

Preventing and Reducing Improper Medicare and Medicaid Expenditures (PRIME) Act

Section-By-Section

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TITLE I— CURBING IMPROPER PAYMENTS

Sec. 101 Requiring Valid Prescriber National Provider Identifiers on Pharmacy Claims.

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. 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 a substantial number of past 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 on the need for the Centers for Medicare and Medicaid Services (CMS) to establish 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 official 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 concluded at the time that, “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

To address the problem, CMS issued in 2011 new guidance establishing requirements and procedures to ensure that identifiers are valid. The guidance required that only the National Provider Identifier become the identifier for the Medicare Part D program (a total of four differing identifiers were in use in 2011). Further, Medicare Part D plan sponsors will have to ensure that the provider identifier is valid. However, these steps have been made through guidance, not a change in statute.⁵

To address these findings, the legislation:

- 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.
- Requires that Prescription Drug Plan (PDP) sponsors obtain valid prescriber identifiers on all pharmacy claims under Medicare Part D, and requires that the identifiers be validated.
- In effect, the legislation puts the existing guidance into statute.

Sec. 102 Reforming How CMS Tracks and Corrects the 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 Medicare Recovery Audit Contractors (RACs). These are private contractors hired by CMS to identify payment errors made to Medicare providers.³⁰ RACs also report identified

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 CMS, [“Note To: Medicare Advantage Organizations, Prescription Drug Plan Sponsors, and Other Interested Parties”](#) (Feb. 18, 2011).

vulnerabilities that result in payment errors to CMS. CMS and its Medicare Administrative Contractors (MACs) are responsible for taking corrective actions for the systemic or ongoing 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.

In 2010, the GAO found that CMS had not developed 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 had not taken adequate corrective actions on the range of 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.⁶

When CMS (or its contractor) recovers a Medicare or Medicaid overpayment, a portion may be retained under current law for some program integrity activities. However, Medicare law regarding the allocation of the recoveries differs from similar recoveries by other agencies. The Improper Payments Elimination and Recover Improvement Act allows an agency that recovers an overpayment to retain 25% for the preventing improper payments and similar program integrity purposes, as well as allowing the agency Office of Inspector General to retain 5%.⁷

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.
- The allocation of a portion of Medicare and Medicaid recoveries will conform to that of other federal agencies, thereby following the federal-wide *Improper Payments Elimination and Recovery Act of 2010*. This change will not affect the rules as to whether a recovery is made, or the level of recovery from a provider, merely the allocation of any recovery.

Sec. 103 Improving Senior Medicare Patrol and Fraud Reporting Rewards.

The Senior Medicare Patrol (SMP) recruits retired professionals and others 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 semiannually:⁸

- 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;
- 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;

⁶ GAO, *Medicare Recovery Audit Contracting: Lessons Learned to Address Improper Payments and Improve Contractor Coordination and Oversight*, [GAO-10-864T](#), July 15, 2010.

⁷ *The Improper Payments Elimination and Recovery Act of 2010*; <http://www.gpo.gov/fdsys/pkg/PLAW-111publ204/pdf/PLAW-111publ204.pdf>

⁸ HHS OIG, *Memorandum Report: Performance Data for the Senior Medicare Patrol Projects: May 2010 Performance Report*, [OEI-02-10-00100](#), May 19, 2010.

- 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. Medicaid does not have such a program. A similar reward program for the IRS is much more successful in encouraging potential fraud reporting.⁹

To improve this program, the legislation requires:

- HHS to develop 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, and extends the program to include Medicaid. The plan shall also include 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.

Sec. 104 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.

Sec. 105 Establishing Medicare Administrative Contractor Error Reduction Incentives.

The Medicare fee-for-service (FFS) claims reimbursement process is extremely error prone. In 2012, Medicare reported \$29.6 billion in improper payments in its FFS program, an 8.5% error rate.¹⁰ 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. 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.¹¹ 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.¹²

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.¹³

To reduce payment errors:

⁹ Internal Revenue Service, *FY 2009 Annual Report to Congress on the Use of Section 7623*.

¹⁰ Department of Health and Human Services, *FY 2010 Agency Financial Report*, Nov. 15, 2010.

¹¹ 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.

¹² GAO, *Medicare Contracting Reform: Agency Has Made Progress with Implementation, but Contractors Have Not Met All Performance Standards*, [GAO-10-71](#), March 25, 2010.

¹³ DOD, *Department of Defense Agency Financial Report: Addendum A*, Nov. 15, 2010.

- 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 may include substantial reduction in payments under award fee contracts, for MACs that reach certain error thresholds.

Sec. 106 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.¹⁴

The legislation would establish that:

- Any person who knowingly, 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.

TITLE II—IMPROVING DATA SHARING

Sec. 201 Access to National Directory of New Hires.

- HHS shall grant access to National Database of New Hires to CMS and the HHS OIG (under current law this database, which is maintained by HHS, excludes access to both).

Sec. 202 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.¹⁵ 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 comprise 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.¹⁶ 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.¹⁷ 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.

¹⁴ HHS, [Budget in Brief](#) for fiscal year 2012

¹⁵ GAO, *Medicare Part D: Challenges in Enrolling New Dual-Eligible Beneficiaries*; [GAO-07-272](#), May 4, 2007.

¹⁶ Kaiser Commission on Medicaid and the Uninsured; [Where Does the Burden Lie? Medicaid and Medicare Spending for Dual Eligible Beneficiaries](#), April 2009.

¹⁷ HHS & DOJ, [Health Care Fraud and Abuse Control Program Annual Report For FY 2005](#), August 2006.

To address these issues, the legislation:

- 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.

Sec. 203 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...”¹⁸

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.¹⁹

To address these weaknesses, the legislation establishes that:

- 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 individual who is eligible to receive benefits.

TITLE III—REPORT ON IMPLEMENTATION

Sec. 301 Report on Implementation.

- *Report to Congress on Plan.* Within 270 days of passage, the Secretary shall report to Congress a plan for implementing this Act.

¹⁸ HHS OIG, MSIS Data Usefulness for Detecting, Fraud, Waste, and Abuse, [OEI-04-07-00240](#), Aug. 26, 2009.

¹⁹ MACPAC, [Report to the Congress on Medicaid and CHIP](#), March 2011.