

Summary of the Discussion Draft of “Protecting the Integrity of Medicare Act 2014”

Section 1- Short Title and Table of Contents

Section 2 – Prohibition of Inclusion of Social Security Account Numbers on Medicare Cards

This provision establishes cost-effective procedures to ensure that a Social Security account number (SSN) is not displayed, encoded, or embedded on an individual’s Medicare card. The Secretary of the Department of Health and Human Services (HHS), further referred to in this document as “the Secretary”, will establish and implement a process that involves the least amount of disruption to Medicare beneficiaries and health care providers. \$320 million in funding is provided to the Centers for Medicare and Medicaid Services (CMS) for the explicit purpose of implementing this change.

The Government Accountability Office (GAO) first recommended removing the SSN from government documents in 2002. In 2007, the Bush Administration found that the SSN is “the most valuable commodity for an identity thief” and directed all federal agencies to develop a plan for reducing the use of SSNs in government transactions. In 2008, the Social Security Administration (SSA) Inspector General recommended that the SSN be removed from Medicare cards.

Section 3 – Preventing Wrongful Medicare Payments

Beginning in 2015, this provision prevents wrongful Medicare payments for incarcerated, unlawfully present, and deceased individuals by establishing Medicare administrative contractor (MAC) claims processing edits that prevent payments from being made. Recovery Audit Contractors (RACs) will review claims to recoup any payments that are made despite the edit requirement. The HHS Office of Inspector General (OIG) will review and report on these activities to make sure they have their intended effect.

The HHS OIG has issued reports in the past few years highlighting the improper payments made for these ineligible populations: [Deceased](#), [Unlawful](#), and [Incarcerated](#).

Section 4 – Measures Regarding Medicare Beneficiary Smart Cards

This provision directs the Secretary to explore, once a mandated report is released by the GAO, the cost-effectiveness and technological viability of using smart cards as identification for Medicare beneficiaries.

Section 5 – Modification of Face-to-Face Encounter Documentation Requirement

This provision expands who can document the face-to-face encounter required for Medicare durable medical equipment prescriptions beyond physicians to align with the professionals who can furnish the face-to-face encounter, including nurse practitioners and physician assistants, as allowed by state law.

Section 6 – Reducing Improper Medicare Payments

This provision requires the Secretary to direct each MAC to establish an improper payment outreach and education program to provide information to providers of services and suppliers in the contractor's region. The information will include the provider's or supplier's most frequent and expensive payment errors, a notice of new topics that have been approved for audits by RACs, as well as specific instructions to correct and avoid errors and audit issues in the future.

This section requires MACs to give priority to reducing improper payments and preventing administrative errors as identified through the outreach and education program as those providers who have high improper payment or error rates. RACs will assist MACs by providing them with a list of improper payments on a quarterly basis. This information is to be provided to the RACs by the Secretary. The information will include the provider's and supplier's highest rate and greatest total dollar amounts of improper payments. The report will also include the items and services that have the highest rate and greatest total dollar amounts of improper payments.

The Secretary will retain a portion, not exceeding 15 percent, of the recovered amounts to implement corrective actions to help reduce the error rate of payments. The Secretary will use these funds to implement the programs in this section as well as prior authorization programs established in provisions contained in other sections of this discussion draft bill.

Section 7 – Medicaid Fraud Control Units

This provision allows Medicaid fraud control units to investigate and prosecute complaints of abuse and neglect of Medicaid patients in home and community based facilities, which receive payments under the State plan.

Section 8 – Improved Use of Funds by HHS Inspector General

This provision improves oversight and enforcement activities by providing the HHS OIG up to 1.5 percent of all amounts collected from Medicare false claim and fraud cases. These funds will be in addition to any appropriation provided for these activities.

Section 9 – Strengthening the Medicaid Program

This provision strengthens the Medicaid integrity program by providing the Secretary greater flexibility in how available resources are used to protect Medicaid from fraud, waste, and abuse.

Section 10 – Expansion of the Senior Medicare Patrol (SMP)

This provision requires the Secretary to develop a plan to encourage greater participation by individuals to report Medicare fraud and abuse. The plan shall include: recommendations for ways to enhance rewards for individuals reporting under the SMP incentive program; how to extend the program to Medicaid; and an improved SMP public awareness and education campaign to encourage participation. The plan shall be provided to Congress not later than 180 days after the date of enactment.

Section 11 – Requiring Valid Prescriber National Provider Identifiers on Pharmacy Claims.

This provision requires that CMS use the National Prescriber Identifiers (NPIs) as the only allowed prescriber identifier for the Medicare prescription drug program and requires that all subscriber claims be submitted with a valid prescriber NPI.

Section 12 – Improving Claims Processing and Detection of Fraud Within the Medicaid and CHIP Programs.

This provision requires that for payment to be made, each claim under Medicaid and the Children’s Health Insurance Program (CHIP) include a valid identification number of an individual who is verified and eligible to receive benefits.

Section 13 – Alternative Sections for Technical Noncompliance

This provision establishes a fixed financial penalty for an individual or entity that voluntarily discloses a technical violation of the Stark self-referral laws submitted through the existing Self-Referral Disclosure Protocol. This ensures that the penalty for technical noncompliance—e.g. an arrangement that is not in writing, that is not signed by one or more parties—is commensurate with the nature of the violation. The per-arrangement penalty will be capped at \$5,000 if submitted within the year of the noncompliance and \$10,000 thereafter. These predictable amounts are in contrast to the extensive liability exposure under current law. The Secretary will be required to promptly indicate whether it accepts these technical noncompliance disclosures. The Secretary will submit a report to Congress describing the impact of the changes made by this provision.

Section 14 – Electronic Medicare Summary Notice Option

This provision provides existing beneficiaries the option to receive a Medicare summary notice (MSN) electronically beginning in 2015. After 2017, new beneficiaries will be notified of their right to receive their summary statements electronically at the time of their enrollment. Under both these scenarios the beneficiary may rescind their decision to receive notices electronically and elect to receive them by mail again as many times as decided by the Secretary, but no less than once. The Secretary is encouraged to expand the electronic option to other Medicare statements and notifications using a similar process. Electronic MSNs and other statements and notifications may be provided more frequently than the title requires. The Social Security Administration has garnered nearly \$70 million dollars a year in program savings from a similar change.

Section 15 – Renewal of MAC Contracts

This provision allows the Secretary to bid MAC contracts every 10 years instead of the five current years. Currently, MAC contracts are for one guaranteed year and four option years, subject to yearly reviews by the Secretary for performance and efficiency. The five- year

contract period limits the Secretary's ability to replace poor performing MACs mid-cycle. Prospective bidders can only win the contract for the years that remain in the cycle before having to go through the entire bidding process all over again. Contracts will continue to be subject to annual renewal, now only with nine option years based on MAC performance. This increase in the potential total length of the contracts gives CMS more opportunity to replace subpar MACs and improves the ability of MACs to realize the results of their efforts and innovations.

Section 16 – Sharing Funds Recouped Through Medicare-Medicaid Data Match Program with States

This provision requires the Secretary to come up with incentives for states to fully invest in and join the Medi-Medi program. Increased participation by states will strengthen the Medi-Medi program.

Section 17 – Programs to Prevent Prescription Drug Abuse Under Medicare Part D

This provision creates a high-risk beneficiary drug management program under the supervision of a part D plan sponsor (PDP).

Beneficiaries determined to be of high risk can be locked in, as they are able to be currently in the Medicaid program (pharmacy only), into one physician and one pharmacy for certain opioids and other high-risk drugs. The section does not prevent beneficiaries from accessing any other prescribed drugs from whatever pharmacy they choose. The Secretary shall conduct reviews to remove beneficiaries from the high-risk program if it is concluded that they are no longer high risk. States shall be given the authority to share information in an effort to prevent prescription drug issues that involve crossing state lines.

This section will also put in place a review process for frequently abused drugs to monitor prescribers and beneficiaries. In order to manage such plans PDP sponsors will submit reports to Medicare Drug Integrity Contractors (MEDICs) on a monthly basis on providers and supplier services. Currently, MEDICs' duties only include receiving information from plans and investigating with very little reporting or accountability. The provisions outlined in this section will apply to the drug plan after January 1, 2015.

This section also provides for the MEDIC program to act as the state-by-state contact for which the providers can 'ping' beneficiary information to verify whether they have been locked-in by another plan.

This provision corrects vulnerabilities as beneficiaries who are high risk, drug abusers can be locked into one pharmacy under Medicaid but not under Medicare. Information sharing between states is currently limited, allowing for state-to-state drug shopping and is addressed by this section.

Section 18 – Application of Common Rule to Clinical Data Registries

This provision requires that the Secretary issue guidance on the application of the “Common Rule,” which provides protection for individuals involved in research. to clinical data registries. The guidance must be issued no later than one year after enactment.

Section 19 – Exclusion From Medicare Program Those Convicted For Defrauding Such Program

This provision requires that providers who are convicted of defrauding the Medicare program lose their eligibility for Medicare benefits, with the ability to earn back the entitlement by working 40 honest quarters.

Current consequences for providers who commit Medicare fraud are very light and limited to their practice of medicine within Medicare. Those who defraud the Medicare program should not be eligible to receive Medicare benefits unless they are able to re-earn the entitlement, protecting taxpayers from having to pay for the benefits of criminals who defraud seniors.

Section 20 – Gainsharing Study and Report

This provision requires the Secretary to issue a report describing how a permanent physician-hospital gainsharing program can best be established. The report is due no later than one year after enactment.

Section 21 – Modification of Medicare Home Health Surety Bond Condition of Participation Requirement

This provision requires the Secretary to require each home health agency to obtain a surety bond in the amount of no less than \$50,000 as a condition of participation in the Medicare program.

Section 22 – Requirement for Prior Authorization for Chiropractic Visits for Spinal Manipulation Reimbursement After 12 Visits

This provision requires the Secretary to subject a chiropractor’s request to furnish a service (or set of services) that manipulates the spine to correct a subluxation to prior authorization if that chiropractor has an aberrant billing pattern or meets another threshold. The provision directs the Secretary to review claims to ensure that these services are appropriate without subjecting all services to prior authorization. This targeted approach, along with the requirement that the Secretary make a prior authorization decision within 25 days, ensures beneficiaries have access to needed services.

An [OIG report](#) highlights misuse of the chiropractor billing codes that has resulted in improper payments that have cost the Medicare millions of dollars.

Section 23 – Limiting Payments for Vacuum Erection Systems for Medicare Beneficiaries

This provision requires that the Secretary include vacuum erection systems (VES) in the Durable Medical Equipment Competitive Bidding Program by 2016. Establishing a competitively bid rate will correct the excessive amount that Medicare currently pays for VES.

An [OIG report](#) documents overpayment for these products.

Section 24 – Requiring Prior Authorization for Reimbursement for Blepharoplasty and Eye Brow Surgeries

This provision creates a prior authorization program to ensure that Medicare pays only for eyelift (blepharoplasty) and browlift (browplasty) surgeries that are medically necessary. This provision is based on a study by the Center for Public Integrity that showed that Medicare paid for a significant number of eyelift and eyebrow surgeries performed for cosmetic reasons.

Section 25 – National Expansion of Prior Authorization Demonstration Program for Repetitive Scheduled Non-Emergent Ambulance Transport

This provision requires the Secretary to expand the prior authorization process for “repetitive scheduled non-emergent ambulance transports” that CMS is implementing in three states through its Center for Medicare & Medicaid Innovation. The provision expands that program to additional states in 2015 and establishes a national program starting in 2017.

The HHS OIG and the Medicare Payment Advisory Commission have highlighted a high billing error rate for these services that exposes the Medicare program to unnecessary waste.