COMPUTER MATCHING AGREEMENT
BETWEEN
THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES
AND
THE DEPARTMENT OF VETERANS AFFAIRS
VETERANS HEALTH ADMINISTRATION
FOR
IDENTIFICATION AND RECOVERY OF DUPLICATE PAYMENTS FOR MEDICAL CLAIMS

Centers for Medicare & Medicaid Services No. 2024-64
Department of Health and Human Services No. 2403

Effective Date: June 24, 2024
Expiration Date: December 23, 2025

I. PURPOSE, LEGAL AUTHORITY, AND DEFINITIONS

A. Purpose

The purpose of this Computer Matching Agreement (Agreement) is to establish and govern a matching program to identify dual enrolled beneficiaries and duplicate claims for the benefit of both Health and Human Services, Center for Medicare & Medicaid Services (CMS) and the Department of Veterans Affairs, Veterans Health Administration (VHA), known as the Parties. The matching program will assist the Parties in identifying (1) those VHA enrolled beneficiaries who are also enrolled as Medicare beneficiaries, (2) specific claims where VHA and CMS made duplicate payments for the same health care services, and (3) potential fraud, waste, and abuse.

CMS will use VHA beneficiary information to identify those VHA beneficiaries who are also enrolled in Medicare and where CMS made payment on claims for which VHA also made payment. Any claims where both the VHA and CMS made payment will be reviewed by both agencies and recoupment action will be initiated against the providers as appropriate. (Note that information about beneficiaries, which is retrieved by beneficiaries' personal identifiers and constitutes Privacy Act records, will be used to conduct the matches, but the match results will be used to take actions affecting only providers and suppliers. Some providers and suppliers are solo practitioners (individuals), but they are not Privacy Act covered individuals in this matching program, because each Party's claims payment records to be used in this matching program contain information about both beneficiaries and their providers and suppliers and are retrieved by beneficiary identifiers only.)

CMS recoveries will be made in accordance with the Medicare recovery laws and statutes. The Social Security Act at section 1862(a)(3) (42 U.S.C. § 1395y(a)(3)) precludes Medicare from making payment for services or items that are paid for directly

or indirectly by another government entity. Similarly, CMS's regulations at 42 CFR § 411.8 provides that Medicare does not pay for services that are paid for directly or indirectly by a government entity. VHA recovery may be appropriate for claims VHA paid under 38 U.S.C. § 1725 which specifies that VHA is a payor of last resort. Existing laws and regulations establish the department or agency that is financially responsible in a situation in which a beneficiary is eligible, or potentially eligible, for a medical service under the laws administered by the Secretary of Veterans Affairs and the Administrator of the Centers for Medicare & Medicaid Services.

The Privacy Act of 1974, as amended, 5 U.S.C. § 552a (in particular, as amended by the Computer Matching and Privacy Protection Act of 1988), requires the Parties participating in a matching program to execute a written agreement specifying the terms and conditions under which the matching program will be conducted. CMS has determined that the exchange of beneficiary data between the Parties constitutes a "matching program" as defined in 5 U.S.C. § 552a(a)(8).

CMS will be the "recipient agency" as defined in 5 U.S.C. § 552a(a)(9) and VHA will be the "source agency" as defined in 5 U.S.C. § 552a(a)(11). The responsible component for CMS is the Office of Financial Management and Center for Program Integrity (CPI). The VA's Office of Management and the VHA are the responsible VA components.

By entering into this Agreement, the Parties agree to comply with the terms and conditions set forth herein, as well as applicable law and regulations. The terms and conditions of this Agreement will be carried out by authorized employees and contractors of CMS and VA.

B. Legal/Statutory Authority

The following statutes and regulations govern or provide legal authority for the uses of data, including disclosures, under this Agreement:

1. This Agreement is executed pursuant to the Privacy Act of 1974, as amended (5 U.S.C. § 552a), and implementing guidance promulgated thereunder, including Office of Management and Budget (OMB) Circular A-108 "Federal Agency Responsibilities for Review, Reporting, and Publication under the Privacy Act" published at 81 FR 94424 (Dec. 23, 2016) and OMB guidelines pertaining to computer matching published at 54 FR 25818 (June 19, 1989).

2. Section 1128J of the Social Security Act (42 U.S.C. § 1320a-7k) states in paragraph 1.A.(i) that the Integrated Data Repository (IDR) of the Centers for Medicare & Medicaid Services shall include claims and payment data for health-related programs administered by the Secretary of Veterans Affairs.

3. The Secretary of Veterans Affairs established policies and procedures for the detection and prevention of duplicate billings and payments by the Secretary of non-Department health care providers under 38 U.S.C. § 1703, through the comparison of

a billing or payment made by the Secretary for a medical service to a billing or payment made for the same medical service by the Administrator under title XVIII of the Social Security Act (42 U.S.C. §§ 1395 et seq.).

4. 38 CFR § 1.481(a) permits the Secretary of Veterans Affairs to disclose records to other Federal agencies for purposes of performing other health care-related activities or functions which the law defines to include activities related to reimbursement for care and treatment by a health care provider.

5. 45 CFR § 164.506(c) permits a covered entity to use or disclose protected health information for its own payment activities and to disclose protected health information for the payment activities of another covered entity or health care provider the information is shared with.

6. 38 U.S.C. § 1725, Reimbursement for emergency treatment, defines the requirements for reimbursement of "unauthorized" care claims for nonservice-connected disabilities. These types of claims are referred to as Millennium Bill (otherwise known as Mill Bill) claims. 38 U.S.C. § 1725(d) gives the United States the independent right to recover any amount paid under this section when, and to the extent that, a third party (including another Federal entity) subsequently makes a payment for the same emergency treatment.

C. Definitions

For the purposes of this Agreement:

1. The "Act" means the Social Security Act.

2. "Breach" means the loss of control, compromise, unauthorized disclosure, unauthorized acquisition, or any similar occurrence where (1) a person other than an authorized user accesses, or potentially access, personally identifiable information (defined further below), or (2) an authorized user access, or potentially accesses, personally identifiable information for an other than authorized purpose OMB Memorandum M-17-12, Preparing for and Responding to a Breach of Personally Identifiable Information (January 3, 2017)).

3. "CMS" means the Centers for Medicare & Medicaid Services.

4. "CWF" means Common Working File, which is a system used by CMS to maintain national Medicare records for individual beneficiaries enrolled in the program. The system is used to determine the eligibility of patients and to monitor the appropriate usage of Medicare benefits.

5. "Duplicate Payment" means a claims payment that was, and should not have been, made by one Party for the same service(s) for which the other Party made a claims payment. Note: there are authorized situations where VHA and CMS share payment

responsibility and it will be proper for either of them to pay all or for each of them to pay part of the outstanding balance.

6. "EDB" means CMS' Enrollment Database.

7. "Finder File" means file that identifies the source agency data elements that will be matched by the recipient agency.

8. "HHS" means the United States Department of Health and Human Services.

9. "IDR" means Integrated Data Repository, that is a high-volume data warehouse integrating Parts A, B, C, D, and DME claims, beneficiary, and provider data sources, along with ancillary data such as contract information, risk scores, and many others.

10. "Incident" means an occurrence that (1) actually or imminently jeopardizes, without lawful authority, the integrity, confidentially, or availability of information or an information system; or (2) constitutes a violation, or imminent threat of violation of, law, security policies, security procedures, or acceptable use policies (OMB Memorandum M-17-12 – Preparing for and Responding to a Breach of Personally Identifiable Information (January 3, 2017)).

11. "Medicare" means the health coverage program established under Title XVIII of the Act.

12. "MBD" means CMS' Medicare Beneficiary Database.

13. "Personally Identifiable Information" or "PII" refers to information which can be used to distinguish or trace an individual's identity, either alone or when combined with other information that is linked or linkable to a specific individual (OMB Memorandum M-17-12 – Preparing for and Responding to a Breach of Personally Identifiable Information (January 3, 2017)).

14. "Protected Health Information" or "PHI" means individually identifiable health information" as defined in the HIPAA Privacy Rule at 45 CFR § 160.103.

15. "Provider" is defined in 42 CFR § 400.202 as a hospital, a Critical Access Hospital (CAH), a skilled nursing facility, a comprehensive outpatient rehabilitation facility, a home health agency, or a hospice that has in effect an agreement to participate in Medicare, or a clinic, a rehabilitation agency, or a public health agency that has in effect a similar agreement but only to furnish outpatient physical therapy or speech pathology services, or a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization services.

16. "Recipient Agency" is defined by the Privacy Act at 5 U.S.C. § 552a(a)(9) and means any agency, or contractor thereof, receiving records contained in a system of records from a source agency for use in a matching program.

17. "Recovery" means to recoup improper claims payments made to providers.

18. "SOR" means "System of Records," a group of any records under the control of any agency from which information is retrieved by the name of the individual or by some identifying number, symbol, or other identifying particular assigned to the individual.

19. "SORN" means a "System of Records Notice," a notice published in the Federal Register, as required by the Privacy Act, to provide public notice of the existence and character of a system of records maintained by a federal agency.

20. "Source Agency" is defined by the Privacy Act at 5 U.S.C. § 552a(a)(11) and means any agency which discloses records contained in a system of records to be used in a matching program, or any State or local government, or agency thereof, which discloses records to be used in a matching program.

21. "Supplier" is defined in 42 CFR § 400.202 as a physician or other practitioner, or an entity other than a provider, that furnishes health care services under Medicare.

22. "VA" means the United States Department of Veterans Affairs.

23. "VHA" means Veterans Health Administration.

II. RESPONSIBILITIES OF THE PARTIES

VHA and CMS Responsibilities:

1. VHA will provide to CMS on a recurring basis, but not more than monthly, a data extract (i.e., finder file) of all its Veteran beneficiaries enrolled in VHA healthcare.

2. CMS will receive the VHA beneficiary finder file and will match the VHA beneficiary data finder file to the Medicare enrolled beneficiaries (Part A and B), identifying the dual enrolled beneficiaries.

3. CMS will update the appropriate IT systems to capture VHA enrollment information for the matched dual enrolled beneficiaries.

4. CMS will send to VHA a response file, identifying the matched VHA and Medicare beneficiaries.

5. VHA will update the appropriate IT systems to capture Medicare enrollment information for dual enrolled beneficiaries.

6. VHA will match the CMS-provided response file containing matched beneficiaries to VHA paid medical claims data and will extract all claims where VHA authorized and

made payment for the matched beneficiaries.

7. VHA will send the claims file for the matched beneficiaries to CMS.

8. CMS will receive the VHA claims file identifying where VHA made payment for authorized services and will match the VHA claims to Medicare claims payments made for the same services.

9. CMS will update the appropriate IT systems to capture VHA medical claim information for the matched dual enrolled beneficiaries.

10. CMS will send a duplicative claim payment response file to VHA identifying those claims for which Medicare has made payment. This file represents duplicate claims for which both VHA and CMS made payment and one of the agencies will take action to recover its payment.

11. VHA will initiate recovery for claims where the VHA payment was for nonservice connected care made under 38 U.S.C. § 1725 payment authority.

12. CMS will initiate recovery for all claims where VHA payment was made but the payment was not under 38 U.S.C. § 1725 payment authority.

13. CMS and VHA will periodically share information on the status of recoveries.

Attachment B contains additional information about the data fields that will be shared, which will be transferred via an agreed upon electronic secure transfer file protocol.

III. JUSTIFICATION AND ANTICIPATED RESULTS

A. Cost Benefit Analysis

As required by 5 U.S.C. § 552a(u)(4), a Cost Benefit Analysis (CBA) was prepared for this matching program by CMS and VHA, which is included as Attachment A. The CBA reflects that total costs to conduct the matching program are estimated to be $6,330,024 and total monetary benefits of the matching program are estimated to be $45,000,000 for the first 12-month period of the Agreement. The CBA, therefore, demonstrates that the matching program is likely to be cost effective.

B. Other Supporting Justifications

The parties to this Agreement have determined that a matching program is the most efficient, expeditious, and effective means for CMS and VHA to identify medical claims for which Medicare and VHA made a payment for the same healthcare services to enable recovery activities by the appropriate agency. Matching VHA enrollees to Medicare enrollees to identify dual enrolled beneficiaries enables VHA to reduce the volume of medical claims data transmitted to CMS.

C. Specific Estimate of Any Savings

CMS anticipates it may save more than $40 million dollars annually by conducting this matching program with the VHA. This amount is based on a pilot match of VHA and CMS claims for calendar year 2019. CMS determined from its analysis of the pilot match that it paid $42 million in duplicate claims where the VHA was the primary payer. From the same pilot, VHA estimates it may save up to $2.25 million in the first 12 months through identification of duplicate claims recoverable by VHA.

IV. RECORDS DESCRIPTION

The Privacy Act at 5 U.S.C. § 552a(o)(1)(C) requires that each CMA specify a description of the records that will be matched and exchanged, including each data element that will be used, the approximate number of records that will be matched, and the projected starting and completion dates of the program.

A. Systems of Records

CMS will disclose data to VHA retrieved from these systems of records by Medicare beneficiary identifiers:

1. Common Working File (CWF), System No. 09-70-0526, last published in full at 71 FR 64955 (11/6/06), and partially updated at 78 FR 23938 (4/23/13), 78 FR 32257 (5/29/13), and 83 FR 6591 (2/14/18). Routine use numbers 2a and 10 authorize disclosures to VHA to contribute to the accuracy of CMS's proper payment of Medicare benefits, and to investigate potential fraud, waste, or abuse.

2. Medicare Beneficiary Database (MBD), System No. 09-70-0536, last published in full at 71 FR 70396 (12/4/06), and partially updated at 78 FR 23938 (4/23/13), 78 FR 32257 (5/29/13), and 83 FR 6591 (2/14/18). Routine use numbers 2a and 11 authorize disclosures to VHA to contribute to the accuracy of CMS's proper payment of Medicare benefits, and to investigate potential fraud, waste, or abuse.

3. Medicare Integrated Data Repository (IDR), System No. 09-70-0571. last published in full at 71 FR 74915 (12/13/06), and partially updated 76 FR 65196 (10/20/11), 78 FR 23938 (4/23/13), 78 FR 32257 (5/29/13), and 83 FR 6591 (2/14/18). Routine use numbers 2a and 11 authorize disclosures to VHA to contribute to the accuracy of CMS's proper payment of Medicare benefits, and to investigate potential fraud, waste, or abuse.

4. National Claims History (NCH), System No. 09-70-0558, last published in full at 71 FR 67137 (11/20/06), and partially updated at 76 FR 65196 (10/20/11), 78 FR 23938 (4/23/13), 78 FR 32257 (5/29/13), and 83 FR 6591 (2/14/18). Routine use numbers 2a and 10 authorize disclosure to VHA to contribute to the accuracy of CMS's proper payment of Medicare benefits, and to investigate potential fraud, waste, or abuse.

VHA will disclose data to CMS retrieved from these systems of records by VHA beneficiary identifiers:

5. SOR 147VA10, entitled "Enrollment and Eligibility Record-VA," last published at 86 FR 46090 (August 17, 2021), routine use number 12. This routine use authorizes disclosures to federal agencies for purposes of preventing and detecting possible fraud or abuse by individuals in their operations and programs.

6. SOR 23VA10NB3, entitled "Non-VA Care (Fee) Records," last published at 80 FR 45590 (July 30, 2015), routine use numbers 12 and 30. Routine use 12 authorizes disclosures to CMS for its use in identifying potential duplicate payments for healthcare services paid by VA and CMS. Routine use 30 authorizes disclosure to assist in preventing and detecting possible fraud or abuse by individuals in federal programs.

B. Number of Records Involved

The data extract (i.e., finder file) that VHA provides to CMS initially will contain approximately 12 million VHA enrolled beneficiaries. Subsequent finder files, which VHA will provide on a recurring basis but not more often than monthly, will contain only updates and newly enrolled beneficiaries and are therefore expected to contain fewer records.

Based on other research initiatives, VHA and CMS estimate the initial matched response file that CMS returns to VHA will contain records (with CMS enrollment information appended) for approximately 6 million VHA enrollees who are also Medicare enrolled beneficiaries. Subsequent response files are expected to contain fewer records.

Based on a research pilot, VHA estimates that approximately 5 million claims for the dual enrolled beneficiaries will be disclosed to CMS initially and then approximately 1 million additional claims will be disclosed to CMS monthly. The agencies estimate that, in the initial match, CMS will identify approximately 100 thousand VHA claims that match to CMS' own payment records and will return the matched data to VHA (VHA claims with the CMS claims information appended). Subsequent matches could identify approximately 25 thousand claims.

C. Data Elements Used in the Match

1. Each data extract (finder file) that VHA provides to CMS will contain the following identifying information required to match VHA enrollment records with CMS enrollment records; and each Response File that CMS sends back to VHA will contain the following information identifying the dual enrolled beneficiaries. See Attachment B for a more detailed list of data elements.

VHA Beneficiary Finder File Data:

a. Transaction type: Add or Update
b. SSN
c. Medicare Claim Number (if available)
d. Date of Birth
e. Beneficiary First Name
f. Beneficiary Last Name
g. Beneficiary Sex
h. Enrollment Category (Enrolled or Not Enrolled)
i. Enrollment Status
j. Enrollment time frames: effective date and/or, when applicable, end date
k. Date of death (if applicable)

CMS Response File Data:

a. Action type: Add/Update/Delete Record
b. SSN
c. MBI
d. Date of Birth
e. Beneficiary First Name
f. Beneficiary Last Name
g. Beneficiary Sex code
h. Medicare Enrollment time frames: Effective and termination dates
i. Medicare and VHA Dual enrollment timeframes: Effective and termination dates
j. Date of death

2. Based on the results in each response file, identifying the beneficiaries who are dual enrolled, VHA will provide CMS with a file containing medical claims VHA paid in full or in part for those dual enrolled beneficiaries. CMS will match the records to its own claims and payment systems and return to VHA a response file containing matched claims (claims that CMS paid in full or in part for the same services), with CMS information appended to the claims data VHA provided. See Attachment "B" for a detailed list of data elements.

VHA Claims File Data Fields:

a. Patient Information from Matched Beneficiary File (e.g., SSN, Date of Birth, Name, Sex)
b. Claim Identification Fields (e.g., Claim Number, Claim Line)
c. Service Identification Fields (e.g., Service Date, Type, Place)
d. Additional Claim Relevant Identification Fields (e.g., Revenue Codes)
e. Billing Provider Identification Fields (e.g., Name, National Provider Identification number).

f. Additional Relevant Provider Identification Fields (e.g., Rendering Provider, Attending Provider)
g. Procedure Codes and Modifiers
h. Diagnosis Codes and Qualifiers
i. Payment Identification Fields (e.g., Date, Amount, Units, Payment Authority)

CMS Claims File Data Fields that are Added to the VA File for Matched Claims:

a. Patient Information from Matched Beneficiary File (e.g., SSN, Date of Birth, Name, Sex)
b. Claim Identification Fields (e.g., Claim Number, Claim Line)
c. Service Identification Fields (e.g., Service Date, Type, Place)
d. Additional Claim Relevant Identification Fields (e.g., Revenue Codes)
e. Billing Provider Identification Fields (e.g., Name, National Provider Identification number).
f. Additional Relevant Provider Identification Fields (e.g., Rendering Provider, Attending Provider)
g. Procedure Codes and Modifiers
h. Diagnosis Codes and Qualifiers
i. Payment Identification Fields (e.g., Date, Amount, Units)

D. Frequency of Data Exchanges

VHA and CMS anticipate initiating a new match on a recurring basis but not more often than monthly. Due to the multiple stages of the matching program, each match may take several months to fully complete.

E. Projected Starting and Completion Dates of the Matching Program

Effective Date – June 24, 2024

Expiration Date – December 23, 2025 (December 23, 2026, if renewed for 1 year)

V. NOTICE PROCEDURES

A. Direct Notice

1. Beneficiaries

As part of the Medicare enrollment process, CMS informs Medicare eligible individuals that CMS may conduct matching programs with their data.

VHA informs VHA enrollees on Form 10-10EZ, Application for Health Benefits that their data may be used in matching programs.

2. Providers and Suppliers

CMS and VA are not required by the Privacy Act to notify individual providers and suppliers of this matching program, because the data about them that will be used to conduct the matches and to take any actions affecting them will be retrieved only by beneficiary identifiers. Nevertheless, CMS notifies Medicare providers and suppliers that their information may be used in matching programs, by means of a Privacy Act statement on the following enrollment forms:

- CMS-855A Medicare Enrollment Application for Institutional Providers
- CMS-855B Medicare Enrollment Application for Clinics, Group Practices, and Certain Other Suppliers
- CMS-855I Medicare Enrollment Application for Physicians and Non-Physician Practitioners
- CMS-855R Medicare Enrollment Application for Reassignment of Medicare Benefits
- CMS-855O Medicare Enrollment Application for Eligible Ordering and Referring Physicians and Non-physician Practitioners
- CMS-855S Medicare Enrollment Application for Durable Medical
- CMS-20134 Medicare Enrollment Application for Medicare Diabetes Prevention Program (MDPP) Suppliers

B. Constructive Notice

CMS will also publish notice of this matching program in the Federal Register as required by the Privacy Act (5 U.S.C. § 552a (e)(12)), which will provide constructive notice to beneficiaries and providers.

VI. VERIFICATION PROCEDURES AND OPPORTUNITY TO CONTEST FINDINGS

These procedures are based on provisions in the Privacy Act at 5 U.S.C. § 552a(p) which do not technically apply to this matching program, because the only Privacy Act records that will be used in the matching program are records about beneficiaries, retrieved by beneficiary identifiers, and the actions that will be taken based on those records will affect only providers and suppliers.

A. Verification Procedures

CMS and VHA will verify information obtained under this Agreement prior to initiating any action against a provider or supplier and will reexamine all matches by comparing applicable data elements and will take steps to verify the provider's or supplier's identity using CMS' National Plan and Provider Enumeration System (NPPES).

B. Opportunity to Contest Findings

CMS and the VHA will recover duplicate payments from their providers through established processes. CMS and VHA will verify any adverse information. Once the information is verified, the agencies will issue the provider a bill of collection or demand notice, if applicable, or an offset to the provider remittance advice, or any other device(s) either agency utilizes to recover its payment, and an opportunity to contest if the provider is disputing the recovery.

The affected individuals (i.e., solo practitioner providers) will have at least 30 days to respond to a notice of adverse action unless a statute or regulation provides a different period of time. See 5 U.S.C. § 552a(p)(1)(C) and guidance on notice and opportunity to contest in Final Guidance Interpreting the Provisions of Pub. L. 100-503, the Computer Matching and Privacy Protection Act of 1988, 54 FR 25818, 25827 (June 19, 1989).

VII. DISPOSITION OF MATCHED ITEMS

These procedures are required by the Privacy Act at 5 U.S.C. § 552a(o)(l)(F), (H), and (I).

In accordance with the CMS Records Schedule Bucket 6 - Provider and Health Plan Records, CMS will dispose of data finder files no sooner than 7 year(s) after cutoff, but longer retention is authorized. VHA will dispose of data finder files in accordance with VHA Records Control Schedule 10-1, which authorizes retention of non-record keeping copies (those retained for reference only) of electronic records if required for business use. VHA will dispose of the finder files when no longer required for reference, and no later than 7 years after they are received from CMS. VHA will not create permanent files, or a separate system comprised solely of the CMS data outside the stated purposes of this agreement.

VIII. SECURITY PROCEDURES

VHA and CMS will comply with the requirements of the Federal Information Security Management Act (FISMA), 44 U.S.C. Chapter 35, Subchapter II, as amended by the Federal Information Security Modernization Act of 2014 (Pub. L. 113-283), codified at 44 U.S.C. §§ 3551 et. seq; related OMB circulars and memoranda, such as Circular No. A–130, Managing Federal Information as a Strategic Resource (July 28, 2016), and Memorandum M-17-12 Preparing for and Responding to a Breach of Personally Identifiable Information (January 3, 2017); National Institute of Standards and Technology (NIST) standards; and the Federal Acquisition Regulations, including any applicable amendments published after the effective date of this Agreement. These laws, directives, and regulations include requirements for safeguarding Federal information systems and personally identifiable information (PII) used in Federal agency business processes, as well as related reporting requirements. Both agencies recognize, and will implement, the laws, regulations, NIST standards, and OMB directives, including those published after the effective date of this Agreement.

FISMA requirements apply to all Federal contractors, organizations, or entities that possess or use Federal information, or that operate, use, or have access to Federal information systems on behalf of an agency. Each agency is responsible for oversight and compliance of its contractors and agents.

A. Incident Reporting

If either VHA or CMS experiences an incident involving the loss or breach of PII provided by VHA or CMS under the terms of this Agreement, it will follow the incident reporting guidelines issued by OMB. In the event of a reportable incident under OMB guidance involving PII, the agency experiencing the incident is responsible for following its established procedures, including notification to the proper organizations (e.g., United States Computer Emergency Readiness Team, the agency's privacy office). In addition, the agency experiencing the incident (e.g., electronic or paper) will notify the other agency's Systems Security Contact named in this Agreement. If CMS is unable to speak with the VHA Systems Security Contact within one hour or if for some other reason notifying the VHA Systems Security Contact is not practicable (e.g., it is outside of the normal business hours), CMS will call VHA's National Network Service Center toll free at 1-877-697-4889. If VHA is unable to speak with CMS's Systems Security Contact within one hour, VHA will contact CMS IT Service Desk at (800) 562-1963 or email CMS_IT_Service_Desk@cms.hhs.gov.

B. Breach Notification

VHA and CMS will follow PII breach notification policies and related procedures issued by OMB. If the agency that experienced the breach determines that the risk of harm requires notification to affected individuals or other remedies, that agency will carry out those remedies without cost to the other agency.

C. Administrative Safeguards

VHA and CMS will restrict access to the data matched and to any data created by the match to only those users (e.g., employees, contractors, etc.) who need it to perform their official duties in connection with the uses of the data authorized in this Agreement. Further, VHA and CMS will advise all personnel who have access to the data matched and to any data created by the match of the confidential nature of the data, the safeguards required to protect the data, and the civil and criminal sanctions for noncompliance contained in the applicable Federal laws.

D. Physical Safeguards

VHA and CMS will store the data matched and any data created by the match in an area that is always physically secure and technologically secure from access by

unauthorized persons (e.g., door locks, card keys, biometric identifiers, etc.). Only authorized personnel will access data created by the match.

E. Technical Safeguards

VHA and CMS will process the data matched and any data created by the match under the immediate supervision and control of authorized personnel in a manner that protects the confidentiality of the data, so that unauthorized persons cannot retrieve any data by computer, remote terminal, or other means.

Authorized users must use two factor authentication when accessing agency systems where data is stored. VHA will strictly limit authorization to those electronic files necessary for the authorized analyst to perform his or her official duties. All data in transit will be encrypted using algorithms that meet the requirements of Federal Information Processing Standards (FIPS) 140-2.

F. Security Assessments

NIST Special Publication 800-37, as revised, encourages agencies to accept each other's security assessments in order to reuse information system resources and/or to accept each other's assessed security posture in order to share information. NIST 800-37 further encourages that this type of reciprocity is best achieved when agencies are transparent and make available sufficient evidence regarding the security state of an information system so that an authorizing official from another organization can use that evidence to make credible, risk-based decisions regarding the operation and use of that system or the information it processes, stores, or transmits. Consistent with that guidance, the parties agree to make available to each other upon request system security evidence for the purpose of making risk-based decisions. Requests for this information may be made by either party at any time throughout the duration or any extension of this Agreement.

IX. RECORDS USAGE, DUPLICATION AND REDISCLOSURE RESTRICTIONS

A. Records Usage

CMS will update its IT systems with the VHA beneficiary data and claims data provided in VA's finder files, which VA provides for purposes of identifying dual enrolled beneficiaries and duplicate claims payments for recovery.

VHA will update its IT systems with CMS beneficiary data, which is provided by CMS for the purpose of identifying medical claims for the population of dual enrolled beneficiaries. VHA will not add the matched claims data from CMS to a system of records and will use it only to identify claims for which VHA's payment to the provider or supplier was erroneous and to conduct recovery activities.

CMS and VHA will comply with the following limitations on use, duplication, and disclosure of the electronic files exchanged in this matching program, and data provided by the other Party under this Agreement that is not incorporated in the Party's Privacy Act system of records (the Data).

CMS and VHA will not use or disclose the Data for any purpose other than the purposes authorized by this Agreement or required under applicable Federal law, without the consent of the other party.

B. Duplication

CMS will not create permanent files, or a separate system comprised solely of the VHA data outside the stated purposes of this agreement.

CMS and VHA will not duplicate or disseminate the other Party's Data, within or outside their respective agencies, without the written consent of the other party, except as required by Federal law or for purposes under this Agreement.

C. Redisclosure Restrictions

The VHA and CMS beneficiary and claims finder files, will not be redisclosed for any purposes other than what is stated in this Agreement. Any request for the finder files will be referred to the originating Party.

X. RECORDS ACCURACY ASSESSMENTS

CMS and VHA estimate that at least 99 percent of the information in the systems of records cited in Section VI.A. are accurate, based on their operational experience.

XI. COMPTROLLER GENERAL ACCESS

The Government Accountability Office (Comptroller General) may have access to all VHA and CMS data it deems necessary in order to monitor or verify compliance with this Agreement.

XII. REIMBURSEMENT/FUNDING

CMS and VHA both benefit from the detection of duplicative payments for same service. Therefore, each Party will be responsible for all expenses it may incur in connection with the preparation, negotiation, and execution of this Agreement and performance of the activities described in the Agreement.

XIII. DURATION OF AGREEEMENT

A. Effective Date:

The Effective Date of this Agreement is June 24, 2024, provided that CMS reported the proposal to establish this matching program to the Congressional committees of jurisdiction and OMB in accordance with 5 U.S.C. § 552a(o)(2)(A) and (r) and OMB Circular A-108 and, upon completion of OMB's advance review, CMS published notice of the matching program in the Federal Register for at least thirty days (30) in accordance with 5 U.S.C. § 552a(e)(12).

B. Term: The term of this Agreement will be eighteen (18) months.

C. Renewal: The parties may, within three (3) months prior to the expiration of this Agreement, renew this Agreement for a period not to exceed one additional year if CMS and VHA certify the following to the HHS and VA Data Integrity Boards (DIBs):

1. The matching program will be conducted without change; and

2. The parties have conducted the matching program in compliance with this Agreement.

D. Modification: The parties may modify this Agreement at any time by a written modification, mutually agreed to by both parties, provided that the change is not significant. A significant change would require a new agreement.

E. Termination: This Agreement may be terminated at any time upon the mutual written consent of the parties. Either party may unilaterally terminate this Agreement upon written notice to the other party, in which case the termination will be effective ninety (90) days after the date of the notice, or at a later date specified in the notice.

XIV. LIABILITY

Each party to this agreement shall be liable for acts and omissions of its own employees.

XV. INTEGRATON CLAUSE

This Agreement constitutes the entire Agreement of the parties with respect to its subject matter and supersedes all other data exchange Agreements between the parties that pertain to the disclosure of the specified beneficiary and claims data between CMS and VHA for the purposes described in this Agreement. CMS and VHA have made no representations, warranties, or promises outside of this Agreement. This Agreement takes precedence over any other documents that may conflict with it.

XVI. PERSONS TO CONTACT

a. CMS Contacts

Program Issues
Richard Mazur
CMS Technical Adviser
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Murari Selvakesavan
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Office of Information Technology
Enterprise Architecture and Data Group
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Jim Brogan
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b. VA Contacts

Program Issues
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Associate Director, Program Integrity Office
Office of Business Oversight
Department of Veterans Affairs
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Austin, Texas 78772
Telephone: (512) 673-8960
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Privacy and Agreement Issues
Stephania Griffin
Director, Information Access, and Privacy Office
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Security Issues

Anthony McFarlane
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Office of Information and Technology, Office of Information Security
Information Security Operations, Enterprise Security Operations
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Ashton Botts
Information System Security Officer, Health Administration Center
Office of Information and Technology, Office of Information Security
Information Security Operations, Enterprise Security Operations
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Email: Ashton.Botts@va.gov

XVII. APPROVALS

A. Department of Veterans Affairs – Office of Management Approving Official

The signatories below warrant and represent that they have competent authority on behalf of their respective agencies to enter into the obligations set forth in this Agreement.

Electronic Signature Acknowledge: The signatories may sign this document electronically by using an approved electronic signature process. Each signatory electronically signing this document agrees that his/her electronic signature has the same legal validity and effect as his/her handwritten signature on the document, and that it has the same meaning as his/her handwritten signature.

Approved by (Signature of Authorized VA Approving Official)

Margaret E Drye Digitally signed by MARGARET DRYE Date: 2023.11.28 09:32:19 -06'00'

Maggie Drye
Deputy Executive Director, Office of Business Oversight
Office of Management
Department of Veterans Affairs

B. Department of Veteran Affairs – Veterans Health Administration Approving Official

The signatories below warrant and represent that they have competent authority on behalf of their respective agencies to enter into the obligations set forth in this Agreement.

Electronic Signature Acknowledge: The signatories may sign this document electronically by using an approved electronic signature process. Each signatory electronically signing this document agrees that his/her electronic signature has the same legal validity and effect as his/her handwritten signature on the document, and that it has the same meaning as his/her handwritten signature.

Approved by (Signature of Authorized VA Approving Official)

STEVEN LIEBERMAN
Digitally signed by STEVEN LIEBERMAN
Date: 2023.12.30 11:02:11 -05'00'

Steven L. Lieberman, M.D.
Deputy Under Secretary for Health
Veterans Health Administration
Department of Veterans Affairs

C. Centers for Medicare & Medicaid Services Program Officials

Electronic Signature Acknowledgement: The signatories may sign this document electronically by using an approved electronic signature process. Each signatory who electronically signs this renewal agrees that his/her electronic signature has the same legal validity and effect as his/her handwritten signature on the document, and that it has the same meaning as his/her handwritten signature.

The authorized program official, whose signatures appear below, accept, and expressly agree to the terms and conditions expressed herein, confirm that no verbal agreements of any kind shall be binding or recognized, and hereby commit their respective organizations to the terms of this Agreement.

Approved by (Signature of Authorized CMS Program Official)

Olivia L. Williams -S

Digitally signed by Olivia L. Williams -S
Date: 2023.11.21 17:20:35 -05'00'

Olivia Williams
Director
Financial Services Group
Office of Financial Management
Centers for Medicare and Medicaid Services

D. Centers for Medicare & Medicaid Services Approving Officials

Electronic Signature Acknowledgement: The signatories may sign this document electronically by using an approved electronic signature process. Each signatory who electronically signs this renewal agrees that his/her electronic signature has the same legal validity and effect as his/her handwritten signature on the document, and that it has the same meaning as his/her handwritten signature.

The authorized approving official, whose signatures appear below, accept, and expressly agree to the terms and conditions expressed herein, confirm that no verbal agreements of any kind shall be binding or recognized, and hereby commit their respective organizations to the terms of this Agreement.

Approved by (Signature of Authorized CMS Approving Official)

Leslie Nettles -S

Digitally signed by Leslie Nettles -S
Date: 2023.11.27 09:35:27 -05'00'

Leslie Nettles, Acting Director
Division of Security, Privacy Policy, and Oversight, and
Senior Official for Privacy
Information Security Privacy Group
Office of Information Technology
Centers for Medicare & Medicaid Services

E. U.S. Department of Veterans Affairs – VA Data Integrity Board

The authorized DIB official, whose signature appears below, accepts, and expressly agrees to the terms and conditions expressed herein, confirms that no verbal agreements of any kind shall be binding or recognized, and hereby commits their respective organization to the terms of this Agreement.

VA Data Integrity Board has reviewed and approved this Computer Matching Agreement and has found it to comply with the Privacy Act of 1974, as amended (5 U.S.C. § 552a).

Approved by

JOHN OSWALT
JOHN OSWALT
2024.02.05
09:51:08 -05'00'

John Oswalt
Chair, Data Integrity Board
Department of Veterans Affairs

F. U.S. Department of Health & Human Services Data Integrity Board

The authorized DIB official, whose signature appears below, accepts, and expressly agrees to the terms and conditions expressed herein, confirms that no verbal agreements of any kind shall be binding or recognized, and hereby commits their respective organization to the terms of this Agreement.

HHS Data Integrity Board has reviewed and approved this Computer Matching Agreement and has found it to comply with the Privacy Act of 1974, as amended (5 U.S.C. § 552a).

Approved by

Cheryl R. Campbell -S

Digitally signed by Cheryl R. Campbell -S
Date: 2024.03.04 19:15:24 -05'00'

Cheryl R. Campbell
Chairperson
Data Integrity Board
Department of Health and Human Services

Attachments:
A – Cost Benefit Analysis (CBA)
B – VHA File Layout & CMS Response File Layout

Attachment A

Cost Benefit Analysis for the Matching Program (#2023-64) Between the Department of Veterans Affairs (VA) and Veterans Health Administration (VHA) and the Centers for Medicare and Medicaid Services (CMS) for Identification and Recovery of Duplicate Payments for Medical Claims

This cost benefit analysis (CBA) provides information about the expected costs and benefits of conducting this matching program, the purpose of which is to enable CMS and VHA to identify and recover, and avoid future, duplicate payments made to providers on claims for the same health care services rendered to beneficiaries dual-enrolled in VHA health care and Medicare. The four key elements of the CBA demonstrate that the matching program is likely to be cost effective, i.e., that it will avoid and recover improper payments totaling more than $45 million in the first 12-months, at a cost of approximately $6.3 million, resulting in savings of approximately $38 million per year, which will increase public trust in VHA and CMS as stewards of taxpayer dollars. In addition to seeking recoveries from providers who submitted duplicate claims, the agencies will educate those providers to help reduce the number of duplicative claims submitted to VHA and CMS in the future.

I. Match Objective

Under this matching program, CMS and VHA will first identify the VHA enrolled beneficiaries who are also enrolled as Medicare beneficiaries, and then identify whether VHA and CMS made duplicate payments for the same health care services for these individuals. Any claims where the VHA made payment under 38 U.S.C. § 1725 (The Millennium Bill) will be recovered by the VHA.

All other claims where CMS made payment for services authorized and paid for by the VHA will be recovered by CMS in accordance with the Medicare recovery laws and statutes. The Social Security Act at section 1862(a)(3) (42 U.S.C. § 1395y(a)(3)) precludes Medicare from making payment for services or items that are paid for directly or indirectly by another government entity.

II. Background Considerations and Methodology

Without this matching program, VHA and CMS would be unable to efficiently identify dual enrolled beneficiaries and duplicate claims paid by VHA and Medicare for the same healthcare services.

This CBA used calendar year 2019 claims data to estimate the number and dollar value of claims for which VHA and Medicare made duplicate payment. For this one year alone, CMS made over $42.5 million dollars of duplicate payments for the same services for which VHA also made payment. CMS and the VHA are confident that overpayments were also made by both agencies for years prior to and after the 2019 calendar year, since no relevant factors existed that were unique to that year.

Matching program costs for CMS will be primarily labor, upstart, and annual maintenance to perform data programming, matching, review/adjudication of results, and recovery of funds. The costs for VA will primarily consist of staff resources for extracting data and reviewing/adjudicating results, with the addition of some computer costs for transmitting data. Costs for both agencies are categorized below as personnel costs and computer costs. Although this is a new matching program, and therefore the quantified costs and benefits are only estimates, CMS and VHA strongly believe that the benefits will significantly outweigh the costs to CMS and VHA.

III. Costs

Key Element 1: Personnel Costs

1. **For Agencies –**

   a. Source Agency (VHA): VHA will incur costs for staff labor. For staff extracting and preparing finder files, VHA estimates 148 hours of work and used the 2023 OPM payment schedule for GS 13, Step 5 in the Rest of the US geographic locality area, which has an hourly wage of $106.98 ($53.49 rate plus fringe). These personnel costs are estimated to be $15,833.04 (148 hours x $106.98 = $15,833.04).

   VHA staff will also spend an estimated 3,010 hours processing bills of collection to recoup duplicate payments. VHA used the 2023 OPM payment schedule for GS 11, Step 5 in the Austin-Round Rock, TX geographic locality area, which has an hourly wage of $76.92 ($38.46 rate plus fringe). These personnel costs are estimated to be $231,529.20 (3,010 hours x $76.92 = $231,529.20). VHA's total estimated personnel costs are **$247,362.24** ($15,833.04 + $231,529.20 = $247,362.24).

   b. Recipient Agency (CMS): CMS will incur costs for data matching along with Staff performing the work will include employees predominately located in the Washington-Baltimore-Arlington, DC-MD-VA-WV-PA geographic locality. CMS used estimates based on 2023 OPM payment schedules. The Washington-Baltimore-Arlington, DC-MD-VA-WV-PA geographic locality, hourly rates used in CMS' estimation for a GS-14, Step 10 is $82.45 ($164.90 rate plus fringe).

   CMS OFM staff will spend an estimated 780 administrative hours per 12-month period for a GS-14, to assist in preparing the CMA process between the VHA and CMS. CMS OFM estimates that total personnel costs for this data matching will be **$128,622** (780 hours x $164.90 = $128,622).

   c. Justice Agencies (Treasury/DOJ): N/A. VHA and CMS do not anticipate any personnel costs for Justice Agencies as part of this matching program.

2. **For Clients –**

N/A.

3. **For Third Parties –**

   Costs are not quantified, but are not likely to be significant.

   VHA and CMS anticipate that providers from whom recoveries are sought will need to expend time and resources to respond to bills of collection issued by VHA and CMS as a result of this matching program. However, providers are currently subject to bills of collection that arise from existing operational activities, so they already have mechanisms in place to perform necessary activities to process or respond to bills of collection. We cannot reasonably estimate the increased cost resulting from additional bills of collection resulting from this matching program.

4. **For the General Public –**

   N/A.

Key Element 2: Agencies' Computer Costs

1. **Source Agency (VHA):** VHA estimates it will incur **$18,900** in computer costs for increased storage and processing capacity and building and maintaining file transfer protocols to conduct the matching program. VHA computer costs are minimal because VHA personnel will extract and prepare the data to be matched, which costs are included in VHA personnel costs outlined in Key Element 1, above. Additionally, VHA does not require any additional tools or software or modification of IT systems to conduct this matching program.

2. **Recipient Agency (CMS):** CMS development costs will be incurred by OIT (for transmission and storage of beneficiary and claim data) and OFM (for coordination of benefits to match beneficiaries and claims, as well as duplicate claim payment recovery).

   CMS/OIT's anticipated first-year computer costs to store the VHA claims data in the IDR and subsequent per year cost for continued operations and maintenance are listed below. No additional tools, software, or processing capacity will be required. Further, there are no facility costs or other direct tangible item costs for this matching program.

   OFM will use the Medicare Secondary Payer Systems Contract (MSPSC) to develop matching and recovery functions. There are no anticipated computer costs for the MSPSC as the MSPC's current inhouse systems are sufficient to extract any applicable beneficiary eligibility and provider claims data. MSPSC costs are maintenance and development costs identified below."

   - $3,000,000 CMS OIT initial development costs
   - $400,000 CMS OIT continued operations and maintenance

- $2,285,140 MSPSC initial development costs
- $250,000 MSPSC continued operations and maintenance

The total estimate of CMS computer costs is **$5,935,140**.

3. **Justice Agencies (Treasury/DOJ):** N/A, for the same reason stated under Key Element 1.

IV. Benefits

Key Element 3: Avoidance of Future Overpayments –

Through this matching program, VHA and CMS will educate those providers who summitted duplicate claims for the same service, to help reduce the number of duplicative claims submitted to VHA and CMS for the same health care services. The agencies cannot estimate the dollar value of avoided future duplicate payments.

Key Element 4: Recovery of Overpayments and Debts –

1. VHA estimates recoveries of $2.5 million in the first 12 months that the matching program is operational.

2. CMS estimates recovering $42.5 million in duplicate payments in the first 12 months that the matching program is operational. Recoveries will start with FY 2019 going forward, computer matching program will be cost effective for each agency individually as well as the Federal Government in total because the estimated benefits outweigh the estimated costs, as depicted in Chart 1.

Chart 1: Summary of Benefits and Costs for 12 Month Matching Period

Benefits

Recovery of Overpayments and Debts	
VHA	$2,500,000
CMS	$42,500,000
Estimated VHA and CMS Total Benefits:	**$45,000,000**

Costs

Personnel Costs	
VHA	$247,362
CMS	$128,622
Justice Agencies	$0
Clients	$0
Third Parties	$0

General Public	$0
Total Personnel Costs	**$375,984**

Computer Costs	
VHA	$18,900
CMS - $3M start-up costs and $400,000 annually	$3,400,000
CMS - Start-up 2,285,140, Yearly O&M 250,000	$2,535,140
Total Computer Costs	**$5,954,040**

Estimated VHA and CMS Total Costs:	**$6,330,024**
Net Benefit of the Matching Program:	**$38,669,976**

Signatory Authority

Margaret L Dyc
Digitally signed by MARGARET DRYE
Date: 2023.11.28 09:38:39 -06'00'

Maggie Drye
Deputy Executive Director
Office of Business Oversight
Department of Veterans Affairs

Approve/Disapprove

JON RYCHALSKI
Digitally signed by JON RYCHALSKI
Date: 2023.12.04 12:58:13 -05'00'

Jon J. Rychalski
Assistant Secretary for Management and
Chief Financial Officer
Department of Veterans Affairs

Attachment B

1. VHA Beneficiary Finder File

VHA will send a file of all its Veteran beneficiaries enrolled in VHA healthcare to CMS with the following data elements.

A. Transaction Type
B. Social Security Number (SSN)
C. VHA Beneficiary Identifier
D. Medicare Beneficiary Identifier (MBI or HIC)
E. Beneficiary Date of Birth
F. Beneficiary Date of Death
G. Beneficiary First Name
H. Beneficiary Last Name
I. Birth Sex Code
J. VHA Enrollment Effective Date
K. VHA Enrollment End Date

2. CMS Beneficiary Response file –

CMS will match the VHA beneficiary finder file to the Medicare enrolled beneficiaries (Part A and B), identifying the dual enrolled beneficiaries. CMS will create a beneficiary response file of the matched beneficiaries and send to VHA with the following data elements.

Data Fields from VHA File:

A. Transaction Type
B. Social Security Number (SSN)
C. VHA Beneficiary Identifier
D. Medicare Beneficiary Identifier (MBI)
E. Beneficiary Date of Birth
F. Beneficiary Date of Death
G. Beneficiary First Name
H. Beneficiary Last Name
I. Beneficiary Sex code
J. VHA Enrollment Effective Date
K. VHA Enrollment End Date

Additional CMS Response Items:

L. Medicare Health Insurance Claim Number (HICN)
M. Beneficiary Date of Birth
N. Beneficiary Date of Death
O. Beneficiary First Name
P. Beneficiary Last Name

Q. Beneficiary Sex code
R. Current Part A Effective Date
S. Current Part A Termination Date
T. Current Part B Effective Date
U. Current Part B Termination Date
V. Response Code 1
W. Response Code 2
X. Response Code 3
Y. Response Code 4

3. VHA Claim File Data Elements

VHA will match the CMS provided beneficiary response file to VHA medical claims and will extract all claims where VHA made payment for the matched beneficiaries. VHA will send the match claims file to CMS with the following data elements.

Data Fields from Matched Beneficiary Response File:

A. Social Security Number (SSN)
B. VHA Beneficiary Identifier
C. Medicare Beneficiary Identifier (MBI or HIC)
D. Beneficiary Date of Birth
E. Beneficiary Date of Death
F. Beneficiary First Name
G. Beneficiary Last Name
H. Beneficiary Sex code
I. VHA Enrollment Effective Date
J. VHA Enrollment End Date

VHA Claims Data Added to Response File:

K. Community Care Claim ID
L. Claims Processing System
M. Payment Authority
N. Billing Provider (NPI, TIN, Name, Address)
0. Rendering Provider Information (NPI, Name, Address)
P. Operating Provider Information (NPI, Name, Address)
Q. Attending Provider Information (NPI, Name, Address)
R. Service Facility/ Organizational Provider (NPI, Name, Address)
S. Referring Provider (NPI, Name, Address)
T. Claim Dates of Service From Date
U. Claim Dates of Service To Date
V. Admission Date
W. Discharge Date
X. Total Claim Charge Amount
Y. Claim Payment Amount

Z. Diagnosis Codes
AA. Facility Type Code (Bill Type)
BB. Line-Item Dates of Service
CC. Line-Item Charge Amount
DD. Line-Item Provider Payment Amount
EE. Service Line Number
FF. Service Line Revenue Code
GG. Procedure Codes (HCPCS)
HH. Procedure Modifiers
II. Units of Service Billed
JJ. National Drug Code (NDC)
KK. Type of Service Code
LL. Place of Service Code
MM. Mammography Certification Number
NN. Clinical Laboratory Improvement Amendment (CLIA) Number

CMS Claim Response File

CMS will receive the VHA claims file identifying where VHA made payment for services and will match the VHA claims to Medicare claims payments made for the same services.
CMS will send a duplicative claim payment response file to VHA identifying those claims for which Medicare has made payment. This file represents duplicate claims for which both VHA and CMS made payment. The response file will include the original VHA data fields plus the CMS claims data fields that were used to confirm a positive match against the VHA claims data, as well as CMS remittance dates, claim numbers, claim paid amounts, and any relevant claims payment information.