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CMS Seems to Tee Up More UPIC Reviews for Medicaid; Extrapolation Is Decided Early

By Nina Youngstrom

Providers should brace for more scrutiny of their Medicaid claims from unified program integrity contractors (UPICs) because of new marching orders from CMS. UPICs—which perform fraud, waste and abuse activities for CMS—are a familiar presence in the Medicare audit and investigation world, but CMS seems to be raising their profile on the Medicaid side.

Medicaid Transmittal 12,467, released Jan. 18, elaborates on the UPICs' "proactive project development" and follow-up.[1] It was surprising even to see revisions to the *Medicaid Program Integrity Manual* because they're infrequent compared to revisions to the *Medicare Program Integrity Manual.*

"These revised provisions serve as a reminder of the aggressive role the feds are taking in Medicaid enforcement," said attorney Judy Waltz, with Foley & Lardner LLP in San Francisco. Although the federal government doesn't pay for all Medicaid spending, it has a stake in preventing fraud, waste and abuse and recovering associated overpayments. For example, the percentage that the federal government kicks in for Medicaid—called the Federal Medical Assistance Percentage—is 50% in California, 64.6% in Ohio and 60% in Texas, according to KFF.[2]

Several items in the transmittal are eye-catching. For example, UPICs will decide to extrapolate error rates on the front end, before the audit is completed, which Waltz finds a bit troubling. CMS also has now set a $50,000 "floor" for the "sample dollars at risk" in a Medicaid UPIC audit or investigation of a specific set of claims.

UPICs perform program integrity activities in Medicare Parts A and B and Medicaid. They have access to the unified care management (UCM) system, a national database used by CMS, the HHS Office of Inspector General (OIG), the Federal Bureau of Investigation and other Medicare enforcers and contractors with a stake in Medicare and Medicaid fraud investigations. UPIC targets must be approved by CMS and, when relevant, the state Medicaid agency (SMA).

UPICs became far more of a force to be reckoned with in 2021 after CMS announced changes in Medicare Transmittal 10,984.[3] UPICs are now required to have "formal and informal communication" with state survey agencies, OIG, the U.S. Department of Justice (DOJ), Medicaid agencies, other Medicare contractors, state surveyors "and other organizations as applicable to determine information that is available and that should be exchanged to enhance program integrity activities." Lawyers consider this a game-changer because the investigative information became well-coordinated across agencies, and UPICs are able to identify proactive leads. That raises the stakes for providers who become a target.

A March 2023 update to the *Medicaid Integrity Manual* explained the responsibility of UPICs in the Medicaid space.[4] "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," it stated.

But language in the brand-new update elaborates that the "investigation plan of action is required to cover the dollars at risk for the scheme or service codes in question rather than the total dollars paid for all services during the time period."

The transmittal explains that "for Medicaid leads and investigations, dollars at risk will be identified at two levels:"

1. "Total dollars at risk include only the dollars for the service code/scheme that are outliers on any specific data algorithm, and which will be the focus of the investigation/audit. This amount is required when submitting a potential lead to CMS for review/approval and for pre-vetting with CMS and vetting with the SMA.

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

Extrapolation Comes Early With Medicaid UPICs

Waltz said the new language in the transmittal means UPICs will develop an extrapolation strategy early on. "This seems to be inconsistent with the approach that CMS takes in Medicare that you look at the error rate that you have identified after the audit and then assess whether extrapolation is appropriate," she noted. "Here it seems that the UPIC decides up front whether they will use extrapolation. That may, theoretically, improve the design of the audits, as they should be looked at for statistically valid random samples, but likely means that extrapolation will be applied to any error rate." The statute that only allows Medicare contractors to extrapolate overpayment amounts when there has been "a determination of sustained or high level of payment error, or documentation that educational intervention has failed to correct the payment error," as the *Medicare Program Integrity Manual* explains,[5] wouldn't apply to UPIC Medicaid audits, Waltz said.

The $50,000 floor is helpful because providers could reasonably consider whether the dollar figure of an identified problem is low enough that it's advantageous to repay Medicaid "rather than considering a more fulsome disclosure" to avoid a UPIC review/investigation, Waltz noted. "That said, it's a pretty low floor given how costly medical care is these days, even accounting for the low payment amounts in Medicaid." And the transmittal has a twist: It states that UPICs are permitted to propose an investigation plan to CMS even when the dollars at risk are below $50,000 if there's something compelling about it. "I read that to say they will do a cost-benefit analysis," Waltz said. One caveat: the threshold goes out the window when fraud is suspected, the transmittal stated.

'People Can Get a Little Lackadaisical'

Another upside to CMS limiting the amount of dollars at risk to a specific set of claims is it "should reduce the potential bias that some providers sense towards big operations," Waltz said. Larger players may feel they have a target on their backs because of their growth or market power, but UPICs are being told to focus on a risk area (e.g., hospice). "They're not saying, 'This entity is so big, they must be doing something wrong.' They're picking the risk issue, not just the entity."

Waltz added that maybe it's time for providers to revisit extrapolation requirements in their state Medicaid programs and remember they may differ from Medicare's. "Sometimes people can get a little lackadaisical and think if something works for Medicare it works for Medicaid as well, but Medicaid is a different world and it's

different in every state."

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1 Centers for Medicare & Medicaid Services, "Updates of Chapter 1, Chapter 3, and Chapter 5 in Publication (Pub.) 100-15, Including Updates to the Definitions and Additional Clarification to the Proactive Project Development and Creation of Overpayment Records Guidance," Pub 100-15, Medicaid Program Integrity, Trans. 12,467 (Jan. 18, 2024), https://bit.ly/48Nbheg.
2 KFF, "Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier," Timeframe: FY 2025, January 25, 2024, https://bit.ly/47QctMw.
3 Nina Youngstrom, "CMS Gives UPICs More Powerful Policing Role; 'This Raises the Risk Level' for Providers," *Report on Medicare Compliance* 30, no. 33 (September 20, 2021), https://bit.ly/3CZFIh2.
4 Centers for Medicare & Medicaid Services, "Chapter 3 - Medicaid Investigations & Audits," *Medicaid Program Integrity Manual*, Pub. 100-15, April 13, 2023, https://go.cms.gov/4b7GQkA.
5 Centers for Medicare & Medicaid Services, "Chapter 8 - Administrative Actions and Sanctions and Statistical Sampling for Overpayment Estimation," *Medicare Program Integrity Manual*, Pub. 100-08, October 26, 2023, https://go.cms.gov/3vReOK4.