

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**THE MEDICARE-MEDICAID
(MEDI-MEDI) DATA MATCH
PROGRAM**



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EXECUTIVE SUMMARY: THE MEDICARE-MEDICAID (MEDI-MEDI) DATA MATCH PROGRAM
OEI-09-08-00370

WHY WE DID THIS STUDY

The Medicare-Medicaid Data Match program (Medi-Medi program) enables program safeguard contractors (PSC) and participating State and Federal Government agencies to collaboratively analyze billing trends across the Medicare and Medicaid programs to identify potential fraud, waste, and abuse. Participation is optional. The Social Security Act mandates that the Medi-Medi program increase the effectiveness and efficiency of the Medicare and Medicaid programs through cost avoidance (i.e., prepayment denials); savings; and recoupment of fraudulent, wasteful, or abusive expenditures.

HOW WE DID THIS STUDY

We analyzed data collected from the Centers for Medicare & Medicaid Services (CMS), PSCs, State Medicaid program integrity agencies, and other Federal and State agencies participating in the Medi-Medi program. The period of our review was 2007 and 2008.

WHAT WE FOUND

The Medi-Medi program produced limited results and few fraud referrals. During 2007 and 2008, the program—in which 10 States had chosen to participate—received \$60 million in appropriations and it avoided and recouped \$57.8 million. The program produced 66 referrals to law enforcement, and law enforcement accepted 27 of these. Among the 10 participating States collectively, each State averaged 2.8 Medicare referrals to law enforcement per year; law enforcement accepted an average of 1.15 referrals per State per year. In comparison, each State averaged 0.5 Medicaid referrals to law enforcement per year; law enforcement accepted an average of 0.2 referrals per State per year. Also, State Medicaid programs received less benefit from the Medi-Medi program than Medicare received. Of the \$46.2 million total in Medicare and Medicaid expenditures recouped through the program during 2007 and 2008, more than three-quarters—\$34.9 million—was recouped for Medicare.

WHAT WE RECOMMEND

We recommend that CMS reevaluate the goals, structure, and operations of the Medi-Medi program to determine what aspect of the program, if any, should be part of CMS's overall program integrity strategy. CMS concurred with our recommendation. CMS commented that since the period of our review, it has made significant strides in enhancing the effectiveness of the Medi-Medi program. However, since our period of review, CMS has not provided any data to illustrate enhanced effectiveness, such as the number of referrals, accepted referrals, and the actual—not potential—Medicare and Medicaid expenditures avoided and recouped through the program. These data would enable Congress to make an informed decision whether to continue funding the program and enable State and Federal agencies to make an informed decision whether to participate.

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OBJECTIVES

To determine:

1. Whether program safeguard contractors (PSC) performed the required tasks for the Medicare-Medicaid Data Match program (Medi-Medi program).
2. To what extent the Medi-Medi program identified fraud, waste, and abuse.

BACKGROUND

Medicare-Medicaid Data Match Program

The Medi-Medi program enables PSCs and participating State and Federal Government agencies to collaboratively analyze billing trends across the Medicare and Medicaid programs to identify potential fraud, waste, and abuse. The PSCs' primary goal with regard to the Medi-Medi program is to identify cases of suspected fraud and take immediate action to ensure that monies are not inappropriately paid out and that any inappropriate payments are recouped.¹ The purpose of analyzing Medicare and Medicaid claims data collectively is to detect aberrant billing patterns that may not be evident when analyzing the data separately.

Funding for the Medi-Medi program. After the Centers for Medicare & Medicaid Services (CMS) implemented an initial pilot program in one State in 2001, nine additional States opted to participate.² Between fiscal years (FY) 2001 and 2005, the program received approximately \$30 million in funding from a combination of Health Care Fraud and Abuse Control funds and Federal Bureau of Investigation funds.³ The Deficit Reduction Act (DRA) of 2005 established and funded an expanded Medi-Medi program, appropriating funding on an FY basis starting in 2006. In FY 2006, funding was \$12 million. By FY 2009, funding had increased to \$48 million. Starting in FY 2010 and for each subsequent

¹ CMS, *Medicare Program Integrity Manual*, Pub. 100-08, ch. 4, § 4.2. Accessed at <https://www.cms.gov/manuals/downloads/pim83c04.pdf> on October 25, 2010.

² In 2003, Florida, Illinois, New Jersey, North Carolina, Pennsylvania, and Texas joined the program. In 2004, Ohio and Washington joined, followed in 2005 by New York. CMS, *Medicare-Medicaid Data Match Program (Medi-Medi) Policies and Procedures Manual* (Medi-Medi PPM), August 20, 2007, p. 3.

³ The Health Insurance Portability and Accountability Act of 1996 established a national Health Care Fraud and Abuse Control Program under the joint direction of the Attorney General and the Secretary of Health and Human Services (HHS) (acting through the Inspector General). The program was designed to coordinate Federal, State, and local law enforcement activities with respect to health care fraud and abuse. HHS and Department of Justice, *Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2010*, p. 1. Accessed at <http://oig.hhs.gov/publications/docs/hcfac/hcfacreport2010.pdf> on June 29, 2011.

year, the DRA has funded the program at \$60 million per year.⁴ During the period of our review—2007 and 2008—\$60 million was appropriated to fund the program: \$24 million in 2007 and \$36 million in 2008.⁵

Authorities. Section 1893(g) of the Social Security Act (SSA) sets forth the requirements for conducting the Medi-Medi program.⁶ Section 1893(g) requires that certain program integrity functions be performed. PSCs are expected to perform these functions, which consist of:

- identifying program vulnerabilities by using computer algorithms to look for payment anomalies (including billing or billing patterns identified with respect to service, time, or patients that appear suspect or otherwise implausible);
- working with States, the Attorney General, and the Inspector General of HHS to coordinate actions to protect the Federal and State shares of Medicare and Medicaid expenditures; and
- increasing the effectiveness and efficiency of Medicare and Medicaid through cost avoidance (i.e., prepayment denials); savings; and recoupment of fraudulent, wasteful, or abusive expenditures.

In addition, section 1893(g)(1)(B) of the SSA requires that, no less frequently than quarterly, any data and statistics collected by the Medi-Medi program be made available to the Attorney General, the Director of the Federal Bureau of Investigation, the Inspector General of HHS, and the States (including the Medicaid Fraud Control Units).

Medi-Medi Statement of Work tasks. To address the requirements in section 1893(g) of the SSA, CMS requires PSCs to perform program integrity tasks listed in a Medi-Medi Statement of Work (SOW).⁷ However, in those SOWs, CMS does not impose minimum output standards—national or otherwise—relating to the extent to which PSCs make referrals to Federal or State law enforcement agencies or the amount of fraud, waste, and abuse expenditures avoided or recouped.⁸ For each of the 10 States that participated during 2007 and 2008, CMS awarded a

⁴ P.L. 109-171 § 6034.

⁵ DRA § 6034.

⁶ Section 6034 of the DRA added section 1893 of the SSA, which permanently established the Medi-Medi program at section 1893(g). P.L. 109-171 § 6034.

⁷ The SOW is a contract between CMS and a PSC.

⁸ PSCs are required to submit a monthly status report to CMS identifying the providers being referred to law enforcement and indicating whether those referrals were accepted. However, according to CMS Medicare program integrity staff, the purpose of collecting these data is to provide them upon request to third parties, such as Congress, the Government Accountability Office (GAO), and/or the HHS Office of Inspector General.

SOW to a PSC.⁹ CMS awarded 10 individual SOWs among 8 PSCs. (One PSC was awarded three SOWs.) The SOW is incorporated into each PSC's broader program integrity task order. During 2007 and 2008, 10 SOW tasks were listed:¹⁰

1. Incorporate a project plan that defines the steps and timelines for implementing the Medi-Medi program, including identifying resource needs and responsible parties to complete the implementation steps.
2. Incorporate a detailed information technology plan identifying how the PSC shall receive, store, safeguard, manipulate, and analyze data.
3. Submit to CMS a monthly status report reflecting the PSC's results from the previous month. Among other information, the report must contain information about Medi-Medi program data analysis; providers being referred to law enforcement; the status of those referrals (i.e., whether law enforcement accepts or declines them); outcome of civil or criminal prosecution or administrative action; and the amount of Medicare and/or Medicaid expenditures avoided and recouped.
4. Develop a joint operating agreement with the State Medicaid program integrity agency (and any other necessary parties) to establish guidelines, duties, and shared expectations for the Medi-Medi program.
5. Provide State Medicaid program integrity staff with access to matched Medicare and Medicaid data within 4 months of executing a computer match agreement.
6. Analyze data, including data matching, trending, and statistical activities, to enhance the detection and prevention of Medicare and Medicaid fraud and abuse.
7. Develop and refer potential fraud cases and/or data leads to the appropriate State or Federal law enforcement agencies.

⁹ CMS is transitioning program integrity work from PSCs to Zone Program Integrity Contractors (ZPIC). CMS began awarding contracts to ZPICs in September 2008. However, in 2008, the initial transition process occurred in only two participating States. The chief difference between PSCs and ZPICs is that ZPICs cover broader geographical areas and multiple parts of the Medicare program, whereas PSCs cover more limited areas and scopes.

¹⁰ The tasks listed in the SOW for each PSC vary, but not substantially. This list summarizes the 10 tasks identified in a SOW.

8. *Facilitate a quarterly steering committee*¹¹ with Federal and State agencies participating in the Medi-Medi program, and prepare minutes of those meetings.
9. *Prepare a “lessons learned” report* discussing matching and combining Medicare and Medicaid data.
10. *Perform transition activities*, working closely with ZPICs to ensure that all program integrity activities continue during the transition from PSCs to ZPICs.¹² Such activities include (but are not limited to) transferring medical records, information on investigations and on cases referred to law enforcement, and other data to ZPICs.

During the first year that CMS awarded Medi-Medi SOWs to PSCs, it required them to perform three of these tasks—incorporating a project plan (task #1), incorporating an information technology plan (task #2), and preparing “lessons learned” reports (task #9)—on a one-time basis. Because all of the SOWs were awarded prior to 2007, each PSC performed those three tasks prior to the period of our review. With respect to task #10—performing transition activities—only two ZPICs were officially awarded SOWs during 2008, according to CMS Medicare program integrity staff.¹³ One of these two ZPICs had previously performed tasks under a SOW as a PSC. The other ZPIC had not, so the PSC in that instance was required to perform transition activities. Therefore, during 2007 and 2008, nine PSCs were required to perform six tasks (tasks #3–8) and the remaining PSC was required to perform seven tasks (tasks #3–8 and task #10).

Administration of the Medi-Medi Program

Even though the purpose of the Medi-Medi program is to address vulnerabilities in both Medicare and Medicaid, during 2007 and 2008 the Medi-Medi program was administered solely by CMS Medicare program integrity staff.¹⁴ In February 2010, CMS announced a reorganization. The Medicare integrity program is now administered by the CMS Medicare

¹¹ The actual schedule is determined jointly by the applicable PSC, the State Medicaid program integrity agency, and other participating Federal and State agencies.

¹² According to Medicare program integrity staff, when a PSC under a SOW is subsequently awarded a SOW as a ZPIC, the PSC is not required to perform transition activities. This task is required only when the SOW is awarded to a ZPIC that is an entity different from the preceding PSC.

¹³ Although SOWs were awarded to two ZPICs during 2008, the transition was not completed in 2008. Thus, for our 2007–2008 period of review, only PSCs performed the SOW tasks.

¹⁴ Administering the Medi-Medi program includes, but is not limited to, CMS’s procuring funding to award SOWs to PSCs, providing program guidance, assessing PSCs, entering into contracts with PSCs, and partnering with State Medicaid agencies and other applicable Federal and State law enforcement agencies to facilitate the program. CMS, Medi-Medi PPM. The date of the manual is August 20, 2007.

Program Integrity Group; similarly, the CMS Medicaid integrity program is now administered by the CMS Medicaid Program Integrity Group. Both of these integrity programs fall under the direction of the CMS Center for Program Integrity. Despite the reorganization, the Medi-Medi program remains administered solely by Medicare—specifically, by the CMS Medicare Program Integrity Group. For the purpose of this report, we refer to this entity as “the CMS Medicare program integrity staff,” as that was its name during the period of our review.

CMS Medi-Medi program guidance. The Medi-Medi PPM provides PSCs, State Medicaid program integrity agencies, and Federal and State law enforcement agencies with Medi-Medi program guidance, which includes (but is not limited to) information relating to:

- identifying the roles and responsibilities of PSCs and participating agencies,
- implementing the Medi-Medi program,
- data connectivity and sharing, and
- data matching.

Law enforcement agencies that typically participate in the Medi-Medi program are the Federal Bureau of Investigation, the HHS Office of Inspector General, Medicaid Fraud Control Units, and/or State offices of Attorneys General (the Medi-Medi partners).¹⁵

The Medi-Medi PPM also identifies activities that should be performed by State Medicaid program integrity agencies and Medi-Medi partners. Although PSCs receive a portion of the Medi-Medi appropriations from CMS, States receive no funding to participate and State participation is optional.¹⁶ However, for the States that do participate in the Medi-Medi program, each State’s Medicaid program integrity agency is encouraged to complete certain ongoing activities to benefit the program. These include (but are not limited to) providing Medicaid policy and data assistance, participating in Medi-Medi data work groups, and working on joint investigations.¹⁷

For those Medi-Medi partners that do participate, the Medi-Medi PPM identifies activities that they should perform. They generally include (but

¹⁵ For the purpose of this report, these law enforcement agencies will be individually referred to by their proper names and collectively referred to as the Medi-Medi partners. Although other State and Federal law enforcement agencies may participate, the Medi-Medi partners are the agencies to which PSCs are required to make data and statistics available.

¹⁶ According to Medicare program integrity staff, the remaining appropriations are used for Medi-Medi program expansion, data systems, and a national Medi-Medi coordinator.

¹⁷ CMS, Medi-Medi PPM, pp. 5-6.

are not limited to) participating in the steering committee meetings for the applicable State, receiving referrals, and providing feedback to the meeting attendees about referrals.¹⁸

The *Medicare Program Integrity Manual* also provides PSCs with additional guidance on the Medi-Medi program.¹⁹ The manual identifies PSC program integrity requirements, such as the processes for sharing fraud referrals with Medi-Medi partners.

Assessments of PSCs. PSCs are subject to annual assessments by CMS Medicare program integrity staff.²⁰ In addition, CMS assigns a contract officer's technical representative to assess each PSC's performance.

The 2007 and 2008 *Program Safeguard Contractor (PSC) Performance Evaluation Guidelines* (Evaluation Guidelines) provide guidance for assessing PSCs' performance under the broader program integrity task order, as well as with regard to the tasks applicable to the Medi-Medi SOW. The Evaluation Guidelines provide assessment guidance regarding the following six SOW tasks:

- submitting to CMS a monthly status report (task #3),
- developing a joint operating agreement (task #4),
- providing remote user support and access (task #5),
- performing data analysis (task #6),
- developing and referring potential fraud cases (task #7), and
- facilitating a steering committee (task #8).

The Evaluation Guidelines further require that CMS document its assessment findings in its *PSC BI [Benefit Integrity] Evaluation Control Objectives and Findings Tables* (Findings Tables).²¹

The Findings Tables are an internal CMS document that contains the comprehensive results of each PSC's annual assessment. The document identifies key elements of the required tasks that need to be completed by the PSCs. The Findings Tables contain the review methodology used for rating a PSC's performance, as well as the rating score and assessment findings. The ratings range from "0" (unsatisfactory) to "5" (outstanding). CMS provides the PSC with an oral summary of the ratings and findings.

¹⁸ CMS, Medi-Medi PPM, § 2.

¹⁹ CMS, *Medicare Program Integrity Manual*, Pub. 100-08, ch. 4. Accessed at <https://www.cms.gov/manuals/downloads/pim83c04.pdf> on October 25, 2010.

²⁰ HHS, *Acquisition Policy Memorandum 2009-07*, p. 5.

²¹ CMS, *Program Safeguard Contractor Performance Evaluation Guidelines 2007*, p. 45, and CMS, *Program Safeguard Contractor Performance Evaluation Guidelines 2008*, p. 45.

Pursuant to the Federal Acquisition Regulation, CMS summarizes the results of the Findings Tables in a *Standard Contractor Performance Report* (Performance Report).²² For each assessment of a PSC, CMS submits a summary into the National Institutes of Health contractor performance system. The Performance Report contains the actual assessment rating score and the summarized findings. Although the contractor performance system is not accessible to the public, PSCs use this system to review their own assessments.²³

Current and Planned Sources of Medicare and Medicaid Data

In 2007 and 2008, PSCs extracted Medicare claims data through the CMS National Claims History files and shared system files. Unlike CMS, which collects its Medicaid claims data from each State via the Medicaid Statistical Information System (MSIS),²⁴ PSCs obtain Medicaid claims data directly from the participating States' Medicaid Management Information Systems (MMIS) to match them to Medicare data. For each participating State, the State Medicaid program integrity agency receives matched Medicare and Medicaid claims data from the PSC. The matched data may also be shared with Medi-Medi partners.

The One PI System. A source for Medicare and Medicaid data that is being developed by CMS is the One PI System. (The "PI" in the name stands for "Program Integrity.") According to the Medi-Medi PPM and CMS Medicare program integrity staff, the concept of the One PI System is to enable access to integrated Medicare and Medicaid data. The Medi-Medi PPM provides guidance on using the One PI System.

One PI users obtain data from the CMS-managed integrated database repository. As of the date of this report, the repository is fully functional for accessing data from Medicare Parts A, B, and D; limited provider data; and beneficiary data.²⁵ However, Medicaid data are not yet included. Until CMS can integrate Medicaid data into the repository, the One PI System cannot be used to collectively match or analyze Medicare and Medicaid data for fraud, waste, and abuse. The contract to implement the One PI System

²² Federal Acquisition Regulation § 42.1501.

²³ CMS uses the National Institutes of Health contractor performance system to record PSC performance. However, as of September 30, 2010, the National Institutes of Health stopped its service of accepting performance information and encouraged users to transition to the Department of Defense Contractor Performance Assessment Reporting System.

²⁴ States are required to submit all their eligibility and claims data to CMS on a quarterly basis through MSIS. CMS uses MSIS to collect, manage, analyze, and disseminate information on eligibles, beneficiaries, utilization, and payment for services covered by State Medicaid programs. SSA § 1903(r); CMS, *Medicaid Statistical Information Statistics (MSIS)*. Accessed at <http://www.cms.gov/MSIS/> on January 17, 2011.

²⁵ The repository provides access to users through a variety of data analysis software tools, such as SAS, MicroStrategy, Cognos, Business Objects, and Advantage Suite.

was awarded in September 2006, and the system was to be implemented within 5 years at a projected cost of \$105 million.²⁶

The Fraud Investigation Database

The Fraud Investigation Database is a nationwide data entry and reporting system designed to track Medicare, Medicaid, and Medi-Medi fraud and abuse data. Under the Medi-Medi program, PSCs are required to enter into the database information about PSC-initiated investigations, cases referred to law enforcement, and payment suspensions related to fraud and abuse.²⁷ State Medicaid program integrity agencies, Medi-Medi partners, and other Federal and State law enforcement agencies use the database to access the information that PSCs enter into it.

Related Studies

In 2004, GAO issued a report that, in part, provided information about CMS's efforts to support and oversee State program integrity activities, such as the Medi-Medi program.²⁸ GAO found that CMS conducted little oversight of these activities.

In 2005, GAO released a report that focused on (1) the level of resources CMS applied to helping States prevent and detect fraud and abuse in Medicaid and (2) the implications of that level of support for CMS fraud and abuse control activities.²⁹ GAO found that the expansion of the Medi-Medi data match project was slow, potentially leaving unrealized millions of dollars in cost avoidance and cost savings. GAO concluded that developing a strategic plan for Medicaid fraud and abuse control activities would give CMS a basis for providing resources that reflect the financial risk to the Federal Government.

METHODOLOGY

Scope

This evaluation focused on the PSCs' performance under the SOW during the period of 2007 and 2008. We selected this period because CMS had completed its own internal assessment of the Medi-Medi program (known as

²⁶ CMS Medicare program integrity staff and CMS One PI staff.

²⁷ CMS, *Medicare Program Integrity Manual*, Pub. 100-08, ch. 4, § 4.11. Accessed at <https://www.cms.gov/manuals/downloads/pim83c04.pdf> on May 27, 2010.

²⁸ GAO, *Medicaid Program Integrity: State and Federal Efforts to Prevent and Detect Improper Payments*, GAO-04-707, July 2004. Accessed at <http://www.gao.gov/new.items/d04707.pdf> on May 26, 2010.

²⁹ GAO, *Medicaid Fraud and Abuse: CMS's Commitment to Helping States Safeguard Program Dollars Is Limited*, GAO-05-858T, June 28, 2005. Accessed at <http://www.gao.gov/new.items/d05855t.pdf> on May 26, 2010.

a “lessons learned” report) for the period preceding 2007.³⁰ In addition, CMS expressed an interest in the results of our independent evaluation from 2007 and 2008 for its transition from using PSCs for the Medi-Medi program to using ZPICs instead. As of the date of this report, the transition is still in process.

We report whether PSCs performed the SOW tasks required in 2007 and 2008. We also report the number of referrals made to law enforcement through the Medi-Medi program and the number that were accepted. In addition, we identify the actual dollars associated with Medicare prepayment denials and the Medicare and Medicaid dollars recovered. Finally, we report the extent to which CMS assessed PSCs’ performance under the SOW.

Data Collection

We obtained the following from CMS Medicare program integrity staff:

- sources for CMS requirements for the Medi-Medi program for 2007 and 2008 (see Appendix A for a list of these documents);
- documentation (including the Findings Tables and the Performance Reports) illustrating the extent to which PSCs performed SOW tasks;
- documents that PSCs produced as required by 3 of the 10 SOW tasks during 2007 and 2008: monthly status reports (required by task #3), joint operating agreements (required by task #4), and quarterly minutes (for task #8, which requires PSCs to facilitate a joint steering committee);³¹
- the number of referrals made to law enforcement and the number that CMS identified as being accepted; and
- the dollars associated with Medicare prepayment denials and/or the dollars recovered through each State’s Medi-Medi activities.

To validate and supplement the documentation that we obtained from Medicare program integrity staff, we:

- sent questionnaires to and conducted structured in-person interviews with CMS Medicare program integrity staff;

³⁰ Optimal Solutions Group L.L.C., *Final Lessons Learned Report (HHSM-500-2006-00165G)*, January 29, 2007.

³¹ Because all of the SOWs were awarded prior to 2007, each PSC had already been required to complete tasks 1, 2, and 9 (incorporating a project plan, incorporating an information technology plan, and preparing a “lessons learned” report) and we did not collect these documents during our review. However, we requested that CMS Medicare program integrity staff verify through questionnaires and structured interviews that these tasks had been completed.

- conducted structured in-person interviews with CMS One PI staff, an official from the Center for Medicaid and State Operations, and contract officers' technical representatives;³²
- conducted structured in-person interviews with staff from each of the PSCs;
- conducted structured interviews with staff from each of the 10 State Medicaid program integrity agencies that participated in the Medi-Medi program (conducting 5 of these 10 interviews in person),³³ and
- conducted structured interviews (by telephone) with staff from a total of 37 of the potential 41 various Medi-Medi partners associated with the 10 participating States.³⁴

Data Analysis

Unit of analysis. Our unit of analysis is the 10 Medi-Medi SOWs awarded to PSCs, which correspond to the participating 10 States. For ease of reporting, we use the term “10 PSCs” to represent the 10 SOWs awarded among 8 PSCs.

Analysis of the SOW tasks. Even though the 2007 and 2008 SOWs included 10 tasks, we assessed PSC performance related only to the tasks CMS required PSCs to continue to perform in 2007 and 2008.

We reviewed the Medi-Medi program requirements for 2007 and 2008 to identify all the requirements related to the SOW tasks. For each PSC, we then reviewed the Findings Tables and Performance Reports to determine whether CMS had—as required by the Evaluation Guidelines—documented the assessments. We also reviewed responses from our structured interviews and questionnaires to supplement and/or validate our determination of whether the PSC performed the tasks according to the requirements.

For a number of SOW tasks, we applied additional data-analysis methodologies:

- For the requirement that each PSC submit to CMS a monthly status report (task #3) and develop a joint operating agreement (task #4), we reviewed the 2007 and 2008 monthly status reports and joint operating agreements.

³² We interviewed a Center for Medicaid and State Operations official to gain a Medicaid perspective of the Medi-Medi program. Upon enactment of the DRA, the Center for Medicaid and State Operations administered the Medicaid integrity program within CMS.

³³ To reduce travel costs, we conducted interviews and reviewed documentation and/or data at 5 of the 10 State Medicaid program integrity locations near PSC locations.

³⁴ Although the number of Medi-Medi partners that participated in the interviews varied among States, we interviewed at least three Medi-Medi partners from each participating State.

- For the requirement that each PSC perform data analysis (task #6) and develop and refer potential fraud cases (task #7), we reviewed 2007 and 2008 monthly status reports and CMS’s responses to our questionnaires. As part of our structured interviews, while onsite at each PSC location, we also reviewed various examples of each PSC’s data analysis and case development. For the task of performing data analysis, we calculated the sum of unique data analysis projects performed by each PSC. These projects included identifying patterns of potential Medicare and/or Medicaid fraud and performing data analysis targeted to specific providers and/or services. A PSC may perform data analysis for a unique project over several months. If a PSC reported that it continued to perform data analysis for that same project in subsequent months, we counted that project for each of those months as one of the unique data analysis projects being performed during that month.
- For the requirement that each PSC facilitate a steering committee (task #8), we reviewed minutes from the meetings.

See Appendix B for documentation and data we analyzed to determine whether PSCs performed the required SOW tasks.

Although CMS rates PSCs’ performance using a system ranging from “0” (unsatisfactory) to “5” (outstanding), because of this system’s subjective nature, we did not attempt to rate PSC performance. We considered a task performed if documentation and/or data existed demonstrating that the task was performed.

Analysis of fraud, waste, and abuse identified through the Medi-Medi program. We analyzed the responses of CMS Medicare program integrity staff to our questionnaire to identify the number of Medicare and Medicaid referrals made to Federal and State law enforcement agencies and the number that were accepted. In addition, we calculated the amount of Medicare and Medicaid expenditures avoided through prepayment denials and the amount of dollars recovered. We limited the scope of this analysis to actual dollars recovered, as opposed to potential dollars recovered.

We report fraud, waste, and abuse expenditures “avoided” (meaning prepayment denials) or “recouped” (meaning funds recovered). This terminology is consistent with the language in section 1893(g) of the SSA.

Analysis of the Medi-Medi program assessment process. For each PSC, we reviewed the 2007 and 2008 program requirements. We then reviewed the 2007 and 2008 Findings Tables and Performance Reports to determine the extent to which CMS recorded its assessment of each PSC’s performance of the required SOW tasks. We also reviewed responses from our structured

interviews and questionnaires to supplement and/or validate our determination of the extent of CMS's assessment of PSCs' performance.

Data Limitations

Each program (Medicare and Medicaid) and each participating State operate under different circumstances and/or policies. For example, each participating State's Medi-Medi activities are unique to that State, and although PSCs are required in their SOWs to refer potential fraud cases to State Medicaid program integrity agencies and/or Federal or State law enforcement agencies, PSCs do not control what those entities do with their referrals. In addition, there may be more Federal law enforcement agency resources available for Medicare than there are State law enforcement agency resources available for Medicaid.

PSCs vary as to how much information on data analysis projects they include in their monthly status reports. In addition, the project descriptions they include in these reports are not comprehensive and do not necessarily identify the providers; the relevant program (i.e., Medicare or Medicaid); or the results or disposition of the projects. For example, some reports state that a PSC completed a certain number of data requests, without any additional information. In other monthly reports, other PSCs list only the titles of the data analysis projects.

PSCs also differ as to what they consider to be a data analysis project. Some PSCs include preliminary data analysis projects in their monthly status reports, whereas other PSCs list only projects for which they have already completed the preliminary data analysis and which they consider viable fraud cases. Further, some PSCs have not only listed new data analysis projects in their reports, but have also listed ongoing ones. This may explain the range in the number of unique data analysis projects performed by PSCs each month.

Because of these limitations in the monthly status reports, we did not attempt to correlate the number of unique data analysis projects to the number of Medicare and/or Medicaid referrals or to the amount of expenditures avoided or recouped.

PSCs, State Medicaid program integrity agencies, and Medi-Medi partners may not always agree as to which of them initiated a referral for fraud, waste, or abuse, or which of them was responsible for expenditures that were avoided or recouped.³⁵ To minimize the time burden on the State Medicaid program integrity agencies and the Medi-Medi partners, we limited their

³⁵ This statement is based on responses given during our structured interviews with PSCs and State Medicaid program integrity agencies.

involvement to structured interviews and did not ask them to verify CMS's reported output.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

Although most PSCs performed all of the required tasks, the Medi-Medi program produced limited results and few fraud referrals

For the period of 2007 and 2008, 7 of the 10 PSCs performed all of the required SOW tasks while each of the remaining 3 PSCs performed all but 1 of the required tasks. See Appendix C for our analysis of PSCs' performance of SOW tasks in 2007 and 2008.

Three of the PSCs did not develop and refer potential fraud cases during 1 of the 2 years of the review period

The SOW states that "fraud cases shall be developed" and further states that "the PSC shall refer potential fraud cases and/or data leads to the appropriate State or Federal law enforcement agency..." Of the three PSCs that did not perform all of the required tasks, all did not develop and refer potential fraud cases in 1 of the 2 years of our review period. Two of those three PSCs did not refer any potential Medicare or Medicaid fraud cases in 2007. The remaining PSC did not refer any potential cases through the program in 2008.

A total of \$60 million was appropriated for the Medi-Medi program, and \$57.8 million in expenditures were avoided and recouped

The DRA appropriated funding for the Medi-Medi program on an FY basis. According to CMS Medicare program integrity staff, the actual combined total of fraud, waste, and abuse expenditures avoided or recouped through the Medi-Medi program during that period was \$57.8 million (see Table 1).

Table 1: Combined Totals of 2007 and 2008 Expenditures Avoided and Recouped

Program	Expenditures Avoided	Expenditures Recouped	Total
Medicare	\$11,593,283	\$34,934,559	\$46,527,842
Medicaid	Not reported ³⁶	\$11,303,554	\$11,303,554
Totals	\$11,593,283	\$46,238,113	\$57,831,396

Source: OIG analysis of Medi-Medi data.

³⁶ During 2007 and 2008, CMS did not collect data from PSCs regarding the amount of Medicaid expenditures avoided through the Medi-Medi program.

Of the fraud, waste, and abuse expenditures avoided or recouped, 66 percent was attributed to Medi-Medi activities in three States

Of the combined \$57.8 million in fraud, waste, and abuse expenditures avoided or recouped through the Medi-Medi program, a combined total of \$37.9 million was attributed to Medi-Medi activities in three States; individual totals were \$14.5 million, \$14.3 million, and \$9.2 million, respectively³⁷ (see Table 2).³⁸

Table 2: Combined 2007 and 2008 Medicare Expenditures Avoided and Recouped and Medicaid Expenditures Recouped by Each Medi-Medi Program

Medi-Medi Program	Expenditures Avoided	Expenditures Recouped	Total
1	\$8,849,636	\$5,666,021	\$14,515,657
2	\$0	\$14,250,957	\$14,250,957
3	\$364,909	\$8,799,834	\$9,164,743
4	\$991,901	\$3,877,993	\$4,869,894
5	\$0	\$4,490,955	\$4,490,955
6	\$370,499	\$3,654,965	\$4,025,464
7	\$0	\$3,000,191	\$3,000,191
8	\$895,617	\$1,285,350	\$2,180,967
9	\$104,468	\$1,211,847	\$1,316,315
10	\$16,253	\$0	\$16,253
Total	\$11,593,283	\$46,238,113	\$57,831,396

Source: OIG analysis of Medi-Medi data.

Expenditures avoided. CMS reported that, as a result of the Medi-Medi program, a total of \$11.6 million in Medicare expenditures was avoided through prepayment denials during the period of 2007 and 2008. However, of this amount, \$8.8 million (76 percent) was attributed to Medi-Medi activities in one State.

Expenditures recouped. During the same period, a total of \$46.2 million in Medicare and Medicaid expenditures was recouped through the Medi-Medi program. However, of this amount, \$28.7 million (62 percent) was attributed to the same three Medi-Medi programs that recouped and avoided \$14.5 million, \$14.3 million, and \$9.2 million, respectively, in total Medicare and Medicaid expenditures.

The Medi-Medi program produced only 66 law enforcement referrals; 27 were accepted

During 2007 and 2008, a combined total of 66 Medicare and Medicaid referrals were made to Federal and State law enforcement through the

³⁷ Because of rounding, the sum of these figures does not equal \$37.9 million.

³⁸ The Medi-Medi programs in Table 2 are ranked by the total amount of Medicare and Medicaid expenditures reported as having been avoided or recouped.

Medi-Medi program, and law enforcement accepted 27 of these (see Table 3).

Table 3: Combined 2007 and 2008 Medi-Medi Law Enforcement Referrals

Program	Number Referred to Law Enforcement	Number Accepted by Law Enforcement	Percentage Accepted by Law Enforcement
Medicare	56	23	41%
Medicaid	10	4	40%
Totals	66	27	41%

Source: OIG analysis of Medi-Medi data.

As a result of Medi-Medi activities among the 10 States collectively, each State averaged 2.8 Medicare referrals to law enforcement per year; an average of 1.15 of those referrals were accepted. In comparison, each State averaged 0.5 Medicaid referrals to law enforcement per year; an average of 0.2 of those were accepted.

Medi-Medi activities in a single State produced 27 of the total referrals (41 percent) and 10 of the total accepted referrals (37 percent). Of the Medi-Medi activities in the 10 States, 41 percent of the total referrals and 37 percent of the accepted referrals were attributed to Medi-Medi activities in a single State (see Table 4). This is the same State that recouped \$14.3 million total Medicare and Medicaid expenditures during 2007 and 2008.

Table 4: Combined 2007 and 2008 Medi-Medi Law Enforcement Referrals

Medi-Medi Program	Referred to Law Enforcement	Accepted by Law Enforcement
1	27	10
2	8	2
3	7	5
4	6	3
5	6	1
6	4	3
7	4	1
8	2	1
9	1	1
10	1	0
Total	66	27

Source: OIG analysis of Medi-Medi data.

Results from the Medi-Medi program improved slightly between 2007 and 2008

Between 2007 and 2008, the amount of Medicare expenditures avoided through the Medi-Medi program increased by \$1.1 million and the amount of Medicare expenditures recouped increased by \$10 million. During the

same period, Medicaid expenditures recouped increased by \$4.4 million. In addition, the total number of Medicare and Medicaid referrals made to Federal and State law enforcement increased by 18, while the number of those referrals accepted increased by 5.

State Medicaid programs received less benefit from the Medi-Medi program than Medicare received

Compared with Medicare, Medicaid received less benefit from the Medi-Medi program. Of the \$46.2 million total in Medicare and Medicaid expenditures recouped through the Medi-Medi program during 2007 and 2008, more than three-quarters—\$34.9 million—was recouped for Medicare and \$11.3 million was recouped for Medicaid. Between 2007 and 2008, the amount of Medicare expenditures recouped increased by \$10 million, while the amount recouped for Medicaid increased by \$4.4 million. During the same period, of the 66 law enforcement referrals made, more than five-sixths—56 of the referrals—were for Medicare and 10 were for Medicaid. Law enforcement accepted 23 of the Medicare referrals and only 4 of the Medicaid referrals.

Although Medi-Medi appropriations were intended to expand the program, no new States were participating as of 2008 and two of the participating States ultimately withdrew

The DRA provisions were intended to establish and fund an expanded Medi-Medi program. However, during the period of our review, only 10 States had chosen to participate. Of those 10 States, 2 States withdrew, finding that it offered them minimal expenditure avoidance and recoupment of Medicaid funds.³⁹ State participation in the program is voluntary, and States must contribute their own resources to participate. One of the two States that withdrew reported that it invested \$250,000 of its own resources in the program, but recouped only \$2,000 over a 5-year period (which included 2007 and 2008). However, during 2007 and 2008, that State also administered its own Medicaid integrity program independent of the Medi-Medi program, and this independent program recouped \$28.9 million.

After 2008, 7 additional States joined the Medi-Medi program, resulting in a total of 15 participating States.⁴⁰ As a result of the transition to ZPICs, the seven additional States joined the Medi-Medi program as part of three geographic areas.⁴¹

³⁹ Of the two States that withdrew, one withdrew in September 2008 and the other withdrew in January 2010.

⁴⁰ Information provided by Medicare program integrity staff.

⁴¹ Colorado and Oklahoma were included in one ZPIC geographic area. Arkansas, Georgia, and Mississippi were included in a second geographic area, and Iowa and Utah were included in a third geographic area. Information provided by Medicare program integrity staff.

During 2007 and 2008, 54 percent of the funds appropriated for the Medi-Medi program were used to develop the One PI System, but the system will not include Medicaid claims data until at least 2015

In total, \$60 million was appropriated to fund the Medi-Medi program during 2007 and 2008.⁴² Of this amount, 54 percent (\$32.5 million) was used to develop the One PI System.⁴³ During 2009 and 2010, \$108 million in total was appropriated to fund the Medi-Medi program, and an even larger percentage of those funds—64 percent (\$69 million)—was used to develop the One PI System.⁴⁴ However, according to Medicare program integrity staff and CMS One PI staff, the One PI System will not be available for the Medi-Medi program until at least 2015, 4 years after its originally scheduled implementation date.

According to CMS Medicare program integrity staff, the lack of appropriate Medicaid claims data for CMS to integrate into the integrated data repository is the main barrier to using the One PI System for the Medi-Medi program. CMS currently collects Medicaid claims data from each State via MSIS. According to CMS Medicare program integrity staff, MSIS data in their current form would not be appropriate to integrate into the integrated data repository because the data are specific to each State and lack many of the standardized data elements needed for program integrity work.⁴⁵ Some examples of standardized data elements needed for program integrity work but not included in MSIS are provider names and addresses, information about types of procedures and services, and beneficiary names.

Limitations in the administration of the Medi-Medi program may have diminished its potential

Lack of inclusion of the Medicaid Program Integrity Group in the administration of the Medi-Medi program, limitations of the Fraud Investigation Database, and the lack of documentation in CMS's annual assessments of PSCs may limit the potential of the Medi-Medi program.

⁴² Data provided by CMS One PI staff and Medicare program integrity staff.

⁴³ Information provided by Medicare program integrity staff.

⁴⁴ Ibid.

⁴⁵ MSIS was designed to collect specific information from each Medicaid agency that would allow CMS to report on State Medicaid program characteristics and utilization. According to CMS Medicare program integrity staff, MSIS data were not designed to support fraud analytics and they lack standard data elements necessary for that purpose. Because of a lack of standardization, the data cannot be used for national analysis. CMS anticipates that it will eventually be able to integrate Medicaid claims data into the integrated data repository by receiving from States data with common data elements—i.e., definitions, formats, and representations will not vary by State.

Federal officials from the CMS Medicare Integrity Group do not include Federal officials from the CMS Medicaid Integrity Group in administering the Medi-Medi program

The Medi-Medi program is intended to be a collaborative effort to combat Medicare and Medicaid fraud, waste, and abuse. However, according to CMS Medicare program integrity staff and a former Center for Medicaid and State Operations official, although Medicaid program integrity agencies are involved at the State level, Federal officials from the CMS Medicare Integrity Group do not include Federal officials from the Medicaid Integrity Group in administering the Medi-Medi program.

During structured interviews, 5 of the 10 State Medicaid program integrity agencies and 3 of the 10 PSCs suggested that CMS include Federal officials from the Medicaid Integrity Group. According to the respondents, this would enable CMS Medicare program integrity staff and PSCs to better understand the Medicaid side of the program, such as how to better interpret and analyze Medicaid claims data. Four of the 10 participating State Medicaid program integrity agencies said that PSCs do not understand Medicaid and that as a result they primarily analyze Medicare claims data.

Access to information in the Fraud Investigation Database is limited

For the purpose of the Medi-Medi program, PSCs are required to enter information into the Fraud Investigation Database relating to Medicare, Medicaid, and Medi-Medi fraud, waste, and abuse investigations.⁴⁶ PSCs are required to do this in part to make such information available to State Medicaid program integrity agencies.⁴⁷ The database is intended to provide State Medicaid program integrity agencies with information about Medicaid, Medicare and Medi-Medi investigations.

Five of the ten participating State Medicaid program integrity agencies report they do not use the Fraud Investigation Database because CMS did not provide access to it. An additional four State Medicaid program integrity agencies reported they have difficulty accessing the database because it is not user-friendly. The remaining State Medicaid program integrity agency reported: “[O]ver the years we have periodically tried to use the [Fraud Investigation Database], but found it to be cumbersome and of limited use.”

⁴⁶ CMS, *Medicare-Medicaid Data Match Program (Medi-Medi) Policies and Procedures Manual*, p. 65.

⁴⁷ CMS, *Medicare Program Integrity Manual*, Pub. 100-08, ch. 4, § 4.11. Accessed at <https://www.cms.gov/manuals/downloads/pim83c04.pdf> on May 27, 2010.

PSCs do not receive rating scores directly assessing their performance of required tasks listed in the Medi-Medi Statement of Work

The Evaluation Guidelines include guidance for assessing performance on the six tasks. However, CMS does not identify each of the required SOW tasks in either the Findings Tables or Performance Reports, nor does it document its ratings of PSCs on their performance of each SOW task. According to CMS Medicare program integrity staff, because the SOW is added onto a broader program integrity task order, the majority of the content in the Findings Tables and Performance Reports applies to the performance under that broader task order. In addition, content in the Findings Tables and Performance Reports assessing PSCs' performance under the broader program integrity task order is commingled with content about their performance under of SOW tasks. As a result, PSCs do not receive rating scores specific to their performance of each SOW task. According to CMS Medicare program integrity staff, CMS has never made a decision not to renew a PSC's broader program integrity task order based solely on a PSC's performance under the SOW. CMS uses the Findings Tables to document assessment findings and ratings and to provide verbal feedback to PSCs regarding their performance under the SOWs.

RECOMMENDATION

The SSA requires that the Medi-Medi program increase the effectiveness and efficiency of the Medicare and Medicaid programs through cost avoidance (i.e., prepayment denials); savings; and recoupment of fraudulent, wasteful, or abusive expenditures. However, during 2007 and 2008, the Medi-Medi program produced limited results and few fraud referrals, and the majority of those results were attributed to Medi-Medi activities in three States. Compared with Medicare, State Medicaid programs received less benefit from the Medi-Medi program. Limitations in the administration of the program may have diminished its potential.

We recommend that CMS:

Reevaluate the goals, structure, and operations of the Medi-Medi program to determine what aspect of the program, if any, should be part of CMS's overall program integrity strategy

As part of this reevaluation, CMS could:

- Determine how, if at all, the Medi-Medi program could be a more effective program integrity resource.
- Determine whether appropriations for the Medi-Medi program should continue to be used to develop and implement the One PI System.
- Determine whether including officials from the Medicaid Program Integrity Group in administering the Medi-Medi program would improve its results.
- Ensure that each participating State Medicaid program integrity agency has appropriate access to useful information in the Fraud Investigation Database. As needed, CMS also could provide additional user guidance to State Medicaid Program Integrity agencies for using the database.
- Establish appropriate standards in the SOW to measure PSCs' performance in relation to the number of fraud referrals and the amount of Medicare and Medicaid fraud, waste, and abuse expenditures avoided and recouped.
- Directly assess PSCs' performance of each task listed in the SOW, and determine whether performing those tasks produces cost-effective results. In addition, CMS could assess the benefit of providing PSCs with comprehensive written analyses of their performance of each SOW task (and any corrective action plans).

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with our recommendation. CMS commented that since the period of our review, it has made significant strides in enhancing the effectiveness of the Medi-Medi program and its overall program integrity efforts. CMS further stated that the program has been a useful tool in helping fight fraud, waste, and abuse and that the program will become more effective over time as more States participate. However, CMS has not provided any data to illustrate enhanced effectiveness of the program since the period of our review. CMS has not provided any data regarding the number of referrals, accepted referrals, and the actual—not potential—Medicare and Medicaid expenditures avoided and recouped. These data would enable Congress to make an informed decision whether to continue appropriating funding for the program. These data would also enable stakeholders (i.e., CMS, States, and Medi-Medi partners) to make an informed decision on whether to use their resources to participate.

For the full text of CMS’s comments, see Appendix D.

APPENDIX A

Sources for Centers for Medicare & Medicaid Services Requirements for the Medicare-Medicaid Data Match Program

Sources for Requirements	Description
<i>Medicare Program Integrity Manual</i>	Identifies Program Safeguard Contractors' (PSC) program integrity requirements, such as the requirement to enter data into the Fraud Investigation Database.
<i>The Medicare-Medicaid Data Match Program (Medi-Medi) Statement of Work (SOW)</i>	Identifies the tasks that PSCs were required to perform for the period of 2007 and 2008.
<i>The Medicare-Medicaid Data Match Program (Medi-Medi) Policies and Procedures Manual</i>	Provides Medi-Medi program guidance to PSCs, State Medicaid program integrity agencies, and Federal and State law enforcement agencies.
<i>PSC Performance Evaluation Guidelines</i>	Sets forth the Medi-Medi SOW performance requirements and provides guidance for assessing PSCs' performance.
<i>PSC BI [Benefit Integrity] Evaluation Control Objectives and Findings Tables</i>	Identifies the key elements and review methodology for assessing PSC performance, as well as the corresponding written assessment and rating.

APPENDIX B

Required Tasks Listed In the Statement of Work and Documentation Analyzed To Determine Whether the Task Was Performed

A shaded background indicates that Program Safeguard Contractors (PSC) were not required to perform the task during the period of our review. Only one PSC was required to perform transition activities (Task #10).

Medicare-Medicaid Data Match Program Tasks and Documentation and Data Analyzed	
Statement of Work (SOW) Tasks	Documentation and Data Analyzed
1. Incorporate a project plan.	This Medicare-Medicaid Data Match Program (Medi-Medi program) SOW task was required to be performed prior to 2007. Therefore, we did not include this task in our analysis.
2. Incorporate an information technology plan.	This Medi-Medi SOW task was required to be performed prior to 2007. Therefore, we did not include this task in our analysis.
3. Submit to Centers for Medicare & Medicaid Services (CMS) a monthly status report.	Monthly status reports
	Questionnaire responses from CMS Medicare program integrity staff
	Structured interviews with CMS Medicare program integrity staff PSCs
	<i>PSC BI [Benefit Integrity] Evaluation Control Objectives and Findings Tables (Findings Tables)</i>
	<i>Standard Contractor Performance Report (Performance Report)</i>

continued on next page

APPENDIX B (continued)

Medi-Medi Program Tasks and Documentation and Data Analyzed (continued)	
SOW Tasks	Documentation and Data Analyzed
4. Develop a joint operating agreement.	Joint operating agreement
	Questionnaire responses from CMS Medicare program integrity staff
	Structured interviews with CMS Medicare program integrity staff and PSCs
	Findings Tables
	Performance Reports
5. Provide remote user access and support.	Structured interviews with CMS Medicare program integrity staff, PSCs, and State Medicaid program integrity agencies
	Findings Tables
	Performance Reports
6. Perform data analysis.	Monthly status reports
	Structured interviews (with CMS Medicare program integrity staff, PSCs, and State Medicaid program integrity agencies)
	Findings Tables
	Performance Reports

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APPENDIX B (continued)

Medi-Medi Program Tasks and Documentation and Data Analyzed (continued)	
SOW tasks	Documentation and Data Analyzed
7. Develop and refer potential fraud cases.	Monthly status reports
	Structured interviews with CMS Medicare program integrity staff, PSCs, State Medicaid program integrity agencies, and Medi-Medi Partners
	Questionnaire responses from CMS Medicare program integrity staff
	Findings Tables
	Performance Reports
8. Facilitate a steering committee.	Quarterly steering committee minutes
	Structured interviews with CMS Medicare program integrity staff, PSCs, State program integrity agencies, and Medi-Medi partners
	Findings Tables
	Performance Reports
9. Prepare "lessons learned" reports.	This Medi-Medi SOW task was required to be performed prior to 2007. Therefore, we did not include this task in our analysis.
10. Perform transition activities.	Structured interviews with CMS Medicare program integrity staff and PSCs
	Questionnaire responses from CMS Medicare program integrity staff
	Findings Tables
	Performance Reports

APPENDIX C

Analysis Results of Program Safeguard Contractors' Performance of Selected Tasks in the Statement of Work for the Medicare-Medicaid Data Match Program

Task #3: *Submit to the Centers for Medicare & Medicaid Services [CMS] a monthly status report.* Each program safeguard contractor (PSC) submitted a monthly status report to CMS. Although the format of the reports varied among PSCs, the reports contained the content required by the Statement of Work (SOW), such as information about provider referrals, the nature of investigations, data analysis projects, and Medicare and/or Medicaid expenditures avoided or recouped.

Task #4: *Develop a joint operating agreement.* Each PSC developed a joint operating agreement with its State Medicaid program integrity agency and other applicable agencies to establish guidelines, duties, and shared expectations for the Medi-Medi program. In addition, as suggested by the *Medicare-Medicaid Data Match Program (Medi-Medi) Policies and Procedures Manual*, those agreements were revised as necessary in 2007 and 2008.

Task #5: *Provide remote user support and access.* For PSCs, State Medicaid program integrity agencies, and Medi-Medi partners, each PSC provided remote user support and access to matched Medicare and Medicaid claims data. However, in 2007, for Medi-Medi programs in two States, those two PSCs were not able to provide access to matched Medicare and Medicaid data within 4 months of executing a computer match agreement. According to CMS Medicare program integrity staff, the delay was due to connectivity issues caused by firewalls to the server. PSCs provided access to the data through a variety of means, including the use of transmission level-1 lines (commonly referred to as T-1 lines), file transfer via the Internet, data tapes, and/or data disks. According to PSCs and State Medicaid program integrity agencies, user support and access improved in those States where PSCs provided staff to work directly onsite with the State Medicaid program integrity agency staff.

Task #6: *Perform data analysis.* Based on our review of the monthly status reports, *PSC BI [Benefit Integrity] Evaluation Control Objectives and Findings Tables, Standard Contractor Performance Report*, and structured interviews, each PSC performed data analysis. Each PSC performed at least 36 total unique data analysis projects during 2007 and 2008. The number of unique projects per PSC ranged from 36 to 677. In 2007, each PSC performed at least 16 unique data analysis projects, and in 2008, each PSC performed at least 10 unique projects.

APPENDIX C (continued)

Task #7: *Develop and refer potential fraud cases.* Based on our review of the monthly status reports, questionnaire responses from CMS, and structured interviews, 7 of the 10 PSCs developed and referred potential fraud cases in both 2007 and 2008. However, among PSCs that did so during that time, the number of referrals ranged from 2 PSCs that referred 4 potential fraud cases each to a PSC that referred 27 fraud cases.

Task #8: *Facilitate a steering committee.* Each of the PSCs facilitated a steering committee with its State Medicaid program integrity agency and Medi-Medi partners and prepared minutes from committee meetings. However, the Medi-Medi SOW states that the steering committee “should meet not less frequently than quarterly.” Although PSCs may have scheduled quarterly meetings, according to the dates entered on the committee minutes, five PSCs may have met less frequently in 2007 and one PSC may have met less frequently in 2008.

Task #10: *Perform transition activities.* Based on responses provided by CMS Medicare program integrity staff to our questionnaire, one PSC was required to perform transition activities and that PSC performed this task by submitting the required information to the Zone Program Integrity Contractor that was awarded the SOW.

APPENDIX D

Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: JAN 27 2012

TO: Daniel R. Levinson
Inspector General

FROM: ~~Martin Tavener~~ /S/
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "The Medicare-Medicaid (Medi-Medi) Data Match Program" (OEI-09-08-00370)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the OIG draft report entitled, "The Medicare-Medicaid (Medi-Medi) Data Match Program." The purpose of this report was to determine whether Program Safeguard Contractors (PSC) performed the required tasks for the Medicare-Medicaid Data Match Program (Medi-Medi program) and the extent to which the Medi-Medi program identified fraud, waste, and abuse.

Since the period of review of this report (2007-2008), CMS has made significant strides in enhancing the effectiveness of the Medi-Medi program and the Agency's overall program integrity efforts. CMS has established the Center for Program Integrity (CPI) that leads a collaborative effort to fight waste, fraud, and abuse in Medicare and Medicaid. Specifically, since the formation of CPI, both the CMS Medicare and Medicaid Integrity Program groups have been working collaboratively on the ongoing operation of the Medi-Medi program.

The Medi-Medi program has been a useful tool in helping to fight fraud, waste, and abuse. The program continues to refer potential fraud referrals to law enforcement, and CMS is examining opportunities to share best practices among States that have had successful referrals. Six States have been added to the Medi-Medi program for a total of 15 participating States, and there has been strong interest from additional States in participating. CMS continues to work with States to identify and collaborate on improvements to the program.

The CMS has already implemented many of the suggestions made by OIG including improving access to the Fraud Investigations Database for States and establishing appropriate performance standards for PSCs and Zone Program Integrity Contractors (ZPIC). In addition, Medicaid program integrity staff regularly collaborates in administrating the Medi-Medi program.

As suggested by OIG, CMS is currently assessing the Medi-Medi program regarding program integrity efforts and provides further detail on OIG's suggestions below.

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OIG Recommendation

The CMS should reevaluate the goals, structure, and operations of the Medi-Medi program to determine what aspect of the program, if any, should be part of CMS' overall program integrity strategy.

CMS Response

The CMS concurs with this recommendation. As suggested by OIG, CMS is currently assessing the Medi-Medi program to ensure its effectiveness regarding program integrity efforts.

In addition, OIG specifically suggested that CMS consider the following aspects of the program in its reevaluation. We have addressed each below in detail to provide more information on CMS' recent and ongoing efforts to improve the efficiency of the Medi-Medi program.

- **Assess how, if at all, the Medi-Medi program could be a more effective program integrity source.** CMS believes the Medi-Medi program will become more effective over time as more States participate. CMS is already working to identify ways the program can be improved and be more beneficial to States. CMS is conducting a variety of pilots to provide more Medicaid data that States can use in their program integrity efforts and identify opportunities for sharing lessons learned from States who have made successful referrals and recouped Medicaid expenditures. States often also receive benefits which are not as quantifiable such as information sharing, cross-training, data analysis tools, and co-location opportunities. Since the period of review of this report, 2007-2008, 6 States have been added to the program for a total of 15 participating States, and additional States have expressed an interest in participating. Through the additional States' participation, the Medi-Medi program will be able to further the collaboration in analyzing trends to identify potential fraud, waste, and abuse in the Medicare and Medicaid programs throughout the country.
- **Assess whether appropriations for the Medi-Medi program should continue to be used to develop and implement the One Program Integrity (One PI) System.** One PI is designed to provide access through a single portal to an authoritative source of Medicare, Medicaid, and Children's Health Insurance Program (CHIP) Enterprise Data in support of program integrity analytics and investigations in the Medicare and Medicaid programs and their interaction, as represented by Medi-Medi. Past One PI investments have been leveraged to develop harmonized Medicare and Medicaid data models. One PI is currently able to access a rich set of Medicare provider, beneficiary, and claims data and a variety of pilots and approaches are underway to cleanse and load newly expanded State data sets into the data model for access through One PI. Once this data is loaded and matched, contractors engaged in the Medi-Medi program will be able to use One PI to provide access through a single portal to an authoritative source of matched Medicare, Medicaid, and CHIP Enterprise Data in support of data analytics and investigations. CMS believes this will provide significant benefit to States in their program integrity efforts.

The CMS will continue to evaluate and assess appropriations through Medi-Medi for the development of the One PI system. Formal reviews will occur during appropriations

APPENDIX D (continued)

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planning stages and through the Agency's Information Technology Investment Review Board.

- **Assess whether including officials from the Medicaid Program Integrity Group in administering the Medi-Medi program would improve the program's results.** CMS agrees with OIG's assessment and is pleased to report that representatives from CMS' Medicaid Integrity Group (MIG) currently attend Medi-Medi Steering Committee Meetings with the States, ZPICs, and CMS. Beyond this existing involvement of the MIG with Medi-Medi, CPI is currently undertaking an assessment of the most effective way to ensure synergy between the Medicare and Medicaid Program Integrity Groups. In addition, CMS collaborates with all appropriate stakeholders throughout CMS to ensure that the Medi-Medi program objectives are met.
- **Ensure that each State Medicaid program integrity agency participating in the Medi-Medi program has access to the Fraud Investigation Database (FID) and to the information in the FID. As needed, CMS also could provide additional user guidance to State Medicaid Program Integrity agencies for using the FID.** CMS agrees with OIG's assessment and is pleased to report that the user guidance and FID training for the States is now provided annually at the National Association for Medicaid Program Integrity (NAMPI) conferences. In October 2009, the FID became an Internet-based system. This design provided the opportunity for each State Medicaid program integrity agency participating in the Medi-Medi program to have access to the FID in a more user-friendly format.
- **Establish appropriate standards in the Medi-Medi Statement of Work (SOW) to measure PSCs' performance in relation to the number of fraud referrals and the amount of Medicare and Medicaid fraud, waste, and abuse expenditures avoided and recouped through the Medi-Medi program.** OIG expressed also that CMS could directly assess PSCs' performance of each task listed in the Medi-Medi SOW and whether performing those tasks produces cost-effective results. In addition, OIG noted that CMS could assess the benefit of providing PSCs with comprehensive written analysis of their performance (and any corrective action plans) in relation to each Medi-Medi SOW task. With the inception of the ZPICs, the successors to the PSCs, each contractor is provided with a comprehensive written analysis of their performance in relation to each Medi-Medi SOW task as part of the evaluation. The evaluation is conducted by the Contracting Officer's Representative who is familiar with the ZPIC's intricacies, activities, and performance in the Medi-Medi program. The evaluation is based on criteria set forth in the SOW.

The CMS is committed to the Medi-Medi program and its ability to identify fraud, waste, and abuse.

Again, thank you for the opportunity to comment on this draft report. We look forward to working with OIG on this and other issues.

ACKNOWLEDGMENTS

This report was prepared under the direction of Timothy S. Brady, Regional Inspector General for Evaluation and Inspections in the San Francisco regional office.

Michael Henry served as the team leader for this study. Other principal Office of Evaluation and Inspections staff from the San Francisco regional office who contributed to the report include Loul Alvarez, Christina Lester, and Marcia Wong; central office staff who contributed includes Scott Manley and Louise Schoggen. We also would like to acknowledge the contributions by Ann Maxwell of the Chicago regional office and Robert A. Vito of the Philadelphia regional office.

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The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.