Evolution of the Process: Casework Updates & Trends

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Agenda



What has changed and why?



CMS perspective and updates



SHIP, SMP, and MIPPA casework trends



Questions

New Medicare Questions Process

ACL has centralized the Medicare policy questions process

- Starting June 1st all Medicare policy questions, issues, and clarifications should be directed to ACL (ACLcases@acl.hhs.gov)
- **Do not email CMS**: SHIP/SMP/MIPPA grantees should no longer send these questions or email cases directly to CMS
- If you're unclear on what to do with a case or beneficiary situation, email ACL.

ACL process for emailed questions:

- ACL will triage and provide answers directly to questioner
- If/When ACL needs assistance or clarification we will work directly with policy experts and SMEs at CMS

Individual beneficiary cases that need CMS intervention to resolve should be referred to CMS via 1-800-Medicare or CTM (as appropriate).

Benefits of the New Process

Centralizing Will

Provide ACL better insight into the questions and challenges team members are experiencing

Ensure more consistent answers and responses

Streamline communication across ACL, CMS, OIG, and SHIP/SMP/MIPPA grantees

Clarifications on Managing Cases

Internal State/Program Triage Expectation

- States/Programs should have an established process for handling team member questions and inquiries internally.
  - This can be done in whatever way makes most sense for the program leadership such as funneling through site leadership or working with designated staff.
- Questions should only be emailed to ACL after they've been triaged by the state process.

Benefits Explanations

- The majority of SHIP/SMP/MIPPA inquiries and one-on-one sessions involve explaining one or more parts of Medicare and how those benefits work.
- SHIP/SMP/MIPPA team members are well versed in answering and handling these questions.



Questions on benefit policy, coordination, or new changes to Medicare should be sent to ACL for clarification and guidance.

Cases Involving Provider Billing

Errors or Clarification	Work with provider directly to correct errors or receive clarification on billing question.
Potential Fraud & Original Medicare	Refer to OIG & CMS* via ACL and SIRS
Potential Fraud & MA/PDP	Contact Plan to report potential provider fraud.
	Refer to OIG via ACL and SIRS

* New process

Cases Involving MA or PDP Marketing

Agent/Broker Violations

- **Contact the Plan** – Plans are responsible for managing their agent and broker behavior.
- **Contact the state Department of Insurance (DOI)** – DOI manages individual agent licenses and can revoke these if warranted.

Cases Involving MA or PDP Enrollment

Step 1: Work with the Plan

- Always try to work directly with the plan to resolve the issue

Step 2: Report Unresolved Issues to CMS

- Report to CMS via CTM (if you have access) or 1-800-Medicare
- SMP related cases (i.e. potential fraud) should go through ACL via SIRS

Step 3: Changing Enrollment

- Prospective (i.e. future/new) enrollments can be initiated via Medicare Plan Finder or by calling 1-800-Medicare
- Retroactive (past) enrollments should be initiated via 1-800-Medicare

Unknown Marketing Violation or Issue

Marketing Violations with no Agent/Broker or Beneficiary involved

- Alert ACL via the ACLcases@acl.hhs.gov email address.
- Send copies of materials and any details you have on the issue with the email to ACL.
- ACL will consolidate and share these complaints with CMS DHPO

SHIP Complaint Tracking Module (CTM) Reminders

Always contact the Plan first.

- The first step with each case involving a plan should be to contact the plan directly for resolution. Only submit CTM complaints when working with the plan fails.

Providers have their own process.

- Do not submit complaints on behalf of a provider. CMS has a process for providers to use that they need to follow.

Congress needs to work directly with CMS, not the SHIP.

- Congressional inquiries and issues are high profile and follow a very specific process at CMS. Do not submit a complaint on behalf of a congressional staffer or representative.

CTM isn't for policy questions.

- Only submit complaints on behalf of a beneficiary for issues impacting that beneficiary. General questions or policy clarifications should be sent to ACL (ACLcases@acl.hhs.gov) and not submitted to CTM.

Program Integrity Casework Updates and Trends

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Centers for Medicare & Medicaid Services

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Ms. Smith's Journey

Ms. Smith, age 70, has Original Medicare. Ms. Smith reviews her Medicare Summary Notice and discovers a claim for an unsolicited continuous glucose monitor (CGM). The fraudulent charge caused her legitimate CGM prescriptions to be denied.

1 Inquiry and Intake

Seeking assistance with her fraudulent claim, Ms. Smith contacts her regional SMP to help resolve the issue with Medicare. Ms. Smith's inquiry is forwarded to CMS, where it arrives in the MPOIG SMP/SHIP Referral Case BOX folder for MPOIG action.

2 Information Gathering

Assigned analyst reviews the inquiry to collect needed information — including dates of service, beneficiary identifier, provider details, and claim details.

3 Research and Analysis

Assigned analyst reviews CMS policy and examines relevant systems (e.g. MBR, ELMO, NGD, PECOS) to confirm the fraudulent claim and determine other potential concerns. Analyst discovers a suspicious claim for diabetic shoes from the same supplier, which Ms. Smith verifies as fraudulent.

4 Coordination

Analyst completes an Allegations of Fraud form with the identified information and sends it to CMS' Center for Program Integrity (CPI) for review. Analyst works with the Medicare Administrative Contractor to ensure Ms. Smith receives her CGM device and supplies.

5 Resolution and Communication

The analyst verifies that fraudulent claims are under review and confirms the beneficiary received DME, ensuring Ms. Smith's access to care and avoiding future coverage problems.

How IFM Supports Each Step

Leading Payor Oversight

IFM provides comprehensive contractor oversight through Beneficiary Customer Service and Medical Review (MR) QASPs and MR Technical Monitoring, ensuring Medicare payment integrity at every level.

Combating Fraud & Abuse

Through targeted initiatives such as the Hospice Rapid Response Team ($5M+ identified), Petitions for Remission and Restitution ($34.4M recovered), Program Integrity casework, and Medical Review, IFM actively detects and eliminates fraud.

Empowering Beneficiaries

IFM advocates directly for the people Medicare serves — managing 16,000+ beneficiary and Congressional cases with a 98% QA compliance rate, ensuring every individual receives the coverage they are entitled to.

Our Mission: We deliver quality customer service to beneficiaries, advocates, providers, associations, district Congressional offices, government agencies, and healthcare communities by providing expertise on Medicare eligibility, coverage and payment policy and claims processing and billing.

Program Integrity Casework Trend

Data Range: June 2025 – June 2026

- MPOIG received a total of 2,193 Program Integrity cases.
  - DME-related fraud accounts for 51% of our Program Integrity casework.

- Approximately 40% of MPOIG's Program Integrity cases – roughly two out of every five – were sent to us by SHIP and SMP partners.

Hospice Rapid Response Team (RRT) Process

Rapid Response Team Process

Enhanced complaint mitigation process from the time MPOIG Hospice RRT receives intake for a Hospice Fraudulent Election, through referral, resolution, and beneficiary notification.

1 Intake Received

Complaint intake is received in the OPOLE Fee for Service mailbox for MPOIG Hospice RRT action.

2 Review & Fraud Form

MPOIG Hospice RRT reviews the complaint intake to confirm beneficiary was fraudulently enrolled in hospice. The Allegation of Fraud intake form is completed with the beneficiary's information, provider's information, and the confirmation attestation.

3 Referral & Coordination

Allegations of Fraud intake form is forwarded to CPI, and in turn forwarded to the MAC with an attestation to remove the fraudulent hospice election, and to the UPIC for fraud investigation and identification of other affected beneficiaries.

MAC | UPIC

4 Resolution

The MAC removes the fraudulent hospice election from the beneficiary's medical record and notifies CPI. MPOIG Hospice RRT is notified from CPI on the same day.

5 Beneficiary Notification

MPOIG Hospice RRT notify the beneficiary that the fraudulent hospice election has been removed.

How RTT Enhances the Process

Immediate Acknowledgment

Confirmation of receipt is sent to the sender as soon as the complaint intake arrives at the OPOLE Fee for Service mailbox.

Dual-Path Referral via CPI

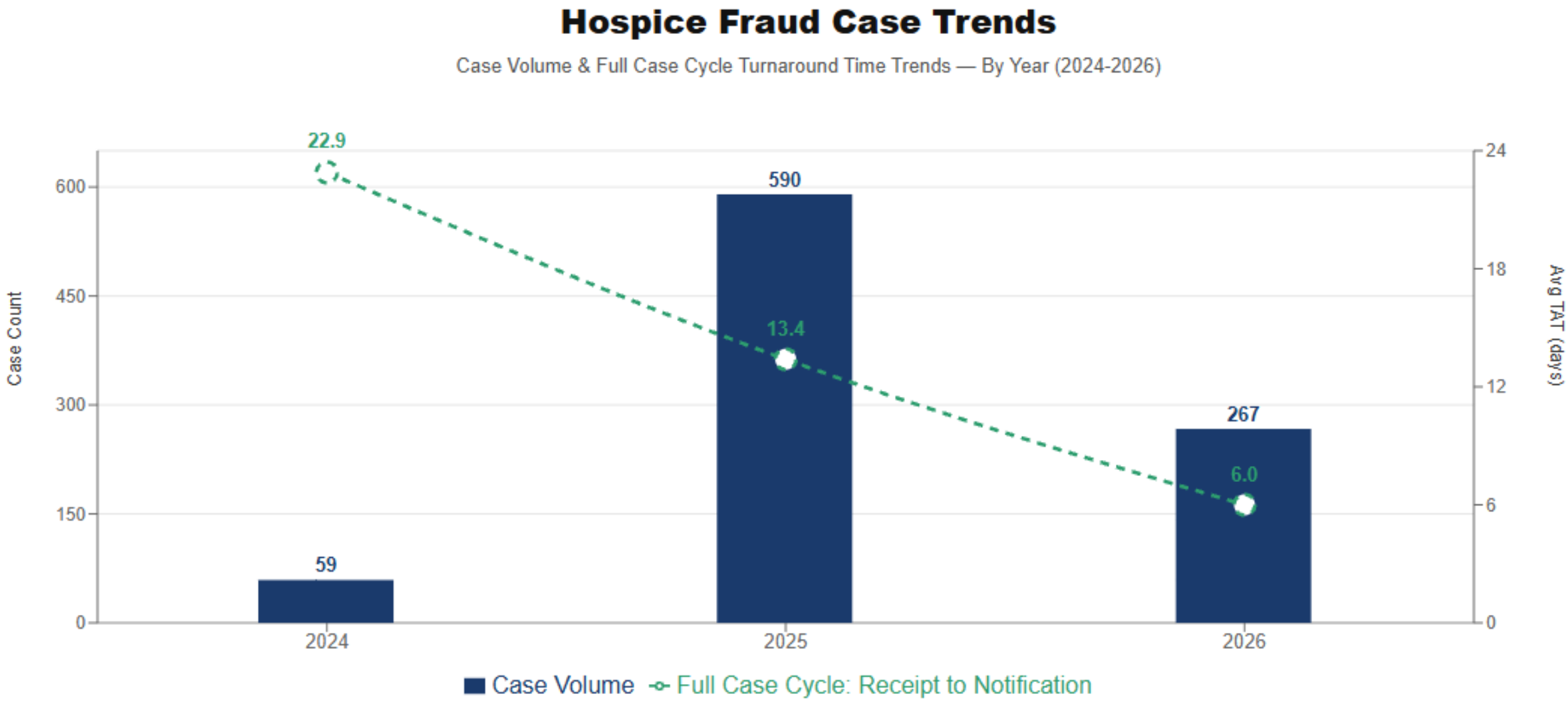
Once CPI receives the completed Allegation of Fraud form, it is routed simultaneously to the MAC for removal of the fraudulent election and to the UPIC to identify other affected beneficiaries.

Same-Day Notification Loop

CPI notifies MPOIG Hospice RRT the same day the MAC removes the fraudulent election, allowing the beneficiary to be notified without delay.

Purpose: The enhanced Rapid Response Team process delivers faster removal of fraudulent hospice elections, broader fraud detection through parallel UPIC referral, and timely notification back to the affected beneficiary.

Hospice Fraud Case Trends



Fax to BOX: Modernizing SMP & SHIP Submissions

What Is Changing?

- Referrals submitted through ACL via SIRS
- Replacing the outdated fax-based process with a secure, digital BOX folder system
- Upload cases directly to BOX
- Effective Date: August 1, 2026

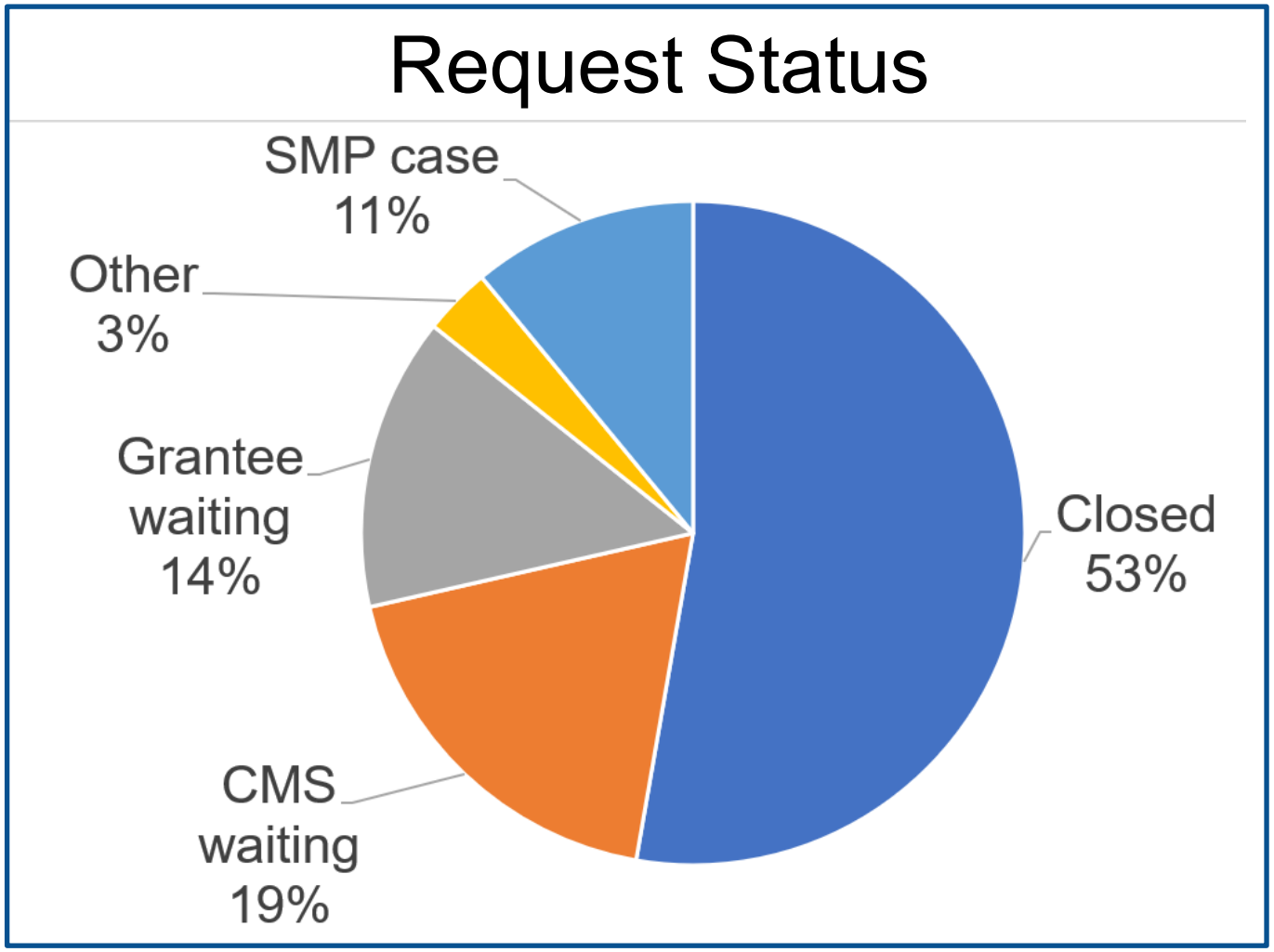
Key Benefits

- Secure, centralized digital folder accessible to SMP & SHIP partners
- Full audit trails and timestamps for every submission
- Improved document traceability and accountability
- Eliminates risks associated with traditional fax transmissions

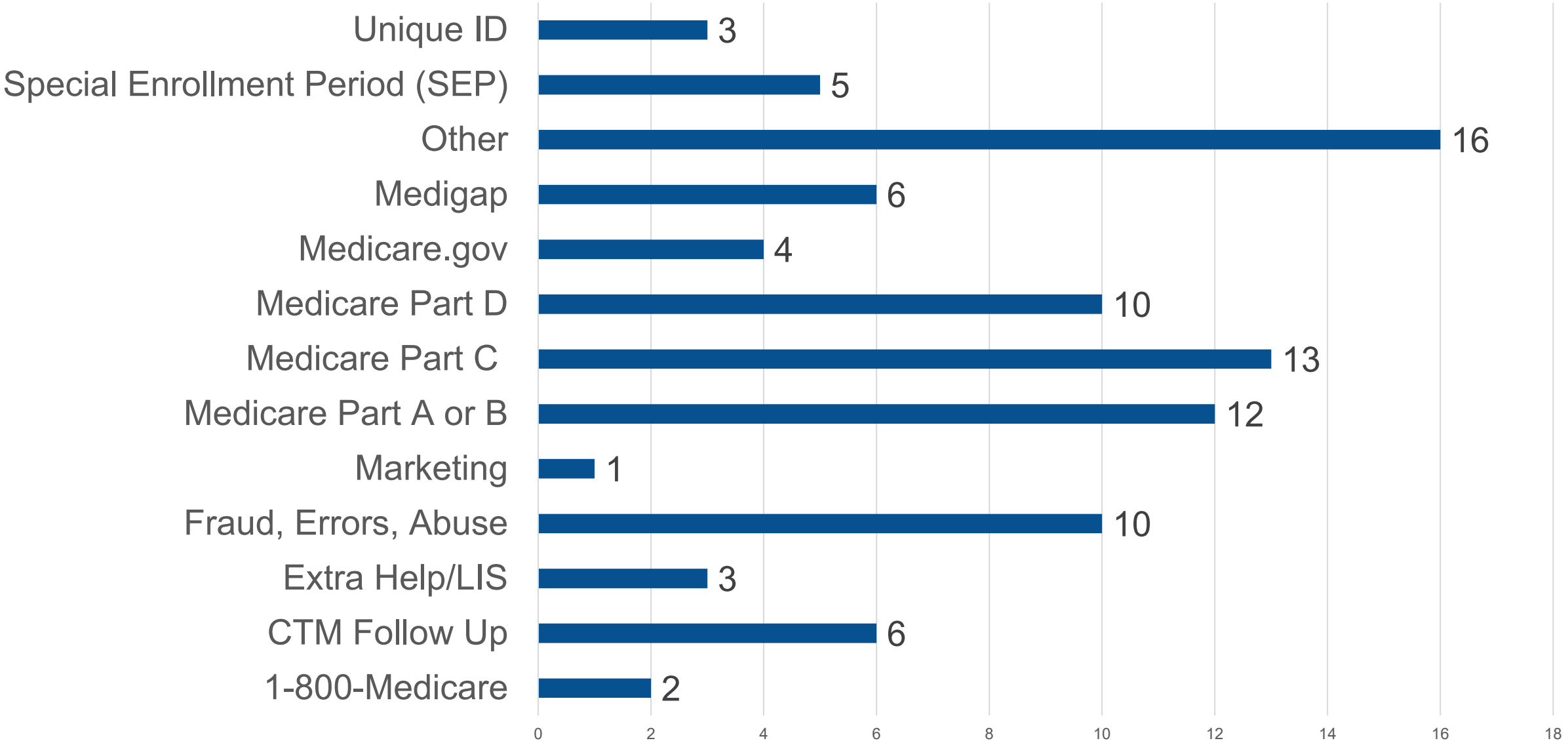
OHIC Program Case Trends

June & July 2026: General Stats

- 40 states, USVI and PR
- 90 inquiries total
  - 38 in June
  - 53 in July



June & July 2026: Issue Categories



June & July 2026: SHIP Sample

- **Special Enrollment Period (SEP) - Pennsylvania**
  - Is husband eligible for Part C or D SEP? Benefit lifetime limit exhausted in retiree plan for husband. Wife is covered and not yet exhausted lifetime limit.
  - CMS Guidance
    - Not losing coverage. Confirm whether retiree drug coverage is considered Part D creditable.
    - Potential options: 5 star SEP, AEP (5 mos to coverage start date), Part D inadequate coverage SEP
- **Medicare Online Enrollment - Maine**
  - Site inaccurately lists ‘active Medicare application exists’. SSA tollfree notes known issue for online enrollment if enrolled in Medicare Part A or B (or both) and working to resolve it. Beneficiary scheduled phone appointment at earliest available time in September.

Questions?