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CMS Gives UPICs More Powerful Policing Role; 'This Raises the Risk Level' for Providers

By Nina Youngstrom

Sweeping changes to the *Medicare Program Integrity Manual* will make CMS's unified program integrity contractors (UPICs) more of a force to be reckoned with, and providers will feel it with voluntary repayments, exclusions and other areas related to fraud, waste and abuse, attorneys say.

Effective Oct. 12, UPICs are required to have "formal and informal communication" with state survey agencies, the HHS Office of Inspector General (OIG), 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," according to Medicare Transmittal 10984, released Sept. 9.[1]

"They are the goliaths that will have to be dealt with," said attorney Judy Waltz, with Foley & Lardner LLP in San Francisco. "The idea that all this investigative information becomes well-coordinated among the various enforcers is pretty amazing and scary." Providers should recognize when they hear from a UPIC how serious it is, she said.

"This raises the risk level especially because you have an entity being assigned a role of aggregating information across different touchpoints," said former CMS legal officer Brenna Jenny, with Sidley Austin LLP in Washington, D.C. Providers will "begin to engage with a powerful new central audit function designed to police the landscape of all administrative reviews and fraud investigations across relevant state and federal actors."