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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.