S.1251

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TITLE I— PREVENTING PRESCRIPTION DRUG WASTE, FRAUD, AND ABUSE

Sec. 101 Requiring Valid National Provider Identifiers of Prescribers on Pharmacy Claims and Limiting Access to the National Provider Identifier Registry.

The Medicare prescription drug program requires that claims for reimbursement include a provider identifier for each prescription, which is used to demonstrate that a prescriber, such as a physician, is a valid provider under the Medicare program. Currently, acceptable prescriber identifiers include National Provider Identifiers (NPI), Drug Enforcement Administration (DEA) registration numbers, Unique Physician Identification Numbers (UPIN), and State license numbers. In fact, these identifiers are "the only data on Part D drug claims to indicate that legitimate practitioners have prescribed medications for Medicare enrollees."[1] However, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) has shown that that there are substantial numbers of reimbursed prescription drug claims with an invalid prescriber identification number.

The HHS OIG testified during a July 15, 2010 Senate Federal Financial Management Subcommittee hearing that CMS has not established a process to ensure valid identification numbers on reimbursed prescriptions under the Medicare Part D prescription drug program.[2] The HHS OIG detailed that $1.2 billion in Medicare Part D prescription drug claims in 2007 contained invalid prescriber identifiers, representing more than 18 million prescription drug claims.[3] These identifiers were not listed in NPI, DEA number, and UPIN registries, or had been deactivated or retired. In some cases, clearly invalid numbers were used (e.g., AA0000000, 000000000) and accepted by pharmacies dispensing prescription drugs. The HHS OIG described the prescriber identification numbers as valuable program safeguards for the Medicare prescription drug program. The HHS OIG concludes "it appears that CMS and Part D plans do not have adequate procedures in place to detect invalid values in the prescriber identifier field." The HHS OIG conducted a similar investigation of Schedule II medications and invalid prescriber identifiers under the Medicare program. [4]

In an April 2011 hearing before the House Committee on Ways and Means, Subcommittee on Oversight, a convicted Medicare fraudster testified that the publicly available prescriber identifier number is a useful tool in the commission of fraud against the Medicare program and recommended that these identifiers should be secured by the Medicare program.[5] The NPI registry and provider identifiers are publicly available via the HHS Website (https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do) and easily searchable, which can facilitate fraudulent use of prescriber identifiers. The American Medical Association[6] and National Health Care Anti-Fraud Association are proponents of making health care provider identifier numbers more secure.[7]

To address these findings, the Medicare and Medicaid FAST Act:

- Requires that Prescription Drug Plan (PDP) sponsors obtain valid prescriber identifiers on all pharmacy claims under Medicare Part D, and requires the provided prescriber identifiers be validated.
- Requires that National Prescriber Identifiers be adopted by Centers for Medicare and Medicaid Services (CMS) as the only allowed prescriber identifier for the Medicare prescription drug program.

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[1] HHS OIG, *Invalid Prescriber Identifiers on Medicare Part D Drug Claims*, OEI-03-09-00140, June 2010.
[2] Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security, *Preventing and Recovering Medicare Payment Errors*, July 15, 2010.
[3] HHS OIG, *Invalid Prescriber Identifiers on Medicare Part D Drug Claims*, OEI-03-09-00140, June 2010.
[4] HHS OIG, *Oversight of the Prescriber Identifier Field in Prescription Drug Event Data for Schedule II Drugs* (A-14-09-00302), Feb 2, 2011.
[5] House Committee on Ways and Means, Subcommittee on Oversight, *Improving Efforts to Combat Health Care Fraud*, March 2, 2011.
[6] AMA Comments on Health Insurance Portability and Privacy Act Administrative Simplification: National Plan and Provider Enumeration System Data Dissemination Notice, July 2007.
[7] National Health Care Anti-Fraud Association, *Combating Health Care Fraud in a Post-Reform World: Seven Guiding Principles for Policymakers*, Oct. 6, 2010.

- Requires HHS to, in consultation with stakeholders, establish procedures and rules to modify access to the National Provider Identifier Registry to governmental and non-governmental entities, as appropriate, in order to deter its fraudulent use.

Sec. 102 Encouraging the Establishment of State Prescription Drug Monitoring Programs.

GAO identified, as part of a five state review, 65,000 Medicaid beneficiaries that were visiting 6 or more doctors to obtain prescriptions for 10 frequently abused controlled substances. Under this "doctor shopping scheme", these individuals incurred $63 million in Medicaid costs for prescription drugs.[8] With a consolidated database of controlled substance sales, states could better identify individuals that are obtaining unacceptable levels of controlled substances, including sales from numerous states. The Drug Enforcement Agency (DEA) supports PDMPs and encourages their use by medical professionals.[9]

To address these weaknesses, the Medicare and Medicaid FAST Act:

- Encourages the establishment and use of a Prescription Drug Monitoring Program (PDMP), an electronic reporting system of distribution of controlled substances to end users by each state, by giving states an increased share of recoveries that are attributable to data contained in an electronic PDMP as a financial incentive. The PDMP must be certified by the Attorney General to be in compliance with specific PDMP requirements.
- Establishes a commission to examine PDMP interoperability issues, such as best practices with respect to uniform electronic formats and interfaces between programs. The commission is to include the Secretary of HHS, the Attorney General, and other agency heads and stakeholders. The commission shall sunset 3 years after enactment of this Act and members will not be compensated.
- Requires the Secretary of HHS to report to Congress on how Medicare Part D oversight contractors and other oversight activities can utilize state PDMPs.

Sec. 103 Updating of DEA Database of Controlled Substances Providers.

Currently, the Drug Enforcement Agency (DEA) has approximately 1.3 million registrants for the prescription or distribution of controlled substances. This data is available for confirmation by other registrants and various states and agencies, including CMS. DEA currently matches its database of controlled substances prescribers on a monthly basis against the death records maintained by Social Security Administration (SSA) in order to reconcile these databases and curb healthcare fraud. According to testimony in 2009, DEA is working to improve this process.[10] Conducting a DEA to SSA data match on a daily basis would prove beneficial. Further, while the DEA has some access to individual state's medical licensing information, the DEA could improve its access through a national-level database such as through the Federation of State Medical Board.

To strengthen controls over prescribing of controlled substances, the Medicare and Medicaid FAST Act requires:

- Not less frequently than on a daily basis, the Department of Justice shall update the database of the Drug Enforcement Agency of persons registered to manufacture, distribute, or dispense a controlled substance under part C of title II of the Controlled Substances Act (21 U.S.C. 821 et seq.) to reflect any changes in the information in the Death Master File of the SSA. It is the sense of Congress that these updates should include other information determined relevant by the Attorney General such as information from state medical boards.

[8] GAO, *Medicaid: Fraud and Abuse Related to Controlled Substances Identified in Selected States*, GAO-09-957, Sept. 9, 2009.
[9] Statement of Joseph T. Rannazzisi, Deputy Assistant Administrator, Office of Diversion Control, Drug Enforcement Administration Before the Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security; Committee on Homeland Security and Governmental Affairs, United States Senate. "*A Prescription for Waste: Controlled Substance Abuse in Medicaid,* Sept. 20, 2009.
[10] IBID, Statement of Joseph T. Rannazzisi.

- The Attorney General, along with the Secretary and HHS OIG, shall establish policies, procedures, and rules to restrict access to the DEA database, as appropriate, including providing access to governmental and nongovernmental entities, as appropriate.
- Policies and procedures will also be developed to review and investigate Medicare Part D claims that contain registration numbers that are not assigned by the Attorney General for distribution of controlled substances.

TITLE II—CURBING IMPROPER PAYMENTS

Sec. 201 Addressing Vulnerabilities Identified by Recovery Audit Contractors.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and the Tax Relief and Health Care Act of 2006 resulted in the implementation and use of Recovery Audit Contractors (RACs) in Medicare. RACs are private companies hired to identify payment errors made to Medicare providers. [30] CMS pays RACs contingency fees on overpayments collected and underpayments identified. Further, RACs are required to report identified vulnerabilities that result in payment errors to CMS. CMS and its Medicare Administrative Contractors (MACs) are responsible for taking corrective actions for vulnerabilities identified by the RACs, including the determination of the causes of each type of vulnerability, and addressing them in order to reduce future improper payments.

The GAO found that CMS did not develop a process to take corrective actions or implement sufficient monitoring, oversight, and control activities to ensure the "most significant" RAC-identified vulnerabilities were addressed. Further, CMS did not take corrective actions on RAC-identified vulnerabilities, such as conducting provider education or implementing computer system changes to help prevent future improper payments. CMS and the MACs did not implement corrective actions for 35 of 58 (60 percent) of the most significant vulnerabilities that led to improper payments during a two-year RAC demonstration.[11]

To address these findings, this legislation requires that:

- HHS shall address overpayment vulnerabilities identified by Recovery Audit Contractors (RACs) in a timely manner, by establishing a process for tracking the effectiveness of changes made to payment policies and procedures that address the vulnerabilities identified by RACs.
- As part of previously established reporting requirements to the Congress, the HHS Secretary shall annually report on the types and financial cost of improper payment vulnerabilities identified by RACs, how the Secretary is addressing such improper payment vulnerabilities, and an assessment of the effectiveness of changes made to payment policies and procedures. HHS shall ensure that each report does not include information that would be sensitive or otherwise negatively impact program integrity.

Sec. 202 Improving Senior Medicare Patrol and Fraud Reporting Rewards.

The Senior Medicare Patrol (SMP) recruits retired professionals to serve as educators and resources in helping beneficiaries to detect and report fraud, waste, and abuse in the Medicare program. The HHS OIG collects performance data collected semiannually:[12]

- More than 2.8 million beneficiaries have been educated during more than 74,000 group education sessions led by SMP staff or SMP projects;
- Over 1 million one-on-one counseling sessions were held with or on behalf of a beneficiary;
- Over 23 million people are estimated to have been reached by SMP community education events;

[11] GAO, *Medicare Recovery Audit Contracting: Lessons Learned to Address Improper Payments and Improve Contractor Coordination and Oversight*, GAO-10-864T, July 15, 2010.
[12] HHS OIG, *Memorandum Report: Performance Data for the Senior Medicare Patrol Projects: May 2010 Performance Report*, OEI-02-10-00100, May 19, 2010.

- Approximately 1.2 million media outreach events have been conducted;
- Nearly 177,000 complaints received from beneficiaries, their families or caregivers as a result of educational efforts were resolved or referred for further investigation;
- Nearly $106 million in savings, including Medicare and Medicaid funds recovered, beneficiary savings and other savings have been attributed to the project as a result of documented complaints.

There is an existing reward program that provides up to $1,000 to beneficiaries who help identify Medicare fraud. However, a similar reward program for the IRS is much more successful in encouraging potential fraud reporting.[13]

To facilitate this program, the Medicare and Medicaid FAST Act requires:

- HHS to develop a plan, including suggested legislative changes to implement a plan to encourage greater participation by individuals to report fraud and abuse in the Medicare program. The plan shall include recommendations for ways to enhance rewards for individuals reporting under the incentive program, including providing a monetary reward prior to the full recovery of an overpayment. The plan shall also have the SMPs conduct a 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.

Sec. 203 Prohibiting the Display of Social Security Account Numbers on Newly Issued Medicare Identification Cards and Communications Provided to Medicare Beneficiaries.

Currently, Social Security Numbers (SSNs) of Medicare beneficiaries are displayed on Medicare identification cards making them vulnerable to theft and fraudulent use. Many states and other federal agencies have eliminated the use of SSNs on identification cards. In 2004, GAO reported that millions of SSNs were subject to exposure on individual identity cards issued under federal auspices. At that time, an estimated 42 million Medicare cards displayed entire nine-digit SSNs, as did some Department of Defense insurance cards, approximately 8 million DOD identification cards, and 7 million Department of Veterans Affairs' beneficiary cards.[14] All of these agencies, except Medicare, were taking steps to reissue cards without social security numbers. Medicare cards still show this information, over 6 years later.

In May 2006, a Presidential Identity Theft Task Force was formed to develop a coordinated plan to prevent identity theft, help victims, and prosecute the criminals who perpetrate it. The task force issued its Strategic Plan, with several recommendations for action, the following year.[15] One recommendation was to restrict the public display and the transmission of SSNs. Specifically the task force stated that "federal agencies should reduce the unnecessary use of Social Security numbers (SSNs), the most valuable commodity for an identity thief." Further, the Social Security Administration includes not using SSNs on identification cards as a best practice for protecting SSNs from identity theft.[16]

To better protect beneficiaries from fraud, this Act requires that:

- Not later than 2 years after the date of enactment, the HHS Secretary, in consultation with the Commissioner of Social Security Administration, shall establish and begin to implement procedure to eliminate the unnecessary collection, use, and display of Social Security account numbers of Medicare beneficiaries.
- Not later than 4 years after the date of enactment, the HHS Secretary, in consultation with the Commissioner of Social Security shall ensure that each newly issued Medicare identification card does not display (or electronically store in an unencrypted format) a Medicare beneficiary's Social Security account number. The use

[13] Internal Revenue Service, *FY 2009 Annual Report to Congress on the Use of Section 7623*.
[14] GAO, *Social Security Numbers: Governments Could Do More to Reduce Display in Public Records and on Identity Cards*; GAO-05-59, Nov. 9, 2004.
[15] The President's Identity Theft Task Force, *Combating Identity Theft, A Strategic Plan* (April 2007).
[16] Social Security Administration: Philadelphia Region, *Avoid Identity Theft: Protect Social Security Numbers*.

of a partial Social Security account number is acceptable if the Secretary determines that such use does not allow an unacceptable risk of fraudulent use.

- Not later than 4 years after the date of enactment, the HHS Secretary shall prohibit the display of a Medicare beneficiary's Social Security account number on written or electronic communication provided to the beneficiary unless the Secretary determines that inclusion of Social Security account numbers on such communications is essential for the operation of the Medicare program.
- HHS shall establish a pilot program utilizing smart card technology to evaluate the applicability of smart card technology to the Medicare program and whether such cards would be effective in preventing fraud under the Medicare program. The term "smart card" includes a card that may rely on existing commercial data transfer networks, maybe be adapted from the financial services industry, contain individual biometric identification provided it is encrypted and not contained in any central database, technology utilized in the TRICARE program, or other technology determined appropriate by the HHS Secretary.
- The pilot program shall be implemented not later than 1 year after the date of enactment of this Act and shall be conducted in not less than 2 states for a period of not less than 180 days or more than 2 years.
- The HHS Secretary shall report to Congress not later than 12 months after completion of the pilot to include a summary of the pilot program and findings, including the costs or savings to the Medicare program as a result of the implementation of the pilot program, whether the use of smart card technology resulted in improvement in the quality of care provided to Medicare beneficiaries under the pilot program, whether such technology was useful in preventing or detecting fraud, waste, and abuse in the Medicare program, and recommendations regarding whether the use of smart card technology should be continued or expanded.

Sec. 204 Requiring Prepayment Review of All Durable Medical Equipment Claims at High Risk of Waste, Fraud, and Abuse.

Abuse in the prescription and supply of durable medical equipment, often reported in power wheelchairs, has been a problem at CMS for nearly ten years. Also, the number and cost of power wheelchair reimbursement continues to grow. In 1999, Medicare paid $289 million for motorized wheelchairs. In 2007, approximately 173,300 Medicare beneficiaries received power wheelchairs, at a cost of $686 million.[17]

A standard power wheelchair costs the Medicare program an average of $4,018 to lease, compared with $1,048 for suppliers to buy—four times what the supplier pays. This cost to reimbursement difference can attract unscrupulous providers. The HHS Inspector General reported that criminal gangs are increasingly involved in Medicare fraud. In one case in California criminal gangs were responsible for at least $90 million in power wheelchairs and orthotic device fraud.[18] The President's Fiscal Year 2012 Budget for the Department of Health and Human Services proposed that all power wheelchair claims undergo a required prepayment or earlier review.[19]

To implement the President's proposal and improve controls over high risk durable medical equipments, this legislation requires that:

- The HHS Secretary in consultation with the HHS OIG shall establish, not later than 270 days after the date of enactment, policies and procedures for prepayment review, which may include pre-certification, for all claims for reimbursement for durable medical equipment at high risk of waste, fraud, and abuse, including power wheelchairs.

[17] HHS OIG,Power Wheelchairs In The Medicare Program: Supplier Acquisition Costs And Services, OEI-04-07-0040, Aug. 2009.
[18] HHS OIG, Testimony of Daniel Levinson, "Medicare's Competitive Bidding Program For Durable Medical, Equipment: Implications for Quality, Cost and Access," September 15, 2010.
[19] HHS, Budget in Brief for fiscal year 2012

Sec. 205 Strengthening Medicaid Program Integrity Through Flexibility.

- Allows program integrity funds within the Centers for Medicare and Medicaid Services to be spent for hiring federal staff, whereas current law restricts some program integrity funding only through contracting. This allows CMS to develop more in-house program integrity expertise, and avoid losing expertise when a contract is changed.

TITLE III—IMPROVING DATA SHARING ACROSS AGENCIES AND PROGRAMS

Sec. 301 Improving Data Sharing Across Agencies and Programs.

The various claims data, provider, beneficiary and other databases maintained by CMS are critical for program integrity efforts. However, these databases and related information technology systems are often antiquated and need substantial improvements. Also, databases are updated or accessed at an inadequate frequency. For example, data transfers of Medicare claims data can happen monthly, weekly or daily depending on the system, database, or contractor type. The National Health Care Anti-Fraud Association has proposed data consolidation and improved data analysis for health care fraud detection and prevention.[20]

The provider databases represent critical and more updated information that would greatly assist in curbing fraud. For example, in 2008 the Committee on Homeland Security and Government Affairs, Permanent Subcommittee on Investigations, reported that, from 2000 through 2007, Medicare paid for approximately 478,500 claims that contained the UPINs of deceased doctors, and the number of claims paid could have been as high as 570,000. It was estimated that the amount of money paid for these claims is well over $76.6 million, and it is possible that that number actually exceeded $92 million.[21]

One solution under pursuit by CMS is the establishment of the Integrated Data Repository (IDR) and One Program Integrity (One PI). The IDR is intended to warehouse Medicare prescription drug data as well as data on inpatient care, physician services, and other services[22] provided under Medicare Parts A, B and D. One PI is to provide access to IDR data and analytical tools. CMS calls the IDR, an "integral part of the CMS data warehouse strategy" because it "ensures a consistent, reliable, secure, enterprise-wide view of data supporting CMS and its partners in more effective delivery of quality health care at lower cost to CMS' beneficiaries through state-of-the-art health informatics."[23] Data from the IDR is accessible for analysis using the One PI system and to Medicare Drug Integrity Contractors (MEDICS)as needed. However, data on Medicare Part A & B claims paid are transferred to the IDR, on a weekly basis from the Common Working File. Also, less than 50 people are currently using the IDR and One PI systems, and program integrity contractors have only limited access to the capabilities of One PI or the IDR.

The President's Fiscal Year 2012 Budget for the Department of Health and Human Services endorses improvement to the CMS data and information infrastructure. The budget proposes increased flexibility by the Secretary to focus technology on areas with the greatest return on investment.[24]

In order to ensure that the CMS, other Federal agencies, entities that are under contract with the CMS, partners of law enforcement at the State and local level, and state Medicaid offices operate with greater coordination to curb fraud and

[20] National Health Care Anti-Fraud Association, *Combating Health Care Fraud in a Post-Reform World: Seven Guiding Principles for Policymakers*, Oct. 6, 2010.
[21] United States Senate, Permanent Subcommittee On Investigations, Committee on Homeland Security and Governmental Affairs; *Medicare Vulnerabilities: Payments For Claims Tied To Deceased Doctors*, July 9, 2008.
[22] HHS OIG, *CMS's Implementation Of Safeguards During Fiscal Year 2006 To Prevent And Detect Fraud And Abuse In Medicare Prescription Drug Plans*, OEI-06-06-00280, Oct 2007.
[23] CMS Integrated Data Repository (IDR) Overview
[24] HHS, Budget in Brief for fiscal year 2012

improper payments (including through the sharing of information on providers of services and suppliers that have operated in one State and are excluded from participation in the Medicare program), the HHS Secretary, the Attorney General, and the Social Security Administrator shall provide for increased coordination and data sharing.

Specific steps required by this section are:

- *Improving Data Sharing Internally and with CMS Oversight Contractors*. Requires HHS to establish policies and procedures to ensure that claims and other data is accessible to Medicare program safeguard contractors and other oversight contractors occur on no less than a daily basis.

- *Require Ongoing Analysis of Claims Data By Oversight Contractors.* Requires Medicare program safeguard contractors and other oversight contractors to analyze the data transferred on an ongoing basis for purposes of pre- and post-payment reviews. The data to be reviewed includes claims payment, claims denial, and other claims data, data on providers of services and suppliers, and Medicare beneficiary data.

- *Require Provider Database Reviews and Verification.* Requires HHS to establish policies and procedures to review and update for accuracy and completeness, on a daily basis, the Medicare provider databases, including the Provider Enrollment and Chain Ownership System or PECOS. The verification is to include data matches against the SSA Death Master File (which is the federal database of people who have died), and other appropriate federal databases as determined by the Secretary, such as the Department of Justice and each State's Department of Correction list of Incarcerated Persons. HHS is required to periodically consult with external organizations, including the Federation of State Medical Boards, to determine the best suited data sources to detect fraudulent application for enrollment. HHS shall also grant access to National Database of New Hires to CMS (Under current law this database, which is maintained by HHS, excludes access to the CMS). Finally, HHS shall employ analytic software for ongoing analysis of the provider databases to verify and update provider supplied data. This verification may include the use of commercial database sources.

- *Require Beneficiary Data Base Review and Verification*. Requires HHS to establish policies and procedures to review and update on a daily basis beneficiary databases, including, but not limited to the Eligibility Database, for accuracy, including data matches against the SSA Death Master File, and other appropriate federal databases as determined by the Secretary (currently, many of these data checks and updates happen on only a weekly or monthly basis). This includes a list of incarcerated individuals from the Department of Justice and each State's Department of Corrections. Further, HHS shall use analytic software for ongoing analysis of the beneficiary databases to verify and update provider supplied data. This verification can include the use of commercial database sources. The Attorney General shall provide the HHS Secretary access to a list of convicted individuals for use in preventing fraud, waste, and abuse under Medicare and Medicaid programs.

- *Continued Efforts On Integrated Data Depository And One PI Project And Expanded Access By Agencies*. Requires CMS to continue to incorporate Medicare claims and payment, provider, and beneficiary data into the Integrated Data Repository (IDR) and fully implement the waste, fraud, and abuse detection software called the "One PI Project." Further, HHS shall establish policies and procedures to ensure that the IDR will be updated with claims payment data, provider databases and beneficiary databases, including the Common Working File, on a daily basis. Access to the full range of data contained in the IDR and related analytic tools will be made available to program safeguard contractors and other oversight contractors by not later than September 30, 2012. This access will include both real time portal access and other means in accordance with protocols established by the HHS Secretary.

- *Access to CMS Databases by Federal Law Enforcement.* The Secretary shall ensure access to the full range of data contained in the IDR and related analytic tools is made available for federal and other appropriate law

enforcement, including the HHS OIG and the DOJ, not later than September 30, 2012. This access will include both real time portal access and other means in accordance with protocols established by HHS.

- *Inclusion of Prepayment Claims Data and Medicaid Data.* The HHS Secretary shall ensure the IDR includes access to prepayment claims data by not later than September 30, 2012, and incorporates Medicaid data by not later than September 30, 2014. If States are not able to provide certain data by such date, a substantial amount of the Medicaid program data should be included by such date.

- *Expand Database Access to Appropriate State Agencies*. For purposes of enhancing data sharing in order to identify programmatic weaknesses and improve the timeliness of analysis and actions to prevent waste, fraud, and abuse, relevant State agencies, including the State Medicaid plans, State child health plans, and State Medicaid fraud control units, shall have access to the full range of data contained in the Integrated Data Repository, including the One PI system, by not later than September 30, 2013. The Secretary may, in consultation with the Inspector General of the Department of Health and Human Services, give such access to State attorneys general and State law enforcement agencies.

- *Establish Strong Privacy Protocols and Security Requirements*. HHS shall ensure that any data provided to an entity or individual under the provisions of, or amendments made by this section, is provided to such entity or individual shall be in accordance with protocols established by the Secretary. The Secretary shall consult with the Inspector General of HHS prior to implementing this subsection. These protocols will ensure the secure transfer and storage of any data provided to another entity or individual. In establishing the protocols, the Secretary will take into account recommendations by the HHS Inspector General.

Sec. 302 Expanding Automated Prepayment Review of Medicare Claims.

Currently, the claims processing system under the two parts of the Medicare fee-for-service program— Federal Intermediary Standard System (FISS) for Medicare Part A and the Medicare Multi-Carrier System (MCS) for Medicare Part B—are not interoperable, and claims cannot be compared before payment. This means that medical services under one part with a relationship or dependency of service under the other cannot be cross-checked. For example, trips by ambulance to an emergency room cannot be routinely compared to service in the emergency room to determine if the trip was valid.

Further, there is no current process to verify the ongoing eligibility of Medicare providers and suppliers from the time of enrollment through reenrollment. Thus, a health care provider whose license to practice is rescinded may remain an eligible provider under the Medicare program.

Finally, there is no process in place to track claims that are submitted and rejected via automatic edits prior to payment. Without tracking of this information, CMS is missing out on a vital data source to identify appropriate areas for billing education and to detect fraudsters who just bill the system over and over until they identify a path for submitting claims that pass the edits and are ultimately paid. In an April 2011 before the House Committee on Ways and Means, Subcommittee on Oversight, a convicted Medicare fraudster testified that Medicare should put in place a method for detecting multiple billings for rejected claims.[25]

To better detect fraud or waste between Medicare Parts A and B, and expand automated prepay review of Medicare claims, the Medicare and Medicaid FAST Act:

- Requires the Secretary to establish a prepayment review of all Medicare A and B claims by not later than September 30, 2012. Prepayment review shall include a program integrity system to compare claims submitted

[25] House Committee on Ways and Means, Subcommittee on Oversight, *Improving Efforts to Combat Health Care Fraud*, March 2, 2011.

under Medicare Part A and B to identify errors or fraud including duplicate claims for items or services; claims where payment of benefits under one such part is only available if such payment is dependent upon an associated payment in another such part; and obtain other program integrity information or analysis as determined useful by the Secretary. Not later than September 30, 2013, the Secretary shall establish a plan for including Medicare Part D claims for use in this analysis.

- Not later than September 30, 2013, the HHS Secretary shall establish an automated risk-based verification system of Medicare service and supply providers on an ongoing basis for the period between enrollment and revalidation. This system shall include criminal background checks for provider of services and suppliers who the HHS Secretary determines present a high risk of waste, fraud, and abuse. This screening process shall be in addition to, and not duplicate, current screening.
- Requires that not later than September 30, 2013, the HHS Secretary establish a process for identifying and tracking, including by provider of services and supplies, claims for payment that were rejected or denied under the automated edit process of a Medicare administrative contractor.

Sec. 303 Improving the Sharing of Data between the Federal Government and State Medicaid Programs.

Dual eligible beneficiaries are those eligible to receive both Medicare and Medicaid coverage. Dual eligible beneficiaries are generally poorer, are more likely to have extensive health care needs, and use more medications than other Medicare beneficiaries.[26] Dual eligible beneficiaries are typically higher cost to Medicare and Medicaid, so the payment errors have corresponding higher dollar value. The approximately 7 million dual eligible beneficiaries compromise less than 20 percent of Medicare enrollees, but they cost the state and federal governments more for their health care than all of the remaining 30 million Medicare beneficiaries.[27] Currently, only a small number of state Medicaid offices are receiving information from CMS on payment errors relating to dual eligible beneficiaries.

Medicare-Medicaid or "Medi-Medi" is the comparing of claims data from Medicare and Medicaid to detect potential fraud and abuse patterns that are difficult to detect when examined independently. There have been Medi-Medi data projects in various states over time. Individual Medi-Medi projects uncover a variety of health care fraud schemes. In fiscal year 2005, the Pennsylvania Medi-Medi project uncovered a weakness in the process for billing and processing pharmaceutical drug claims stemming from the Medicare program and the Medicaid program using different procedure coding systems. As a result, $20 million in potential overpayments were identified for calendar year 2004 alone.[28] There is a need for greater coordination between Medicare and state Medicaid programs in order to better identify claims for improper payments, and to determine whether the same service paid by both programs.

The Medicare and Medicaid FAST Act:

- Requires HHS to establish a plan to encourage and facilitate the inclusion of States in the Medicare and Medicaid Data Match Program and revises the Medicare and Medicaid Data Match Program to improve the program by furthering the design, development, installation, or enhancement of an automated data system to collect, integrate, and access data for program integrity, oversight, and administration purposes.
- Requires HHS to develop and implement a plan that allows each State agency access to relevant data on improper payments for health care items or services provided to dual eligible individuals.
- Requires HHS, in consultation with the HHS OIG, submit to Congress a plan to increase the recovery of overpayments for health care items or services provided to dual eligible individuals. This plan is to be provided not later than one year after the date of enactment of this Act.

[26] GAO, *Medicare Part D: Challenges in Enrolling New Dual-Eligible Beneficiaries;* GAO-07-272, May 4, 2007.
[27] Kaiser Commission on Medicaid and the Uninsured; *Where Does the Burden Lie? Medicaid and Medicare Spending for Dual Eligible Beneficiaries*, April 2009.
[28] HHS & DOJ, Health Care Fraud and Abuse Control Program Annual Report For FY 2005, August 2006.

Sec. 304 Improving Claims Processing and Detection of Fraud within the Medicaid and CHIP Programs.

The HHS OIG analysis of the Medicaid Statistical Information System – the only source of nationwide Medicaid claims and beneficiary eligibility information– revealed that the U.S. Government does not provide "timely, accurate, or comprehensive information for fraud, waste, and abuse detection." The HHS OIG stated that "Our results indicate opportunities for States and CMS to reduce the timeframes for file submission and validation.... Further, there are opportunities for CMS to improve the documentation and disclosure of error tolerance adjustments and expand current State Medicaid data collection and reporting to further assist in fraud, waste, and abuse detection..."[29]

In its report to Congress, the Medicaid and CHIP Payment and Access Commission (MACPAC) reported that issues such as data timeliness, consistency, and availability have presented longstanding challenges. For instance, different Medicaid and CHIP data are collected from states at different times for different purposes, with states reporting some information on their Medicaid and CHIP programs more than once. In addition to these redundancies, there are gaps in some of the data sources created in this process that limit their usefulness and need improvements.[30]

To address these weaknesses, Medicare and Medicaid FAST Act requires:

- HHS shall require that for payment to be made, each claim under Medicaid and the Children's Health Insurance Program include a valid beneficiary identification number of an individiaul who is eligible to receive benefits and a valid National Provider Identifier for a provider that is eligible to receive payment.

Sec. 305 Reports.

To inform the Congress, the Medicare and Medicaid FAST Act requires the following reports:

- *Report to Congress on Plan*. Within 270 days of passage, the Secretary, in consultation with the Commissioner of Social Security and the Attorney General, shall report to Congress a plan for implementing Sections 301 through 304 of this Act.
- *Expanding Reporting under the Annual Health Care Fraud and Abuse Control Account Report:* Updates to the Annual Health Care Fraud and Abuse Control Account Report are to include potential challenges in meeting the deadlines for implementation of the provisions and amendments made in Sections 301 through 304 of this Act.
- *Report to Congress on Interagency Cooperation and Data Sharing.* Not later than 180 days after enactment of this Act, the HHS Secretary, in consultation with the Administrator of the Veterans Administration, the Secretary of Defense, the Director of the Office of Personnel Management, and the head of any other relevant Federal agency that administers a Federal health care program, shall submit to Congress a report on the potential of data sharing to prevent and detect potential fraud and improper payments under the Medicare program.

TITLE IV—IMPROVING CMS CONTRACTOR PERFORMANCE

Sec. 401 Establishing Medicare Administrative Contractor Error Reduction Incentives.

The Medicare fee-for-service (FFS) claims reimbursement process is extremely error prone. In 2010, Medicare reported $34.3 billion in improper payments in its FFS program, a 10.5% error rate.[31] CMS established the Comprehensive Error Rate Testing (CERT) program to calculate a national paid claims error rate for all the Medicare Fee-For-Service program Medicare Administrative Contractors (MACs) and comparable entities.

[29] HHS OIG, MSIS Data Usefulness for Detecting, Fraud, Waste, and Abuse, OEI-04-07-00240, Aug. 26, 2009.
[30] MACPAC, *Report to the Congress on Medicaid and CHIP*, March 2011.
[31] Department of Health and Human Services, FY 2010 Agency Financial Report, Nov. 15, 2010.

Recently, the HHS OIG reported that the Jurisdiction 1 Medicare administrative contractor overpaid $7,545,772 in certain outpatient services from January 1, 2006, through June 30, 2009—a seventy percent error rate in the transactions reviewed by the HHS OIG.[32] The contractor made these overpayments because there were not sufficient edits in place to prevent or detect the overpayments and the contractor had not collected these overpayments at the time of the audit.

In 2010, GAO reported on Medicare administrative contractor award fee incentive metrics. For the three Medicare administrative contractors reviewed, a metric for decreasing the CERT rate was not considered in the determination of the incentive fee awarded.[33]

The Department of Defense health care system, TRICARE, uses an incentive payment model in which an error rate is determined for its reimbursement contractors under an established audit process. The reimbursement contractor is liable for the total amount above a 2% error rate. This contractual design, along with pre and post payment controls, is reported to minimize DOD's risk for improper payments in this program.[34]

To reduce payment errors:

- HHS shall establish a plan to provide incentives for MACs and applicable fiscal intermediaries and carriers to reduce their improper payment error rates. The plan may include a sliding scale of bonus payments and additional incentives for MACs that reduce their error rates to certain benchmark levels and shall include penalties, including substantial reduction in payments under award fee contracts, for MACs that reach a certain error threshold.

Sec. 402 Separating Provider Enrollment and Screening from Medicare Administrative Contractors.

Under current law, Medicare Administrative Contractors (MACs) perform both provider enrollment and the paying of provider claims. In the President's Budget for HHS for fiscal year 2011, the Administration proposed separating the functions of provider enrollment from the paying of provider claims. The Administration proposal specifically limited the number of administration contractors that would carry out provider enrollment, and would establish designated enrollment regions of the country, standardizing the process and creating efficiencies.[35]

To enact the President's proposal, the Medicare and Medicaid FAST Act requires that:

> Enrolling and screening of Medicare providers shall be carried out under one or more contracts. Such contracts shall be separate from any contract to serve a MAC.

Sec. 403 Developing Measurable Performance Metrics for Medicare Contractors.

The Medicare and Medicaid FAST Act requires:

- Not later than 12 months after enactment, HHS shall submit to Congress a report containing measurable metrics for improving Medicare contractor performance, including MACs, program safeguard contractors, and other similar contractors, Medicare Drug Integrity Contractors, qualified independent contracts, and other contractors that perform administration or oversight functions under the Medicare program. The report should include

[32] HHS OIG, *Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by Palmetto GBA, LLC, in Jurisdiction 1 for the Period January 1, 2006, Through June 30, 2009*, A-09-10-02018, May 3, 2011.
[33] GAO, Medicare Contracting Reform: Agency Has Made Progress with Implementation, but Contractors Have Not Met All Performance Standards, GAO-10-71, March 25, 2010.
[34] DOD, *Department of Defense Agency Financial Report: Addendum A*, Nov. 15, 2010.
[35] HHS, Budget in Brief for fiscal year 2011

recommendations for the development of measurable performance metrics and recommendations for such legislation and administrative action as the Secretary considers appropriate. No more than 270 days after reporting to Congress, GAO shall submit to Congress a report containing a review of the HHS report.

TITLE V—OTHER PROVISIONS

Sec. 501 Strengthening Penalties for the Illegal Distribution of a Medicare, Medicaid, or CHIP Beneficiary Identification or Billing Privileges.

The President's Fiscal Year 2012 Budget for the Department of Health and Human Services includes a budget proposal to encourage the strengthening of penalties for the knowing distribution of Medicare, Medicaid, or CHIP beneficiary identification numbers.[36]

The Medicare and Medicaid FAST Act requires:

- Any person who knowingly, intentionally, and with the intent to defraud, purchases, sells or distributes, or arranges for the purchase, sale, or distribution of a Medicare, Medicaid, or CHIP beneficiary identification number or billing privileges under Medicare, Medicaid, or CHIP shall be imprisoned for not more than 10 years or fined not more than $500,000 ($1,000,000 in the case of a corporation), or both.

Sec. 502 Providing Implementation Funding.

The Medicare Improvement Fund (MIF) was established by the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008. Funds in the MIF are available to HHS for the purpose of making improvements under the Medicare Parts A & B programs, including addressing projected shortfalls in the program. The amounts in the MIF have been modified many times by several pieces of legislation, but the net effect is that there will be $275 billion in the MIF in fiscal year 2015.

- This Act allows $75 million to be transferred from the Medicare Improvement Fund in order to make these funds available for program integrity activities under this Act.

[36] HHS, Budget in Brief for fiscal year 2012