&A in the Medicaid program. (See state signature page for the legalauthority for each specific state, if needed.)

CMS would cite to 45 CFR § 164.501 (definition of "Health Oversight Agency") and 45CFR § 164.512(d) as bases under which it believes the participating SMA may make the contemplated disclosures of Medicaid data to CMS' contractor. It would also note that under § 6034(g)(1)(B) of the DRA (42 U.S.C. 1395ddd(g)(1)(B)), CMS is required to disclose certain data and statistical information collected by the Medi-Medi program to States and other named parties. This data can then be used by each receiving state's own FW&A programs.

C. Definitions

For purposes of this Agreement, the following definitions apply:

1. *"Custodian" means the Medicaid and/or Medicare Integrity Program entity with which CMS is contracting as its Business Associate under the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules at 45 Code of Federal Regulations (CFR) Parts 160 and 164 to perform the data exchange of matched data and related functions described in this Agreement. The term Custodianshall apply to a Unified Program Integrity Contractor (UPIC) and/or the One ProgramIntegrity Systems Integrator and shall be designated on the Custodian signature page(s) of this Agreement;*
2. *"Medicare" means the health insurance program established under Title XVIII of theAct;*
3. *"Medicaid" means the Medicaid program established under Title XIX of the Act,together with other health care programs established under state law;*
4. *"One Program Integrity" (One PI)- Serves as a system application, tool and databasesproviding access to the CMS Integrated Data Repository (IDR) which houses, at a minimum, the most current Medicare Parts A and B billing and payment data;*
5. *"State Medicaid Agency" means the single State agency administering or supervisingthe administration of a State Medicaid plan.*

II. DESCRIPTION OF EXCHANGE OF MATCHED DATA

The information provided by CMS on Medicare records and the participating SMA on Medicaid records will be used in an information exchange program of matched data of claimsand eligibility in the Medicare and SMA programs. CMS and the participating SMA data will be matched by linking elements of both programs that identify Medicare beneficiaries and Medicaid Program recipients as well as providers who are common to both programs. Inaddition to the provider and beneficiary/recipient identifiers, the match

will include claim data elements identifying services, procedures, diagnostic codes, prescription drugs, and other related information that may permit detection of FW&A. The exchange program of matched data described herein will be conducted via sophisticated fraud detection software that identifies patterns and deviations there-from, in data sets to identify potential FW&A.

As such, the software may match any or all fields in one record against any or all fields in one or more other records. Because of the impossibility of precisely identifying beforehand all possible matching combinations, this Agreement instead sets forth in Section III. A., a list that includes, but is not limited to, examples of data elements contained in the Medicare and Medicaid records subject to matching exchange.

In light of § 6034(g)(1)(B) of DRA, this information exchange of matched data will ultimately enhance the ability of CMS and the participating SMA to detect FW&A, as well as effectuate potential administrative actions for practitioners, providers, and suppliers in both the Medicare and Medicaid programs. Combining claims and eligibility data from multiple health programs provides a more complete picture of beneficiary/recipient care and provider practices than can be gained by analyzing data from one program in isolation and likely will reveal patterns of FW&A undetectable from analysis of data from any one particular program. This premise will be thoroughly evaluated in conducting this exchange of matcheddata, and to meet the DRA requirements. CMS may require additional reporting requirements from the SMA to determine the outcomes of the administrative actions identified from the matched data. To ensure adequate program evaluation, all Medicaid related reports created by the Custodian pursuant to the exchange will be provided to the participating SMA as they are provided to CMS as permitted by law.

Potential FW&A will be detected through data analysis and investigation. Identified potential FW&A in the Medicare program will be more fully developed, and referred to entities that may include the Medicare Administrative Contractors (MAC), UPIC, National Benefit Integrity (NBI), Medicare Drug Integrity Contractor (MEDIC), and/or law enforcement agencies including the HHS' Office of Inspector General, the Department of Justice, as well as other entities that are legally obligated to obtain such information. Identified potential FW&A in the State Medicaid Program detected by the exchange of matched data will be more fully developed and referred to appropriate SMA authorities, the UPIC, and/or law enforcement agencies to include both HHS' Office of Inspector General, the Department of Justice, and the SMA's Medicaid Fraud Control Unit (MFCU). Identified potential FW&A that involve both the Medicare and SMA Programs will be more fully developed and referred to the appropriate parties for further action.

III. DESCRIPTION OF RECORDS

The Privacy Act requires that each Exchange Agreement for matched data specify a description of the records which will be matched and exchanged, including a sample of data elements that will be used, the approximate number of records that will be matched, and the projected starting and completion dates of the program.

Data Elements to be used for Matching

A. Data Elements Included in Records File by the participating SMA

The participating SMA shall make available to CMS records for the matching that, at a minimum, will include the following data elements:

Recipient Identification
Recipient Identification RelationalRecipient Claim Number
Recipient Claim Number Account NumberRecipient Identification Code
Recipient Given Name Recipient Middle Name Recipient Surname NameRecipient Birth Date

Social Security Numbers
Recipient Social Security Number RelationalRecipient Social Security Number

Provider Data
Provider Identification Number (PIN) Provider National Provider Identifier (NPI)
Provider Social Security Number or Tax Identification Number

Procedure Data
HCPCS Procedure CodesCPT Procedure Codes

Diagnoses Data
ICD 9 Detail Diagnosis Code/ ICD 10 Detail Diagnosis Code (following transition)ICD 9 Primary Header Diagnosis Code/ ICD 10 Primary Header Diagnosis Code (following transition)

B. Data Elements Included in Records File by CMS

CMS shall make available records for the matching that, at a minimum, will include the following data elements:

Part A Entitlement
Beneficiary Part A Entitlement Relational Beneficiary Part A Entitlement Start Date
Beneficiary Part A Entitlement Termination DateBeneficiary Part A Entitlement Status Code

Part B Entitlement
Beneficiary Part B Entitlement Relational Beneficiary Part B Entitlement Start Date
Beneficiary Part B Entitlement Termination DateBeneficiary Part B Entitlement Status Code

Part D Entitlement
Beneficiary Part D Entitlement Relational Beneficiary Part D Entitlement Start Date
Beneficiary Part D Entitlement Termination DateBeneficiary Part D Entitlement Status Code

Entitlement Reason

Beneficiary Entitlement Reason Code Relational Beneficiary Entitlement Reason Code Change DateBeneficiary Entitlement Reason Code

Provider Data
Provider Identification Number (PIN)
Provider National Provider Identifier (NPI)
Provider Social Security Number or Tax Identification NumberDrug Enforcement Administration (DEA) number
Provider State License Identifier (if applicable)

Procedure Data
HCPCS Procedure CodesCPT Procedure Codes

Diagnoses Data
ICD 9 Detail Diagnosis Code/ ICD 10 Detail Diagnosis Code (following transition)ICD 9 Primary Header Diagnosis Code/ ICD 10 Primary Header Diagnosis Code (following transition)

Member Data
Name
Date of birthGender
SSN
SMA Member Identified

C. Disclosure of Information by CMS to the Participating SMA

The participating SMA record files will be matched against CMS files and all exchangeddata on individual recipients or providers that impact the Medicaid program will be madeavailable to the participating SMA.

D. Projected Starting and Completion Dates

The Agreement shall remain in effect for a period not to exceed 5 years from the last dateof when all parties have signed this agreement; however, within 3 months prior to the expiration of this Agreement, CMS may renew this Agreement for not more than 5 additional years subject to the requirements of the participating agencies.

E. CMS data for the Exchange of Matched Data are maintained in the Following Database:

Medicare Integrated Data Repository (IDR), System No. 09-70-0571 was published at 71FR 74915 (December 13, 2006). Data maintained in this system will be released pursuant to routine use number 11 as set forth in the system notice. The One PI Custodian will release matched data to the participating SMA. If such system infrastructure shall change then an amendment shall be added to this document to accountfor such change.

F. Number of Records Involved and Operational Time Factors

1. *Medicare records will include the entire body of Medicare data for all eligible beneficiaries residing in the participating State and providers billing for treatment and services for the time period of analysis.*

2. *Each participating SMA's records file will contain records representing that SMA's total Medicaid utilization, as stated on the SMA signature page, related to individualswho are Medicaid recipients for the time period of analysis.*

3. *CMS will provide the Custodian with access to claims and eligibility data for the Medicare program updated on a monthly basis. Presently, three or more years of dataare accessible at any given time. The custodian will have access to the time period asspecified for the analysis period.*

4. *The participating SMA will provide the CMS with access to current Medicaid Program claims and eligibility data with updates on the frequency specified on theparticipating SMA's signature page. The participating SMA will be able to make available a minimum of 3 years of Medicaid data for FW&A analysis.*

IV. RETENTION AND DESTRUCTION OF IDENTIFIABLE RECORDS

The data files provided for the data exchange program will be maintained and disclosed by CMS, and neither CMS nor the participating SMA will create a separate electronic file consisting of individuals whose records were provided in this exchange program. However, as a result of this project, files will be created for both Medicare and participating Medicaid states based on this merged data to support recovery of overpayments, or to pursue investigation and possible prosecution of fraud, waste and abuse cases. These files will be destroyed in a manner consistent with the destruction of other, similar files, created via other means. Other than files created for the aforementioned purposes, CMS and the participating SMA will retain all identifiable records received from the exchange of this matched data onlyfor the period of time required for the period of performance related to the data of this program, and will then destroy the records. Older data will be deleted as new data becomes available. Magnetic tape files shall be erased. Electronic data shall be deleted. The User agrees to destroy and send written certification of the destruction of the files to CMS within 30 days. The User agrees not to retain CMS files or any parts thereof, or specific bidding information, and those files that can be used in concert with other information to identify after the aforementioned file(s) are destroyed unless the appropriate Systems Manager or the person designated in this Agreement grants written authorization.

CMS shall maintain, acquire, use and disclose all state Medicaid data provided by the participating SMA under this Agreement in compliance with applicable laws and regulations governing such information, including but not limited to 42 U.S.C. § 1396a(a)(7), 42 CFR § 431.300 et seq., and 45 CFR § 205.50 et. seq. This responsibility includes treating all Medicaid recipient data provided by the participating SMA as confidential. CMS shall provide the participating SMA with a list of personnel authorized to access the State

Medicaid data upon request.

V. SAFEGUARDS AND SECURITY PROCEDURES

CMS has safeguards in place for authorized users and monitors such users to ensure against excessive or unauthorized use. Personnel having access to identifiable data have been trained in the Privacy Act and information security requirements. Employees who maintain identifiable data are instructed not to release data until the intended recipient agrees to implement appropriate management, operational and technical safeguards sufficient to protect the confidentiality, integrity and availability of the information and information systems and to prevent unauthorized access.

The collection of identifiable data will conform to all applicable Federal laws and regulations and Federal, HHS, and CMS policies and standards as they relate to information security and data privacy. These laws and regulations include but are not limited to: the Privacy Act of 1974; the Federal Information Security Modernization Act of 2014; the Computer Fraud and Abuse Act of 1986; the Health Insurance Portability and Accountability Act of 1996; the E-GovernmentAct of 2002, the Clinger-Cohen Act of 1996; the Medicare Modernization Act of 2003, and the corresponding implementing regulations. OMB Circular A-130, Managing Information as a Strategic Resource, Appendix III, and Security of Federal Automated Information Resources also applies. Federal, HHS, and CMS policies and standards include but are not limited to: all pertinent National Institute of Standards and Technology publications; and the HHS Information Systems Security and Privacy Program (IS2P).

A. *CMS and the participating SMA agree to safeguard data received from each other as follows:*

1. *Access to the records of matched data and to any records created by the matching ofthe data exchange will be restricted to only those authorized employees and officialswho need them to perform their official duties in connection with the uses of the information authorized in this Agreement. Further, all personnel who will have access to the records of the matched data and to any records created by the matchingof the data will be advised of the confidential nature of the information, the safeguards required to protect the record and the civil and criminal sanctions for noncompliance contained in applicable Federal laws.*
2. *The exchanging of records of the matched data and any records created by the matching of the data will be stored in an area that is physically safe from access by unauthorized persons during duty hours as well as non-duty hours or when not in use.*
3. *The records of the matched data, and any records created by the matching of the data,will be processed under the immediate supervision and control of authorized personnel, to protect the confidentiality of the records in such a way that unauthorizedpersons cannot retrieve any such records by means of computer, remote terminal or other means.*

4. *The records of the matched data and records created by the matching of the data willbe transported under appropriate safeguards.*
5. *CMS may make on-site inspections, and may make other provisions to ensure that theCustodian maintains adequate safeguards. CMS shall provide the participating SMA with any reports and/or documentation relating to such on-site inspections at its request.*
6. *The records of the matched data and the records created by the matching of the data shall be safeguarded by administrative, physical, and technical safeguards that reasonably and appropriately protect confidentiality, integrity and availability of the data as these terms are defined in the Health Insurance Portability and AccountabilityAct (HIPAA) Security Rule at 45 CFR Parts 160 and 164. CMS shall ensure that theCustodian is in compliance with this requirement.*

B. *CMS and the participating SMA shall also adopt policies and procedures to ensure that information contained in their respective records shall be used solely as provided in thisAgreement.*

C. *CMS and the participating SMA will comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules. This program of exchanging matched data employs systems which contain Protected Health Information (PHI) as defined by HHS regulation "Standards for Privacy of Individually Identifiable Health Information" (45 CFR §§ 160.103) (65 Fed. Reg. 82462 (Dec. 28, 2000)). Disclosures ofPHI authorized by the routine uses cited may only be made if, and as, permitted or required by the HIPAA Privacy Rule.*

D. *CMS, the data Custodian, and the participating SMA will comply with the Breach notification procedures set forth in OMB Memorandum M-17-12 "Preparing for and Responding to a Breach of Personally Identifiable Information" upon discovery by a Party to this contract of any suspected or confirmed Breach, inappropriate use of data, or Security Incident. The Party experiencing the event will notify the other agency's SystemSecurity Contact named in this Agreement within one (1) hour of discovering the loss, potential loss, Security Incident, or Breach.*

If the Custodian and/or the participating SMA is unable to speak with the CMS Systems Security Contact within one hour or if for some other reason notifying the CMS Systems Security Contact is not practicable (e.g., it is outside of the normal business hours), the data Custodian and /or participating SMA will contact the CMS IT Service Desk at 410-786-2580 or e-mail CMS-IT-ServiceDesk@cms.hhs.gov.

E. *The Party that experienced the loss, potential loss, Security Incident, or Breach will be responsible for following its established procedures, including notifying the proper organizations (e.g., United State Computer Emergency Readiness Team (US-CERT)), conducting a breach and risk analysis, and making a determination of the need for notice and/or remediation to individuals affected by the loss. Parties under this Agreement will follow PII Breach notification policies and related procedures*

as required by OMB guidelines. If the Party experiencing the Breach determines that the risk of harm requiresnotification to the affected individuals or other remedies that Party will carry out these remedies without cost to the other Party.

The SMA agrees to establish appropriate administrative, technical, and physical safeguards to protect the confidentiality of the data and to prevent unauthorized use or access to it. The safeguards shall provide a level and scope of security that is not less thanthe level and scope of security requirements established by the Office of Management and Budget (OMB) in OMB Circular No. A-130, Appendix III--Security of Federal Automated Information Systems) as well as Federal Information Processing Standard 200entitled "Minimum Security Requirements for Federal Information and Information Systems"; and, Special Publication 800-53 "Recommended Security Controls for FederalInformation Systems". The SMA acknowledges that the use of unsecured telecommunications, including the Internet, to transmit individually identifiable, bidder identifiable or deducible information derived from the file(s) specified prohibited.

Further, the SMA agrees that the data must not be physically moved, transmitted or disclosed in any way from or by the site indicated in without written approval from CMS unless such movement, transmission or disclosure is required by a law.

VI. RECORDS USAGE, DUPLICATION, AND RE-DISCLOSURE RESTRICTIONS

CMS and the participating SMA agree to the following limitations on the access to and disclosure and use of, the tapes and information provided under this Agreement.

1. *That the data files provided for the program of exchanging matching data will be maintained and disclosed by the CMS Custodian and will be handled as indicated in Section IV of this Agreement.*
2. *That the data supplied and the records created by the matching will be used and accessedonly for the purposes of, and to the extent necessary in, the program created by this Agreement.*
3. *That the data provided by the participating SMA will not be duplicated in a separate fileor disseminated for purposes other than those intended by this Agreement without the written consent of the participating SMA.*
4. *That, other than for purposes of a particular match under this program, no file will becreated that consists of information concerning only matched individuals.*

VII. REIMBURSEMENT FUNDING

All work to be performed by the Custodian to carry out the exchange in accordance with this Agreement will be performed on a contractual basis by the Custodian as prescribed inthe contract between the Custodian and CMS. All work to be performed by the participating SMA to carry out the requirements of this exchange program in accordance with this Agreement will be performed on a non-reimbursable basis, except to the extent that those requirements may include administrative or other activities eligible for Federal financial participation.

VIII. APPROVAL AND DURATION OF AGREEMENT

A. *Effective Date: This Information Exchange Agreement will become effective from the last date of when all parties have signed this agreement and will remain in effectfor a period not to exceed 5 years from the effective date of the Agreement. This Agreement may be renewed for consecutive 5 year periods subject to the requirements of the participating agencies. Information exchange activities will continue without interruptions during agreement renewal procedurals.*

B. *This Agreement may be terminated at any time with the consent of both parties. If either party does not want to continue this program, it shall notify the other party of its intention not to continue at least 90 days before the end of the then current period of the Agreement. Either party may unilaterally terminate this Agreement upon written notice to the other party requesting termination, in which case the terminationshall be effective 90 days after the date of the notice or at a later date specified in the notice provided the expiration date does not exceed the original or the extended completion date of the exchange. At such time when the agreement terminates, CMS and the SMA will determine such appropriate closeout procedures to insure the safeguard of CMS data and data obtained from the SMA. The closeout process will also bring any outstanding analysis, audits and other investigative activities to a finalstatus for transition to the applicable party.*

IX. PERSONS TO CONTACT

A. *The CMS contact for Programmatic issues:*

Elizabeth Lindner
DFO-N Director
Division of Field Operations - NorthInvestigations and Audits Group Center for Program Integrity
Centers for Medicare and Medicaid ServicesPhone: 312-353-2990
E-mail: elizabeth.lindner@cms.hhs.gov

B. *The CMS contact for Privacy issues:*

Barbara Demopulos
CMS Privacy Advisor
Division of Security, Privacy Policy and GovernanceInformation Security and Privacy Group
Office of Information Technology
Centers for Medicare & Medicaid Services 7500 Security Boulevard, Mail Stop: N1-14-40
Baltimore, MD 21244-1849
Telephone: 410-786-5357

E-mail: Barbara.demopulos@cms.hhs.gov

C. *The contact person for the participating SMA can be found on the SMA signature page.*

D. *The contact person for the Custodian can be found on the Custodian signature page.*

E. *The contact person for the CMS One Program Integrity Systems Integrator can be foundon the CMS One Program Integrity Systems Integrator signature page*

X. APPROVALS

A. Centers for Medicare & Medicaid Services Program Official

The authorized program official, whose signature appears below, accepts and expressly agrees to the terms and conditions expressed herein, confirm that no verbal agreements of any kind shall be binding or recognized, and hereby commits his respective organizationsto the terms of this Agreement.

Approved by (Signature of Authorized CMS Program Official)	
Print name of CMS CPI Official	***Date:***

B. Centers for Medicare & Medicaid Services Approving Official

The authorized approving official, whose signature appears below, accepts and expressly agrees to the terms and conditions expressed herein, confirm that no verbal agreements of any kind shall be binding or recognized, and hereby commits his respective organizations to the terms of this Agreement.

Approved By (Signature of Authorized CMS Approving Official)	
Michael Pagels, Director *Division of Security, Privacy Policy and Governance, andActing Senior Official for Privacy* *Information Security & Privacy GroupOffice of Information Technology* *Centers for Medicare & Medicaid Services*	***Date:***

C. Participating State Program Official

The authorized Participating State program official, whose signature appears below, accepts and expressly agrees to the terms and conditions expressed herein, confirms that no verbal agreements of any kind shall be binding or recognized, and hereby commits his/her respective organization to the terms of this Agreement.

NAME OF PARTICIPATING STATE

Approved by (Signature of Authorized State Program Official)	
Print name of Authorized State Program Official	***Date:***

The Participating State Records to Be Exchanged for Matching:

The data for the _____ *that will be made available for the exchange program described herein are maintained in the following data files and the frequency of the exchange of data will be made on a monthly basis. (All or part of these files may be used in this data-exchange program):*

MMIS *which will submit approximately* _____ *of claims and* _____ *of encounters annually.*

The type of data files being shared on a monthly basis by the

_____

shall include but is not limited to:

Claims *– managed care/encounter data, crossover and TPL claims, adjustments/ voids, denied claims.*

Eligibility *- files that include all data elements that are associated with claim adjudication, and any retro-active eligibility activity*

Provider *- Medicaid files including any Medicare and NPI reference files*

Participating State Legal Authority (as needed):

D. CMS Custodian Official

The authorized CMS Custodian official, whose signature appears below, accepts and expressly agrees to the terms and conditions expressed herein,confirms that no verbal agreements of any kind shall be binding or recognized, and hereby commits his/her respective organization to the terms of this Agreement.

Approved by (Signature of Authorized CMS Custodian Official)	
Print name of Authorized CMS Custodian Official	*Date:*

E. CMS One Program Integrity Systems Integrator

The authorized OptumServe Technology Services (One PI) systems support contractor official, whose signature appears below, accepts and expressly agrees to the terms and conditions expressed herein, confirms that no verbal agreements of any kind shall be bindingor recognized, and hereby commits his/her respective organization to the terms of this Agreement.

Approved by (Signature of OptumServe Technology Services official)	
Print name of OptumServe Technology Services Official	*Date:*

Appendix J

Joint Operating Agreement (JOA)
((Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

Joint Operating Agreement (JOA) Between [Insert UPIC name] and [SMA name]

[Insert Date]

Change History Log

Version	*Date*	*Changed By*	*Description of Change*

Section 1. Introduction

[This template is a guide and includes suggested language which may be changed pending the agreement of the UPIC and the state Medicaid agency (SMA).]

1.1 Unified Program Integrity Contractor (UPIC) Purpose

The purpose of the UPIC in Medicaid is to work with SMAs to identify potential fraud, waste, and abuse across the Medicaid and Medicare programs. The program incorporates data matching, coordination, and information sharing to identify fraudulent or wasteful billing behavior that goes undetected when the programs are reviewed in isolation.

1.2 Partner Responsibilities

Medicaid program integrity is a collaborative effort between CMS, [Insert UPIC name] (under contract to CMS), [Insert SMA name], and law enforcement officials. The following table summarizes the roles and responsibilities of each partner.

CMS	***[Insert SMA name]***
Provide funding and oversight for the UPIC *Conducts outreach to states to assess the program integrity needs* *Provides open forum for communication and facilitates information sharing* *Participate in the Initial State Collaboration Meeting and program management meetings* *Execute the Information Exchange Agreement* *Establish connectivity with SMA* *Provide CMS system training* *Provide Medicare and Medicaid policy and data assistance* *Participate in national-level document sharing*	*Participate in Initial State Collaboration Meeting* *Renew Information Exchange Agreement, if applicable* *Complete Joint Operating Agreement* *Establish connectivity, if needed* *Provide Medicaid data, if applicable* *Provide and participate in training* *Contribute to the Data Analysis Project Management Strategy* *Provide Medicaid policy and data assistance* *Participate in the Data Workgroup (if applicable)* *Participate in program management meetings* *Follow established fraud, waste, and abuse investigations, audits, and referral processes* *Work on joint investigations or share investigative findings* *Contribute to state-level and national level document sharing*
[Insert UPIC name]	

Facilitate the Initial State Collaboration Meeting *Establish Joint Operating Agreement* *Develop Data Analysis Project Management Strategy* *Provide and receive training* *Facilitate program management meetings* *Provide Medicare and Medicaid policy and data assistance* *Conduct data matching and/or data analysis* *Conduct fraud, waste, and abuse investigation and referral processes* *Work on joint investigations* *Contribute to state-level and national-level document sharing* *Participate in Data Workgroup*	

1.3 Joint Operating Agreement Purpose

This Joint Operating Agreement (JOA) is an agreement between [insert UPIC name] and [insert SMA name] to establish guidelines, duties, and shared expectations of how each will conduct business with the other. This JOA will include any agreement between the SMA and the UPIC on program implementation and operation that is not specified in the PIM.

[Insert UPIC name] and [Insert Medicaid State Agency name] collaborated on the development of this JOA and agree with the terms of the agreement.

1.4 Maintaining the JOA

1.4.1 Annual Updates

The JOA should be revisited annually. The [insert UPIC name] Medicaid Operations Lead will be responsible for coordinating the review and revision process.

1.4.2 On-going Updates

All updates are to be sent to the [insert UPIC name] Medicaid Operations Lead. Within [insert number] weeks, the [insert UPIC name] Medicaid Operations Lead will distribute a draft to all points of contact identified in this JOA. Feedback is to be

provided within [insert number] weeks. The [Insert UPIC name] project lead will then distribute a final draft to all points of contact. The [Insert SMA name] contact person will provide approval of the changes via email or other written format.

1.4.2 Tracking of Changes

Changes to the JOA are identified in the Change History Log on the second page of this document and are controlled via a version number in the upper right-hand corner of each page of the document. Changes to the appendices to this document are also controlled via a version number in the upper right-hand corner of each appendix.

1.5 Liability

Although [insert UPIC name] has a contractual relationship with CMS, there is no privity of contract between [insert UPIC name] and [insert SMA name]. [Insert UPIC name] will be indemnified and protected by limitations on liability according to the terms of the [insert UPIC name]'s "[insert name of UPIC contract". [Insert UPIC name] will be indemnified and protected by limitations on liability according to the terms of its UPIC contract. [Insert UPIC name] is protected against criminal or civil liability as a result of the performance of duties as a program integrity contractor under its contract as long as it uses due care. See 63 Fed. Reg. 13,590 (1998) (to be codified at 42 C.F.R. 421.316) (proposed March 20, 1998). In light of the provisions of [insert UPIC name]'s current contract with CMS and the constraints of law, no amendments to [insert UPIC name]'s contract will be made with respect to indemnification or limitations on liability.

1.6 Guiding Documents

The [insert UPIC name] is required to adhere to applicable federal laws, regulations, the CMS Program Integrity Manual (PIM), and the Statement of Work established with CMS.

The [Insert SMA name] is required to adhere to applicable federal and state laws, and regulations.

Section 2. Implementation

This section describes the implementation of Medicaid program integrity coordination efforts in [Insert State].

2.1 Information Exchange Agreement

When applicable, the [insert SMA name] will renew the Global Information Exchange Agreement (IEA) with CMS.

Section 3. Dispute Resolution

<Describe the process for resolving disputes between the UPIC and the SMA.>

Section 4. Communications Plan

4.1 Points of Contact

To assure that communication is properly directed, [insert UPIC name] and [insert SMA name] will each identify (in the Master Contact List) representative(s) to serve as:

Medicaid Operations Lead and/or Program Integrity Manager – Responsible for acting as the main project lead for Medicare program integrity coordination efforts. The lead is responsible for establishing and maintaining the JOA and for leading the resolution of any JOA-related issues that may arise.

Data Manager – Responsible for the exchange of information regarding data analysis issues, including understanding the data sources.

[Other roles may be added as appropriate and do not necessary require the level of Key Personnel as listed in the UPIC SOW.]

4.2 Regular Collaboration

[Insert information on regular meetings that will occur between the UPIC and the SMA. Two examples are shown below.]

4.2.1 Program Management Meeting

[Insert UPIC name] and [insert SMA name] will participate in Program Management Meetings. The staff participating in the Program Management Meetings are identified in the "Master Contact" list at the end of the JOA. [Insert information on the role of the Program Management Meetings and the frequency of meetings]

4.2.2 Medicaid Program Integrity Coordination Data Workgroup

[Insert UPIC name] and [insert SMA name] will participate in a data workgroup. The staff participating in the data workgroup is identified in the Master Contact table at the end of the JOA. [Insert information on the role of the data workgroup and the frequency of meetings]

Section 5. Training and Information Sharing

[Describe how the UPIC and the SMA will provide cross-training on programs, policies, and data. See the Medicaid PIM for guidance.]

5.1 Initial Cross-Training

5.2 Ongoing Training

5.3 Subject-Matter Experts

Section 6. Connectivity and Data Sharing

6.1 Connectivity

[Insert UPIC name] and [insert SMA name] and CMS will work together to determine how data will be shared.

[Insert UPIC name] will develop an Information Technology (IT) Plan providing details about the data sharing, including security concerns. [Insert SMA name] and CMS will provide input to the IT Plan.

6.2 Data Sources

[Describe the source of Medicaid data, including the type and elements]

6.3 Reserved

6.4 Data Validation

[Insert UPIC name] is responsible for validating data to ensure program needs are met. If data are not of sufficient quality, [Insert UPIC name] will identify the problem to [Insert SMA name] and to CMS. [Insert UPIC name] and [insert SMA name] will work together through the Data Workgroup to resolve any data problems that arise.

6.5 Security - [Due to the content of this information, it may not be revised by the SMA or the UPIC.]

[Insert UPIC name] and [Insert SMA name] will meet the security requirements detailed below (of note, should the SMA have an IEA in place with the UPIC, these security requirements are also detailed in that agreement).

***A.** [Insert UPIC name] and the participating SMA agree to safeguard data received from each other as follows:*

1. *Access to the records of data will be restricted to only those authorized employees and officials who need them to perform their official duties in connection with the uses of the information authorized in this Agreement. Further, all personnel who will have access to the records of the data will be advised of the confidential nature of the information, the safeguards required to protect the record and the civil and criminal sanctions for noncompliance contained in applicable Federal laws.*
2. *The exchanging of records of the data will be stored in an area that is physically safe from access by unauthorized persons during duty hours as well as non-duty hours or when not in use.*
3. *The records of the data will be processed under the immediate supervision and control of authorized personnel, to protect the confidentiality of the records in such a way that unauthorized persons cannot retrieve any such records by means of computer, remote terminal or other means.*
4. *The records of the data will be transported under appropriate safeguards.*

5. *The records of the data shall be safeguarded by administrative, physical, and technical safeguards that reasonably and appropriately protect confidentiality, integrity and availability of the data as these terms are defined in the Health Insurance Portability and Accountability Act (HIPAA) Security Rule at 45 CFR Parts 160 and 164. CMS shall ensure that the Custodian is in compliance with this requirement.*

B. *[Insert UPIC name] and the participating SMA will comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules. This program of exchanging data employs systems which contain Protected Health Information (PHI) as defined by HHS regulation "Standards for Privacy of Individually Identifiable Health Information" (45 CFR §§ 160.103) (65 Fed. Reg. 82462 (Dec. 28, 2000)). Disclosures of PHI authorized by the routine uses cited may only be made if, and as, permitted or required by the HIPAA Privacy Rule.*

C. *[Insert UPIC name] and the participating SMA will comply with the Breach notification procedures set forth in OMB Memorandum M-17-12 "Preparing for and Responding to a Breach of Personally Identifiable Information" upon discovery by a Party to this contract of any suspected or confirmed Breach, inappropriate use of data, or Security Incident. The Party experiencing the event will notify the other agency's System Security Contact named in this Agreement within one (1) hour of discovering the loss, potential loss, Security Incident, or Breach.*

If the Custodian and/or the participating SMA is unable to speak with the CMS Systems Security Contact within one hour or if for some other reason notifying the CMS Systems Security Contact is not practicable (e.g., it is outside of the normal business hours), the data Custodian and /or participating SMA will contact the CMS IT Service Desk at 410- 786-2580 or e-mail CMS-IT-ServiceDesk@cms.hhs.gov.

D. *The Party that experienced the loss, potential loss, Security Incident, or Breach will be responsible for following its established procedures, including notifying the proper organizations (e.g., United State Computer Emergency Readiness Team (US-CERT)), conducting a breach and risk analysis, and making a determination of the need for notice and/or remediation to individuals affected by the loss. Parties under this Agreement will follow PII Breach notification policies and related procedures as required by OMB guidelines. If the Party experiencing the Breach determines that the risk of harm requires notification to the affected individuals or other remedies that Party will carry out these remedies without cost to the other Party.*

The SMA agrees to establish appropriate administrative, technical, and physical safeguards to protect the confidentiality of the data and to prevent unauthorized use or access to it. The safeguards shall provide a level and scope of security that is not less than the level and scope of security requirements established by the Office of Management and Budget (OMB) in OMB Circular No. A-130, Appendix III--Security of Federal Automated Information Systems) as well as Federal Information Processing Standard 200 entitled "Minimum Security Requirements for Federal Information and Information Systems"; and, Special Publication 800-53 "Recommended Security Controls for Federal Information Systems". The SMA

acknowledges that the use of unsecured telecommunications, including the Internet, to transmit individually identifiable, bidder identifiable or deducible information derived from the file(s) specified prohibited.

Further, the SMA agrees that the data must not be physically moved, transmitted or disclosed in any way from or by the site indicated in without written approval from CMS unless such movement, transmission or disclosure is required by a law.

Section 7. Data Analysis

[Insert UPIC name] will conduct data analysis and report results of the data analysis to [insert SMA name].

7.1 Identifying and Prioritizing

[Insert UPIC name] and [insert SMA name] will contribute to the identification and prioritization of potential vulnerabilities as identified in the Policies and Procedures Manual.

[Describe how the vulnerabilities will be identified and when the prioritization will occur, i.e. through the data workgroup, through the Project Leads, or other processes.]

7.2 Data Analysis Project Management Strategy

[Insert UPIC name] will develop a Data Analysis Project Management Strategy that describes the ongoing and ad hoc analyses that will be completed each year. [Insert SMA name] will provide input to the plan.

[Describe how collaboration will occur, i.e. through the data workgroup or the Project Leads]

7.3 Data Analysis Reports

[Insert UPIC name] will adhere to the reporting requirements outlined Medicaid PIM. [Describe any requirements that are unique to the SMA regarding data analysis reports]

Section 8. Investigations and Referrals

[Insert UPIC name] will adhere to the requirements of the Program Integrity Manual (PIM) and the PPM.

[Insert SMA name] will adhere to [Insert applicable regulation document.]

[Provide a summary of the clarifications agreed to by the UPIC and the SMA on the overall strategy for working collaboratively on program integrity activities, especially those issues that might be outside of the PIM, PPM, or state regulations.]

8.1 Joint Investigations

[Describe how joint investigations will be conducted.]

8.2 Referrals

[Insert UPIC name] will refer Medicare cases per the Program Integrity Manual. [Insert SMA name] will refer cases to the [insert applicable agency] per the [insert applicable regulation document.]

[Insert any information that would be unique to the state program.]
(See Master Contact List on next page)

Master Contact

Name	*Role*	*Title*	*Phone Numbers*	*Email*	*Mailing Address*
[Insert UPIC name]					
[Insert SMA name]					

Appendix K

Medicaid Program Integrity Manual Acronyms

(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

American Academy of Professional Coders (AAPC)
Business Function Lead (BFL)
Center for Program Integrity (CPI)
Centers for Medicare & Medicaid Services (CMS)
Certified Professional Coder (CPC)
Children's Health Insurance Program (CHIP)
Civil Monetary Penalty (CMP)
Contracting Officer's Representative (COR)
Current Procedural Terminology (CPT)
Deficit Reduction Act (DRA)
Department of Justice (DOJ)
Federal Medical Assistance Percentage (FMAP)
Federal Financial Participation (FFP)
Final Findings Report (FFR)
Initial Findings Report (IFR)
Internet Only Manual (IOM)
Local Coverage Determination (LCD)
Medicaid Fiscal Agent (MFA)
Medicaid Fraud Control Unit (MFCU)
Medical Review (MR)
National Coverage Determination (NCD)
Department of Health and Human Services - Office of Inspector General/ Office of Investigations (HHS-OIG/OI)
Program Integrity (PI)
State Medicaid Agency (SMA)
Surveillance Utilization Review Subsystem (SURS)
Umbrella Statement of Work (USOW)
Unified Program Integrity Contractor (UPIC)

Appendix L

State Collaboration Vetting Form Sample

(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

Date Sent to State: *Click here to enter text.*

Sent to: *Click here to enter text.* ***CC:*** *Click here to enter text.*

Sent by: *Click here to enter text.*

Provider Information

Provider Name: Click here to enter text.

Provider Entity Type (LLC, Inc., etc.): Click here to enter text.

Provider Location: Click here to enter text.

Provider NPI: Click here to enter text.

Provider TPI: Click here to enter text.

Provider Medicaid ID: Click here to enter text.

ZPIC Internal Tracking Number: Click here to enter text.

Review Period: Click here to enter text.

Type of Provider: Click here to enter text.

Provider Ownership: Click here to enter text.

HHS-OIG Exclusion List: Click here to enter text.

Previous Reviews/Administrative actions taken (UPIC and/or MAC): Click here to enter text.

Prior/Current State Action:

Current or past known non-OIG State administrative actions taken: Click here to enter text.

Current or past known State OIG reviews/actions taken: Click here to enter text.

Potential Medicaid Allegations (if applicable, attach additional information to support the Medicaid peril)

Description of specific suspected behavior, Medicaid violation or scheme in this investigation:
Click here to enter text.

Medicaid Payment Requirements/Policy:

Click here to enter text.

Top Three Procedure Codes: Click here to enter text.

Medicaid Dollars at Risk Related to the Allegation: Click here to enter text.

Response from the State: (select one)

☐ *The State has no interest in this provider.*

Please indicated why state has no interest:

☐ *The State is interested in joint collaboration and will work with the UPIC.*

☐ *The State requests the UPIC to develop an investigation on this provider and advise of its progress during the ongoing investigation.*

☐ *The State requests further information:*

UPIC Contact (Name & Phone): *Click here to enter text.*

State Investigations Contact (Name & Phone): *Click here to enter text.*

State Audit Contact (Name & Phone): *Click here to enter text.*

State Response Date: *Click here to enter text.*

Additional feedback from the State: *Click here to enter text.*

Appendix M

Vulnerability Template

(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

Vulnerability Template Date Submitted:

Submitted By:

Name:

Organization:

Phone:

Email:

Vulnerability

Vulnerability Title:

Provider Type (if applicable):

Vulnerability Description:

Risk Factors (specific conditions, drivers, and/or actions that likely cause the vulnerability or increase the chances of it occurring):

- *Be as specific as possible about what the root cause(s) of the vulnerability may be. This field provides detail that may be used to ultimately help "solve the problem" and mitigate the vulnerability.*

For the below, provide risk assessment point valuation and provide a written justification for each (This is not required but will greatly assist in the vulnerability process).

Likelihood (likelihood for the identified vulnerability. Provide 1-2 sentences behind the reasoning for selecting this level of likelihood for the vulnerability):

4 - Almost Certain (≥75% likelihood to occur)
3 - Likely (≥50% - <75% likelihood to occur)
2 - Possible (≥25% - <50% likelihood to occur)
1 - Unlikely (<25% likelihood to occur)

Patient Harm (Provide 1-2 sentences behind the reasoning for selecting this level of likelihood for the vulnerability):

4 - Life Threatening
3 - Significant
2 - Minimal
1 - No harm

Financial Impact (Provide 1-2 sentences behind the reasoning for selecting this level of financial impact for the vulnerability):

4 - Greater than $200m (≥$200 million)
3 - $100m - $200m (≥$100 million <$200 million)
2 - $10m - $100m (≥$10 million ≤$100 million)
1 - Less than $10m (<$10 million)

Breadth (Provide 1-2 sentences behind the reasoning for selecting this level of breadth for the vulnerability):

4 - National
3 - Regional
2 - Pocketed
1 - Isolated

Existing Controls (Provide current projects or activities that are underway to address the risk factor):

Suggested Mitigation Activities (Suggestions for action items (i.e. key results) that may help to mitigate the risk factor(s):

Source (i.e. person/organization that first identified it):

FPS Model-Related (Y/N):

- *If yes, simultaneously report the information consistent with requirements of the FPS.*

Attachments (If applicable, upload document(s), such as Office of Inspector General reports or relevant data that can provide additional information or context on the vulnerability being reported):