Conceptional Mark of S.861, as Modified

Sec. 1. Short Title

Current Law

No Provision

S.861, as modified:

Establishes the title of the Act as the "Preventing and Reducing Improper Medicare and Medicaid Expenditures Act of 2015" or the "PRIME Act of 2015."

Sec. 2 Strengthening Medicaid Program Integrity Through Flexibility.

Current Law

Among other changes, the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) amended the Social Security Act (SSA) by adding Sec. 1936 which established the Medicaid Integrity Program (MIP). SSA Sec. 1936 appropriated as much as $75 million annually in MIP funding to support and enhance state program integrity efforts by sustaining and expanding national Department of Health and Human Services (HHS) activities such as provider audits, overpayment identification, and payment integrity and quality of care education. SSA Sec. 1936, as originally enacted, restricted how MIP funding could be used and required the Secretary of HHS (the Secretary) to hire a specified (100) number of full-time equivalent (FTE) staff. SSA Sec. 1936 further restricted MIP funding to contractor payments and limited the Secretary's ability to use MIP funds for equipment, travel, training, and salaries and benefits.

S.861, as modified:

S. 861, as modified, would provide the Secretary with increased flexibility to spend program integrity funds under the Medicaid Integrity Program by 1) allowing for the hiring of federal employees to perform program integrity activities and 2) increase the number the number of program integrity staff allowed for under current law from 100 to such numbers as determined necessary by the Secretary to carry out the program.

Sec. 3 Establishing Medicare Administrative Contractor Error Reduction Incentives.

Current Law

Medicare law requires participating providers and suppliers to comply with Medicare requirements stipulated in the SSA as well as the Centers for Medicare and Medicaid Services (CMS) regulations. Medicare law also requires the Secretary to provide incentives for Medicare

Administrative Contractors (MACs) to provide quality service and to promote efficiency (SSA § 1874A(b)(1)(D)), but does not specifically require the Secretary to use incentives for MACs to reduce errors. In addition, the Secretary is required to develop contract performance requirements for MAC duties and standards for measuring MAC's performance in meeting those requirements (SSA § 1874A(b)(3)). Moreover, in developing standards for measuring performance, the Secretary is required to consult with stakeholders and to make the performance standards publically available.

Section 505(a) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA, P.L. 114-10) required MACs to have an improper payment outreach and education program which would provide outreach, education, training, and technical assistance to providers and suppliers within each contractor's geographic service area (SSA § 1874A(a)(4)). In addition, MACRA Sec. 509(c) required the Secretary to make MAC performance information publically available (SSA § 1874A(b)(3)(A)(iv)).

CMS also requires all Medicare contractors to provide outreach and education to providers and suppliers and provides guidance to Medicare contractors on communications and interactions with providers and suppliers in the Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 6 – Provider Customer Service Program (Rev. 31, 02-13-2015). This manual identifies a number of Medicare contractor requirements to provide education, outreach, and overall support through the Provider Customer Service Program (PCSP). CMS makes data available on the results of the PCSP on its Contractor-Provider Customer Service Program website including contractor performance data.

In July 2014, CMS announced the establishment of a Provider Relations Coordinator. CMS indicated that the Provider Relations Coordinator was intended to improve communications between providers and CMS and to help increase program transparency while offering more efficient resolutions to providers affected by the medical review process. Providers were instructed to raise broader concerns about the medical review process with the Provider Relations Coordinator, but to continue to interact with MACs and RACs on individual claim questions.

S.861, as modified:

To reduce Medicare payment errors, S. 861, as modified, requires the Secretary to establish incentives for Medicare Administrative Contractors to reduce improper payment error rates and otherwise improve payment accuracy. The incentives provided may include a sliding scale of award fee payments to either reduce the improper payment rates to certain thresholds as determined by the Secretary, or accomplish tasks that further improve payment accuracy. Further, the Secretary may include substantial reductions in award fee payments for Medicare Administrative Contractors that reach an upper end of improper payments or fail to accomplish payment accuracy tasks, as determined by the Secretary. These changes shall apply to contracts established or renewed on or after a date that is 3 years after the enactment of S. 861, as modified,, or in the case of existing contracts or those established within 3 years of passage, the Secretary shall implement through contract modifications.

Sec. 4 Strengthening Penalties for the Illegal Distribution of a Medicare, Medicaid, or CHIP Beneficiary Identification or Billing Privileges.

Current Law

Current law does not provide specific penalties for selling, trading, bartering, or otherwise distributing beneficiary or identification numbers or billing privileges. Beneficiary identification numbers and provider/supplier billing privileges could be used to submit fraudulent claims to Medicare, Medicaid, or the state Children's Health Insurance Program (CHIP) programs.

S.861, as modified:

S.861, as modifiedamends the Social Security Act to establish that whoever without lawful authority knowingly and willfully purchases, sells or distributes, or arranges for the purchase, sale, or distribution of a beneficiary identification number or unique health identifier for a health care provider under Medicare, Medicaid or the Children's Health Insurance Program (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. 5 Improving the Sharing of Data between the Federal Government and State Medicaid Programs.

Current Law

CMS initiated the Medicare-Medicaid Data Match Program (referred to as (Medi-Medi) as a pilot program in 2001.[1] Medi-Medi was intended to help CMS and states identify overpayments and fraud that affected both Medicare and Medicaid. Based on comparative Medicare and Medicaid data, CMS investigated atypical billing patterns that may not have been evident when analyzing the data from each program separately. If problems were identified, CMS, through a contractor, coordinated with states (for Medicaid) and providers (for Medicare) to recover federal overpayments.

The Medi-Medi pilot was funded mostly by CMS with some addition support from the Federal Bureau of Investigation (FBI). California was the only state in the original pilot in 2001. In 2005, CMS was allocated $19 million from the Health Care Fraud and Abuse Control (HCFAC) program to continue the California Medi-Medi pilot and expand it to eight other states.[2] In 2006, Section 6034 of the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) required the Secretary to expand the Medi-Medi program nationwide and established dedicated funding ($12 million in FY2006, rising to $60 million annually in FY2010 and every year thereafter).

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[1] CMS founded the California Medicare and Medicaid Data Analysis Center (CMMDAC) on September 28, 2001 to show proof of concept for the Medicare-Medicaid data analysis and to demonstrate the value of comparative Medicare-Medicaid claims data analysis for the detection, prosecution, and elimination of aberrant practices.

[2] Only Texas, Illinois, Pennsylvania, North Carolina, New Jersey, Ohio, and Washington agreed to participate in the Medi-Medi pilot in 2005.

In a 2012 report, the HHS Office of Inspector General (OIG) found that the Medi-Medi program had produced limited results and few fraud referrals.[3] During 2007 and 2008, CMS had Medi-Medi projects in 10 states, which produced about 66 fraud referrals to law enforcement, of which 27 cases were accepted.[4] OIG also found that state Medicaid programs received less benefit from the Medi-Medi program than Medicare received.

Section 510 of MACRA required the Secretary to study and, as appropriate, specify incentives to encourage states to participate in the Medi-Medi Data Match program. Also, MACRA authorized the Secretary to use the limited waiver authority available in the Medi-Medi Data Match program to specify those state incentives.[5]

S.861, as modified:

S. 861, as modified, requires the Secretary to establish a plan to encourage and facilitate the participation of States in the Medicare and Medicaid Data Match Program. S. 861, as modified, also revises the Medicare and Medicaid Data Match Program to improve the program by amending the Social Security Act in order to further the design, development, installation, or enhancement of the use of algorithms and data system to collect, integrate, and access data for program integrity, oversight, investigative and administration purposes. Further, S. 861, as modified, provides states with data on improper payments made for items or services provided to dual eligible individuals by requiring the Secretary to develop and implement a plan that allows each access for state Medicaid agencies to relevant data on improper or fraudulent payments made under the Medicare program.

Sec. 6 Report on Implementation.

Current Law

No provision

S.861, as modified:

Not later than 18 months after the date of the enactment of S.861, as modified, the Secretary would be required to submit to Congress a report on the implementation of S.861, as modified, and sections 506 and 507 of the Medicare Access and CHIP Reauthorization Act of 2015 (Public Law 114–10).

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[3] The Department of Health and Human Services Office of Inspector General (OIG), *The Medicare-Medicaid (Medi-Medi) Data Match Program* (OEI-09-08-00370), April 2012.

[4] In 2008, the following 10 states were participating in the Medi-Medi program: California, Florida, Illinois, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Texas, and Washington.

[5] Under the Medi-Medi program, the Secretary has authority to waive only such requirements of SSA title XVIII, and titles XI and XIX as are necessary to carry out the Medi-Medi program (SSA §1893(g)(2)).