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UPICs Hold Promise To Enhance Program Integrity Across Medicare and Medicaid, But Challenges Remain

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Report in Brief
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Why OIG Did This Review

Unified Program Integrity Contractors (UPICs) are the Centers for Medicare and Medicaid Services' (CMS's) only program integrity contractors that safeguard *both* the Medicare fee-for-service (FFS) and the Medicaid programs from fraud, waste, and abuse. Combined, Medicare and Medicaid provided health care coverage to 139 million people at a cost of $1.5 trillion in 2020. Given the cost and scope of these Federal health care programs, it is essential that UPICs successfully detect and deter fraud, waste, and abuse.

How OIG Did This Review

We requested and analyzed workload data related to program integrity activities for each of the five UPICs in 2019. In addition, we sent a survey to each UPIC to ask about the challenges it faced in performing these activities. From CMS, we requested and reviewed certain deliverables that UPICs submitted related to their program integrity activities conducted in 2019. We also sent CMS a questionnaire asking about the effects of the unification of Medicare and Medicaid program integrity activities; how CMS measures the effectiveness of UPICs; and any challenges UPICs face in conducting their work. We also asked both UPICs and CMS about the effects of the COVID-19 pandemic on UPICs' work.

Key Takeaway

Although UPICs hold promise for leveraging cross-program consolidation to strengthen oversight, improvements are needed to better combat fraud, waste, and abuse—particularly in Medicaid.

What OIG Found

In 2016, CMS began consolidating its Medicare and Medicaid program integrity activities to enhance its ability to detect and deter fraud, waste, and abuse across both programs. UPICs conducted substantially more Medicare FFS program integrity work in 2019 compared to that for Medicaid. The UPICs also conducted only minimal activities related to Medicaid managed care, even though most Medicaid enrollees receive services through managed care. Overall, UPICs conducted disproportionately fewer Medicaid activities compared to the levels of funding they received from CMS for Medicaid program integrity activities.

UPICs faced several challenges that could have contributed to the lower levels of program integrity activities in Medicaid. These challenges included problems with Medicaid data availability and quality, and differences across States' Medicaid policies and regulations.

We found wide unexplained disparities in program integrity activities across UPICs, even after adjusting for the size of their respective oversight responsibilities. Further, strategies that unify Medicare and Medicaid data to improve program integrity have not yet produced significant results.

At the same time, CMS and UPICs have laid a foundation for improvements. The development of collaborative processes, analytical tools, and new technologies across the UPICs—including the Unified Case Management (UCM) system and Major Case Coordination (MCC) initiative—helps to achieve the benefits of unifying program integrity activities. Lastly, despite challenges caused by the COVID-19 pandemic, UPICs were able to identify vulnerabilities related to the pandemic and continue program integrity activities with some limitations.

What OIG Recommends and How the Agency Responded

We recommend that CMS (1) implement a plan to increase UPICs' Medicaid program integrity activities, particularly related to managed care; (2) make improvements to the UCM system; (3) implement a plan to help ensure the success of the MCC for Medicaid referrals; and (4) identify the reasons for the unexplained variation in program integrity activities across UPICs. CMS concurred with all our recommendations.

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BACKGROUND

OBJECTIVES

1. To determine the extent to which the Centers of Medicare & Medicaid Services' (CMS's) unified program integrity contractors (UPICs) performed program integrity activities to identify fraud, waste, and abuse in 2019.
2. To identify the challenges that UPICs have encountered in conducting program integrity activities for both the Medicare and Medicaid programs.
3. To identify any benefits that resulted from unifying program integrity activities across Medicare and Medicaid.

UPICs are the only program integrity contractors that safeguard both the Medicare fee-for-service (FFS) and Medicaid programs from fraud, waste, and abuse. Combined, Medicare and Medicaid provided health care coverage to 139 million people at a cost of $1.5 trillion in 2020. Given the cost and scope of these Federal health care programs, it is essential that UPICs successfully detect and deter fraud, waste, and abuse. Unsuccessful efforts to safeguard program integrity leave Medicare and Medicaid financially vulnerable and puts enrollees' health and welfare at risk.

Over the past few decades, the Office of Inspector General (OIG) has produced a substantial portfolio of work that examined the fraud detection and investigation activities of previous program integrity contractors, found vulnerabilities in these contractors' efforts to combat fraud and abuse, and made recommendations to reduce program vulnerabilities. This report is OIG's first evaluation of program integrity activities since the CMS's initiative to join Medicare and Medicaid program integrity activities under unified contractors.

Background

Unified Program Integrity Contractors

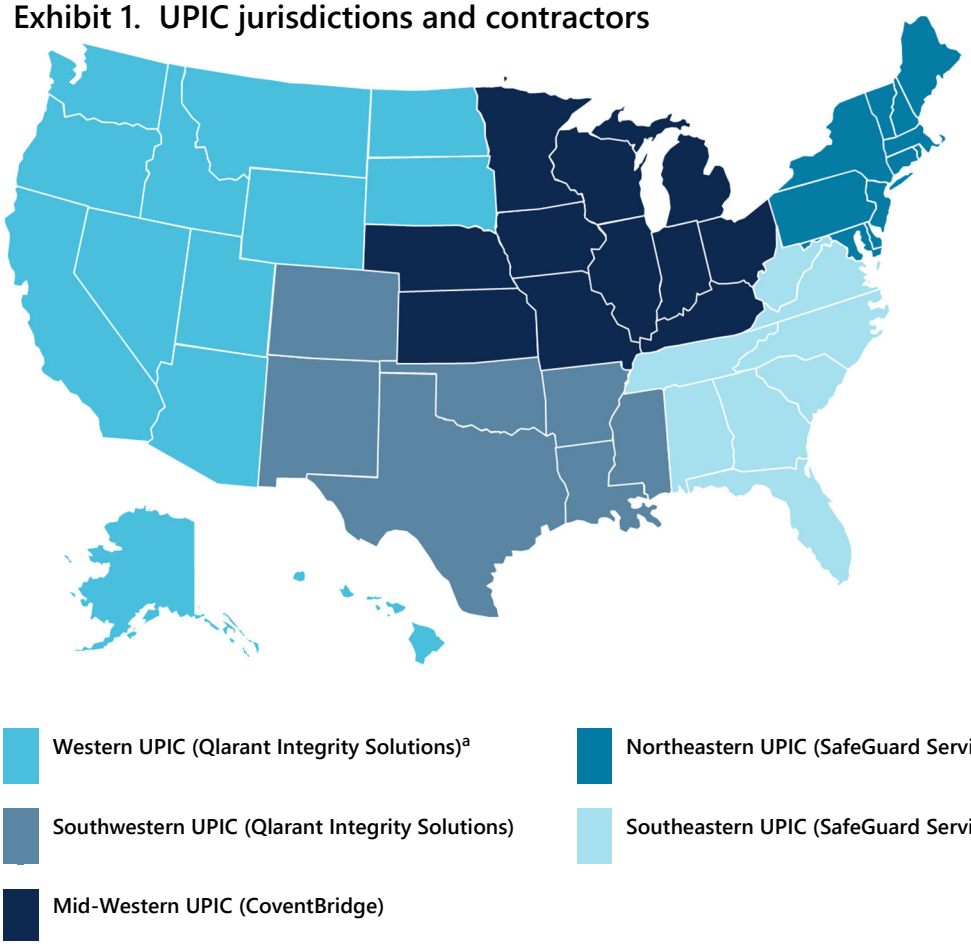
In 2016, CMS began consolidating its program integrity contractors' activities to enhance its ability to detect, prevent, and proactively deter fraud, waste, and abuse across the Medicare FFS (i.e., Medicare Part A and Medicare Part B) and Medicaid FFS and managed care programs. CMS stated it would achieve this by:

- consolidating Medicare and Medicaid program integrity activities previously handled by separate contractors;

- sharing and coordinating information among Medicare and Medicaid partners, such as Medicare contractors, State Medicaid agencies,[1] managed care organizations (MCOs), and law enforcement; and
- recommending administrative actions such as payment suspensions, civil monetary penalties, and exclusions in a timely manner.[2]

UPICs operate in five geographic jurisdictions and integrate the functions previously performed by the Zone Program Integrity Contractors (ZPICs), Program Safeguard Contractors (PSCs), and Medicaid Integrity Contractors. Since June 2018, a fully operational UPIC has covered each of the five jurisdictions shown in Exhibit 1.

Exhibit 1. UPIC jurisdictions and contractors



Source: CMS, *Umbrella Statement of Work Appendices, Appendix B*, p. 13, February 2020. SafeGuard Services, LLC, *UPIC Locations*. Accessed at http://www.safeguard-servicesllc.com/Home/locations on March 4, 2020.

[a] The Western UPIC also covers American Samoa, Guam, and the Northern Mariana Islands.

[b] The Northeastern UPIC covers Medicare Part B in Arlington County, Fairfax County, and the city of Alexandria in Virginia; the Southeastern UPIC covers Medicare and Medicaid in all other areas of Virginia.

[c] The Southeastern UPIC also covers Puerto Rico and the Virgin Islands.

[1] Throughout this report, we refer to State Medicaid agencies as "States"; we also include U.S. territories and the District of Columbia in the term "States."

[2] CMS, *UPIC Umbrella Statement of Work*, April 2020, § 1.1.

UPICs' Funding

In calendar year 2019, UPICs received $101 million in funding from CMS. Each UPIC received between $16.5 million and $24.5 million in funding. CMS determines UPIC funding on the basis of historical workload data and regularly evaluates and adjusts funding based on fluctuations in workload.

Although the UPIC contract includes Medicare, Medi-Medi,[3] and Medicaid program integrity work, there is separate and distinct funding to conduct work for each of the three programs. Each UPIC submits a Basis of Estimate to CMS that reflects how the UPIC anticipates allocating its resources, time, and workload across Medicare, Medicaid, and Medi-Medi activities. CMS requires UPICs to track all costs incurred and bill them to the correct program's funding source (i.e., Medicare, Medicaid, or Medi-Medi). CMS tracks UPICs' use of funds by requiring each jurisdiction to submit a monthly cost report that summarizes costs for each of the three programs and includes a plan to correct any projected rate adjustments. CMS expects UPICs' time and resources spent across Medicare, Medicaid, and Medi-Medi to generate a positive return on investment. However, the UPICs are not required to directly align their output (e.g., investigations opened, cases referred, etc.) with the funding received. This is because CMS wants the UPICs to take the appropriate action based on the facts of each case.

UPICs are also eligible for performance-based award fees. CMS evaluates the UPICs on the basis of criteria in an award fee plan that links to CMS's goals of achieving enhanced detection and prevention of fraud, waste, and abuse across the Medicare and Medicaid programs. According to CMS, it determines award fees based on performance, quality, timeliness, and coordination between the UPICs and other program integrity contractors.

UPICs' Activities

UPICs conduct a variety of required program integrity activities—within their assigned jurisdictions—in accordance with the contractual requirements described in the UPIC Statement of Work created by CMS. UPICs prioritize and screen leads to determine whether they merit an investigation, conduct investigations, perform data analysis, review medical records, recommend claims processing edits, identify overpayments for collection, and identify vulnerabilities. As a result of these activities, UPICs make referrals to law enforcement and identify the need for administrative actions such as payment suspensions, civil monetary penalties, and revocations. In addition, UPICs provide support and education to various stakeholders, and support appeals related to Medicare and Medicaid administrative actions.[4]

[3] The Medicare-Medicaid data match program (Medi-Medi) analyzes billing trends across the Medicare and Medicaid programs.

[4] UPICs also may conduct Medicaid provider cost report audits.

UPICs are not the only entities conducting Medicaid program integrity activities. States dedicate resources to their Medicaid program integrity units and State Medicaid Fraud Control Units (MFCUs). In addition, individual Medicaid managed care plans have Special Investigative Units (SIUs) to investigate potential fraud, waste, and abuse.

Screening and Prioritizing Leads and Opening Investigations. UPICs partner with CMS to identify and prioritize leads—i.e., suspected instances of fraud, waste, or abuse—for investigation. CMS instructs UPICs to screen and prioritize leads, identified proactively by the UPIC or from external sources such as law enforcement entities, that are likely to result in administrative actions. From these prioritized leads, UPICs open and conduct investigations to determine the facts of each case as well as the magnitude of the alleged fraud. When the UPIC receives a lead specific to the Medicare or Medicaid program, the Statement of Work requires the UPIC to compare the lead with any available data to determine whether a parallel issue exists in the other program.

Performing Data Analysis Projects. UPICs plan and perform a range of data analysis projects on Medicare and Medicaid claims and encounter data. These analyses support program integrity activities by identifying patterns and trends of fraud, waste, and abuse. CMS directs UPICs to place high emphasis on data analysis activities that lead to effective investigations and successfully support administrative actions. CMS expects UPICs to perform data analyses using the Fraud Prevention System (FPS), Integrated Data Repository (IDR), and One Program Integrity (One PI) portal. Exhibit 2 defines these sources and tools.

Exhibit 2. Data Analysis Sources and Tools Available to UPICs

Fraud Prevention System (FPS):
The FPS is a predictive analytic tool that screens all Medicare Part A and Part B claims to identify potentially problematic providers before issuing a payment to these providers.

Integrated Data Repository (IDR):
The IDR is a centralized repository of integrated Medicare and Medicaid claims and encounter data as well as provider and beneficiary data.

One Program Integrity (One PI) portal:
The One PI portal is a web-based application that includes tools to access and analyze data in the IDR to fight fraud, waste, and abuse.

Source: CMS, *UPIC Umbrella Statement of Work*, April 2020, §§ 5.2.2 and 7.5.1.

Additionally, the Medi-Medi data matching program is an important component of UPICs' data analysis activities. States volunteer for the Medi-Medi data matching program, which generates a data set that analyzes billing trends across the Medicare and Medicaid programs to identify potential fraud, waste, and abuse.

Identifying and Referring Overpayments. UPICs may identify overpayments made to providers that do not necessarily involve fraudulent intent during their analysis of Medicare and Medicaid payments. UPICs refer overpayments made to providers to either Medicare Administrative Contractors or States for collection.

Recommending Administrative Actions. UPICs also may recommend administrative actions as a result of their program integrity activities. Administrative actions include, but are not limited to, revoking certain providers' Medicare

enrollment, terminating certain providers' Medicaid enrollment, suspending payments to certain providers, and implementing civil monetary penalties.[5] UPICs also support the appeals process related to Medicare and Medicaid administrative actions such as claim determinations, overpayment determinations, payment suspensions, provider revocations, and provider terminations.

Making Case Referrals. UPICs make case referrals to various entities as a result of their program integrity activities. UPICs can refer cases of potential fraud, waste, or abuse to OIG, other law enforcement entities, CMS, or States.

CMS established the Major Case Coordination (MCC) forum for both Medicare (April 2018) and Medicaid (January 2020) to provide an opportunity for UPICs to discuss their top investigations with CMS and law enforcement. The goal of the MCC process is to collaborate with all the MCC key decision makers and provide guidance on each investigation.

Reviewing Medical Records. UPICs conduct pre- and post-payment medical reviews of medical records to identify, address, and reduce provider billing errors. UPIC medical review activities may include reopening claims and reviewing providers' medical records to determine the appropriateness and medical necessity of services performed. On the basis of these medical reviews, UPICs recommend whether the claim should be or should have been paid or denied.

Developing and Recommending Edits. The results of UPICs' data analyses can inform their development of edits for Medicare FFS claims processing systems and edit recommendations to States. Edits are added to claims processing systems to evaluate claims submissions to ensure compliance with program requirements and identify and prevent inappropriate payments.

Identifying Vulnerabilities. The results of UPICs' data analyses may identify program vulnerabilities. A vulnerability is a flaw or weakness in policy and/or regulatory authority that increases the likelihood of Medicare or Medicaid making significant inappropriate payments to providers. UPICs report these vulnerabilities to CMS along with suggested ways to address them.

Supporting CMS, States, and Law Enforcement. Given the broad scope of their review responsibilities, UPICs collaborate with and provide support to a variety of stakeholders. UPICs facilitate information sharing across Medicare and Medicaid, assist in others' efforts to identify vulnerabilities, and streamline program integrity efforts across these entities to prevent of fraud, waste, and abuse. UPICs support CMS's program integrity activities and collaborate with States and law enforcement agencies. UPICs support CMS by providing subject matter expertise and collaborating with CMS in its program integrity initiatives. UPICs are required to collaborate with States to build an effective program integrity strategy to combat fraud, waste, and abuse. Further, UPICs collaborate with law enforcement entities—including OIG, State

[5] Administrative actions that UPICs recommend for Medicaid would be taken by the State. The UPICs cannot suspend Medicaid payments or terminate Medicaid provider enrollment.

attorneys general, Medicaid Fraud Control Units, and the Department of Justice—by responding to law enforcement requests for information and assistance. UPICs also educate Medicare Parts A and B and Medicaid providers and suppliers; States; Medicare Advantage plans; and Medicaid managed care entities about program integrity issues.

UPIC Activities During the COVID-19 Pandemic. In March 2020, CMS directed all program integrity contractors, including UPICs, to limit their program integrity activities following the declaration of a national emergency regarding the COVID-19 pandemic.[6] Specifically, CMS instructed UPICs to halt activity that involved any engagement with, communication with, or observation of healthcare providers to ensure that providers could devote all resources to addressing the pandemic. CMS revised this guidance in July 2020 and September 2020 to allow UPICs to resume program integrity activities under certain parameters and instructed UPICs to consult with States to obtain guidance on contacting providers to resume Medicaid program integrity efforts.

UPICs' Reporting Requirements

UPICs submit to CMS a Monthly Status Report and a Quarterly Program Vulnerabilities Report to share the results of their efforts to safeguard Medicare and Medicaid from fraud, waste, and abuse. The Monthly Status Report summarizes a UPIC's monthly activities (e.g., the number of data analysis projects performed, investigations conducted, and overpayments referred for recovery). The Quarterly Program Vulnerabilities Report identifies program vulnerabilities and recommends corrective actions to address them. UPICs also submit plans and reports regarding State and stakeholder education, data analysis projects, and assessments of particular program integrity activities. UPICs have access to the Unified Case Management (UCM) system, which CMS developed as a centralized repository for both Medicare and Medicaid leads and investigations. CMS uses the UCM system to continuously monitor and evaluate UPIC performance.

Related OIG Work

A 2016 OIG report found variation in the level of benefit integrity activities conducted across contractors and years.[7] OIG recommended that CMS examine the trends in workload statistics and determine whether they align with CMS's benefit integrity goals. We also recommended that CMS examine the variation in workload statistics among benefit integrity contractors and identify workload definitions that need to be clarified to ensure that contractors report data uniformly and in the way CMS intends. CMS concurred with our recommendations and established priorities which targeted its investigative focus on certain benefits. CMS provided workload statistics that

[6] CMS, Technical Direction Letter, PI-2020-0004, *Operations During National Emergency*, March 19, 2020.

[7] OIG, *Medicare Benefit Integrity Contractors' Activities in 2012 and 2013: A Data Compendium (OEI-03-13-00620)*, May 2016.

demonstrated the results of CMS's new targeted focus. CMS also updated its system that includes workload statistic definitions to be used by all contractors.

Previous OIG work identified the shortcomings of Medicare and Medicaid program integrity contractors' activities and data. For example, OIG found substantial variation in (1) the number of investigations Medicare program integrity contractors started and (2) the number of cases that they referred to law enforcement.[8] Further, OIG work identified substantial inaccuracies in contractors' workload statistics[9] and found that missing or inaccurate data compromised contractors' ability to accurately perform data analysis.[10]

Methodology

Data Collection

We began this evaluation during the COVID-19 pandemic. Because the objectives of this evaluation centered on the program integrity activities and results of the UPICs, we expected that if we selected a timeframe during the height of the pandemic, our results might not be indicative of the UPICs' general efforts and results. Therefore, we focused the analysis on program integrity activities conducted in 2019—the most recent full year that preceded the pandemic.

We requested workload data related to each of the five UPICs' program integrity activities in 2019. In addition, we sent a survey to each UPIC to ask about their experiences performing these activities, including any challenges. From CMS, we requested and reviewed certain deliverables that UPICs submitted related to their program integrity activities conducted in 2019. We also sent CMS a questionnaire asking about the effects of unification, how CMS measures the effectiveness of UPICs, and any challenges UPICs face when conducting their work. We also asked both UPICs and CMS about the effects of the COVID-19 pandemic on UPICs' work.

We obtained 2019 Medicare FFS and Medicaid spending data for each UPIC jurisdiction. CMS provided Medicare FFS spending data and we collected Medicaid spending data from the Transformed Medicaid Statistical Information System (T-MSIS). T-MSIS is CMS's Medicaid data repository that contains information on enrollees, providers, claims, and managed care encounters.

To collect information on OIG's experience with working with the UPICs, we also spoke with staff in OIG's Office of Investigations and Office of Counsel to the Inspector General.

[8] OIG, *Medicare's Program Safeguard Contractors: Activities to Detect and Deter Fraud and Abuse (OEI-03-06-00010)*, July 2007.

[9] OIG, *Zone Program Integrity Contractors' Data Issues Hinder Effective Oversight (OEI-03-09-00520)*, November 2011.

[10] OIG, *Early Assessment of Review Medicaid Program Integrity Contractors (OEI-05-10-00200)*, February 2012.

Data Analysis

To determine the extent of UPICs' activities, we determined the total number of each program integrity activity conducted by each UPIC in 2019. We then determined the number of these program integrity activities associated with Medicare, Medicaid, and Medi-Medi programs and compared the activities across the five UPICs. We reviewed data on all of the UPICs' activities, but the findings of this report do not include information on requests for information and assistance completed, medical reviews conducted, Medicare appeals handled, and compromised identification numbers identified. While not presented in the findings, Appendix A does contain data about these activities.

We additionally compared the number of program integrity activities conducted to each UPIC's funding. To account for differences in the size of each UPIC's oversight responsibility, we determined the number of program integrity activities for every $100 billion in Medicare and Medicaid spending in each jurisdiction and compared these numbers across the five UPICs.

To identify the benefits of and challenges related to the unification of program integrity activities, we reviewed and analyzed the survey responses from CMS and UPICs. We also reviewed and analyzed responses related to the tools and strategies that UPICs use to detect fraud, waste, and abuse across programs as well as responses regarding the impact of the COVID-19 pandemic.

Limitations

We did not verify the information self-reported to us by the UPICs. However, we followed up with the UPICs in cases in which we found inconsistent responses, data anomalies, or needed further clarification. For the Medicaid spending data that we collected from T-MSIS, CMS notes that the quality of T-MSIS data can vary by State, by time period, and by area of analysis.

Standards

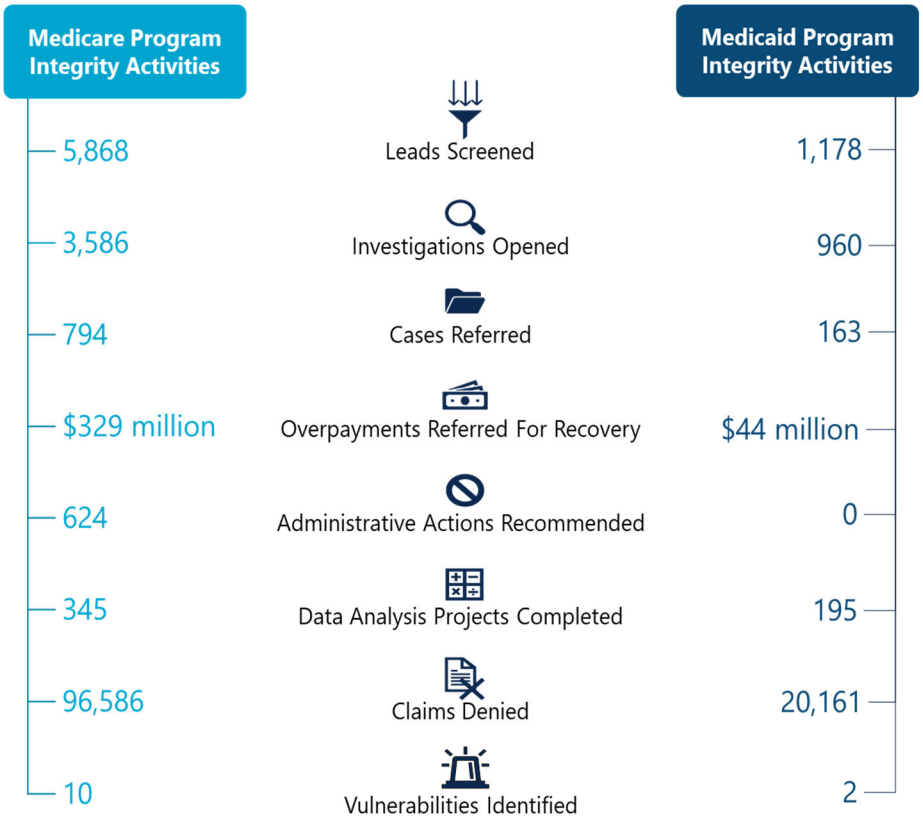
We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

UPICs conducted substantially more program integrity activities for Medicare than for Medicaid

UPICs' 2019 Medicaid work lagged behind its Medicare work for all program integrity activities even though Medicaid spending exceeded Medicare FFS spending by $147 billion.[11] These activities are important tools in safeguarding not only Medicare but also Medicaid programs from fraud, waste, and abuse. Exhibit 3 highlights the substantial differences in results between Medicare and Medicaid program integrity activities. Appendix A includes data that show similar results for UPICs' additional program integrity activities.

Exhibit 3. UPICs performed substantially more Medicare program integrity activities compared to those for Medicaid.[a, b]



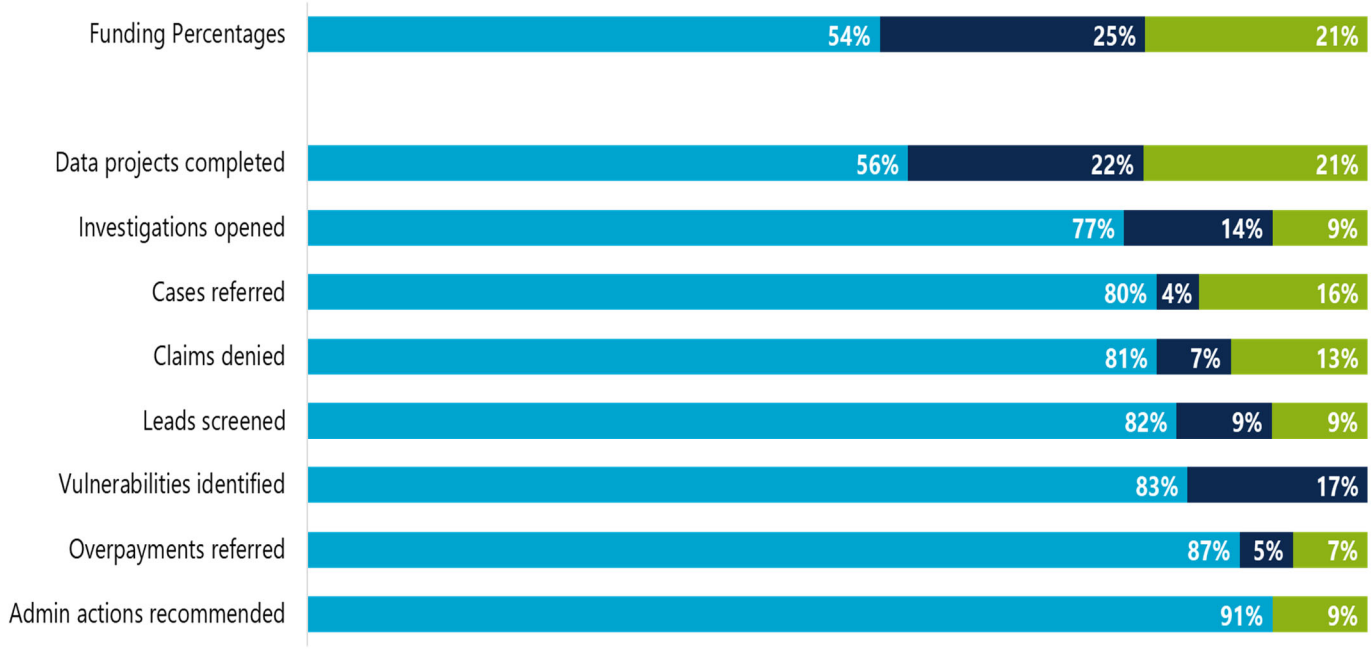
Source: OIG analysis of UPICs' and CMS's responses to OIG request for information.
[a] We added Medi-Medi program integrity activities to both the Medicare activities and Medicaid activities to account for the totality of activities conducted by UPICs.
[b] "Administrative actions recommended" represents the sum of the revocations, exclusions, terminations, payment suspensions, and civil monetary penalties recommended by the UPICs.

[11] Medicaid managed care spending includes both direct service dollars and MCOs' administrative costs.

The percentage of program integrity activities conducted within Medicare, Medicaid, and Medi-Medi did not align with the funding UPICs received

UPICs conducted disproportionately fewer Medicaid and Medi-Medi activities compared to the funding levels for those activities. As shown in Exhibit 4, the UPICs' overall activities did not align with the funding percentages received for Medicare, Medicaid, and Medi-Medi. On average, UPICs' funding for Medicare work accounted for 54 percent of their total funding, Medicaid accounted for 25 percent, and Medi-Medi accounted for the remaining 21 percent. However, overall, Medicaid activities accounted for less than 25 percent of UPICs' program integrity activities. Similarly, Medi-Medi activities accounted for less than 21 percent of UPICs' results in all activities but data projects completed. While CMS does not create benchmarks or goals for UPIC activities, CMS reported that it does expect UPICs to generate a positive return on investment with the funding they receive for each program.[12]

Exhibit 4. Program integrity activities conducted within Medicare, Medicaid, and Medi-Medi did not usually align with the funding that UPICs received.



Source: OIG analysis of UPICs' responses to OIG request for information and survey.
Note: Some totals may not add to 100 percent due to rounding.

[12] CMS stated that the UPICs are not required to directly align their outputs (e.g., investigations opened, cases referred, etc.) with the funding received.

Although most people with Medicaid are enrolled in managed care, UPICs conducted minimal activities for managed care

Even though 83 percent of people with Medicaid received services through managed care in 2019, UPICs estimated that only 11 percent of their Medicaid activities focused on managed care.[13] UPICs reported no data analysis projects completed or vulnerabilities identified related to Medicaid managed care in 2019. Further, they reported only a single Medicaid managed care referral. Across the other program integrity activities, UPICs conducted far more work in Medicaid FFS than managed care.[14] UPICs screened nearly 20 times the number of Medicaid FFS leads (266 versus 14) and opened 82 percent more investigations (238 versus 131) in 2019.

Despite the minimal Medicaid managed care program integrity activities, each UPIC indicated that the level of Medicaid managed care work has increased since 2019. Although the split between Medicaid managed care work versus FFS work across UPIC jurisdictions was not reflective of the jurisdictions' proportion of Medicaid enrollees in managed care during the period under review, UPICs responded that improved relationships with the States, including more access to managed care data and the States' willingness to allow UPICs to conduct work within Medicaid managed care, have contributed to an increase in Medicaid managed care work.

UPICs did not track or report all activities related to Medicaid managed care

CMS did not require UPICs to provide Medicaid workload activities categorized by FFS and managed care in their Monthly Status Reports for 2019. One UPIC could not distinguish FFS from managed care data for any of these five activities. Three UPICs could not report the number of Medicaid data analysis projects completed by FFS or managed care. Two UPICs could not report the number of investigations opened nor the cases referred by FFS or managed care. When the UPICs could provide separate FFS and managed care data, there often were no activities reported for managed care. Appendix B contains the Medicaid FFS and Medicaid managed care activities data reported by the UPICs.

As of 2021, some UPICs expanded the way they record Medicaid activities to distinguish FFS from Medicaid managed care. Additionally, CMS now requires UPICs to identify whether Medicaid data projects, leads, investigations, referrals, appeals, and the outcomes of investigations are related to FFS or managed care.

[13] The percentage of UPICs' Medicaid work related to managed care ranged from 0 percent to 34 percent. Four of the five UPICs reported that this percentage was an estimate.

[14] We requested and UPICs provided Medicaid FFS and Medicaid managed care workload statistics for these program integrity activities: (1) data analysis projects completed, (2) leads screened, (3) investigations opened, (4) cases referred, and (5) vulnerabilities identified.

Overall, UPICs face challenges in conducting Medicaid program integrity activities

The quality and availability of Medicaid data limited UPICs' Medicaid program integrity activities

Both CMS and UPICs acknowledged that a lack of access to high-quality Medicaid data limited UPICs' Medicaid program integrity activities. One UPIC noted that delays in obtaining Medicaid data suitable for program integrity activities have stretched up to 1 year for some States, and in some cases, the data quality is so poor that analysis is not worthwhile. Another UPIC reported that States were reluctant to share data with UPICs because States felt the UPIC work was duplicative of work they could do on their own. In addition to these challenges, CMS responded that many States did not want to give UPICs direct access to their data because of concerns over previous security breaches within the States. As a result, some States implemented additional security measures which contributed to the delays UPICs faced while beginning to work with States.

UPICs reported that problems accessing Medicaid managed care data limited their ability to conduct program integrity activities related to managed care. Because the T-MSIS Medicaid data was not approved for use in all States in 2019, one UPIC reported that it did not have access to any managed care data. Others had to rely on States or MCOs to provide them with managed care data, which can cause delays. Furthermore, even when UPICs received managed care data directly from States, there were problems with data quality.

Access to T-MSIS data for all States has improved UPICs' ability to conduct Medicaid program integrity activities, but problems remain. All UPICs now have access to T-MSIS data for all States, which has alleviated some of the problems associated with accessing State Medicaid data. In August 2021, CMS issued a Technical Direction Letter authorizing UPICs to use this data.[15] Prior to this authorization and due to ongoing data quality validations, CMS did not permit UPICs to use T-MSIS data consistently to conduct program integrity activities in all States. UPICs noted that the uniformity of the T-MSIS data is helpful and reduces the need for UPICs to make ad-hoc data requests to States.

Although T-MSIS data improved the UPICs' ability to conduct program integrity activities, some UPICs did express issues with the quality and completeness of T-MSIS data. UPICs reported problems regarding T-MSIS data, such as missing enrollee and provider identification numbers; unusual dates and payment amounts; and missing claim status indicators. One UPIC reported that the territories in its jurisdiction do not have a system to generate T-MSIS records and therefore they do not submit claims

[15] CMS, Technical Direction Letter U-2021-0005, *Availability and Use of Transformed Medicaid Statistical Information System (T-MSIS) Data for Program Integrity (PI) Purposes*, August 19, 2021.

data to T-MSIS. Therefore, even with UPICs' expanded access to T-MSIS, they may still need to request additional information from States and MCOs.

A lack of Joint Operating Agreements (JOAs) with some States hindered UPICs' ability to obtain Medicaid data. Three UPICs reported that they do not have JOAs with at least one State in their jurisdictions, which limits their ability to conduct Medicaid program integrity activities in those States. A JOA is meant to serve as an outline of the processes that will be used to create an effective working relationship between the UPIC and the State. The UPIC Statement of Work from CMS requires UPICs to sign JOAs with each State in its jurisdictions.

UPICs use not only T-MSIS data, but data provided by the State to perform analyses. Two UPICs reported that without a JOA, the UPIC cannot exchange data with a State. One UPIC noted that the lack of JOAs with two States in its jurisdiction prevented it from making ad-hoc data requests for Medicaid Management Information System data in those States.[16] Another UPIC also did not have a JOA with one of the States in its jurisdiction as the State was not receptive to working with the UPIC to finalize the JOA. A third UPIC did not have a JOA with one State because the State questioned whether it was mandatory or voluntary to work with the UPIC. This UPIC also did not have a JOA with a second State because that State wanted the UPIC to sign a contract—which UPICs cannot do—instead of a JOA.

UPICs may conduct fewer Medicaid investigations because they receive and screen fewer Medicaid leads. Eighty-two percent of all leads screened by UPICs in 2019 were for Medicare. The UPICs opened 2,626 more Medicare investigations than for Medicaid in part because they received 3,368 more Medicare leads. According to one UPIC, external Medicaid leads must come from the States, and it receives very few Medicaid leads from the States. Conversely, there are multiple sources of external leads related to Medicare, such as the Medicare phone hotlines, the Medicare Administrative Contractors, and FPS. The potential for opening a larger number of Medicaid investigations could be realized if the number of leads received from other sources increased.

The inability to duplicate program integrity projects across different States limits UPICs' efficiency

The structure of the Medicaid programs allows States to establish a wide variety of policies and procedures but also can complicate oversight activities because each State's Medicaid program is unique. Differences in State policies, regulations, and organization mean that UPICs' Medicaid program integrity activities can rarely be duplicated across States. All the UPICs reported that differences among State policies create challenges in investigating instances of potential Medicaid fraud and abuse. One UPIC reported that projects had to be tailored to each State because differences

[16] The Medicaid Management Information System is an automated claims processing and information retrieval system that States must have to be eligible for Federal funding.

among States' policies and regulations made the duplication of efforts difficult. According to another UPIC, one of its biggest challenges was designing and maintaining investigative processes that are compliant with States' Medicaid processes, policies, and priorities. One UPIC noted that reorganizations within some States' programs sometimes made it difficult to determine whom to contact within the State.

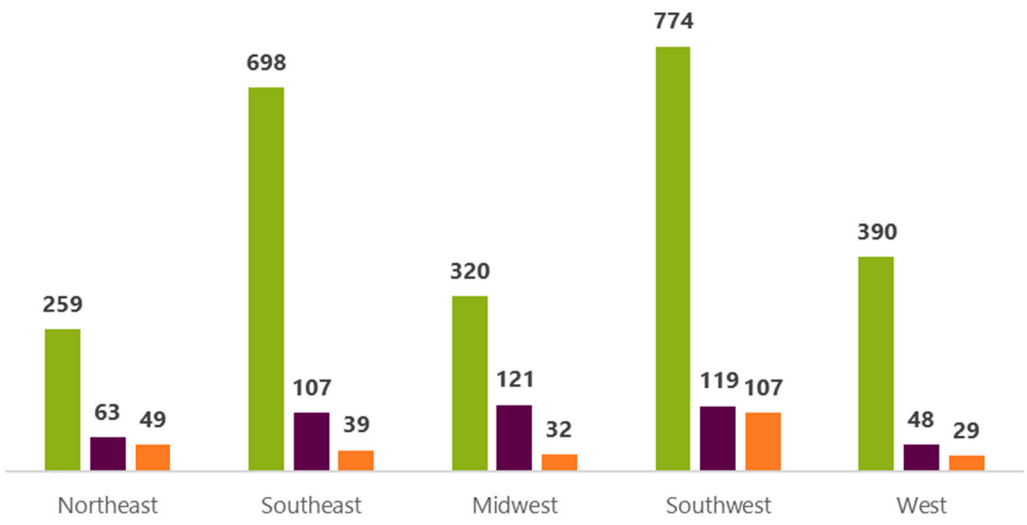
State restrictions and/or contractual requirements also can also hinder UPICs' program integrity efforts. UPICs stated that these restrictions included limits on (1) the types of providers they are allowed to examine and (2) the timeframes they had to review claims. Two UPICs reported that differences in MCO contract language both within and between States creates challenges when conducting program integrity activities in Medicaid managed care. UPICs also reported difficulties with the Medicaid overpayment identification and recovery process. Three UPICs reported that some States in their jurisdiction prohibit the UPIC from identifying overpayments. Another UPIC noted that, in one State, MCOs have 1 year from the date of service to identify and recoup overpayments before the UPIC can seek out overpayments.

Substantial disparities existed in the number of activities conducted across UPICs, even after adjusting for the size of their respective oversight responsibilities

Even after adjusting for jurisdictional oversight responsibility, certain UPICs conducted substantially more program integrity activities than their counterparts, especially investigations opened, cases referred, and data analysis projects completed. The UPIC that opened the most investigations opened three times as many investigations as the UPIC that opened the fewest investigations for every $100 billion in spending. Similarly, one UPIC referred more than twice the number of cases as another UPIC and one UPIC completed more than three times the number of data analysis projects as another. Exhibit 5 shows this variation for these three activities. UPICs also varied in conducting other program integrity activities such as leads screened, administrative actions recommended, claims denied, vulnerabilities identified, and the value of overpayments they referred.

CMS stated that it compares UPIC results across jurisdictions to assess UPICs' effectiveness and to ensure consistency in measuring their performance. However, the extreme variation in the level of all program integrity activities conducted by UPICs raises questions about why such substantial inconsistencies exist across contractors' results.

Exhibit 5. There were substantial disparities in the number of investigations opened, cases referred, and data analysis projects completed by UPICs per $100 billion in spending.



Source: OIG analysis of UPICs' and CMS's responses to OIG request for information as well as analysis of T-MSIS data.

Strategies to improve program integrity by unifying Medicare and Medicaid data did not produce significant results

UPICs developed and employed strategies—strategies that include both new approaches and leveraging established programs such as Medi-Medi data matching—that use both Medicaid and Medicare data to conduct analysis across programs. However, these strategies have yet to produce significant results. When a UPIC receives a lead specific to the Medicare or Medicaid program, CMS requires the UPIC to review that lead against data from the other program to determine whether the issue exists there as well. For States that choose to participate in the Medi-Medi data match program, UPICs also can perform proactive data analysis on integrated Medicaid and Medicare data sets. By analyzing combined Medicare and Medicaid claims data, UPICs can detect problematic billing patterns that may not be evident when analyzing the data separately. Although each of these efforts has produced some positive results, there are challenges that prevent the UPICs from maximizing their potential.

All UPICs reported screening leads across both Medicare and Medicaid, but this cross-program review resulted in only a small percentage of new investigations

Despite CMS's requirement that they review leads across both programs, UPICs estimated that on average only 1 percent of Medicare investigations and 2 percent of Medicaid investigations resulted from screening a lead that originated in the other

program.[17] CMS requires UPICs to screen all leads against both Medicaid and Medicare claims and encounter data to determine if an issue identified in one program is occurring in the other.

Although CMS reported that the consolidation of program integrity activities has provided increased awareness of fraudulent schemes in Medicare that could be occurring in Medicaid or vice versa and allows the UPICs to pursue these schemes in both programs, UPICs reported challenges in performing this cross-program work. UPICs reported that challenges with Medicaid data limit their abilities to effectively pursue schemes in both programs. Three UPICs reported difficulties with performing follow-up of Medicare leads in Medicaid because of challenges in accessing Medicaid data. Another UPIC struggled to conduct cross-program work because of the poor quality and lateness of Medicaid data. In addition to problems with the data, UPICs have faced challenges in consolidating activities because of the Medicare and Medicaid programs' separate statutes, funding streams, and provider types. For example, one UPIC reported that it cannot use a lead related to a Medicaid pharmacy to open a parallel lead in Medicare because the UPIC does not have oversight responsibility for the Medicare Part D pharmacy benefit.[18]

UPICs conducted a limited number of Medi-Medi investigations

Only 9 percent of investigations were related to the Medi-Medi program, despite 21 percent of UPICs' funding, on average, being allocated to Medi-Medi. Under the Medi-Medi program, UPICs can use combined Medicare-Medicaid datasets to review billing trends across providers and service types and potentially identify outliers across both programs. For example, a UPIC may find that a provider has a normal billing pattern for a Medicare service, but upon adding their Medicaid billing for the same type of service, that provider may become an outlier.

UPICs' ability to conduct proactive data analyses across both Medicare and Medicaid is limited, as 35 States chose not to participate in the Medi-Medi data match program in 2019. CMS prohibits UPICs from linking or matching Medicare and Medicaid data for States that do not participate in the Medi-Medi program, which limits UPICs' ability to identify problems across both programs. Increasing State participation in the Medi-Medi program may enhance the benefits of unifying program integrity activities and improve UPICs' ability to identify potential vulnerabilities across both Medicaid and Medicare. In July 2022, CMS reported that it is reimagining the Medi-Medi program, including how it uses Medi-Medi funding. CMS stated that its

[17] Four UPICs provided a specific percentage of investigations that resulted from screening a lead that originated in the other program. The fifth UPIC reported "less than one percent" in their response. We excluded this response and calculated the average using only the specific percentages provided by the four UPICs.

[18] The UPICs coordinate with the Investigations Medicare Drug Integrity Contractor (I-MEDIC), a contractor that works to identify and prevent fraud, waste, and abuse in Medicare Part D. The UPICs can refer suspected cases of Part D fraud to the I-MEDIC. Additionally, the UPICs and I-MEDIC have regularly scheduled monthly meetings to collaborate.

goal is to is to extend the use of the Medi-Medi funding across all States, when appropriate.

The introduction of new collaborative processes, systems, and analytical tools has laid the foundation for continued improvement in UPICs' ability to conduct program integrity activities

CMS and UPICs report that the Major Case Coordination (MCC) initiative improved collaboration and increased the number and quality of Medicare referrals to law enforcement and has the potential to do the same in Medicaid

Biweekly Medicare MCC meetings improved collaboration and increased the number and quality of Medicare referrals. According to CMS, within a year of implementing the Medicare MCC there has been an over 200 percent increase in Medicare referrals to law enforcement. Medicare MCC meetings allow CMS and law enforcement to evaluate each UPIC Medicare and Medi-Medi investigation for its quality, comprehensiveness, and appropriateness for referral. According to CMS, it established the Medicare MCC as a partnership between law enforcement, UPICs, and all CMS components. Since April 2018, UPICs have coordinated biweekly meetings that enable law enforcement and CMS to provide feedback to UPICs.

Most UPICs stated that the collaboration among stakeholders is a benefit of the Medicare MCC. Both UPICs and investigators in OIG reported that this process has improved the relationship between OIG and the UPICs. Investigators in OIG credited these meetings with increasing the quality of referrals they receive. UPICs found that the Medicare MCC (1) ensured that the correct approach is used for each referral; (2) improved efficiency in conducting investigations, making referrals, and identifying overpayments; and (3) supported investigative activity for the purpose of recommending administrative actions. Specifically, UPICs noted that the MCC had made their investigative strategy more targeted for law enforcement referrals.

Four UPICs offered that the MCC initiative could be enhanced by:

- making MCC meetings quarterly rather than biweekly, which would allow UPICs more time to investigate cases;
- giving UPICs more than 1 week after MCC meetings to draft case referrals and administrative actions;
- implementing a "pre-MCC" meeting to avoid jurisdictional overlaps with other UPICs; and

- inviting representatives from the local and regional Federal Bureau of Investigation (FBI) offices to attend Medicare MCC meetings as this would allow UPICs to refer cases declined by OIG directly to the FBI during the meetings.

Similarly, the Medicaid MCC initiative has shown potential to improve State and Federal collaboration regarding Medicaid referrals. On the basis of the success of the Medicare MCC model, CMS implemented an MCC forum for Medicaid at the end of 2019. The first Medicaid MCC meeting occurred in January 2020. According to CMS, as of March 2021, Medicaid MCC meetings were held with 6 States and law enforcement accepted 17 investigations for further review out of the 33 investigations presented by UPICs. The Medicaid MCC participants include the State, State MFCUs, CMS, and OIG as well as other law enforcement. Thus, the Medicaid MCC takes into consideration the State-by-State nature of Medicaid.

Regarding how to improve the Medicaid MCC initiative, one UPIC stated that better communication between stakeholders could improve the process. Another UPIC suggested that States need to better understand the Medicaid MCC process and support the concept of the MCC.

UPICs identified benefits of the Unified Case Management System (UCM), but note the need for additional improvements

The UCM system—the centralized repository for both Medicare and Medicaid investigations—has increased UPICs' awareness of activities being conducted across jurisdictions. According to one UPIC, the UCM system enabled it to identify and coordinate actions with other contractors. It also helped the UPIC ensure that there were no conflicts with other UPICs when developing data analysis projects. One UPIC noted that the UCM system gave it the ability to see records across all UPICs. According to CMS, including all investigation documentation in one system also highlights any overlap between work in Medicare and Medicaid.

Additional changes to the UCM system could improve UPICs' oversight activities. All five UPICs reported challenges with the UCM's reporting capabilities and suggested changes to the UCM system. While UPICs are required to use the UCM, some note that the system does not capture all the information UPICs must track. This requires UPICs to continue to use additional tracking systems and databases to conduct their work. To meet CMS reporting requirements, and account for the data not included in UCM, some UPICs maintain their own internal tracking systems with information not captured by the UCM system. According to two UPICs, integrating the UCM system with other systems such as the Provider Enrollment, Chain, and Ownership System; FPS; the Recovery Audit Contractor data warehouse; and OnePI could improve efficiency and enhance analytic approaches. To track concerns, one UPIC noted that the UCM system Helpdesk could be improved by shifting from an email helpdesk to a more integrated system. A UPIC reported that it was optimistic that CMS's work with a new contractor to improve UCM system

functionality and reporting would be successful, and another UPIC noted that solutions already implemented by this contractor have improved the system's functionality.

UPICs reported that they have developed innovative analytical tools that improve their ability to detect fraud, waste, and abuse

Four UPICs developed new information technology tools to conduct data analysis to detect fraud, waste, and abuse. One of these tools has enhanced a UPIC's ability to identify fraud trends, and three UPICs have developed tools to help prioritize high-risk investigations. Additionally, three UPICs have developed software for predictive analysis and two UPICs developed artificial intelligence software. This software has enhanced UPICs' capabilities of integrating social media and other types of data to find associations among suspect providers as well as uncovering fraud.

Despite challenges caused by the COVID-19 pandemic, UPICs were able to identify vulnerabilities related to the pandemic and—with some limitations—continue program integrity activities

UPICs reported that the COVID-19 pandemic impacted their ability to conduct required program integrity activities in both the Medicare and Medicaid programs. Beginning in March 2020, CMS restricted UPICs from communicating with or conducting onsite visits with healthcare providers and ordered UPICs to terminate prepayment reviews. These limits were put in place to ensure that healthcare providers were able to devote their full resources to combatting the healthcare crisis at hand. CMS's directives affected the UPICs' ability to request medical records and conduct provider interviews, which can delay work on open investigations. In June 2020, CMS revised its earlier directive by requiring UPICs to receive permission before engaging in previously restricted program integrity activities that could endanger the health and wellness of contractors' staff and the community at large.

Despite these challenges, each UPIC identified fraud, waste, and abuse related to the pandemic. UPICs diverted resources to permitted activities such as beneficiary interviews and reviewing the medical records they had received before the pandemic began. Some UPICs also conducted proactive data analysis to monitor schemes related to the pandemic. UPICs reported identifying potential fraud, waste, and abuse connected to improper billing of COVID-19-related services, abuse of telehealth services, and abuse of Respiratory Panel Pathogen testing. Similarly, CMS added several pandemic topics as high-priority areas for program integrity work during calendar year 2021, such as COVID-19 testing and vaccinations. The emphasis on COVID-19 within CMS's priority work areas highlights the continued threat the pandemic poses to program integrity.

During the pandemic, CMS also requested that UPICs undertake new tasks. CMS asked UPICs to validate certain high-risk DME suppliers that enrolled under a set of relaxed enrollment standards instituted during the pandemic. By granting waivers and flexibilities during the pandemic, CMS exempted providers from certain enrollment screening requirements including background checks, site visits, and accreditation requirements. According to CMS, over 2,000 high-risk DME suppliers enrolled under these relaxed provisions. In response, CMS instructed UPICs to validate DME suppliers' enrollment, resulting in over 500 investigations and 40 revocation referrals.

CONCLUSION AND RECOMMENDATIONS

UPICs hold promise for leveraging cross-program consolidation to strengthen oversight by employing new collaborative processes, analytical tools, and technology to conduct program integrity activities. However, we identified several improvements needed to better combat fraud, waste, and abuse—particularly in the Medicaid program. The uniqueness of each State's Medicaid program creates an inherent challenge for UPICs in conducting Medicaid oversight—a challenge not present in conducting oversight of the more uniform Medicare program. We found that UPICs' ability to conduct robust Medicaid oversight—particularly in managed care—was limited due to poor data quality; lack of data access; and differences across State Medicaid laws, regulations, and MCO contracts. These challenges resulted in UPICs conducting only limited program integrity work for Medicaid, especially Medicaid managed care, in 2019. The expansion of program integrity activities to include more Medicaid managed care, improvements in data systems, and further collaboration amongst UPICs and their stakeholders would increase the overall productivity of the UPICs and enhance their detection of fraud, waste, and abuse.

UPICs are CMS's only program integrity contractor that safeguards both the Medicare FFS and the Medicaid programs from fraud, waste, and abuse. Combined, Medicare and Medicare provided health care coverage to 139 million people at a cost of $1.5 trillion in 2020. Given the cost and reach of these Federal health care programs, it is essential that UPICs successfully detect and deter fraud, waste, and abuse. Our findings indicate that while CMS created a framework to improve program integrity in Medicare and Medicaid, improvements are needed to better combat fraud, waste, and abuse.

The findings of this report provide further support for OIG's existing recommendation that CMS ensure that States' reporting of national Medicaid data is complete, accurate, and timely.[19]

Additionally, we recommend that CMS:

[19] OIG, *OIG's Top Unimplemented Recommendations: Solutions To Reduce Fraud, Waste, and Abuse in HHS Programs*, October 2021. Specifically, Recommendation #13 is: "CMS should ensure that States' reporting of national Medicaid data is complete, accurate, and timely." The relevant OIG reports related to this recommendation are *National Review of Opioid Prescribing in Medicaid Is Not Yet Possible* (OEI-05-18-00480); *Weaknesses Exist In Medicaid Managed Care Organizations' Efforts to Identify and Address Fraud and Abuse* (OEI-02-15-00260); *States Could Do More To Prevent Terminated Providers From Serving Medicaid Beneficiaries* (OEI-03-19-00070); and *Data on Medicaid Managed Care Payments to Providers Are Incomplete and Inaccurate* (OEI-02-19-00180).

Implement a plan to increase UPICs' Medicaid program integrity activities, particularly related to managed care

CMS should identify and implement ways to enhance UPICs' work in Medicaid, especially managed care. For example, CMS could:

- require UPICs to conduct more data analysis projects with Medicaid managed care encounter data to generate more proactive leads,
- work with UPICs to increase the use of Medicaid managed care encounter data in its Medi-Medi analyses,
- work with States and UPICs to reduce program integrity limitations that UPICs encounter due to restrictive State requirements and/or MCO contractual language, and/or
- continue to work with States that have yet to sign Joint Operating Agreements with the UPICs.

Make improvements to the Unified Case Management system

UPICs reported that additional changes to the UCM would assist with their program integrity activities. Therefore, CMS should obtain more detailed feedback from UPICs (either through the UCM Helpdesk or some other mechanism) on how the UCM can be improved. After receiving this feedback, CMS should then determine what improvements to implement.

Implement a plan to help ensure the success of the Major Case Coordination initiative for Medicaid referrals

CMS has had success in improving the quality and number of Medicare referrals submitted by UPICs since the implementation of the Medicare MCC. CMS should consider ways to ensure that the Medicaid MCC generates a similar level of success. To start, CMS could increase the number of Medicaid MCC meetings that are conducted. CMS also could seek out opportunities to provide States with education to better understand the Medicaid MCC initiative and how their active participation would benefit the State's fraud detection activities.

Identify the reasons for the unexplained variation in program integrity activities across UPICs

Although there may be valid reasons for some variation among contractors, CMS should examine the substantial disparities in workload activities between UPICs that cannot be explained by their different levels of oversight responsibility or funding. We understand that certain geographical area across the country have historically had

higher levels of fraud, but it is important for CMS to determine if this is the sole reason for these substantial disparities in UPIC activities or if there may be other possible reasons, including performance issues, that might be causing such extreme variation.

AGENCY COMMENTS AND OIG RESPONSE

CMS responded that UPICs are one piece of a complementary network of activities by both the States and Federal government to promote Medicaid program integrity. As part of this network, CMS pointed to State Medicaid program integrity units, MFCUs, and Special Investigation Units within Medicaid managed care plans. CMS also noted that it promotes effective State fraud prevention activities through best practices, oversight reviews, and specialized training.

Further, CMS stated that it has continued to work to refine and direct the UPIC work to where it is most effective. Since OIG's review period, CMS noted that Medicaid managed care work has risen to represent about 50 percent of the current Medicaid UPIC caseload.

CMS concurred with all of OIG's recommendations and has already taken action or has plans to take action for implementation.

In response to our first recommendation on increasing UPICs' Medicaid program integrity activities, CMS stated that its continuous improvement actions include activities focused on increasing the UPICs' Medicaid managed care program integrity activities. In response to our second recommendation to improve the UCM system, CMS indicated that it has started to redesign the UCM system in close collaboration with the UPICs. In response to our third recommendation regarding the Major Case Coordination initiative, CMS stated that it will explore ways to maintain and enhance the initiative and educate States on how this collaboration can help them fight fraud. Finally, in response to our fourth recommendation on addressing unexplained variations across UPIC activities, CMS stated that it continuously monitors the program integrity activities performed across UPICs to ensure the optimal use of program integrity resources.

OIG appreciates CMS's planned efforts to address our recommendations and looks forward to reviewing its actions when complete.

For the full text of CMS's comments, see the Agency Comments appendix at the end of the report.

DETAILED METHODOLOGY

Data Collection

We began this evaluation during the COVID-19 pandemic. Because the objectives of this evaluation centered on the program integrity activities and results of the UPICs, we expected that if we selected a timeframe during the height of the pandemic, our results might not be indicative of the UPICs' general efforts and results. Therefore, we focused the analysis on program integrity activities conducted in 2019—the most recent full year that preceded the pandemic.

CMS Data. From CMS, we obtained documentation on UPICs' 2019 program integrity activities. This documentation included—for each UPIC—workload data from the Monthly Status Reports, Quarterly Vulnerability Reports, transition and implementation plans, data analysis strategies, education plans, and assessments of program integrity activities.

We also surveyed CMS about the effects and challenges created by the unification of program integrity activities, CMS's oversight and assessment of UPICs' work, and the effects of the COVID-19 pandemic on UPICs' program integrity activities.

UPIC Data. From the UPICs, we obtained responses to an information request and survey about their program integrity activities. In response to our information request, UPICs provided the number of specific program integrity activities conducted (workload data) in 2019 for each program (Medicare, Medicaid, and the Medi-Medi program). The requested data included the numbers of data analysis projects completed, investigations opened, cases referred, overpayments referred, and administrative actions recommended.

In response to our survey, UPICs identified (1) the impact of unification on their program integrity activities; (2) their methods to access and use Medicare and Medicaid data for program integrity activities; (3) any challenges they face in conducting their program integrity activities; (4) their strategies for conducting program integrity activities during the COVID-19 pandemic; and (5) the tools and strategies they use to detect fraud, waste, and abuse.

Spending Data. From CMS, we obtained 2019 Medicare spending data for each UPIC jurisdiction. This included the amount of Medicare Part A and Medicare Part B spending.

We obtained total Medicaid spending data for each State in 2019 from the T-MSIS data available on CMS's IDR. To calculate total Medicaid spending for each State, we

added (1) the amount paid for all FFS claims and (2) the amount of monthly capitation payments made to MCOs.[20] We then summed spending for each UPIC jurisdiction.

Data Analysis

To determine the extent of UPICs' activities, we reviewed and analyzed the 2019 program integrity activities provided by UPICs. For each UPIC, we determined the number of:

- investigations opened;
- referrals made;
- administrative actions recommended (including revocations, exclusions, terminations, payment suspensions, and civil monetary penalties recommended);
- data analysis projects conducted;
- leads screened;
- value of overpayments referred;
- medical review case requests conducted;
- claims denied due to pre- and post-payment medical review;
- savings associated with auto-deny edits;
- Medicare appeals handled;
- law enforcement requests for information and assistance completed;
- compromised beneficiary and provider identification numbers identified; and
- vulnerabilities identified.

We then determined the number of these program integrity activities associated with Medicare, Medicaid, and Medi-Medi programs and compared the activities across the five UPICs. We additionally compared the number of program integrity activities conducted to each UPIC's funding. To account for differences in the size of each UPICs oversight responsibility, we determined the number of program integrity activities for every $100 billion in Medicare and Medicaid spending in each jurisdiction and compared these numbers across the five UPICs.

To determine the benefits of and challenges to the unification of program integrity activities, we reviewed and analyzed the survey responses from CMS and UPICs. We analyzed survey responses from CMS and UPICs to identify the benefits that were attributed to unifying program integrity activities as well as the challenges UPICs have encountered in performing program integrity duties during 2019 (prior to the COVID-19 pandemic). We also reviewed and analyzed responses related to the tools and strategies that UPICs use to detect fraud, waste, and abuse across programs, including the use of technological tools. We then analyzed the survey responses from

[20] Under managed care, a State pays an MCO a per-member, per-month fee—known as a capitation payment—for each person enrolled with the MCO. The MCO then pays providers for all Medicaid services included in the MCO's contract with the State.

CMS and UPICs describing the impact of the COVID-19 pandemic on UPICs' program integrity activities during the pandemic.

APPENDICES

Appendix A: Total Program Integrity Activities Conducted by UPICs in 2019

UPICs reported the number of program integrity activities they conducted in 2019. If a UPIC was unable to provide the data requested, it responded with "Unable to determine" or "Did not track."

Exhibit A-1. Total program integrity activities conducted by each UPIC across Medicare, Medicaid, and Medi-Medi in 2019

		Medicare	Medicaid	Medi-Medi	Total
Data analysis projects completed[a]	Northeast	66	22	37	125
	Southeast	43	14	4	61
	Midwest	31	20	15	66
	Southwest	66	35	34	135
	West	44	9	5	58
Leads screened[a]	Northeast	811	128	88	1,027
	Southeast	984	22	243	1,249
	Midwest	1,077	167	52	1,296
	Southwest	1,156	115	127	1,398
	West	1,252	158	78	1,488
Investigations opened[a]	Northeast	501	98	61	660
	Southeast	714	221	157	1,092
	Midwest	508	120	37	665
	Southwest	807	95	78	980
	West	693	63	30	786
Vulnerabilities identified[a]	Northeast	0	0	0	0
	Southeast	0	0	0	0
	Midwest	0	0	0	0
	Southwest	9	0	0	9
	West	1	2	0	3
Cases referred[a]	Northeast	125	5	30	160
	Southeast	116	2	49	167
	Midwest	231	8	13	252
	Southwest	122	2	27	151
	West	70	16	11	97
Value of overpayments referred for recovery[a]	Northeast	$22,225,605	$305,261	$5,729,225	$28,260,091
	Southeast	$36,386,858	$4,075,597	$9,106,658	$49,569,113
	Midwest	$174,436,346	$3,178,395	$2,183,867	$179,798,608
	Southwest	$65,883,281	$1,734,043	$8,143,572	$75,760,896
	West	$4,412,541	$9,398,846	$97,626	$13,909,013

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Exhibit A-1. Total program integrity activities conducted by each UPIC across Medicare, Medicaid, and Medi-Medi in 2019 (continued)

		Medicare	Medicaid	Medi-Medi	Total
Total number of prepay and postpay claims denied[a]	Northeast	19,145	592	4,693	24,430
	Southeast	16,748	3,908	4,383	25,039
	Midwest	16,987	1,163	1,503	19,653
	Southwest	26,229	1,093	877	28,199
	West	4,170	98	1,851	6,119
Total number of payment suspensions submitted[a, b]	Northeast	69	Did not track	9	78
	Southeast	70	0	18	88
	Midwest	161	0	3	164
	Southwest	53	0	4	57
	West	75	0	0	75
Number of Medicare revocations recommended[a]	Northeast	12	Not applicable	3	15
	Southeast	32	Not applicable	8	40
	Midwest	44	Not applicable	3	47
	Southwest	35	Not applicable	3	38
	West	18	Not applicable	4	22
Number of Medicare exclusions recommended[a]	Northeast	0	Not applicable	0	0
	Southeast	0	Not applicable	0	0
	Midwest	0	Not applicable	0	0
	Southwest	0	Not applicable	0	0
	West	0	Not applicable	0	0
Number of Medicaid terminations recommended[a]	Northeast	Not applicable	Did not track	Did not track	Did not track
	Southeast	Not applicable	0	0	0
	Midwest	Not applicable	0	0	0
	Southwest	Not applicable	0	0	0
	West	Not applicable	0	0	0
Number of civil monetary penalties recommended[a]	Northeast	0	0	0	0
	Southeast	0	0	0	0
	Midwest	0	0	0	0
	Southwest	0	0	0	0
	West	0	0	0	0
Investigations resulting in administrative actions	Northeast	314	39	42	395
	Southeast	414	2	95	511
	Midwest	705	25	79	809
	Southwest	371	40	61	472
	West	360	35	63	458
Total number of Medicare appeals handled	Northeast	544	Not applicable	Not applicable	544
	Southeast	47	Not applicable	Not applicable	47
	Midwest	Unable to determine	Not applicable	Not applicable	Unable to determine
	Southwest	6,529	Not applicable	Not applicable	6,529
	West	3,068	Not applicable	Not applicable	3,068
Value of Medicare claims denied by auto-deny edits[c, d]	Northeast	$5,532,541	Not applicable	$0	$5,532,541
	Southeast	$35,379,685	Not applicable	$244,172	$35,623,856
	Midwest	$593,981	Not applicable	$0	$593,981
	Southwest	$11,109,085	Not applicable	$48,705	$11,157,790
	West	$11,643,680	Not applicable	$0	$11,643,680

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Exhibit A-1. Total program integrity activities conducted by each UPIC across Medicare, Medicaid, and Medi-Medi in 2019 (continued)

		Medicare	Medicaid	Medi-Medi	Total
Request for information completed	Northeast	448	2	239	689
	Southeast	684	0	86	770
	Midwest	848	5	10	863
	Southwest	484	2	242	728
	West	383	0	0	383
Request for assistance completed	Northeast	24	3	1	28
	Southeast	5	0	0	5
	Midwest	23	1	0	24
	Southwest	62	3	3	68
	West	42	3	0	45
Medical review case requests conducted	Northeast	447	21	83	551
	Southeast	158	14	58	230
	Midwest	498	57	58	613
	Southwest	272	13	49	334
	West	323	10	44	377
Compromised beneficiary ID numbers identified	Northeast	2	0	0	2
	Southeast	38	0	1	39
	Midwest	Did not track	Did not track	Did not track	Did not track
	Southwest	37	0	0	37
	West	0	0	0	0
Compromised provider ID numbers identified	Northeast	2	0	0	2
	Southeast	3	0	0	3
	Midwest	Did not track	Did not track	Did not track	Did not track
	Southwest	0	0	0	0
	West	0	0	0	0

Source: OIG analysis of UPICs' responses to OIG request for information.

[a] Denotes one of the program integrity activities described in the findings of the report. In the findings, "administrative actions recommended" represents the sum of the revocations, exclusions, terminations, payment suspensions, and civil monetary penalties recommended by the UPICs.

[b] The UPICs reported that the Medi-Medi payment suspensions were related to Medicare providers only.

[c] The Medicare, Medicaid, and Medi-Medi amounts may not sum to the total amount because of rounding.

[d] Auto-deny edits prevent payment for services that are billed inappropriately.

Appendix B: Program Integrity Activities Conducted by UPICs for Medicaid Fee-for-Service and Medicaid Managed Care in 2019

UPICs reported the number of program integrity activities they conducted in 2019. If a UPIC was unable to provide the data requested, it responded with "Unable to determine" or "Did not track."

Exhibit B-1. Program integrity activities conducted by each UPIC across Medicaid fee-for-service (FFS) and Medicaid managed care in 2019

		Medicaid FFS	Medicaid Managed Care	Medicaid FFS and Medicaid Managed Care	Medicaid Total
Data analysis projects completed[a]	Northeast	Did not track	Did not track	Did not track	22
	Southeast	8	0	6	14
	Midwest	Did not track	Did not track	Did not track	20
	Southwest	Did not track	Did not track	Did not track	35
	West	9	0	0	9
Leads screened[a]	Northeast	Did not track	Did not track	Did not track	128
	Southeast	21	0	1	22
	Midwest	0	0	167	167
	Southwest	103	5	7	115
	West	142	9	7	158
Investigations opened[a]	Northeast	Did not track	Did not track	Did not track	98
	Southeast	95	125	1	221
	Midwest	Unable to determine	Unable to determine	Unable to determine	120
	Southwest	80	6	9	95
	West	63	0	0	63
Cases referred[a]	Northeast	Did not track	Did not track	Did not track	5
	Southeast	2	0	0	2
	Midwest	Unable to determine	Unable to determine	Unable to determine	8
	Southwest	1	1	0	2
	West	16	0	0	16
Vulnerabilities identified[a]	Northeast	Did not track	Did not track	Did not track	0
	Southeast	0	0	0	0
	Midwest	0	0	0	0
	Southwest	0	0	0	0
	West	2	0	0	2
Investigations resulting in administrative actions	Northeast	Did not track	Did not track	Did not track	39
	Southeast	2	0	0	2
	Midwest	Unable to determine	Unable to determine	Unable to determine	25
	Southwest	32	2	6	40
	West	35	0	0	35

continued on next page

Exhibit B-1. Program integrity activities conducted by each UPIC across Medicaid fee-for-service (FFS) and Medicaid managed care in 2019 (continued)

		Medicaid FFS	Medicaid Managed Care	Medicaid FFS and Medicaid Managed Care	Medicaid Total
Request for information completed	Northeast	Did not track	Did not track	Did not track	2
	Southeast	Did not track	Did not track	Did not track	0
	Midwest	Unable to determine	Unable to determine	Unable to determine	5
	Southwest	Did not track	Did not track	Did not track	2
	West	0	0	0	0
Request for assistance completed	Northeast	Did not track	Did not track	Did not track	3
	Southeast	Did not track	Did not track	Did not track	0
	Midwest	Unable to determine	Unable to determine	Unable to determine	1
	Southwest	Did not track	Did not track	Did not track	3
	West	0	0	3	3

Source: OIG analysis of UPICs' responses to OIG request for information.

[a] Denotes one of the program integrity activities described in the findings of the report.

Note: Upon reviewing this appendix, CMS noted that UPICs' responses may not align with CMS's requirements and statements on program characteristics.

Appendix C: Agency Comments

Following this page are the official comments from CMS.

DATE: September 14, 2022

TO: Suzanne Murrin
Deputy Inspector General for Evaluation and Inspections

FROM: Chiquita Brooks-LaSure
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: UPICs Hold Promise to Strengthen Program Integrity in Medicare and Medicaid, But Challenges Remain (OEI-03-20-00330)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is committed to program integrity efforts in Medicare and Medicaid, including providing effective support and assistance to states in their efforts to combat Medicaid provider fraud and abuse.

The Medicaid program is funded jointly by states and the federal government, and State Medicaid Agencies (SMAs) administer the Medicaid program on a day-to-day basis according to federal requirements. SMAs are responsible for establishing, within broad federal guidelines, various Medicaid program requirements, such as who will be eligible for benefits, what benefits will be covered, and the service delivery system to be used to provide Medicaid services, typically managed care or fee-for-service. This gives each state broad flexibility in the design of their respective programs and thus results in variation among Medicaid programs.

One way that CMS investigates instances of suspected fraud, waste, and abuse in Medicare and Medicaid is through the activities of the Unified Program Integrity Contractors (UPICs). UPICs are one piece of a complementary network of efforts by both the SMAs and federal government to promote Medicaid program integrity. States dedicate resources to their Medicaid program integrity units and Medicaid Fraud Control Units, while Medicaid managed care plans have Special Investigative Units (SIUs), all of which may investigate potential fraud, waste and abuse. UPICs are funded by CMS and operate in five geographic jurisdictions. Their work includes Medicare and Medicaid program integrity initiatives, as well as examining data from both Medicare and Medicaid to conduct analyses across programs (Medi-Medi). UPICs work in close collaboration with SMAs to conduct proactive Medicaid data analysis, investigations, and audits of all types of Medicaid providers including managed care. The UPICs also identify overpayments and make fraud referrals to law enforcement, and work closely with SMAs to ensure their work aligns with state priorities.

In addition to the UPIC efforts, CMS also promotes best practices and performance standards for states to use in their fraud prevention efforts, conducts State Program Integrity Reviews to assess the effectiveness of the state's program integrity efforts, and leads the Medicaid Integrity

Institute (MII), which provides training tailored to meet the ongoing needs of state Medicaid program integrity employees.

Since the OIG's review period, CMS has continued to work to refine and direct the UPIC work to where it is most effective, and in recent years, Medicaid managed care work has risen to represent about 50 percent of the current Medicaid UPIC caseload. Some variation between jurisdictions and programs is expected because the number of leads received, available budget, and type of investigation all affect workload. For example, Home Health and Hospice investigations are more complex and consume more resources than other types of investigations. A jurisdiction conducting more Home Health and Hospice investigations may conduct fewer investigations overall. In addition, the landscape of fraud varies throughout the country. CMS tracks UPIC initiatives and findings in detail, and expects UPICs' time and resources spent across Medicare, Medicaid, and Medi-Medi to generate a positive return on investment with the funding they receive for each program.

CMS's oversight includes tracking workload differences between jurisdictions as well as working with UPICs to explore other possible reasons for these differences. UPICs can access the Unified Case Management (UCM) system, which CMS developed as a centralized repository for leads and investigations. UPICs create records in the UCM to document the leads received, results of vetting those leads to determine if an investigation is warranted, as well as the outcomes of those investigations. CMS uses the UCM system to continuously monitor and evaluate UPIC performance. CMS is currently spearheading an effort to improve the UCM system, soliciting UPIC feedback to develop a new more user-focused system that prioritizes Human Centered Design.

OIG's recommendations and CMS' responses are below.

OIG Recommendation

CMS should implement a plan to increase UPICs' Medicaid program integrity activities, particularly related to managed care.

CMS Response

CMS concurs with this recommendation. CMS's continuous improvement actions include activities focused on increasing the UPIC Medicaid managed care program integrity activities. To date, Medicaid managed care represents roughly 50 percent of the current Medicaid UPIC caseload. CMS will continue to ensure the optimal UPIC caseload mix for Medicaid managed care.

OIG Recommendation

CMS should make improvements to the UCM system.

CMS Response

CMS concurs with this recommendation. Prior to this audit, CMS had begun work on the redesign effort of the UCM in close collaboration with UPICs. CMS will continue its work on this effort to make improvements to the UCM system.

OIG Recommendation

CMS should implement a plan to promote the success of the Major Case Coordination initiative for Medicaid referrals.

CMS Response

CMS concurs with this recommendation. CMS will explore ways to maintain and enhance the success of the Medicaid Major Case Coordination initiative and to educate states on how this collaboration can help them fight fraud.

OIG Recommendation

CMS should identify the reasons for the unexplained variation in program integrity activities across UPICs.

CMS Response

CMS concurs with this recommendation. CMS continuously monitors the program integrity activities performed across UPICs to ensure the optimal use of program integrity resources. As part of this monitoring, we expect variations between jurisdictions and programs due to a number of factors, including the number of fraud leads received, available budget, and type of investigations. For example, Home Health and Hospice investigations are more complex and consume more resources than other types of investigation.

CMS thanks OIG for their efforts on this issue and looks forward to working with OIG on this and other issues in the future.

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Acknowledgments

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This report was prepared under the direction of Linda Ragone, Regional Inspector General for Evaluation and Inspections in the Philadelphia regional office, and Edward K. Burley, Deputy Regional Inspector General.

Contact

To obtain additional information concerning this report, contact the Office of Public Affairs at Public.Affairs@oig.hhs.gov. OIG reports and other information can be found on the OIG website at oig.hhs.gov.

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