

# Unified Program Integrity Contractor Request for Information (RFI) – Requirements Document

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## A. INTRODUCTION

The Centers for Medicare & Medicaid Services (CMS) has an essential role to predict, detect, prevent, and deter any and all threats to the integrity of the Medicare and Medicaid programs. The Center for Program Integrity (CPI), as part of CMS, is in a pivotal position to effect strategies that will ultimately reduce fraud, waste, abuse, and other improper payments made under these important programs.

To perform this mission, CPI must seek new and innovative approaches, and have the capacity to swiftly anticipate and adapt to the ever changing and dynamic nature of those involved in health care fraud, waste, and abuse activities. CPI is developing a unified program integrity strategy to meet these challenges. The concept of a unified program integrity strategy involves contractors performing work across the Medicare and Medicaid program integrity continuum. 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.

In addition, this unified program integrity strategy is designed to foster and deepen the improvements that CPI has made over the past several years in multiple arenas: (1) Break down the boundaries between Medicare and Medicaid program integrity activities to create a truly holistic and coordinated Medicare/Medicaid program integrity strategy; (2) Create a more unified, coordinated nationwide program integrity strategic framework enabling the CMS to set national goals and priorities (after consultation with the Contractors) to ensure that local or regional program integrity activities are consistent with the CPI's national-level strategy, while still allowing for some regional variation in program integrity activities to respond to local or regional trends in waste, fraud, and abuse; (3) Further enable cooperation and communication between the various regional program integrity Contractors to ensure a truly national approach to providers or trends that cut across regions; (4) Strengthen the CMS's national-level direction of the Contractors' work by ensuring a rapid, accurate flow of information to the CMS about all levels of the contractors' workload and activities; and (5) Ensure that the CPI's new and emerging centralized fraud detection mechanisms and other tools, for example the Fraud Prevention System predictive analytics tool ("FPS") and the Health Care Fraud Prevention Partnership ("HFPP"), are fully and consistently leveraged across the entire nation. This approach will result in a more seamless and rigorous program integrity strategy to protect public dollars and it will also aid in the CMS's ongoing work to create a stronger, more flexible, and transparent data set for our own management of these important programs and Contractors. CMS also anticipates that this approach will lay the

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groundwork for fostering further program integrity coordination with other private and governmental payers across the entire health care industry.

The CMS is currently conducting market research in support of efforts to strengthen the integrity of the Medicare and Medicaid programs through improved contracting approaches and strategies.

## **B. PURPOSE**

The objective of this Request for Information (RFI) is to outline the requirements and provide a description of the work that CPI expects to be performed by this new type of unified contractor, to be called a Unified Program Integrity Contractor or UPIC. The CPI expects to establish several regional UPICs, each of which will support Medicare and Medicaid program integrity requirements in designated States, and whose primary function will be to realize and execute the CPI's nationally-set priorities and goals at the local or regional level. The CPI has not yet established the number or regional boundaries for the UPICs, but CPI expects the number of UPICs will fall between five and fifteen. (References to "the Contractor" in this document should be taken to mean "the UPIC" unless otherwise specified.) In response to this RFI, we are requesting input from industry representatives with expertise in and knowledge of auditing and health care data analysis and investigative methods, techniques, and processes used to prevent, detect, and combat fraud, waste, abuse, and overpayments in the Medicare and Medicaid programs.

It is anticipated the information obtained from this market research activity will be used to assist CMS in defining requirements and developing a Statement of Work (SOW), Performance Work Statement (PWS), or Statement of Objectives (SOO).

## **C. BACKGROUND**

The CPI seeks to integrate the program integrity functions for audits and investigations across Medicare and Medicaid, and to ensure that CPI's national priorities for both Medicare and Medicaid are executed and supported locally. The scope of the UPICs will encompass functions that are currently performed by several contractors, including; Zone Program Integrity Contractors (ZPICs, including their Medicare-Medicaid Data Match ("Medi-Medi") responsibilities), Program Safeguard Contractors (PSCs), and the Medicaid Integrity Contractors (MICs). [In a future stage of this initiative, CPI may also incorporate the work performed by the Medicare Drug Integrity Contractors (MEDICs) as well as Medicare Part C program integrity tasks in the UPIC contract scope. For the time being, the UPIC will address only Parts A and B of Medicare.] The UPICs will operate based on regional jurisdictions, with a single contractor performing Medicare and Medicaid program integrity (PI) audit and investigation work for a designated set of States. Each regional Contractor

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will play a vital role in advising CPI around desired national strategies, as well as recommending locally- or regionally-targeted variations and additions in its own jurisdiction to CPI's national-level program integrity strategy. The PI requirements that UPICs will perform, and the “expected outcomes” to be achieved by UPICs, are set out more fully in the following sections of this document.

As a result, the UPICs will implement and operate under multiple legislative authorities. The Medicare PI responsibilities of the UPICs are authorized by Section 1893 of the Social Security Act (which establishes the Medicare Integrity Program). The Medicare-Medicaid data match responsibilities of the UPICs are authorized by Section 1893(g) of the Social Security Act (enacted in Section 6034(d) of the Deficit Reduction Act of 2005). The Medicaid PI responsibilities of the UPICs are authorized by Section 1936 of the Social Security Act (which establishes the Medicaid Integrity Program). More detail on these legislative authorities is included in Appendix One to this document.

Finally, the UPICs will help CMS to leverage its augmented program integrity authorities found in the Patient Protection and Affordable Care Act of 2010 (more commonly known as the Affordable Care Act or ACA). There are four principal ways that the ACA seeks to improve benefit integrity efforts: (1) providing additional funding to prevent and fight fraud, (2) improving provider screening and compliance, (3) providing new penalties including enhanced administrative actions, and (4) enabling improved data sharing. CMS intends to utilize these authorities to continue moving the Medicare and Medicaid program integrity environment away from the “pay and chase” model and towards a “prevention and detection” model. The types of enhanced administrative actions that CMS wants to achieve through the UPIC initiative are described in more detail under the Section E below, entitled “Expected Outcomes.”

**NOTE:** *In the balance of this document, except where otherwise specified, CMS will use the term “providers” to refer to all the individuals and entities that may furnish health care services and submit claims for payment under the Medicare and Medicaid programs; that is, the term “providers” as used in this document is not limited to the technical definition in Medicare regulations.*

### **D. FUNDAMENTAL ACTIVITIES**

The UPIC (“the Contractor”) shall work on a wide variety of activities that focus on identifying and reducing fraud, waste, and abuse by individuals and entities furnishing items and services (hereafter, for convenience, referred to as “providers”) under the Medicare and Medicaid programs. Specific activities performed by the Contractor upon the direction of CPI shall be dependent upon the nature and severity of the issue for each healthcare provider

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under review and the policies, rules, and guidelines set forth in the Medicare and Medicaid programs. The Contractor shall maintain documentation to support all activities, including any referrals of analytic results or research provided to appropriate entities, as well as completion of the feedback loop with respect to these referrals. The Contractor may be asked to provide documentation to CMS at any time. All activities undertaken by the Contractor shall be aligned with the national-level and regional program integrity priorities identified by CMS.

### **1. Identify and Prioritize Leads**

- a. All Contractor activities will be aligned with CMS-determined priorities, including the most fundamental priority of protecting program dollars by stopping future inappropriate payments by use of any appropriate administrative tool or remedy, or recovering past illegitimate payments.
- b. The contractor shall partner with CMS to identify and prioritize leads for audit and investigation. Workload shall be split into three separate categories with corresponding levels of effort assigned to each category. The Contractor shall use the case management system to track and report all activities performed within these categories, and CMS will determine any adjustments to the levels of effort in support of priority work.
  - i. The first workload category shall be leads prioritized centrally through the FPS based on the results of sophisticated analytics completed in collaboration with the Contractor. The leads prioritized in the FPS includes vulnerabilities identified by many sources, including OIG reports, complaints, HFPP, law enforcement activity, UPIC intelligence, among others. The Contractor shall work with CMS to develop actionable models.
  - ii. The second workload category shall be leads identified and prioritized through collaboration between the Contractor and CMS. These would include leads developed through the approved data project plan, complaints, rapid response leads for urgent matters, and leads addressing local (e.g. Medicaid, emerging) issues.
  - iii. The third workload category shall be leads that are requested to be worked by law enforcement that were not already part of the workload assigned to the Contractor.
- c. The Contractor shall identify program vulnerabilities impacting the Medicare and Medicaid programs. The vulnerabilities identified by the Contractor(s) will be one of the inputs used to identify and prioritize leads.

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- d. The Contractor shall continuously monitor the fraud, waste, and abuse landscape and recommend updates to the priorities to address emerging issues.
- e. The Contractor shall consider the following overarching principles when recommending priority areas:
  - i. Patient abuse or harm;
  - ii. Ability to prevent future fraud, waste or abuse by taking administrative actions to remove providers or suppliers from the affected Program, or otherwise prevent inappropriate future payments;
  - iii. Multi-State fraud;
  - iv. High dollar amounts of potential overpayments;
  - v. Likelihood for an increase in the amount of fraud or enlargement of a pattern, including the potential that findings can be used to refine CMS’s anti-fraud prevention efforts and analytic models;
  - vi. Fraud complaints made by Medicare supplemental insurers;
  - vii. Law enforcement requests for assistance that involve court-imposed deadlines;
  - viii. Law enforcement requests for assistance in ongoing investigations that involve interagency initiatives or projects;
  - ix. Law enforcement requests for early administrative actions to prevent or mitigate losses to the affected Program(s); and,
  - x. Other new elements that may be identified by CMS through technical direction.

### 2. **Conduct Data Analysis and Manage Leads**

- a. The Contractor shall use a variety of techniques, such as data and statistical analysis, trending activities, and collaborative efforts to identify potential fraud, waste, and abuse across the Medicare and Medicaid programs. The Contractor shall continuously participate in and contribute to CPI’s development of national-level and regional-level priorities and activities. Results of these analyses, activities, and efforts will include identification of potential leads for further actions, including audit, investigation, or referral to law enforcement. The Contractor shall focus preferentially on activities and remedies designed to minimize future unnecessary or inappropriate Program expenditures.

Many healthcare providers serve both the Medicare and Medicaid populations, and about nine million individuals were “dually eligible” for both programs in 2008. As a

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- result, CMS has increased its efforts to use advanced technology to detect and prevent potential fraud, waste and abuse in both programs. The Contractor shall create a data matching protocol that identifies the steps necessary to link Medicare and Medicaid data on dual providers and dual beneficiaries across a variety of data sources. The matching protocol may be shared with other CMS contractors to maximize the analysis techniques across the program.
- b. The Contractor shall participate in the development and implementation of predictive and other sophisticated analytics into the FPS. The Contractor shall submit vulnerabilities for potential model development and specific algorithms that were successful in the local area for potential inclusion in the FPS. The Contractor shall be innovative in its data analysis methodologies and collaborate with CMS, States, and other Contractors designated by CMS to develop models that accurately identify fraud, waste, and abuse. The Contractor shall provide subject matter expertise on appropriate models and participate in Command Center missions related to model development. (refer to Section F for more information on the Command Center)
- c. The Contractor shall identify leads through internal data analysis and accept leads as referrals from external entities, including CMS, FPS, and other parties described below at iii. In addition to following-up on CMS-generated leads, the Contractor shall keep CMS informed as to its highest investigative priorities and the techniques it proposes to use in its own proactive work, in such a way as to ensure that CMS always has a full understanding of the Contractor's highest priorities, most common investigative techniques, and how the Contractor is allocating its resources among these activities. Specific requirements include:
- i. The Contractor shall analyze data to identify trends and patterns of potential fraud, waste, and abuse from three perspectives: the Medicare-only perspective, the Medicaid-only perspective, and the joint/composite Medicare and Medicaid perspective. The Contractor shall develop annual data analysis plans that address methodologies and findings within and across both programs.
  - ii. The Contractor shall track all analysis activities based on the primary source of the issue, such as Medicare-only, Medicaid-only, and Joint Medicare/Medicaid.
  - iii. The Contractor shall accept referrals from a variety of external sources that can include, but are not limited to: the Office of Inspector General (OIG), the U.S. Department of Justice (DOJ), the Federal Bureau of Investigation (FBI), the Assistant U.S. Attorney (AUSA), the 1-800-Medicare call center (a CMS

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- contractor), the CMS/CPI Field Offices, the CMS Medicare claims processing contractors known as Medicare Administrative Contractors (MACs), State Medicaid Program Integrity units, State Medicaid Fraud Control Units (MFCUs), and direct complaints from program beneficiaries and healthcare providers.
- iv. The Contractor shall develop a triage protocol for evaluating and proceeding with the referrals submitted based on the priority of cases having the greatest program impact and/or urgency, focusing on saving future expenditures, or otherwise protecting Program funds. The protocol shall be approved by CMS.
  - v. The Contractor shall review the referral and determine if any additional data analysis or any other follow-up work is needed. If additional work is needed, then the Contractor shall perform this work. After the referral has been completely evaluated, the Contractor shall determine whether or not to close the issue, open an investigation, or refer the issue to an appropriate entity.
  - vi. In the event the Contractor receives a lead specific to the Medicare or Medicaid program, the Contractor shall compare the lead with any other data sources available to determine if the issue exists across programs.
- d. As requested by CMS, the Contractor shall analyze data on a multi-state or national level to identify national and regional trends and patterns that may assist in the identification of issues that cross state borders and may require further evaluation.
  - e. The Contractor shall update and refine data mining techniques or risk assessment techniques based on any updates or availability of improved source data (including the FPS and other CMS analytics), reference files, or other successful innovative techniques. Improvements shall be implemented after consultation with CPI.
  - f. The Contractor shall support CMS in the evaluation of information and data from the HFPP. The HFPP is an opportunity for public and private sectors to exchange facts and information in order to reduce the prevalence of fraud in the healthcare industry. As requested by CMS, the Contractor shall provide input to CMS in support of HFPP projects. As requested by CMS, the Contractor shall analyze and research data developed by a Trusted Third Party (TTP) (on behalf of the HFPP) and furnished to CMS. The Contractor shall develop leads referred to it by CMS identified through the HFPP.
  - g. The Contractor shall support CMS in the evaluation of information and data from any new sources that may become available during the course of the UPIC contract.

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- h. The Contractor shall assist in efforts to vet leads identified during analysis to avoid duplication of efforts and promote activities that will generate actionable results, calculated to minimize future Program expenditures.
- i. To improve the efficiency of CMS's PI efforts, the Contractor shall consider the following as it develops leads:
  - i. Relevant national Medicare policies;
  - ii. Relevant local Medicare coverage determinations and policies;
  - iii. Relevant State Medicaid policies (for those States within the UPIC's contract area);
  - iv. Relevant local Medicaid policies (if any);
  - v. Other relevant policies (e.g., State licensure requirements);
  - vi. Other CMS PI efforts, the efforts of other UPICs, and other State and Federal law enforcement efforts, to the extent known to the UPIC.
- j. The Contractor shall coordinate its lead development efforts with other entities, such as CMS/CPI Field Offices (FOs), other CMS contractors, as well as State or Federal agencies, as directed by CMS.
- k. As the Contractor identifies and develops leads through its analysis, the Contractor shall create reports containing suspect claims and suspect providers, and recommendations for further action. The Contractor shall filter, document, and prioritize leads that have the greatest likelihood to produce actionable and defensible results that are cost effective in nature. The Contractor shall keep CPI apprised of its activities, and will as appropriate seek guidance from CPI regarding significant activities and priorities, as well as any proposed changes to previously set priorities. Prioritization of leads shall be done through FPS and consultation with CMS.
- l. In performing this work, the Contractor shall be prepared to work in CMS systems, with CMS as the owner of the data, algorithms and statistical methods, and results. Results of data analysis, including leads, shall be documented by the Contractor and maintained in a new CMS-developed case management system, and FPS as appropriate. Refer to the Information Technology section for additional details on the CMS case management system.

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### **3. Conduct Investigations**

- a. The Contractor shall conduct investigations to substantiate leads and to determine the facts and magnitude of the alleged Medicare and/or Medicaid fraud, waste, or abuse. Investigations may result from either proactive (self-generated) or reactive (externally-generated) leads. All investigations shall be aligned with CPI's national-level and regional-level priorities, and the Contractor shall consult with CPI as needed to insure such alignment.
- b. The Contractor shall conduct a variety of reviews to determine the appropriateness of Medicare Part A and Part B payments, even when there is no evidence of fraud. All Medicare Part A and Part B claims types may be reviewed, including claims submitted by individual practitioners, institutional providers such as hospitals, and other fee for service (FFS) providers. As specified in the Medicare Program Integrity Manual and only as authorized by CMS, the Contractor may request and review additional Medicare FFS data (including Medicare cost report data) from the MAC as part of the investigative process.
- c. The Contractor shall work with each State within their region to develop processes for investigating issues involving Medicaid. This includes Medicaid only investigations and investigations involving both Medicare and Medicaid (relating to providers and beneficiaries that participate in both programs).
  - i. The Contractor shall determine the appropriate State agencies (including other entities contracted by a State to perform audits or PI activities, e.g. Recovery Auditors) to include in investigations and document a protocol for working those issues with the stakeholders. The Contractor shall be prepared to serve as the lead for Medicaid investigations or provide subject matter expertise based on the needs of the State. For example, the State may request a specific clinical expertise from the Contractor to augment the work of investigators. If the program integrity function exists in one or more State agencies outside of the State Medicaid agency, the Contractor shall encourage both the State Medicaid agency and the program integrity activity(ies) to collaborate to lead the program.
  - ii. The Contractor shall convene separate project initiation meetings for each State program and, as applicable, regional programs. The Contractor shall prepare all materials for the project initiation meeting and provide copies to all attendees.

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- iii. The Contractor shall provide Medicare training to the State Medicaid agency staff, and the State Medicaid agency is encouraged to provide reciprocal training on Medicaid to the Contractor on program integrity related issues. This initial training will be discussed at a project initiation meeting and will be coordinated between the Contractor and the State Medicaid agency program leads.
  - iv. As directed by CMS, and subject to the State's approval, the Contractor shall locate one or more staff members at the State Medicaid agency's physical location. This allows Contractor and State Medicaid agency staff to work collaboratively, face-to-face, on a daily basis to discuss policy and data issues. The Contractor shall provide technical assistance to the State for any program integrity related issues.
  - v. As directed by CMS, the Contractor shall collaborate with PI investigations and activities conducted by CMS/CPI's integrity field operations.
- d. After reviewing the background, specialty and profile of the entity under review, the Contractor shall determine through a variety of techniques whether the situation involves potentially fraudulent activity, and what measures if any can be implemented immediately or quickly to minimize expenditures or otherwise protect Program funds. The Contractor shall thoroughly investigate the allegation of fraud and clearly document its findings in a concise (summary) report. Once the Contractor has completed the report, the Contractor (in conjunction with CMS, when required) will determine whether the case justifies referral to law enforcement.
- e. The Contractor shall conduct the requisite medical review and medical investigation to support its Medicare and Medicaid investigations. The Contractor shall have the appropriate clinical staff (e.g., physicians, certified coders, registered nurses, pharmacists, etc.) and/or the capability to obtain all required clinical and specialist expertise to conduct medical review across the full range of Medicare and Medicaid benefit categories, providers, practitioners, and covered services.. The Contractor shall coordinate with the State Program Integrity office to conduct medical review for any Medicaid portion of an investigation.
- f. The Contractor shall maintain files on all investigations. The files shall contain all pertinent documents, e.g., original referral or complaint, investigative findings, reports of telephone contacts, warning letters, documented discussions, any data analysis or analytical work involving the potential subject or target of the investigation, and decision memoranda regarding final disposition of the

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- investigation. Each file will document what steps were taken or considered by the Contractor to minimize potentially inappropriate future expenditures or otherwise to protect Program monies, and if the matter is referred to law enforcement, what discussions or communications occurred with law enforcement on opportunities to minimize future Program expenditures. The Contractor shall maintain accurate, complete, and current files in CMS' case management system. Refer to the **Information Technology** section for additional details on the CMS case management system.
- g. When making a referral to law enforcement, the Contractor shall provide its summary report of the investigation, with the case file, to OIG. In its case file referral, the Contractor shall include copies of the claims (with attachments) at issue as well as copies of documentation of all educational or warning contacts with the provider that relate to the matter.
- h. The Contractor shall close its investigation if law enforcement (e.g., the OIG, MFCU, DOJ, etc.) confirms that it has accepted the Contractor's referral/fraud allegation as a case, regardless of dollar amount or subject matter. The Contractor shall also close its investigation once it has referred a lead back to the MAC or to another UPIC due to an incorrect referral or misrouting. The Contractor shall also close its investigation following the imposition of one or more administrative actions. The Contractor does not prove fraud; such action is within the purview of the U.S. Department of Justice or the State's Attorney General.
4. **Protect Program Dollars**
- The Contractor shall assess the results of its data analysis or investigative work and recommend the appropriate administrative action to CMS (or directly work with the MAC in keeping with CMS instructions), law enforcement (if applicable), and the State Medicaid agency. Administrative actions are the first step to stopping inappropriate payments to providers or removing abusive or fraudulent providers from the Medicare and Medicaid programs. Administrative actions that protect program dollars either by stopping future payment or recovering monies are the highest priority for CMS and its Contractors. The Contractor shall continuously assess the status of data analysis and investigations and recommend administrative actions to CMS (or the MAC), law enforcement (if applicable), and the State Medicaid agency as early as possible. The Contractor shall continuously advise CMS on how to improve its activities in support of administrative actions, and shall continuously keep CMS apprised of its activities in this regard, including any periodically required or continuous reporting using metrics agreed to by CMS.

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- a. When the Contractor recommends an administrative action to CMS (or the MAC) for a provider that is also enrolled in Medicaid, the Contractor shall notify the State Medicaid agency. When the Contractor recommends an administrative action to the State Medicaid agency for a provider that is also enrolled in Medicare, the Contractor shall notify CMS CPI (and/or the MAC in keeping with CMS instructions).
- b. The Contractor shall coordinate with the State Medicaid agency to identify the appropriate administrative actions available and determine how to apply the rules so the actions are applied effectively as a result of data analysis or investigative work.
- c. When required by CMS, the Contractor shall coordinate its actions with law enforcement on any administrative action.
- d. The Contractor shall track and report to CMS all sensitive actions directed by CMS to be undertaken.
- e. Medicare and Medicaid Payment Suspensions:
  - i. The Contractor shall request Medicare payment suspensions in accordance with 42 CFR §§405.370-372. Medicare payments due a provider may be suspended in whole or in part when:
    - CMS or a Medicare contractor (inclusive of the Contractor) has consulted with the HHS OIG (and DOJ as needed) and determined that a credible allegation of fraud exists,
    - CMS or a Medicare contractor (inclusive of the Contractor) possesses reliable information from any source that an overpayment exists or that the payments to be made may not be correct (though additional information may be needed for a final determination of the payment or overpayment amount), or,
    - The provider fails to file a timely cost report.
  - ii. The Contractor shall forward credible allegations of fraud concerning Medicaid providers, including a recommendation that payment be suspended in accordance with 42 CFR §§455.2 and 455.23, to the State Medicaid agency and/or the State MFCU. The Contractor shall involve CMS and the HHS OIG in this action when required.

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- iii. The Contractor shall develop a Medicare payment suspension request using the process identified by CPI and shall follow the process identified with the State for Medicaid requests.
  - iv. For Medicare requests, CMS CPI shall review (inclusive of any needed consultation with law enforcement) and issue a determination.
    - If approved, the Contractor shall coordinate with the MAC to implement the payment suspension.
    - If denied, CPI shall provide the Contractor with the rationale for the denial and CPI will recommend appropriate next steps as a result of the denial.
    - The Contractor shall provide CMS CPI with any additional information requested in support of a payment suspension request.
  - v. The Contractor shall continue appropriate coordination with CMS, the State Medicaid agency, and Federal and State law enforcement while administrative actions are proceeding.
  - vi. For providers enrolled in both the Medicare and Medicaid programs, the Contractor shall notify the State point of contact on any CMS-approved Medicare payment suspensions and recommend appropriate action by the State Medicaid agency. The Contractor shall follow-up to determine if the State suspended Medicaid payments in whole or in part, or took other action.
  - vii. The Contractor shall document and track all Medicare and Medicaid payment suspension requests, including the disposition of each, and report this information in the CMS case management system.
- f. Medicare and Medicaid Enrollment Revocation Actions:
- i. The Contractor shall follow the Medicare enrollment revocation package created by CMS and submit all requests to CPI for review.
  - ii. CPI will be the lead in communicating the revocation request with the appropriate entities and shall inform the Contractor when an action is completed.
  - iii. The Contractor shall respond to CPI questions regarding all revocation requests and provide additional data as requested by CPI.
  - iv. For providers enrolled in both the Medicare and Medicaid programs, the Contractor shall report all completed Medicare revocation actions to the

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appropriate State point of contact and shall follow-up to determine the action taken by the State.

- v. The Contractor shall track and report all Medicare revocation requests, and Medicaid revocation “referrals,” and resulting CMS CPI (for Medicare) and State (for Medicaid) actions and/or pending status on a monthly basis to CMS.

- g. Other administrative actions:

The contractor shall follow, track and report on all other administrative actions in accordance with the Program Integrity Manual.

### **5. Identify Medicare and Medicaid Overpayments**

- a. During the course of its analysis of Medicare and Medicaid payments, resulting from an internal investigation of leads (including medical review as discussed above) or structured audits of paid claims, the Contractor will identify improper payments that do not involve fraudulent intent. In such cases, the Contractor shall identify, determine, and refer the overpayments made to providers (individuals or entities) receiving Federal funds under Medicare and Medicaid.
- b. The Contractor shall follow the guidelines of all applicable Federal debt collection statutes, CMS regulations and manuals with regard to ensuring that it adequately documents all identified overpayments.
- c. The Contractor shall refer Medicare overpayments to the MAC that made the initial claims payment for collection, as required by CMS. The Contractor shall supply the required documentation supporting each overpayment to the MAC.
- d. With respect to Medicaid overpayments, the Contractor shall prepare an Audit Report in a format agreed to by the State Medicaid agency and CMS that includes a section regarding opportunities to minimize future inappropriate Program expenditures. The Contractor shall document the audit protocol applicable to the State and shall submit audit findings and potential overpayments to the State Medicaid Agency and CMS.
- e. The Contractor shall coordinate with the MAC (in the case of Medicare overpayments) and the State Medicaid agency (in the case of Medicaid overpayments) to track the collection progress of all potential overpayments referred by the Contractor, in a format prescribed by CMS.

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### **6. Support to the Administrative Claims Appeals Process**

- a. As requested by CMS, the Contractor shall provide support throughout the Medicare and Medicaid claims administrative appeals processes, with respect to any claims adjustments that were referred by the Contractor to the MAC (in the case of Medicare payments) or to the State Medicaid agency (in the case of Medicaid payments) that are subsequently appealed by the provider. This includes providing supporting documentation (including the medical record) with appropriate reference to statutes, regulations, manuals and instructions.
- b. For Medicare provider appeals of overpayments (claims adjustments) based on the Contractor's referral, the Contractor shall provide assistance in keeping with the Medicare Claims Processing Manual (Pub 100-04, Chapter 29) and as requested by CMS. As required, the Contractor shall furnish a case file (supporting documentation) and other assistance to a MAC, to a Qualified Independent Contractor (QIC), to an Administrative Law Judge (ALJ), or higher appeals level. This may include taking "participant" status in ALJ cases, as well as, attending ALJ hearings in-person as needed and presenting information (or testimony) to ALJs.
- c. For Medicaid provider appeals, the Contractor shall adhere to State laws governing appeals and provide support to the State Medicaid agency, including attending appeals administrative hearings in-person (if this option is available) as needed.

### **7. Provide Support to CMS**

- a. As directed by CMS, the Contractor shall provide support to CMS for all fraud, waste, and abuse activities.
- b. The Contractor shall provide support to CMS in regards to the implementation, management, monitoring and reporting of Medicare administrative actions (e.g., prepayment edits for program integrity, payment suspensions, post-payment reviews, revocations of enrollment privileges, suppression of home health agency Request for Advance Payments (RAPs), civil money penalties, overpayment recoupments, program exclusions, and other available administrative actions, etc.). See the "Expected Outcomes" section below.
- c. The Contractor shall develop and investigate Medicare and/or Medicaid "problem providers" that are identified and referred to it by CMS. This includes provider investigations developed by CMS, including its field office operations, and law enforcement referrals and State Medicaid Agency referrals forwarded through a CMS

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- field office. The Contractor shall share information and reports on all providers under investigation in its geographic area with CMS' field offices.
- d. CMS may submit Requests for Information (RFIs) to the Contractor in the form of regular reports or ad hoc requests. The Contractor is expected to handle the RFIs and respond to the CMS within specified time parameters.
  - e. The Contractor shall also support the CMS through the execution of “Special Studies.” Examples include special studies or projects that begin when a CMS field office operation defines a specific fraud problem that is occurring within its region, for instance, the field office detects a rapid increase in program billings for a particular benefit category.
  - f. The Contractor performs a special role in advising the CMS as to appropriate program integrity strategies and approaches that CMS should consider for adoption in a particular region or nationally. This advisory role will be fulfilled not just through particular reports and other reporting mechanisms identified in this RFI but also on a continuous, as-needed basis, in that whenever a Contractor identifies a significant shift or improvement that is advisable either in its region or nationally, it will bring that matter to the CMS's attention and will provide whatever information is needed to support CMS approval of such new strategies.
  - g. The Contractor shall work with CMS to ensure that all Federal, State and local health care partners within the respective geographic areas are sharing fraud information and trends so that all partners have a common understanding of the fraud concerns of the respective zones. The Contractor will also actively share and provide such data. The Contractor shall participate in and support regional “Fraud Coordination Committees” (FCCs) involving CMS Medicare or Medicaid Field Offices and the applicable State Medicaid staff, as FCCs are established.
- 8. Provide Support for Law Enforcement Inquiries (Requests for Assistance)**
- a. Requests for assistance (or information) include any communication from law enforcement or health care fraud investigative personnel seeking help in connection with the investigation and/or prosecution of suspected Medicare and/or Medicaid fraud or abuse by providers. It is expected that the Contractor will keep CMS apprised of its major interactions with law enforcement, and will seek CMS approval for new, different, or innovative policies, strategies or procedures for interactions with law enforcement. Law enforcement is one of CPI's most important stakeholders, and it is crucial that each Contractor provide CMS with sufficient

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information for CMS to assure that each Contractor’s local activities remain aligned with CMS’s agency-level approach to interactions with law enforcement. Requests may come from a variety of law enforcement or health care fraud investigative personnel, including but not limited to:

- i. Special agents from OIG
  - ii. Investigators or attorneys from State MFCUs
  - iii. Assistant US Attorneys or other DOJ attorneys or staff
  - iv. Special agents or staff from other Federal law enforcement agencies, such as the FBI, US Postal Inspection Service, and IRS
  - v. State Medicaid program integrity staff
- b. As requested, and in accordance with the UPIC contract, the Contractor shall provide information to support law enforcement cases or inquiries on leads submitted by the Contractor.
  - c. As requested, and in accordance with the UPIC contract, the Contractor shall provide information to support law enforcement cases or inquiries on leads generated by entities other than the Contractor.
  - d. The Contractor shall provide law enforcement with access, as needed, to its files, records, and data.
  - e. In all cases, the Contractor shall follow-up with the requestor to confirm that assistance provided fully satisfies the request, and to determine if there is any appropriate administrative action CMS can take to minimize future Program expenditures or otherwise protect Program funds.
  - f. Consistent with the scope and breadth of its policy, clinical, and investigative expertise (as discussed above), the Contractor shall be prepared to testify, when required, in Federal and state court. The Contractor shall have capability to testify (1) its own investigative work and administrative actions, as well as (2) function as experts at trial when required by law enforcement (e.g., HEAT Strike Force, MFCU, DOJ, etc. cases).

### **E. EXPECTED OUTCOMES**

CMS desires to achieve improved Medicare and Medicaid PI program results through the operation of the UPICs. Specifically, CMS intends to actively implement the Medicare and

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Medicaid administrative authorities provided through the ACA and other statutes, and the UPIC will serve a critical role in this strategy. CMS also desires to create a unified, coherent national-level and regional-level program integrity strategy across all CMS health care programs, where all Contractor priorities and activities are aligned with and support the CMS-determined strategies. The UPICs will recommend administrative program actions against Medicare and Medicaid providers that engage in program abuse to CMS and to States. The administrative program actions may include the suspension of payments and the revocation of billing privileges. CMS also desires to improve the quality of case referrals to law enforcement authorities, and the follow-up and support for referrals that remain pending with law enforcement.

## **1. Implement Administrative Actions**

As further explained above in Section D, Fundamental Activities, under “Protect Program Dollars,” CMS expects the UPIC initiative to generate an increased number of proactive, high-quality, appropriate and timely administrative PI actions that are able to be sustained through any applicable administrative or legal review processes. CMS views such administrative actions, which stop inappropriate payments to providers and remove abusive or fraudulent providers from CMS programs, as a cornerstone of the agency’s new PI strategy. The range of administrative actions to be supported, developed and recommended by the Contractor to the appropriate Federal or State authority include but are not limited to the following:

- a. Medicare payment suspensions (42 CFR §§405.370-372)
- b. Medicaid payment suspensions (42 CFR §§455.2 and 455.23)
- c. Medicare enrollment revocations
- d. Medicaid enrollment revocations
- e. Medicare and Medicaid program exclusions
- f. Civil Monetary Penalties

The Contractor shall be prepared to support additional administrative actions as the Congress provides increased PI legal authorities to CMS in the coming years.

## **2. Prepayment Review**

- a. The Contractor shall, based on its analysis of leads and data, and in accordance with the Program Integrity Manual, request the MAC to install claims system edits to enable the Contractor to conduct prepayment review. Edits may flag claims for a specific issue or at the individual provider level and prepayment review will be

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performed by the Contractor. The Contractor shall coordinate with the MAC to implement requested prepayment edits.

- b. The Contractor shall coordinate with the State Medicaid Agency, to provide technical assistance (at the State’s discretion) to enable improvements in the State’s prepayment review activities. The Contractor shall offer to provide the criteria of its pre-payment edits, develop the pre-payment edits, review the results generated by edits, and/or provide related assistance to the State Medicaid Agency.

### **3. Referrals to Law Enforcement**

- a. The Contractor shall refer potential fraud cases to law enforcement and provide support, as required and requested by law enforcement, for these cases. The Contractor shall track all referrals to law enforcement. In addition to tracking referrals, the Contractor shall track the number of hours provided in support of law enforcement. Hours shall be broken out by leads originating from the Contractor and CMS, and leads not originating from the Contractor.
- b. The Contractor shall continue to pursue administrative actions following referral of a fraud allegation to law enforcement, unless directed by CMS to defer action.
- c. In referring a Medicare fraud allegation, or a joint Medicare/Medicaid fraud allegation, the Contractor shall make the initial referral to HHS-OIG. For Medicaid only referrals, either the HHS-OIG may assist in presenting to the State MFCU or the Contractor shall present it to the State MFCU. Once a fraud referral is received, HHS-OIG can open an investigation; return the matter to the Contractor for further development; forward the referral to the local FBI office or other law enforcement agency for investigation; or close the case with no action necessary and refer it back to the Contractor. The Contractor will then complete any original administrative actions that were deferred at CMS request or otherwise not yet completed, or initiate new administrative actions based on its assessment at the time of receipt.
- d. In the event the Contractor does not receive a response from the HHS-OIG within 90 calendar days of the referral and if repeated attempts by the Contractor to find out the decision about the referral are unsuccessful, the Contractor shall refer the case to the FBI, and if declined, then to any other appropriate law enforcement entity. The Contractor shall follow-up with the FBI regarding these referrals; however, within 45 calendar days, if the decision from the FBI regarding the referral is not made, then the Contractor shall (in consultation with CMS CPI) pursue other avenues, such as

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contacting the relevant State licensing board or other regulatory entities for appropriate action.

- e. If HHS-OIG or the FBI declines the potential fraud case, the Contractor shall obtain and maintain clear documentation regarding the reason why the case was not accepted. Any verbal discussions with HHS-OIG or the FBI regarding reasons for non-acceptance of the referral shall also be documented by the Contractor in the official case file.

### **F. INFORMATION TECHNOLOGY (IT)**

**The UPIC will interact with and utilize a robust CMS-developed IT toolset to perform its work, while also bringing its own IT capabilities to CMS’s anti-fraud mission.**

#### **1. Integrated Data Repository (IDR) and One Program Integrity (OnePI)**

[\(http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/IDR/\)](http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/IDR/)

The Contractor shall access the Integrated Data Repository (IDR) as the CMS data warehouse for Medicare claims and related reference information to perform tasks associated with fraud, waste, and abuse activities. The Contractor shall access the One Program Integrity (One PI) system as the centralized suite of robust business intelligence and modeling tools for fighting fraud, waste, and abuse. The IDR provides a single national view of timely and integrated Medicare claims, provider, beneficiary, and related data. The One PI/IDR system will replace the numerous and standalone data warehouses that are currently in place for this purpose. The system will allow for cross program analysis with harmonized data simplifying comparisons of data from multiple data sources.

The One PI system includes the following tools that access the IDR data:

- Business Objects, a business intelligence tool available for analyzing data in the IDR. The Contractor shall be trained in the use of this tool.
- Services Tracking Analysis and Reporting System (STARS) (expected 2013)
- SAS Enterprise Miner (expected 2014)

CMS’s vision for the IDR is that of a national level repository, which will contain Medicare Parts A, B, C and D claims and encounter data and relevant reference data (e.g., provider, beneficiary, and Parts C and D plans) integrated with Medicaid data.

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Data Available in IDR:

- a. Part A (FISS), Part B (MCS), and DME (VMS)
  - All three phases of claims; Enumeration, Adjudication, and Payment Data Posted
  - FY 2012 (10/1/2011) – present
    - Updated on a daily basis
  - FY2006 – 2011 3-phase history available for MCS and VMS
  - FY2011 – 3-phase history available for FISS
  - FY2006 – 2010 3-phase (expected 2013)
- b. Part D prescription drug events (PDEs)
  - From the DDPS (Drug Data Processing System)
  - Since start of Part D program in CY 2006 – current
  - Updated daily
- c. Provider data
  - NPI Crosswalks (updated weekly)
  - NSC DME (updated weekly)
  - NCPDP Data (updated weekly)
  - PECOS global extract file (updated monthly)
- d. Eligibility Data
  - CMS Entitlement, Eligibility, and Enrollment (CME)
  - Updated daily
- e. Additional Reference Data
  - Plan Data
  - NDC Data
  - Geographic data
  - Compromised Numbers Database (expected 2014)
  - Call Center Benefit Integrity Unit Weekly Report Data (expected 2014)
  - Expanded PECOS Extract (expected 2014)
  - Fraud Investigation Database (expected 2014)
- f. Medicaid Data. The IDR is currently conducting a pilot to load Medicaid data into specific data stores that will allow the data to be combined with Medicare data from the IDR production warehouse. The CMS will be transitioning to Transformed Medicaid Statistical Information System (T-MSIS) in 2014. CMS will provide

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information, including a data dictionary, prior to the implementation of T-MSIS so the Contractor can become familiar with the dataset.

## 2. **Fraud Prevention System (FPS)**

The Small Business Jobs Act of 2010 mandates that CMS implement predictive modeling and other advanced analytic technologies to prevent potential fraud, waste, and abuse. CPI implemented this requirement through the launch of the FPS on June 30, 2011.

The FPS applies effective predictive models and other advanced algorithms to identify providers exhibiting a pattern of behavior that is indicative of potential fraud, waste, and abuse. The FPS system screens all national Medicare Part A, Part B, and DME claims during the adjudication process and consolidates alerts by provider. The FPS presents the alert results in a prioritized list, provides detailed information (including claims lines, beneficiaries, associated providers and claims), and tracks the information related to the investigation and the action taken. The FPS is a major resource expected to move Medicare and Medicaid Program Integrity beyond “pay and chase” to prevention and detection.

The FPS generates Alert Summary Records (ASRs) based on the results of data analysis models. The system identifies leads based on priority scores for each ASR. The priority scores constantly evolve because the FPS is a real-time solution and new claims or billing behaviors can result in changes to priority scores.

## 3. **Case Management System**

CMS is currently evaluating development options (including the potential of augmenting systems already in use by CMS) to achieve a standardized case management system for UPIC lead and investigation management. The Contractor shall use the CMS-developed case management system for reporting all workload information. The case management system will serve as the central repository for all contractor workload reporting.

## 4. **Command Center**

The Command Center serves as the Center of Excellence for collaborative capabilities in the prevention and detection of Medicare and Medicaid fraud, driving innovation and improvement. The Center provides an environment for multi-disciplinary teams, including clinicians, data analysts, fraud investigators, and policy experts, to develop consistent approaches for modeling development, investigation and swift action once potential fraud is identified. The Center brings together Medicare and Medicaid officials, as well as law enforcement partners from the HHS Office of the Inspector General, the

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Federal Bureau of Investigation, and CMS’s anti-fraud investigators. CMS CPI coordinates “mission” events within the Command Center.

- a. The Contractor shall participate in Command Center missions in support of the following activities:
  - i. **Semi-Annual Status Missions:** The Contractor shall participate in semi-annual Command Center Rotations (CCRs). The semi-annual CCR meetings will include representatives from all UPICs and will be used to discuss new issues around fraud, waste, and abuse and enable the Contractors to take swift action as a result of collaboration.
  - ii. **Annual Contractor Executive Mission:** This mission will be conducted with Senior Executives from all UPICs (and other CMS contractors at CPI’s invitation) and will discuss pertinent information related to issues impacting the Medicare and Medicaid program with an emphasis on those issues with greatest impact to program integrity.
  - iii. **Model Development Missions:** The Contractor shall participate in model development missions. The purpose of these missions will be to test models scheduled to be released in the FPS, provide feedback on existing models, and discuss ideas for new and innovative models for future releases.
  - iv. **Problem/Investigation-Specific Missions:** As required, the Contractor shall participate in other missions as directed by CMS, such as focused Missions addressing specific PI problems and/or significant investigations.

### **5. Electronic Submission of Medical Documentation**

The Contractor shall establish efficient approaches to receiving medical documentation from providers. One way to be efficient is to encourage providers to submit medical documentation responses via CMS’ Electronic Submission of Medical Documentation (esMD) system. Background information about the esMD system can be found at [www.cms.gov/esMD](http://www.cms.gov/esMD).

6. Where the Contractor proposes to use resources in addition to the CMS resources listed above, the Contractor will seek CMS approval of its proposal, including describing how the use of such resources aligns with CMS’s regional and/or national-level priorities. Any use of such independent resources will be subject to the same transparency,

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accountability and reporting requirements as the use of CMS-provided resources, in order to enable full CMS and outside oversight of Contractor activities.

## G. ADMINISTRATIVE TASKS

### 1. Joint Operating Agreement (JOA)

The Contractor shall develop and enter into CMS-approved (standard format) JOAs with MACs, other UPICs, and other stakeholders as required by CMS. The JOA is a crucial document for identifying the roles and responsibilities of each party. The JOAs between the Contractor and a particular type of entity will be consistent with each other. Where the Contractor believes it is advantageous for any JOA with one entity to differ in any particular from its JOAs with other similar entities, the Contractor shall notify CMS of the difference before the proposed JOA is finalized. The Contractor shall routinely assess JOAs and submit updates as necessary.

### 2. Quality Improvement

- a. The Contractor shall maintain the highest degree of quality for all activities performed throughout the period of performance of the contract. CMS will evaluate contractor performance using measures including, but not limited to:
  - i. Completeness, accuracy, and timeliness of data analysis and collection
  - ii. Completeness, accuracy, and timeliness of all deliverables
  - iii. Completeness, accuracy, and timeliness of medical reviews
  - iv. Completeness, accuracy, and timeliness of submitting required information and reporting to CMS as specified

### 3. Innovation

- a. The Contractor shall use creative approaches to protect the fiscal integrity of Medicare and Medicaid funds, with a focus on preventing unnecessary or inappropriate future expenditures of Program funds, and on removing problematic providers from the Program. The Contractor will be evaluated using measures including, but not limited to:
  - i. Use of data query tools to access and perform multiple forms of analysis in trending data and finding indications of fraud and abuse
  - ii. Use of effective and efficient forms of data analysis approaches

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#### 4. **Continuous Improvement Plan**

The Contractor shall develop and maintain a Continuous Improvement Program (CIP). As part of this program, the Contractor shall implement continuous improvements and innovations in adapting to unforeseen circumstances and become increasingly effective in achieving its goals. Additionally, the CIP shall include areas that can be improved within the Contractor's own operations. These may include items that were discovered as part of the Contractor's internal quality assurance program or based upon feedback from the CMS, employees, and others. Lastly, based upon its experience with performing the requirements in this contract, the Contractor shall recommend to the CMS changes in the programs that it believes will help reduce fraud, waste and abuse. The Contractor shall submit Continuous Improvement Reports to the appropriate COR.

#### 5. **Lessons Learned Report**

The Contractor shall use the lessons learned through the course of work to produce a annual Lessons Learned Report for CMS CPI (or more frequently if required by CMS). The experience of the Contractor will provide insights into future fraud prevention and cost savings strategies. The Contractor shall also report best practices when submitting the Lessons Learned Report to CMS. By identifying Best Practices and Vulnerabilities, CPI expects to be able to identify strategies to prevent future inappropriate payments and further enhance program effectiveness.

#### 6. **Manuals**

The Medicare Program Integrity Manual (PIM) and the Medicaid Integrity Manual (MIM) outline existing process for the ZPIC, Medi-Medi, and MIC programs. These documents also direct the work of several other contractors at CMS. It is our intent to update and combine these documents to support the work of the unified contractor. Please note, the current versions of these documents provide a foundation for the work currently performed and may be beneficial for industry to review.

The current manuals can be found at the Internet-Only Manual section of the CMS website:

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html>

100-08 – Medicare Program Integrity Manual

100-15 – Medicaid Integrity Program (MIP)

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## APPENDIX ONE

### LEGISLATIVE AUTHORITIES FOR UPIC FUNCTIONS

As noted in the Background section, the UPICs will implement and operate under multiple specific legislative authorities that collectively establish the Medicare Integrity Program, the Medicaid Integrity Program, and CMS’s ability to match Medicare and Medicaid program data. For the benefit of parties new to these CMS PI programs, the statutory language is provided below in italics.

#### **Medicare Integrity Program (MIP)**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA, Public Law 104-191) was enacted on August 21, 1996. Section 202 of Public Law 104-191 added a new section, §1893, to the Social Security Act that establishes the MIP.

Sec. 1893. [42 U.S.C. 1395ddd]

*(a) Establishment of Program.—There is hereby established the Medicare Integrity Program (in this section referred to as the “Program”) under which the Secretary shall promote the integrity of the Medicare program by entering into contracts in accordance with this section with eligible entities, or otherwise, to carry out the activities described in subsection (b).*

*(b) Activities Described.—The activities described in this subsection are as follows:*

*(1) Review of activities of providers of services or other individuals and entities furnishing items and services for which payment may be made under this title (including skilled nursing facilities and home health agencies), including medical and utilization review and fraud review (employing similar standards, processes, and technologies used by private health plans, including equipment and software technologies which surpass the capability of the equipment and technologies used in the review of claims under this title as of the date of the enactment of this section).*

*(2) Audit of cost reports.*

*(3) Determinations as to whether payment should not be, or should not have been, made under this title by reason of section 1862(b), and recovery of payments that should not have been made.*

*(4) Education of providers of services, beneficiaries, and other persons with respect to payment integrity and benefit quality assurance issues.*

*(5) Developing (and periodically updating) a list of items of durable medical equipment in accordance with section 1834(a)(15) which are subject to prior authorization under such section.*

*(6) The Medicare-Medicaid Data Match Program in accordance with subsection (g).*

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## Medicare-Medicaid Data Match Program

Section 6034(d) of the Deficit Reduction Act (DRA) of 2005 amended Title XVIII of the Social Security Act (42 U.S.C. 1395ddd.) to include the national expansion of the Medicare-Medicaid Data Match Program (commonly referred to as the “Medi-Medi” program).

Sec. 1893(g). [42 U.S.C. 1395ddd]

*(1) Expansion of program.—*

*(A) In general.—The Secretary shall enter into contracts with eligible entities 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 look for payment anomalies (including billing or billing patterns identified with respect to 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 protect the Federal and State share of expenditures under the Medicaid program under title XIX, as well as the program established under this title; and*

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

*(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).*

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## Medicaid Integrity Program

Section 6034(a) of the Deficit Reduction Act (DRA) of 2005 established the Medicaid Integrity Program (MIP) under section 1936 of the Social Security Act.

Sec. 1936. [42 U.S.C. 1396u-6]

*(a) In General.—There is hereby established the Medicaid Integrity Program (in this section referred to as the “Program”) under which the Secretary shall promote the integrity of the program under this title by entering into contracts in accordance with this section with eligible entities to carry out the activities described in subsection (b).*

*(b) Activities Described.—Activities described in this subsection are as follows:*

*(1) Review of the actions of individuals or entities furnishing items or services (whether on a fee-for-service, risk, or other basis) for which payment may be made under a State plan approved under this title (or under any waiver of such plan approved under section 1115) 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 under this title in a manner which is not intended under the provisions of this title.*

*(2) Audit of claims for payment for items or services furnished, or administrative services rendered, under a State plan under this title, 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, including at such national, State, or regional conferences as the Secretary may establish, of State or local officers, employees, or independent contractors responsible for the administration or the supervision of the administration of the State plan under this title,<sup>[556]</sup> providers of services, managed care entities, beneficiaries, and other individuals with respect to payment integrity and quality of care.*

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### **The Patient Protection and Affordable Care Act.**

The Patient Protection and Affordable Care Act, more commonly known as the Affordable Care Act, enacted in 2010, provides tools to prevent, detect and take strong enforcement action against fraud in Medicare, Medicaid and private insurance. The ACA seeks to improve anti-fraud and abuse measures by focusing on prevention rather than the traditional “pay-and-chase” model. There are four principal ways that the ACA seeks to improve benefit integrity efforts: providing additional funding to prevent and fight fraud, improved screening and compliance, new penalties, and better data sharing. CPI seeks to leverage these authorities in support of the program integrity work assigned to the unified contractor.

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