

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE COULD HAVE SAVED  
UP TO \$128 MILLION OVER 5 YEARS  
IF CMS HAD IMPLEMENTED CONTROLS  
TO ADDRESS DUPLICATE PAYMENTS  
FOR SERVICES PROVIDED TO  
INDIVIDUALS WITH MEDICARE  
AND VETERANS HEALTH  
ADMINISTRATION BENEFITS**

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Christi A. Grimm  
Inspector General

April 2023  
A-09-22-03004

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## Report in Brief

Date: April 2023

Report No. A-09-22-03004

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES  
**OFFICE OF INSPECTOR GENERAL**



### Why OIG Did This Audit

In 1979, the General Accounting Office (now the Government Accountability Office) issued a report that found Medicare made duplicate payments of more than \$72,000 for certain medical services provided to veterans eligible for benefits from both Medicare and the Department of Veterans Affairs (VA), Veterans Health Administration (VHA). Because duplicate payments made by Medicare and VHA have been a longstanding issue, we conducted this audit to determine whether Medicare and VA paid duplicate claims for medical services from January 2017 through December 2021 (audit period) and to identify measures that could be taken to address duplicate payments.

Our objective was to determine whether Medicare paid providers for medical services that were authorized and paid for by VA's community care programs.

### How OIG Did This Audit

Our audit covered \$19.2 billion in Medicare Parts A and B payments for 36.3 million claims for individuals eligible for Medicare and VHA benefits who received services from VA's community providers during our audit period. The \$19.2 billion was associated with all claims related to these individuals irrespective of whether VHA authorized and paid for the claims. After obtaining claims data from VA, we identified paid Medicare claims from CMS data and performed a match to determine whether an enrollee had a paid claim in both the Medicare and VHA claim datasets.

## Medicare Could Have Saved Up To \$128 Million Over 5 Years if CMS Had Implemented Controls To Address Duplicate Payments for Services Provided to Individuals With Medicare and Veterans Health Administration Benefits

### What OIG Found

Medicare paid providers for medical services that were authorized and paid for by VA's community care programs during our audit period, resulting in duplicate payments of up to \$128 million. VHA is solely responsible for paying providers for medical services that it authorized.

These duplicate payments occurred because CMS did not implement controls to address duplicate payments for services provided to individuals with Medicare and VHA benefits. Specifically, CMS did not establish a data-sharing agreement with VHA for the ongoing sharing of data between the two agencies and did not develop an interagency process to include VHA enrollment, claims, and payment data in CMS's data repository. Inclusion of these data, which is required by Federal law, would have allowed CMS to compare VHA claims data with existing Medicare claims data to identify duplicate claims paid for by both Medicare and VHA. Because CMS did not develop an interagency process, CMS did not establish an internal process (such as claims processing system edits) to address duplicate payments for medical services authorized and paid for by VHA. Furthermore, CMS guidance to providers on VA's responsibility to pay for medical services did not clarify that a provider should not bill Medicare for a medical service that was authorized by VHA.

### What OIG Recommends and CMS Comments

We recommend that CMS: (1) establish a comprehensive data-sharing agreement with VHA for the ongoing sharing of data; (2) establish an interagency process to integrate VHA enrollment, claims, and payment data into the CMS Integrated Data Repository to identify potential fraud, waste, and abuse under the Medicare program; (3) establish an internal process (such as system edits) to address duplicate payments made by Medicare for medical services authorized and paid for by VHA, which could have saved Medicare up to \$128 million during our audit period; and (4) issue guidance to providers on not billing Medicare for a medical service that was authorized by VHA.

CMS concurred with all of our recommendations and described actions that it had taken or planned to take to address our recommendations, including working to develop processes to address duplicate payments for services authorized and paid for by VHA.

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## INTRODUCTION

### WHY WE DID THIS AUDIT

The Veterans Health Administration (VHA) of the Department of Veterans Affairs (VA) provides medical services at approximately 1,300 medical facilities and serves 9 million veterans each year.<sup>1</sup> For veterans who cannot receive medical services at VHA medical facilities because of long wait times, travel distances, or other factors, VA has community care programs that allow them to receive medical services from community providers (community care services).<sup>2</sup> These community care services—which include inpatient and outpatient services, skilled nursing facility services, home health services, and durable medical equipment—may be covered by both Medicare and VHA benefits. When VHA authorizes community care services for a veteran who is eligible for both Medicare and VHA benefits (i.e., a dually eligible enrollee), VHA is solely responsible for paying for those medical services.<sup>3</sup> Duplicate claims occur when a provider submits claims for the same services to both Medicare and VHA, and duplicate payments occur when both programs pay the claims.

In 1979, the General Accounting Office (GAO), which is now known as the Government Accountability Office, issued a report that found Medicare made duplicate payments of more than \$72,000 for certain medical services provided to 153 veterans eligible for both Medicare and VHA benefits.<sup>4</sup> Because duplicate payments made by Medicare and VHA has been a longstanding issue, we conducted this audit as part of a collaborative effort with the VA Office of Inspector General (VA-OIG) to determine whether Medicare and VHA paid duplicate claims for medical services from January 1, 2017, through December 31, 2021 (audit period), and to identify measures that could be taken to address duplicate payments. VA-OIG conducted its own review and found that more than 426,000 claims for medical services billed by community providers were paid for by both Medicare and VHA, resulting in duplicate payments.<sup>5</sup> VHA paid \$307 million and Medicare paid \$243 million for these claims, which had dates of service from January 1, 2017, through March 31, 2021.

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<sup>1</sup> VA runs programs benefiting veterans and members of their families. VHA provides primary care services, specialized care services, and related medical and social support services to veterans. A veteran is a person who served in the active military, naval, air, or space service, and who was discharged or released from that service under conditions other than dishonorable (38 CFR § 3.1(d)).

<sup>2</sup> Community providers are providers in a local community that are part of VA's community provider network.

<sup>3</sup> VHA generates an authorization after an eligible veteran has opted to receive community care services. The authorization informs the provider of the veteran's medical needs and the specific services that will be covered.

<sup>4</sup> GAO, *Duplicate Payments for Medical Services by VA and Medicare Programs* ([HRD-80-10](#)), October 22, 1979.

<sup>5</sup> VA-OIG, *Improvements Needed to Reduce Duplicate Payments by VHA and Medicare and Ensure VHA Has Authorized Community Medical Services* ([21-03630-250](#)), December 8, 2022.

## **OBJECTIVE**

Our objective was to determine whether Medicare paid providers for medical services that were authorized and paid for by VA's community care programs.

## **BACKGROUND**

### **Medicare Program**

Title XVIII of the Social Security Act established the Medicare program, which provides health insurance to people aged 65 and over, people with disabilities, and people with end-stage renal disease. Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge, and Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services.

The Centers for Medicare & Medicaid Services (CMS) administers Medicare. CMS contracts with Medicare Administrative Contractors (MACs) to, among other things, process and pay Medicare claims submitted for services, conduct reviews and audits, safeguard against fraud and abuse, and educate providers on Medicare billing requirements.

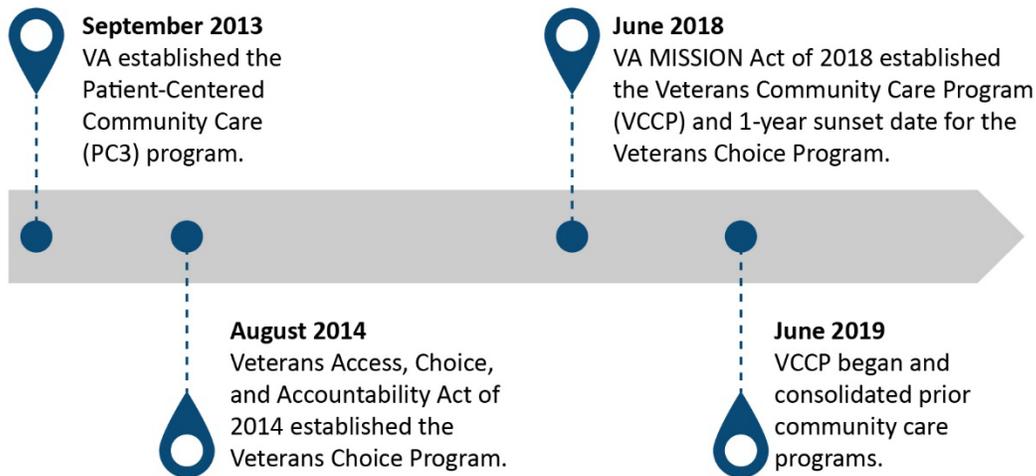
### **Department of Veterans Affairs' Community Care Programs**

VA's community care programs provide medical services to veterans through community providers when veterans cannot receive services at VHA medical facilities. VA may enter into agreements with community providers (including health care providers participating in Medicare) to furnish these services.

VHA administers the VA's community care programs. VHA contracts with third-party administrators, who have a network of providers, to process payments to community providers directly and educate community providers on billing requirements.

VA's community care programs have included Patient-Centered Community Care (PC3) and the Veterans Choice Program; the Veterans Community Care Program (VCCP) consolidated those two programs. Figure 1 shows the history of these three community care programs.

**Figure 1: The History of VA's Community Care Programs**



The PC3 program, Veterans Choice Program, and VCCP have offered the following services:

- **PC3.** The PC3 program offered a network of community providers nationwide that furnished an eligible veteran with timely access to certain medical care when a local VHA medical facility could not readily provide the care because of a lack of an available specialist, long wait times, geographic inaccessibility, or other factors. VHA awarded PC3 contracts to third-party administrators in September 2013 to provide veterans with timely access to quality care from providers available within the contractors' networks, and the program had been fully implemented nationwide as of April 2014.
- **Veterans Choice Program.** In response to problems with veterans' timely access to care at VHA medical facilities, the Veterans Access, Choice, and Accountability Act of 2014 established a temporary program called the Veterans Choice Program, which enabled veterans to obtain health care services from community providers when veterans faced long wait times (exceeding 30 days), lengthy travel distances of more than 40 miles to receive care, or other challenges accessing care at VHA medical facilities.<sup>6</sup>
- **VCCP.** To help address some of the challenges faced by the Veterans Choice Program, such as insufficient community provider networks and significant delays in scheduling appointments, the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (VA MISSION Act) required VA to consolidate community care programs into a permanent program—VCCP.<sup>7</sup> In addition, VA established a new Community Care Network of community providers to replace the PC3 network. Under VCCP, VHA has contracted with third-party administrators to build regional networks of

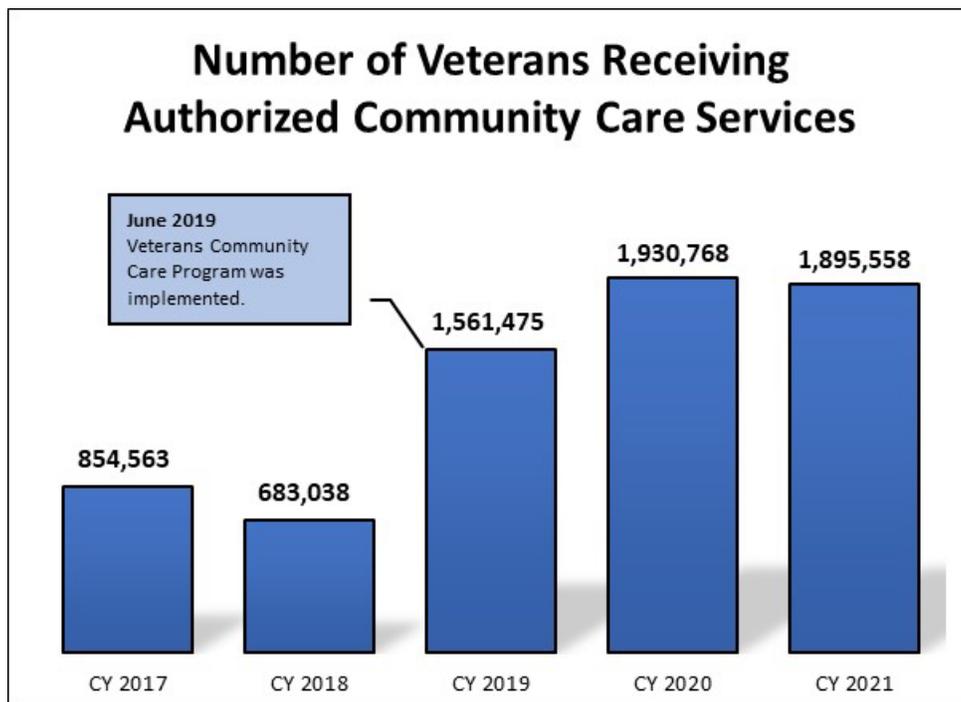
<sup>6</sup> Veterans Access, Choice, and Accountability Act of 2014, P.L. No. 113-146 (August 7, 2014).

<sup>7</sup> VA MISSION Act, P.L. No. 115-182 (June 6, 2018).

community providers and to pay those providers' claims for services delivered to veterans. In June 2019, VCCP replaced the PC3 program and the Veterans Choice Program.

From calendar years (CYs) 2017 through 2021, the number of veterans who received VHA-authorized community care services generally increased. The implementation of VCCP in June 2019 and its expanded eligibility for community care resulted in a significant increase in the use of authorized community care services. (See Figure 2.)

**Figure 2: The Number of Veterans Who Received Authorized Community Care Services Generally Increased Over 5 Years<sup>8</sup>**



### **Payment Responsibilities for Community Care Services Provided to Individuals Dually Eligible for Medicare and Veterans Health Administration Benefits**

Approximately 5.6 million individuals were dually eligible for Medicare and VHA benefits in fiscal year 2020 (October 1, 2019, through September 30, 2020).<sup>9</sup> An individual has dual eligibility when the individual meets both Medicare and VHA eligibility requirements.

<sup>8</sup> Because of the timing of the retrieval of claims data, the number shown for CY 2021 may not include all of the veterans who received authorized community care services in that year.

<sup>9</sup> This information was obtained from the VA Medicare and Medicaid Analysis Center, which distributes CMS data to approved VHA program offices for operational use.

VHA is solely responsible for paying for the community care services it authorized. Medicare payment for other services not authorized by VA may be made in accordance with Medicare requirements. Duplicate claims occur when a provider submits claims for the same services to both Medicare and VHA, and duplicate payments occur when both programs pay the claims. Because Medicare regulations prohibit payment for services that are paid for directly or indirectly by another government entity, subject to a few exceptions, Medicare should not pay claims for services that VHA has paid.<sup>10</sup> Medicare payments associated with these claims are considered overpayments.

## **HOW WE CONDUCTED THIS AUDIT**

Our audit covered \$19.2 billion in Medicare Part A and Part B payments for 36.3 million claims related to dually eligible enrollees who received services from VA's community providers during our audit period (January 1, 2017, through December 31, 2021). The total \$19.2 billion was associated with all claims related to dually eligible enrollees irrespective of whether the claims were authorized and paid for by VHA under VA's community care programs.

We obtained from VA-OIG the PC3, Veterans Choice Program, and VCCP claims data for our audit period.<sup>11</sup> From these data, we extracted enrollee identifiers (e.g., Social Security numbers and birth dates). Using these identifiers, we identified paid Medicare claims from CMS's National Claims History file and performed matches for various factors, such as overlapping dates of service, to determine whether an enrollee had a paid claim in both the Medicare and VHA claim datasets.

We reviewed only claims for services paid for by both Medicare and VHA. We did not assess whether services were medically necessary.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A describes our audit scope and methodology.

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<sup>10</sup> 42 CFR §§ 411.7(a) and 411.8(a).

<sup>11</sup> The data sources and systems that VA-OIG used to retrieve data were: (1) the VA's Financial Service Center and Corporate Data Warehouse for PC3 and Veterans Choice Program claims and (2) the Office of Community Care Program Integrity Tool for VCCP claims. Because of the timing of the retrieval of the claims data, the CY 2021 data may not have included all of the VHA claims for which services were authorized and paid for by VHA.

## FINDING

Medicare paid providers for medical services that were authorized and paid for by VA's community care programs during our audit period, resulting in duplicate payments of up to \$128 million associated with 298,527 claims.<sup>12</sup>

These duplicate payments occurred because CMS did not implement controls to address duplicate payments for services provided to individuals with Medicare and VHA benefits (i.e., dually eligible enrollees). Specifically, CMS did not establish a data-sharing agreement with VHA for the ongoing sharing of data between the two agencies and did not develop an interagency process to include VHA enrollment, claims, and payment data in CMS's data repository. Inclusion of these data, which is required by Federal law, would have allowed CMS to compare VHA claims data with existing Medicare claims data to identify duplicate claims paid for by both Medicare and VHA.<sup>13</sup> Because CMS did not develop an interagency process, CMS did not establish an internal process (such as claims processing system edits) to address duplicate payments for medical services authorized and paid for by VHA.<sup>14</sup> Furthermore, CMS guidance to providers on VA's responsibility to pay for medical services did not clarify that a provider should not bill Medicare for a medical service that was authorized by VHA.

If CMS had developed an interagency process to include VHA enrollment, claims, and payment data in CMS's data repository and had established an internal process that used these data, Medicare could have saved up to \$128 million in payments for claims for medical services that VHA authorized and paid for during our audit period.

## FEDERAL REQUIREMENTS

Medicare does not pay for services furnished by a Federal provider or that are paid for directly or indirectly by a government entity (42 CFR §§ 411.7(a) and 411.8(a)). For hospital care or medical services furnished for a service-connected disability, VA is solely responsible for paying the eligible entity or provider for hospital care or medical services as authorized and furnished to an eligible veteran (38 CFR § 17.1535).<sup>15</sup> Generally, an authorization issued by VA binds VA to pay in full for the items and services provided, and no payment is made under Medicare for such authorized services (*Medicare Benefit Policy Manual (Policy Manual)*, Pub. No. 100-02,

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<sup>12</sup> The duplicate payment amount was \$127,981,462.

<sup>13</sup> The Social Security Act § 1128J(a).

<sup>14</sup> An edit is programming within the standard claim processing system that selects certain claims; evaluates or compares information on the selected claims or other accessible sources; and, depending on the evaluation, takes action on the claims, such as paying claims in full or in part, denying payments, or suspending claims for manual review.

<sup>15</sup> With respect to disability or death, "service-connected" means that such disability was incurred or aggravated, or that such death resulted from a disability incurred or aggravated in the line of duty in the active military, naval, air, or space service (38 CFR § 3.1(k)).

chapter 16, § 50.1.1). Medicare does not pay for any item or service furnished by a non-Federal provider pursuant to an authorization issued by a Federal agency, under the terms of which the Federal Government agrees to pay for the services (Policy Manual, chapter 16, § 50.1.1). Therefore, services that are authorized and paid for by VHA are not eligible for Medicare payment.

### **MEDICARE PAID PROVIDERS FOR MEDICAL SERVICES THAT THE VETERANS HEALTH ADMINISTRATION AUTHORIZED AND PAID FOR UNDER THE DEPARTMENT OF VETERANS AFFAIRS' COMMUNITY CARE PROGRAMS**

Medicare paid providers for medical services that the VHA authorized and paid for under VA's community care programs during our audit period, resulting in duplicate payments of up to \$128 million associated with 298,527 claims.<sup>16</sup> VHA is solely responsible for paying providers for medical services that it authorized.<sup>17</sup>

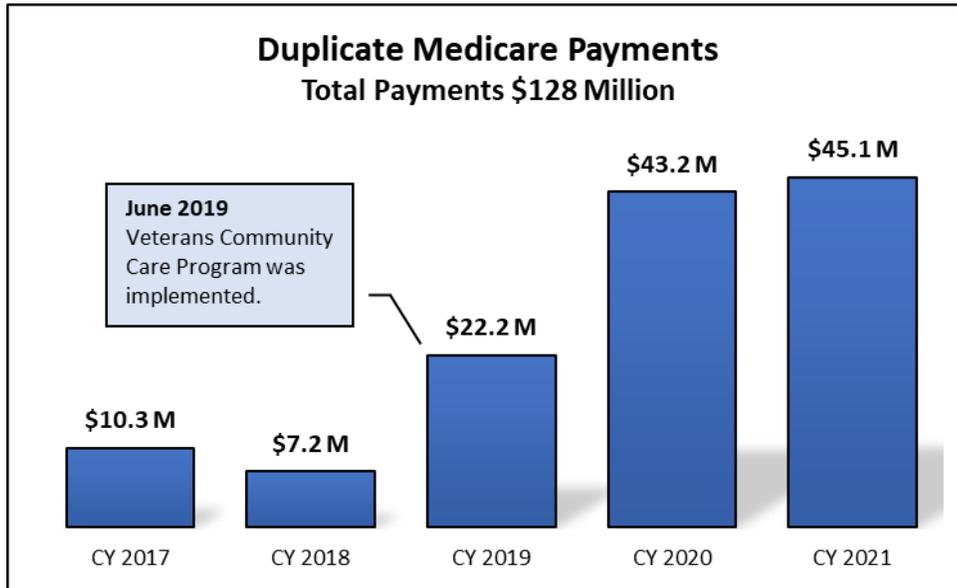
Duplicate Medicare payments generally increased over our 5-year audit period, with significant increases in CYs 2019 and 2020. (See Figure 3.) The VA MISSION Act's expansion of eligibility for veterans to receive health care services from community providers—through lowering the thresholds for wait times and average driving times under implementation of VCCP in June 2019—resulted in increased use of authorized community care services and an increased risk of duplicate payments.

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<sup>16</sup> VA-OIG identified 426,825 duplicate Medicare claims with dates of service from January 1, 2017, through March 31, 2021. Using more current claims data, we identified an additional 81,006 duplicate Medicare claims with dates of service from January 1, 2017, through December 31, 2021. As of August 2022, our analysis showed that about 60 percent of the duplicate Medicare claims (associated with \$128 million in duplicate payments) identified during our audit period were not canceled or were not adjusted to zero payment.

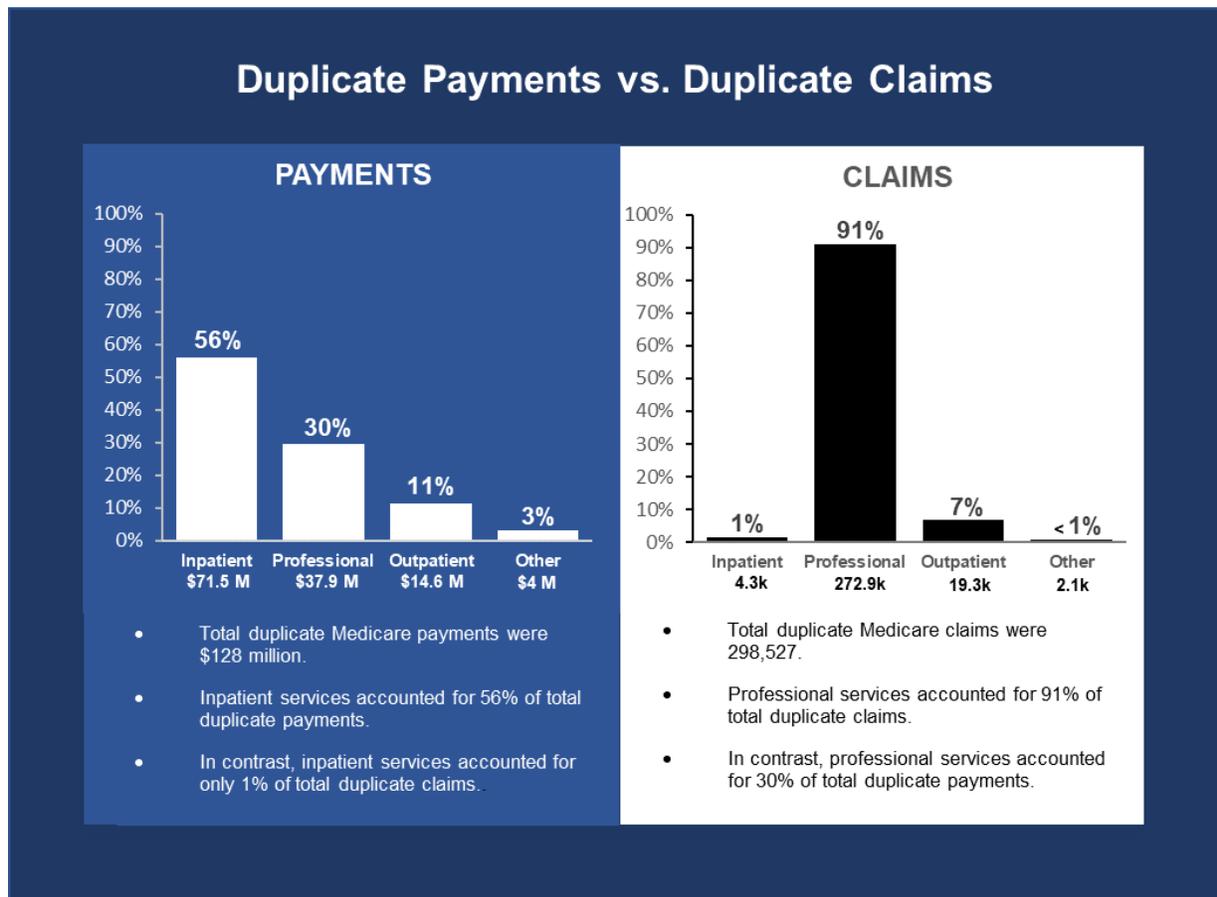
<sup>17</sup> Medicare payment for other services not authorized by VA may be made in accordance with Medicare requirements.

**Figure 3: Duplicate Medicare Payments Generally Increased Over 5 Years**



Medicare made duplicate payments for various types of medical services consisting of inpatient and outpatient services, skilled nursing facility services, home health services, professional services, and durable medical equipment. Of the \$128 million in duplicate Medicare payments, the largest percentage of this amount (56 percent) was for inpatient services, followed by professional services (30 percent) and outpatient services (11 percent). Of the 298,527 duplicate Medicare claims, 91 percent of the claims were for professional services, such as physician’s evaluation and management visits. Inpatient services, such as acute-care-hospital services, accounted for only 1 percent of the total duplicate Medicare claims because the payment amounts for these claims were much higher than the claims for professional services. (See Figure 4.)

**Figure 4: Percentage of Total Duplicate Medicare Payments and Claims by Types of Medical Services**



**CMS DID NOT IMPLEMENT CONTROLS TO ADDRESS DUPLICATE PAYMENTS FOR SERVICES PROVIDED TO DUALY ELIGIBLE ENROLLEES**

Medicare made duplicate payments because CMS did not implement controls to address duplicate payments for services provided to dually eligible enrollees. Specifically, CMS did not: (1) establish a data-sharing agreement for the ongoing sharing of data with VHA or develop an interagency process to include VHA enrollment, claims, and payment data in CMS’s data repository; and (2) establish an internal process to address duplicate payments or furnish guidance to providers on not billing Medicare for VHA-authorized medical services.

**CMS Did Not Establish a Data-Sharing Agreement With the Veterans Health Administration or Develop an Interagency Process To Include VHA Data in CMS’s Data Repository**

CMS did not establish a data-sharing agreement with VHA for the ongoing sharing of data between the two agencies. Without such an agreement, CMS could not develop an interagency process to include VHA enrollment, claims, and payment data in CMS’s Integrated Data

Repository (IDR).<sup>18</sup> Inclusion of these data would have allowed CMS to compare VHA claims data with existing Medicare claims data to identify duplicate claims paid for by both Medicare and VHA.

Section 1128J(a) of the Social Security Act requires that the CMS IDR include, among other data, appropriate claims and payment data from the health-related programs that VA administers. It states that CMS shall enter into agreements with VHA to share and match data for the purpose of identifying potential fraud, waste, and abuse in Medicare. CMS and VHA had established a limited data-sharing agreement to determine whether duplicate payments occurred. However, this data-sharing agreement was prompted by VHA for planning and research to determine whether there were duplicate payments for a limited set of services. In addition, the agreement stated that no action would be taken on duplicate payments. Without a comprehensive data-sharing agreement with VHA for the ongoing sharing of data, CMS could not establish a process to implement the Social Security Act's requirements.

Furthermore, to identify duplicate claims paid for by both Medicare and VHA, CMS did not implement a process to integrate VHA enrollment, claims, and payment data into the CMS IDR. *Medicare Secondary Payer Manual* states that when an individual is identified as having VHA benefits, the MAC may contact the provider to determine whether a claim has been, or will be, submitted to VA (Pub. No. 100-05, chapter 5, § 20.3). However, CMS stated that there were no data-sharing agreements in place with VA for the ongoing sharing of data. Therefore, MACs could not identify duplicate claims paid for by both Medicare and VHA.

### **CMS Did Not Establish an Internal Process or Furnish Billing Guidance to Providers**

Because CMS did not have an interagency process, CMS did not establish an internal process (such as system edits) to address duplicate payments that Medicare made for medical services authorized and paid for by VHA. As a result, MACs could not identify duplicate claims paid for by both Medicare and VHA, and were essentially relying on providers to initiate requests to return payments that were improperly made.

CMS furnishes guidance to providers on VA's responsibility to pay for medical services that are authorized by VHA. The Policy Manual states that generally an authorization issued by VA binds the agency to pay in full for the items and services provided, and no payment is made under Medicare for such authorized services (chapter 16, § 50.1.1). However, the guidance did not clarify that a provider should not bill Medicare for a medical service that was authorized by VHA.

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<sup>18</sup> The CMS IDR is a high-volume data warehouse integrating Medicare claims, enrollee and provider data sources, and a fraud prevention system for the development of analytic tools that aids the Department of Health and Human Services (HHS) in ensuring the integrity of HHS programs, especially Medicare.

## CONCLUSION

Over the 5-year period from CY 2017 through 2021, the number of veterans who received VHA-authorized community care services generally increased. Duplicate Medicare payments for individuals who had both Medicare and VHA benefits also increased. These duplicate payments occurred because CMS did not implement controls to address duplicate payments for services provided to dually eligible enrollees. If CMS had developed an interagency process to include VHA enrollment, claims, and payment data in CMS's data repository and had established an internal process (such as system edits) to address duplicate payments, Medicare could have saved up to \$128 million in payments for claims for medical services that VHA authorized and paid for during our audit period. The information in this report may be useful to CMS and policymakers when they consider measures to identify and address these duplicate payments to promote efficient spending of taxpayer dollars.<sup>19</sup>

## RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services:

- establish a comprehensive data-sharing agreement with VHA for the ongoing sharing of data;
- establish an interagency process to integrate VHA enrollment, claims, and payment data into the CMS IDR to identify potential fraud, waste, and abuse under the Medicare program;
- establish an internal process (such as system edits) to address duplicate payments made by Medicare for medical services authorized and paid for by VHA, which could have saved Medicare up to \$128 million during our audit period; and
- issue guidance to providers on not billing Medicare for a medical service that was authorized by VHA.

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<sup>19</sup> On March 29, 2022, the VA Preventing Duplicate Payments Act of 2022 was introduced in the U.S. House of Representatives. This act would require increased interagency cooperation and coordination as well as policies and procedures to detect and prevent duplicate payments for the same medical services by VA, HHS, and the Department of Defense. As of March 2023, this act had not been passed by Congress.

## CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS concurred with all of our recommendations and described actions that it had taken or planned to take to address our recommendations. CMS had the following comments on our four recommendations:

- Regarding our first recommendation, CMS stated that it is actively engaged with VHA and is working toward establishing a data-sharing agreement for the ongoing sharing of data.
- Regarding our second recommendation, CMS stated that once the necessary data-sharing agreement is in place, CMS will work to establish an interagency process to integrate VHA enrollment, claims, and payments data into the CMS IDR.
- Regarding our third recommendation, CMS stated that it is working to develop processes to address duplicate payments made by Medicare for medical services authorized and paid for by VHA.
- Regarding our fourth recommendation, CMS stated that it will take our recommendation into account when determining appropriate next steps to help ensure that Medicare is not paying for medical services authorized by VHA. CMS also stated that it has educated providers regarding coverage and payment for medical services authorized by VHA.

CMS previously informed us that establishing a long-term solution to address duplicate payments will take time. We acknowledge that CMS is working toward establishing a data-sharing agreement for the ongoing sharing of data and is working to develop processes to address duplicate payments.

CMS also provided technical comments, which we addressed as appropriate. CMS's comments, excluding the technical comments, are included as Appendix B.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

Our audit covered \$19,204,494,499 in Medicare Part A and Part B payments for 36,345,298 claims related to dually eligible enrollees who received services from VA's community providers during our audit period (January 1, 2017, through December 31, 2021). The total \$19.2 billion was associated with all claims related to dually eligible enrollees irrespective of whether the claims were authorized and paid for by VHA under VA's community care programs.

We obtained from VA-OIG the PC3, Veterans Choice Program, and VCCP claims data for our audit period, which consisted of claims for inpatient services, skilled nursing facility services, home health services, professional services, outpatient services, and durable medical equipment. From these data, we extracted enrollee identifiers (e.g., Social Security numbers and birth dates). Using these identifiers, we identified paid Medicare claims from CMS's National Claims History file and performed matches for various factors, such as overlapping dates of service, to determine whether an enrollee had a paid claim in both the Medicare and VHA claim datasets.<sup>20</sup>

We reviewed only claims for services paid for by both Medicare and VHA. We did not assess whether services were medically necessary.

We did not perform an overall assessment of the internal control structures of CMS because our objective did not require us to do so. Rather, we limited our review to those internal controls related to Medicare reimbursement requirements. To determine the effectiveness of internal controls, we interviewed CMS officials to obtain an understanding of the policies and procedures governing the processing and payment of Medicare claims billed when there is a duplicate claim for the same medical service.

Our review enabled us to establish reasonable assurance of the authenticity and accuracy of the data obtained from CMS's National Claims History file, but we did not assess the completeness of the file.

We conducted our audit from February 2022 through February 2023.

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<sup>20</sup> We considered claims paid for by Medicare and VA to be duplicate claims if they had matching Social Security numbers; had the same date of service or overlapping dates of service; and were for the same service for professional service, durable medical equipment, and outpatient claims. For professional service and durable medical equipment claims, we considered claims to be duplicates if they also had a matching billing provider. For inpatient, skilled nursing facility, and home health agency claims, we considered claims to be duplicates if they had matching Social Security numbers and had the same date of service or overlapping dates of service. For home health agency claims, we considered claims to be duplicates if they also had a matching billing provider.

## METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws and regulations and CMS guidance;
- interviewed CMS officials to understand the Medicare Part A and Part B payment requirements when individuals have both Medicare and VHA benefits;
- collaborated with VA-OIG to:
  - determine who is the sole payer for services authorized by VHA;
  - develop a methodology for identifying duplicate Medicare and VHA claims;
  - obtain PC3, Veterans Choice Program, and VCCP claims data; and
  - match VHA enrollees' Social Security numbers against Medicare enrollment files to identify dually eligible enrollees;
- obtained data for paid Medicare claims for service dates during our audit period;
- identified claims paid for by both Medicare and VHA;
- identified whether duplicate Medicare claims were canceled or were adjusted to zero payment;
- calculated the Medicare savings amount for claims for which VHA should have been the sole payer; and
- discussed the results of our audit with CMS officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

## APPENDIX B: CMS COMMENTS



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator  
Washington, DC 20201

**DATE:** March 17, 2023

**TO:** Juliet T. Hodgkins  
Principal Deputy Inspector General  
Office of Inspector General

**FROM:** *Chiquita Brooks-LaSure*  
Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services

**SUBJECT:** Office of Inspector General (OIG) Draft Report: Medicare Could Have Saved Up To \$128 Million Over 5 Years if CMS Had Implemented Controls To Prevent \* Duplicate Payments for Services Provided to Individuals With Medicare and Veterans Health Administration Benefits (A-09-22-03004)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report.

CMS takes the health and safety of individuals with Medicare seriously, and is committed to providing them with access to medically necessary services and, at the same time, working to protect the Medicare Trust Funds from improper payments. CMS shares OIG's concerns regarding preventing, detecting, and recovering duplicate payments made by both Medicare and the Veterans Administration and is actively working towards establishing a data-sharing agreement for the ongoing sharing of data so that we can ensure there is a process in place to address this issue.

In addition, CMS has taken action to reduce improper Medicare payments by educating health care providers and suppliers on proper billing. CMS educates health care providers and suppliers on Medicare billing through various channels including the Medicare Learning Network (MLN), weekly electronic newsletters, and quarterly compliance newsletters. For example, CMS published a MLN booklet of items and services not covered under Medicare which explains that Medicare normally doesn't pay for items and services authorized or paid by a government entity, including those authorized by a federal agency such as the Veterans Health Administration (VHA).<sup>1</sup>

The OIG's recommendations and CMS's responses are below.

### **OIG Recommendation**

The OIG recommends that the Centers for Medicare & Medicaid Services establish a comprehensive data-sharing agreement with VHA for the ongoing sharing of data.

<sup>1</sup> MLN Booklet: Items & Services Not Covered Under Medicare (December 2020). Available at: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Items-Services-Not-Covered-Under-Medicare-Text-Only.pdf>

**\* OIG Note:** For the final report, we changed the title to *Medicare Could Have Saved Up To \$128 Million Over 5 Years if CMS Had Implemented Controls To Address Duplicate Payments for Services Provided to Individuals With Medicare and Veterans Health Administration Benefits*.

**CMS Response**

CMS concurs with this recommendation. CMS is actively engaged with the VHA and is working toward establishing a data-sharing agreement for the ongoing sharing of data.

**OIG Recommendation**

The OIG recommends that the Centers for Medicare & Medicaid Services establish an interagency process to integrate VHA enrollment, claims, and payment data into the CMS IDR to identify potential fraud, waste, and abuse under the Medicare program.

**CMS Response**

CMS concurs with this recommendation. As stated above, CMS is actively engaged with VHA and is working toward establishing a data-sharing agreement. Once the necessary data-sharing agreement is in place, CMS will work to establish an interagency process to capture VHA enrollment, claims, and payments data in the CMS Integrated Data Repository (IDR) to identify potential fraud, waste, and abuse under the Medicare program.

**OIG Recommendation**

The OIG recommends that the Centers for Medicare & Medicaid Services establish an internal process (such as system edits) to address duplicate payments made by Medicare for medical services authorized and paid for by VHA.

**CMS Response**

CMS concurs with this recommendation. CMS is working to develop processes to address duplicate payments made by Medicare for medical services authorized and paid for by VHA.

**OIG Recommendation**

The OIG recommends that the Centers for Medicare & Medicaid Services issue guidance to providers on not billing Medicare for a medical service that was authorized by VHA.

**CMS Response**

CMS concurs with this recommendation. CMS will take the OIG's recommendation into consideration when determining appropriate next steps to help ensure that Medicare is not paying for a medical service authorized by VHA. As stated above, CMS has educated providers regarding coverage and payment for medical services authorized by VHA and we will continue to do so, as necessary.