Short Summary Of Policies

The Medicare and Medicaid FAST Act

- **Requires Valid National Provider Identifiers of Prescribers on Pharmacy Claims.** 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.

- **Encourages the Establishment of State Prescription Drug Monitoring Programs.** A Prescription Drug Monitoring Program (PDMP) is 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 Government Accountability Office (GAO) identified 65,000 Medicaid beneficiaries that were visiting 6 or more doctors to obtain prescriptions for 10 frequently abused controlled substances. The steps under this provision help curb that abuse.

- **Requires Updating of DEA Database of Controlled Substances Providers.** Currently, the Drug Enforcement Administration (DEA) has approximately 1.3 million registrants for the prescription or distribution of controlled substances. But DEA currently only matches its database of controlled substances prescribers on a monthly basis against the death records maintained by the Social Security Administration (SSA) in order to reconcile these databases and curb healthcare fraud. Conducting a DEA-to-SSA data match on a daily basis would prove beneficial.

- **CMS Must Address Vulnerabilities Identified by Recovery Audit Contractors.** 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" Recovery Audit Contractor (RAC)-identified vulnerabilities were addressed. Mandates HHS address overpayment vulnerabilities identified by 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.

- **Improve on Senior Medicare Patrol and Fraud Reporting Rewards.** The Senior Medicare Patrol (SMP) recruits retired professionals to volunteer as educators and resources in helping beneficiaries to detect and report fraud, waste, and abuse in the Medicare program. HHS shall develop an improvement plan, under which HHS could also revise the beneficiary incentive program to encourage greater participation in SMP.

- **Prohibits the Display Of Social Security Account Numbers On Newly Issued Medicare Identification Cards, Conduct Smart Card Pilot.** Not later than 2 years after enactment, HHS and SSA shall begin to eliminate the unnecessary collection, use, and display of Social Security account numbers of Medicare beneficiaries. Not later than 4 years after enactment, new Medicare card wills not display a Medicare beneficiary's Social Security entire account number. HHS shall establish a pilot program to evaluate the applicability of smart card technology to the Medicare program.

- **Requires Prepayment Review of Claims for Durable Medical Equipment 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. HHS, in consultation with the HHS Office of Inspector General (OIG) shall establish policies 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.

- **Strengthen Medicaid Program Integrity.** Allows program integrity funds within CMS to be used to develop more in-house program integrity expertise, and avoid losing expertise when a contract is changed.

- **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. HHS shall: establish improved data sharing of claims payment data internally and with CMS oversight contractors; require ongoing analysis of claims data by oversight contractors; require ongoing provider database reviews and verification; require ongoing beneficiary data base review and verification; improve access to CMS databases by federal law enforcement; expand database access to appropriate state Medicaid agencies; establish strong privacy protocols and security requirement; and report to congress on their implementation.

- **Expand Automated Prepayment Review of Medicare Claims.** Medical services under Part A with a relationship or dependency of service under Part B cannot be cross-checked, and there is no process in place to track claims that are submitted and rejected via automatic edits prior to payment. Requires a process be established to address both shortcomings.

- **Improving Medicare-Medicaid Data-Sharing.** 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. Requires HHS to establish a plan to facilitate the inclusion of States in the Medicare and Medicaid Data Match Program and to improve the program through an automated data system to collect, integrate, and access data for program integrity, oversight, and administration purposes. HHS must implement a plan that allows each State to access relevant data on improper payments for dual eligible individuals.

- **Improving Claims Processing and Detection of Fraud within the Medicaid and CHIP Programs**. The HHS OIG said 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..." HHS shall require that each claim under Medicaid and CHIP include a valid beneficiary identification number and a valid National Provider Identifier, to reduce fraud and errors.

- **Requires Medicare Administrative Contractor Error Reduction Incentives.** The Medicare fee-for-service claims reimbursement process is extremely error prone. In 2010, Medicare reported $34.3 billion in improper payments in its fee-for-service program, a 10.5% error rate. Requires HHS to establish incentives for Medicare Administrative Contractors to reduce their improper payment error rates.

- **Separate Provider Enrollment and Screening from Medicare Administrative Contractors.** Under current law, Medicare Administrative Contractors 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 paying provider claims. The bill accomplishes that, and prevents a potential conflict of interest.

- **Requires Development of Measurable Performance Metrics for Medicare Contractors.**

- **Increases Legal Penalties for the Illegal Distribution of a Medicare/Medicaid/CHIP Beneficiary ID or Billing Privileges.** One reason for massive fraud is that the penalties once caught are too low. The President's Fiscal Year 2012 Budget proposed strengthening of penalties for the fraudulent distribution of Medicare, Medicaid, or CHIP beneficiary identification numbers. Any person who knowingly, intentionally, and with the intent to defraud, purchases, sells or distributes, or arranges for the purchase, sale, or distribution of beneficiary and provider identification numbers faces stiffer penalties.

Offset: Takes $75 M from the Medicare Improvement Fund to offset provisions under this Act.