

Overview of Medicare, Medicaid and Federal Exchange Contractors

CMS and states use contractors to perform many tasks in Medicare, Medicaid, the Children’s Health Insurance Programs and the Exchanges. But there is much confusion as to what the contractors specifically do. This paper provides an overview of contractors related to eligibility determinations, data management systems, enrollment choices, program integrity efforts, and the collection and usage of personal information.

Major Medicaid and Federal Exchange Contractors

I. Enrollment Brokers

Enrollment brokers (EB) do not determine eligibility for Medicaid. EBs enroll Medicaid beneficiaries in Managed Care Organizations.

“Many states use an independent enrollment broker to help beneficiaries with the plan choice and enrollment process; since July 2018, all states have been required to provide independent choice counseling services for all new managed care enrollees and all enrollees who are changing health plans. In addition, states may use community-based organizations to assist enrollees with the enrollment process.” ([MACPAC](#))

Companies currently serving as enrollment brokers are:

- Automated Health System
- Conduent
- Gainwell
 - Spun off from DXC Technologies; Formed by HP Enterprise and CSC, 2018; bought Molina Medicaid Solutions in 2018
- Maximus

Cite: Medicaid Managed Care Enrollment and Program Characteristics, 2022

<https://www.medicaid.gov/medicaid/managed-care/downloads/2022-medicaid-managed-care-state-tables.pdf>

II. Medicaid Management Information System

MMIS contractors handle provider claims processing, but do not determine eligibility for Medicaid.

“The Medicaid Management Information System (MMIS) is an integrated group of procedures and computer processing operations (subsystems) developed to meet principal objectives:” ... “the Title XIX program control and administrative costs; service to recipients, providers, and inquiries; operations of claims control and computer capabilities; and management reporting for planning and control.” ([CMS](#))

Companies with MMIS contracts are:

- Accenture
- Clemson University
- CNSI
- Conduent
- Gainwell Technologies
- General Dynamics (acquired CSRA)
- Noridian
- WIPRO

Former Cite: <https://www.medicaid.gov/medicaid/data-systems/medicaid-management-information-system>. However, CMS is no longer posting the contractors.

III. Eligibility Systems Contractors

Medicaid eligibility contractors build, manage, and operate their Medicaid eligibility and enrollment systems. The systems provide the data for initial eligibility determination and ongoing eligibility renewal, manage documentation and data, and notify applicants and beneficiaries about their eligibility status, renewal requirements, and any changes to their coverage. But they do not make final eligibility determinations for Medicaid.

Companies with contracts for eligibility systems are:

- Conduent
- Deloitte
- GDIT
- Gainwell Technologies
- RedMan

Federal Exchange Support (Current and Recent)

- Accenture
 - Support of the Marketplace application, eligibility and enrollment functions, and the generation and transition of enrollment forms.
- A Squared Group
 - Health Insurance Exchange and Financial Management Operational Analytics
 - The platform uses advanced data analytics, statistical and predictive modelling to process large volumes of data to monitor operational processes, proactively investigate problems or anomalies, validate information, maintain records of analytical work, inform stakeholders both inside and outside the federal government.
- Booz Allen
 - Provide agent and broker support and training
 - Federally Facilitated Exchange (FFE) Oversight
 - Marketplace System Integrator (MSI)
 - Perform system integration activities, release and environment management and communication, and participate in the change control process for Exchange environments that are hosted in a cloud platform.
- Guidehouse
 - Support the Federal Exchange Improper Payment Measurement (FEIPM) Review Cycle and the State Exchange Improper Payment Measurement (SEIPM) Improper Payment Pre-Test and Assessment (IPPTA)
- Grant Thornton
 - Provide annual review of Exchange enrollments, resulting in an improper payment estimate (error rate and dollar amount).
- InRoads Advisory
 - Consumer Direct Response supporting Exchange Customer Service

- IPG Dextra, Inc.
 - Health Insurance Exchange Special Enrollment Period (SEP) Education and Outreach
- KMPG
 - Payment Policy and Financial Management Group External Audit Program
 - “Safeguards the over \$100 billion in annual Exchange payments of the Advance Premium Tax Credit (APTC) and Premium Stabilization payment and charges under the High-Cost Risk Pool (HCRP).” From FPDS
- Maximus
 - Contact Center Operations
 - Serve as call center
 - Eligibility Appeals Operational Support
 - Conduct appeals.
- Novitas
 - Financial Services Support for Exchange Financial Activities
- Serco
 - Support eligibility determinations for consumers purchasing health insurance through the Federal Exchanges.

Cite: Simon&Co. search on Federal Procurement Data System, www.fpds.gov

- AK, AZ, CA, HI, ID, IA, KS, MO, MT, NE, NV, ND, OR, SD, UT, WA, WY, AS, GU, NMI
 - Subsidiary of Noridian Mutual Insurance Company
- Jurisdiction 5: Wisconsin Physicians Service Government Health Administrators
 - IA, KS, MO, NE
 - Division of Wisconsin Physicians Service (WPS) Health Solutions
- Jurisdiction 6: National Government Services, Inc. (As of April 1, 2026, National Government Services is rebranding to Wellpoint Federal)
 - IL, MN, WI
 - Also processes Home Health and Hospice (HH+H) claims for AK, AS, AZ, CA, GU, HI, ID, MI, MN, NV, NJ, NY, NMI, OR, PR, USVI, WI and WA
 - Subsidiary of Elevance Health, Inc. (formerly Anthem Blue Cross and Blue Shield)
- Jurisdiction 8: Wisconsin Physicians Service Government Health Administrators
 - IN, MI
 - Division of Wisconsin Physicians Service (WPS) Health Solutions
- Jurisdiction 15: CGS Administrators, LLC
 - KY, OH
 - Also processes HH+H claims for DE, DC, CO, IA, KS, MD, MO, MT, NE, ND, PA, SD, UT, VA, WV, WY
 - Part of the Celerian Group, a BlueCross BlueShield of South Carolina consortium of companies
- Jurisdiction E: Noridian Healthcare Solutions, LLC
 - CA, HI, NV, AS, GU, NMI
 - Subsidiary of Noridian Mutual Insurance Company
- Jurisdiction F: Noridian Healthcare Solutions, LLC
 - AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY
 - Subsidiary of Noridian Mutual Insurance Company
- Jurisdiction H: Novitas Solutions, Inc
 - AR, CO, NM, OK, TX, LA, MS
 - Subsidiary of GuideWell Source which is owned by GuideWell Mutual Holding, which also owns Florida Blue
- Jurisdiction J: Palmetto GBA, LLC
 - AL, GA, TN
 - Part of the Celerian Group, a BlueCross BlueShield of South Carolina consortium of companies
- Jurisdiction K: National Government Services, Inc (now known as Wellpoint Federal)
 - CT, NY, ME, MA, NH, RI, VT
 - Also processes HH+H claims for CT, ME, MA, NH, RI, VT
 - Subsidiary of Elevance Health, Inc. (formerly Anthem Blue Cross and Blue Shield)
- Jurisdiction L: Novitas Solutions, Inc.

- DE, DC, MD, NJ, PA²
- Subsidiary of GuideWell Source which is owned by GuideWell Mutual Holding, which also owns Florida Blue
- Jurisdiction M: Palmetto GBA, LLC
 - NC, SD, VA³, WV
 - Also processes HH+H claims for AL, AR, FL, GA, IL, IN, KY, LA, MS, NM, NC, OH, OK, SC, TN TX
 - Part of the Celerian Group, a BlueCross BlueShield of South Carolina consortium of companies
- Jurisdiction N: First Coast Service Options, Inc
 - FL, PR, USVI
 - Subsidiary of GuideWell Source which is owned by GuideWell Mutual Holding, which also owns Florida Blue

II. Medicare FFS Data Systems

The current claims FFS processing system has three data systems:

- Fiscal Intermediary Shared System (FISS) for transmitting institutional Part A and B claims from the MACs to CMS. The contract is currently held by Peraton Enterprise Solutions.
- Multi Carrier System (MCS) for transmitting physician and other practitioner from the MACs to CMS. The contract is currently held by Peraton Enterprise Solutions.
- ViPS Medicare System (VMS) for transmitting Durable Medical Equipment, Prosthetics, Orthotics, and Supplies or DMEPOS (aka Durable Medical Equipment Claims System) claims from the MACs to CMS. The contract is currently held by GDIT.

III. Eligibility and Entitlement System

Each night the MACs' FFS claims processing systems create a file containing claims data for its jurisdiction which is sent to the Common Working File (CWF). The CWF determines the beneficiary's eligibility and entitlement status and uses that information to decide what action should be taken on the claim.

- The Contract for CWF System Development and Maintenance is currently held by OddBall

IV. Fraud Pre-Screening

The CWF sends the claims to the Fraud Prevention System (FPS) for fraud pre-screening using models/algorithms written by the Unified Program Integrity Contractors. FPS then returns a response file back to the MAC with various disposition codes, trailers, and error codes, used by the processing systems in automatic processing during the batch cycle. The responses are applied to the pending claim allowing appropriate system action.

- The FPS contract is held by Peraton.

² Includes Part B for the counties of Arlington and Fairfax in Virginia and the city of Alexandria in Virginia.

³ Excludes Part B for the counties of Arlington and Fairfax in Virginia and the city of Alexandria in Virginia.

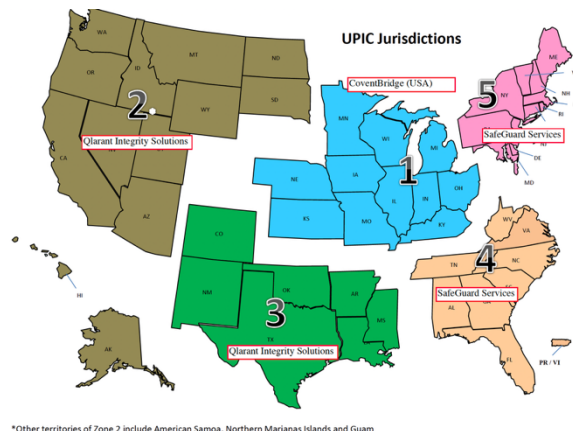
Major Medicare and Medicaid Program Integrity Contractors and Oversight Entities

Program Integrity Contractors for Fee-For-Service Medicare Part A and Part B and Medicaid

I. Unified Program Integrity Contractors (UPICs)

The primary goal of UPICs is to identify cases of suspected fraud, waste, and abuse; develop cases thoroughly and in a timely manner; and take immediate action to ensure that Medicare funds are not inappropriately paid. UPICs have teams of investigators, data analysts, and medical reviewers to perform program integrity functions for the Medicare FFS and Medicaid programs. (More specifics in Appendix) The UPICs operate in five (5) separate geographical jurisdictions in the United States. Three companies hold the contracts:

- CoventBridge
- Qlarant Integrity Solutions
- SafeGuard Services



a. UPICs in Medicare

The UPIC's perform integrity related activities associated with Medicare Parts A, B, Durable Medical Equipment (DME), Home Health and Hospice (HH+H), Medicaid, and the Medicare-Medicaid data match program (Medi-Medi). The UPICs develop investigations and take actions to prevent inappropriate payments from being made to Medicare providers. To do this, UPICs perform provider and beneficiary interviews and site visits, take appropriate administrative actions (e.g., prepayment edits, payment suspensions, revocations), and conduct program integrity reviews of medical records. In Fiscal Year 2024 (FY24) the saving from UPICs administrative actions totaled: \$746.7 million:

- Automated Edits \$67.8 million
- Non-Automated Reviews \$8.3 million
- Post-Payment Reviews \$337.8 million
- Law Enforcement Referrals \$332.7 million⁴

b. UPICs in Medicaid

UPICs also provide support and assistance to state Medicaid agencies by performing several functions to detect and investigate fraud waste and abuse. The UPICs' FY 2024 Medicaid program integrity efforts focused on audits of Medicaid managed care plans. Additionally, UPICs' work in FY 2024 included investigations initiated in 49 states and the District of Columbia. The most common collaborative investigations and audits were conducted in the

⁴ CMS; 2024 Report to Congress: Medicare & Medicaid Program Integrity for Fiscal Year (FY) 2024, September 2025; <https://www.cms.gov/files/document/fy2024-medicare-medicicaid-report-congress.pdf>

areas of hospitals, physicians, clinics, pharmacies and pharmacists, hospices, DME suppliers, and labs.

II. Recovery Audit Contractors

The Recovery Audit programs Contractors (RACs) analyze claims and review those most likely to contain improper payments. (More specifics in Appendix) RACs may also request and analyze provider claim documentation to ensure services provided were reasonable and necessary. Improper payments may include payments for:

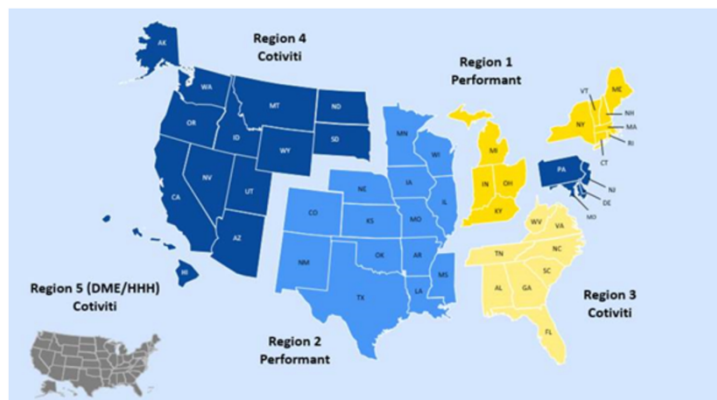
- Items or services that do not meet Medicare’s coverage and medical necessity criteria,
- Items that are incorrectly coded, and
- Services where the documentation submitted did not support the ordered service.

RACs are paid on a contingency fee basis. The amount of the contingency fee is a percentage of the improper payment recovered from, or reimbursed to providers.

a. Medicare RACs

The Medicare RACs review claims for services and items for which payment is made under Medicare Part A or B (fee-for-service) for overpayments and underpayments. The Medicare RACs operate in five (5) separate jurisdictions in the United States. Two companies hold the contracts:

- Cotiviti
- Performant



In FY 2024, the Medicare FFS RAC program identified approximately \$486.64 million in overpayments and recovered \$382.21 million, the majority of which were from hospital outpatient claim reviews.⁵

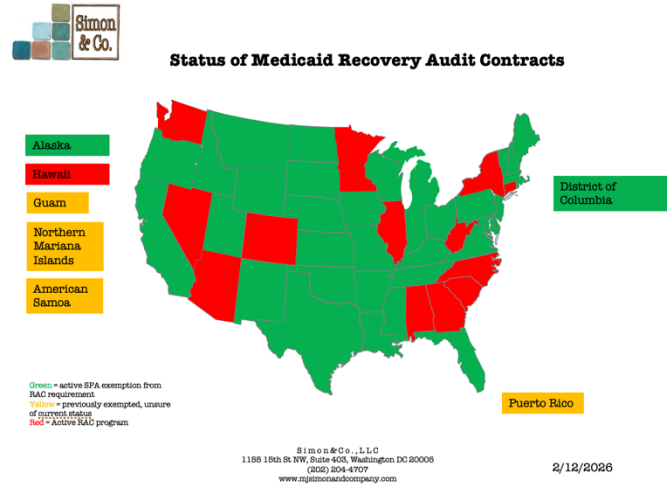
J29 holds the Recovery Auditor Validation contract to review RAC Claim determinations, establish an annual accuracy score for each RAC, and conduct special studies of RAC findings.

b. Medicaid RACs

The Patient Protection and Affordable Care Act (PPACA, Pub. L. No. 111-148) established the Medicaid Recovery Audit Contractor (RAC) program to identify overpayments and underpayments and recoup overpayments. Similar to Medicare RACs, the companies review Medicaid fee-for-service claims for overpayments and underpayments.

⁵ 2024 Report to Congress: Medicare & Medicaid Program Integrity for Fiscal Year (FY) 2024, September 2025; <https://www.cms.gov/files/document/fy2024-medicare-medicaid-report-congress.pdf>

PPACA allowed the Centers for Medicare & Medicaid Services (CMS) to permit exceptions and exemptions to Medicaid RAC program requirements. Recent, Simon&Co. analysis found that only 13 states have active RAC programs. In their State Plan Amendments requesting the RAC exemption, most states cite having high rates of managed care enrollment or other program-integrity initiatives. Many include working with their assigned federal UPIC as an alternative to the RAC program.



The states contract with RAC companies directly. HMS (Health Management Systems) is the primary Medicaid RAC company.

Program Integrity Contractors for Medicare Part C and Part D

I. Plan Program Integrity Medicare Drug Integrity Contractor (PPI MEDIC)

The PPI MEDIC oversees Medicare Part C (Medicare Advantage or MA) and Part D program integrity initiatives including identification of program vulnerabilities, data analysis, health plan audits, outreach and education, and law enforcement support, which includes requests for information (RFI). This also includes analyses to identify trends, anomalies, and questionable prescriber and pharmacy practices, including aberrant opioid prescriptions. Additionally, the PPI MEDIC conducts data analysis that identifies high-risk areas for inappropriate Medicare Part D payments and plan sponsors with potential overpayments for recovery. CMS then notifies the Medicare Part D plan sponsors to conduct a self-audit.

As a result of the PPI MEDIC’s data analysis projects and Part D plan sponsor self-audits, \$6.7 million was recovered from Part D sponsors during FY 2023.⁶

II. Investigations Medicare Drug Integrity Contractor (I-MEDIC)

The I-MEDIC detects, prevents, and proactively deters fraud, waste, and abuse for prescribers and pharmacies in Medicare Part C and Part D. However, the I-MEDIC’s efforts and ensuing recommendations may involve providers/suppliers participating in Medicare FFS, Medicare Part C, and/or Medicare Part D. The I-MEDIC focuses on complaint intake and response, data analysis, investigative activities, referrals to law enforcement partners,

⁶ Annual Report of the Departments of Health and Human Services and Justice; “Health Care Fraud and Abuse Control Program FY 2023; December 2024; <https://oig.hhs.gov/documents/hcfac/10087/HHS%20OIG%20FY%202023%20HCFAC.pdf>

and law enforcement support, which includes requests for information. Qlarant Integrity Solutions is the I-MEDIC.

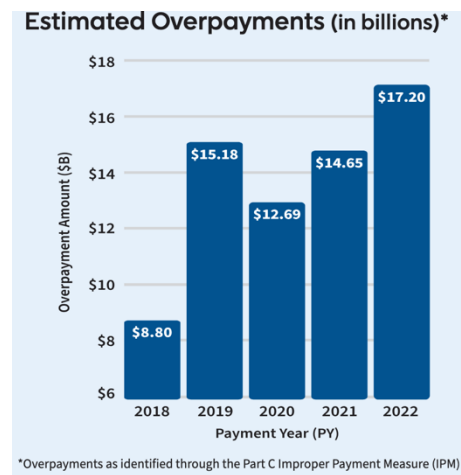
In FY 2023, the I-MEDIC initiated 692 investigations; submitted 65 recommendations for provider revocations; submitted 174 referrals to law enforcement, including 63 immediate advisements; and submitted 181 referrals to other entities, such as state pharmacy and medical boards, Medicare quality improvement organizations, and other Medicare contractors.

III. Contract-Level Risk Adjustment Data Validation (RADV) Audits

RADV audits use medical record review to verify the accuracy of diagnoses submitted by Medicare Part C (MA) organizations for risk adjusted payment. CMS announced a plan to complete all remaining RADV audits for Payment Year (PY) 2018 to PY 2024 by early 2026.

Deloitte is the Lead Analytical Contractor (LAC) for RADV and KPMG has a support contract. NewWave holds the contract for the Centralized Data Analytics Tool (CDAT) which manages the collection and distribution of medical records, medical record abstraction, medical record dispute, management RADV data. J29 holds a contract as a RADV Independent Coding Consultant (J29 heads the National Correct Coding Initiative (NCCI) program by maintaining and further expanding all of the NCCI correct coding edits which only screen Part B fee-for-service claims.)

CMS’s audits for PYs 2011–2013 found between 5% and 8% in overpayments. It is estimated that unsupported medical diagnoses result in overpayments to MAOs of approximately \$17 billion annually.⁷ CMS expects PY 2020 RADV audits to begin as early as February 2026.⁸



Oversight Entities

I. HHS-OIG

OIG was established by law as an independent and objective oversight unit of the Department to carry out the mission of preventing fraud and abuse and promoting economy, efficiency, and effectiveness of HHS programs and operations. In furtherance of this mission, the organization:

- Conducts and supervises audits, investigations, evaluations, and inspections relating to HHS programs and operations;

⁷ CMS; “RADV AUDITS | CMS.GOV/FRAUD: Fast Facts;” July 2025; <https://www.cms.gov/files/document/cpi-radvfact-sheet.pdf>

⁸ CMS; “CMS Rolls Out Aggressive Strategy to Enhance and Accelerate Medicare Advantage Audits;” May 21, 2025; <https://www.cms.gov/newsroom/press-releases/cms-rolls-out-aggressive-strategy-enhance-and-accelerate-medicare-advantage-audits>;

- Identifies systemic weaknesses giving rise to opportunities for fraud and abuse in HHS programs and operations and makes recommendations to prevent their recurrence;
- Leads and coordinates activities to prevent and detect fraud and abuse in HHS programs and operations;

In addition, OIG works with the Department of Justice (DOJ), on behalf of the Secretary, to operate the Health Care Fraud and Abuse Control (HCFAC) Program established by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to coordinate Federal, state, and local law enforcement activities with respect to health care fraud and abuse.

In FY 2023, investigations conducted by HHS’s Office of Inspector General (HHS-OIG) resulted in 651 criminal actions against individuals or entities that engaged in crimes related to Medicare and Medicaid, and 733 civil actions, which include false claims, unjust-enrichment lawsuits filed in Federal district court, and civil monetary penalty (CMP) settlements. HHS-OIG excluded 2,112 individuals and entities from participation in Medicare, Medicaid, and other Federal health care programs.⁹

II. Medicaid Fraud Control Units (MFCUs)

MFCUs investigate and prosecute Medicaid provider fraud as well as abuse or neglect of residents in health care facilities and board and care facilities and of Medicaid enrollees in noninstitutional or other settings. MFCUs do not investigate program integrity in Medicaid managed care.

There are currently MFCUs in all 50 states, the District of Columbia, Puerto Rico and the U.S. Virgin Islands. They are funded jointly by the Federal government and states/territories. Each MFCU receives a Federal grant award of 75% for operation. MFCUs, usually a part of the State Attorney General’s office, must be separate and distinct from the State Medicaid agency.

The HHS-OIG, in exercising oversight for the MFCUs, annually assesses and recertifies each MFCU based on its performance and compliance with federal requirements. In FY24, the MFCUs recovered \$1.4 billion. Hospitals and pharmacists accounted for the largest total amount of civil recoveries in FY 2024. Although pharmaceutical manufacturers accounted for the largest number of civil settlements and judgments in FY 2024, other provider types accounted for higher amounts in civil recoveries.¹⁰

⁹ Annual Report of the Departments of Health and Human Services and Justice; “Health Care Fraud and Abuse Control Program FY 2023; December 2024;

<https://oig.hhs.gov/documents/hcfac/10087/HHS%20OIG%20FY%202023%20HCFAC.pdf>

¹⁰ HHS-OIG, “Medicaid Fraud Control Units Annual Report: Fiscal Year 2024;” March 2025 | OEI-09-25-00090; <https://oig.hhs.gov/documents/evaluation/10227/OEI-09-25-00090.pdf>

Data Brokers in Medicaid

Definition: The Federal Trade Commission law defines a data broker as an entity that, for valuable consideration, sells, licenses, rents, trades, transfers, releases, discloses, provides access to, or otherwise makes available data of United States individuals that the entity did not collect directly from such individuals to another entity that is not acting as a service provider.¹¹

Generally, data brokers collect and sell personal information, such as:

- Social security number
- Precise geolocation
- Browsing history
- Email addresses
- Phone numbers
- Interests
- Health-related information
- Shopping habits.

I. Data Brokers for Asset Verification Systems

The Supplemental Appropriations Act of 2008 (P.L. 110-252) requires states to have mechanisms to verify assets for purposes of determining or redetermining. This requirement was reiterated in the 2019 Medicaid Extenders Act (P.L. 116-3) which added a reduction in federal government's share of Medicaid expenditures (Federal Medical Assistance Percentage) for non-compliance. States use vendors such as Public Consulting Group (PCG) and Softheon to create portals through which Medicaid staff can query the banking system. In 2020 46 states used Accuity to gather this information, according to the Medicaid and CHIP Payment and Access Commission (MACPAC). As the official registrar for financial institution routing number systems in the U.S, Accuity has established a system to obtain individual bank account balances in response to inquiries from Medicaid agencies.

- Ohio has used LexisNexis' Accuity Asset Verifications solution (Accuity) to identify the existence of assets valued over a state set limit;¹²

PCG, Softheon as well as LexisNexis and TransUnion can provide information on other countable assets such as real estate and vehicles and provide analytics or assessments of the risk that an individual has assets that exceed Medicaid eligibility thresholds.

II. Data Brokers for Income and Employment Status

States also use data from data brokers to verify applicant's income and employment status tools which will become more important as states implement community engagement requirements from the One Big Beautiful Bill Act (PL 119-21) by January 2027. For instance,

¹¹ [15 USC § 9901\(c\)\(3\)](#) as added by Pub. L. 118-50, Div. I, § 2, Apr. 24, 2024, 138 Stat. 960, 15 U.S.C. § 9901 (Protecting Americans' Data from Foreign Adversaries Act of 2024) ("PADFAA"), available at <https://www.ftc.gov/legal-library/browse/statutes/protecting-americans-data-foreign-adversaries-act-2024-padfaa>.

¹² Ohio Department of Medicaid (ODM) letter to State Representative Michael Dovilla, May 12, 2025. <https://bloximages.newyork1.vip.townnews.com/theohiopressnetwork.com/content/tncms/assets/v3/editorial/c/b5/cb58f6be-60cb-481c-949a-d1e2b7b69ef2/682b446ccf85b.pdf.pdf>

- Tennessee¹³ and Washington¹⁴ have used the Equifax Workforce Solutions' The Work Number (TWN) database to obtain automated access income and employment verification data furnished to Equifax by employers, It is the largest central repository of payroll information in the United States.

The federal government had provided this data to states in the Verify Current Income (VCI) option of the Federal Data Services Hub through with Equifax Workforce Solutions from 2013-2024. However, CMS terminated the nationwide contract, transitioning to a monthly billed, fee-per-transaction model for states.

III. Data Brokers for Program Integrity

Medicaid agencies and their contractors also use data brokers for program integrity activities such as background checks, or screening for fraud. For instance, LexisNexis Risk Solution's LexID and Scalable Automated Linking Technology (SALT) creates profiles of individuals and providers to detect connections and patterns that may indicate fraud.

¹³ Department of Finance and Administration, Division of TennCare letter to the Fiscal Review Committee, dated September 30, 2022
https://journaliststudio.google.com/pinpoint/document-view?collection=819b1dfb26c6fbba&utm_source=collection_publish_link&docid=44ea77bd0f03c4cc_819b1dfb26c6fbba&dapvm=2

¹⁴ Master Contract between State of Washington, Department of Enterprise Services and Equifax Workforce Solutions LLC, Dated August 1, 2022; https://journaliststudio.google.com/pinpoint/document-view?collection=819b1dfb26c6fbba&utm_source=collection_publish_link&docid=3261e805d5fbc690_819b1dfb26c6fbba&dapvm=2

APPENDIX

Program Integrity Responsibilities of Program Integrity Contractors

Source: CMS; 2024 Report to Congress: Medicare & Medicaid Program Integrity for Fiscal Year (FY) 2024, September 2025;” Table I: program Integrity Contractors, page 12.

Unified Program Integrity Contractors (UPICs): Medicare FFS and Medicaid

- Identify and investigate potential fraud, waste, or abuse in Medicare and Medicaid
- Conduct medical review for Medicare and Medicaid program integrity purposes
- Make referrals to law enforcement for further investigation and potential prosecution
- Provide support for ongoing law enforcement investigations
- Investigate leads generated by the Fraud Prevention System (FPS) and complaints from beneficiaries and a variety of other sources
- Perform proactive data analysis to identify cases of suspected fraud, waste, and abuse in Medicare and Medicaid
- Make recommendations to CMS or states for appropriate provider-related administrative actions (i.e., revocations and payment suspensions) to protect the Medicare Trust Funds and Medicaid dollars
- Implement provider-related administrative actions (i.e., payment suspensions, prepayment edits, auto-denial edits) in coordination with the Medicare Administrative Contractors
- Provide feedback and support to CMS to improve the Unified Case Management System
- Identify improper payments to be recovered within Medicare and Medicaid

Medicare FFS Recovery Audit Contractors (RACs): Medicare FFS

- Conduct post-payment reviews to identify a wide range of improper payments
- Correct improper payments by identifying overpayments to be collected and underpayments to be restored
- Make recommendations to CMS about how to reduce improper payments in the Medicare FFS program

Plan Program Integrity Medicare Drug Integrity Contractor (PPI-MEDIC): Medicare Part C and Part D

- Conduct data analyses of Medicare Part C and Part D issues leading to potential identification of improper payments and regulatory non-compliance
- Coordinate Medicare Part C and Part D program integrity outreach activities for stakeholders, including plan sponsors and law enforcement entities
- Support enforcement of Medicare Part C and Part D through Program Integrity audits, national audits, and self-audits of plan sponsors.

Investigations Medicare Drug Integrity Contractor (I-MEDIC): Medicare Part C and Part D

- Conduct complaint intake and response, data analysis, investigative activities, referrals to law enforcement partners, and law enforcement support
- Detect, prevent, and proactively deter fraud, waste, and abuse for high-risk prescribers/pharmacies in Medicare Part C and Part D