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PREVENTING AND REDUCING IMPROPER MEDICARE AND MEDICAID EXPENDITURES (PRIME) ACT OF 2015

JULY 30, 2015.—Ordered to be printed

Mr. HATCH, from the Committee on Finance,
submitted the following

R E P O R T

[To accompany S. 861]

The Committee on Finance, to which was referred the bill (S. 861) to amend titles XVIII and XIX of the Social Security Act to curb waste, fraud, and abuse in the Medicare and Medicaid programs, having considered the same, reports favorably thereon with an amendment and recommends that the bill, as amended, do pass.

I. LEGISLATIVE BACKGROUND

The Committee on Finance, to which was referred the bill (S. 861) to amend titles XVIII and XIX of the Social Security Act to curb waste, fraud, and abuse in the Medicare and Medicaid programs, reports favorably thereon with an amendment and recommends that the bill, as amended, do pass.

Background and need for legislative action

The Medicaid Integrity Program (MIP) was established by the Deficit Reduction Act of 2005 to support and enhance program integrity efforts, by sustaining and expanding national oversight activities such as provider audits, overpayment identification and payment integrity and quality of care education. This bill enhances MIP by providing the Secretary of Health and Human Services (HHS) the flexibility to appropriately resource oversight activities; improving financial incentives for oversight contractors to encourage appropriate activities and goals; imposing stronger penalties against individuals who commit fraud; and strengthening data-sharing initiatives in the Medicare and Medicaid programs to better identify patterns of fraud, waste, and abuse.

II. EXPLANATION OF THE BILL

PRESENT 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 SSA Sec. 1936, as originally enacted, restricted how MIP funding could be used and required the Secretary of HHS (the Secretary) to hire a specified (100) number of full-time equivalent (FTE)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.

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 med-

ical 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.

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.

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 additional 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).

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

¹ CMS funded 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.

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)).

EXPLANATION OF PROVISION

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) increasing 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.

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.

S. 861, as modified, amends 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.

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.

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).

III. BUDGET EFFECTS OF THE BILL

A. COMMITTEE ESTIMATES

In compliance with paragraph 11(a) of rule XXVI of the Standing Rules of the Senate, and the Preventing and Reducing Improper Medicare and Medicaid Expenditures Act of 2015, the following statement is made concerning the estimated budget effects of the revenue provisions of the of the “Preventing and Reducing Improper Medicare and Medicaid Expenditures Act of 2015,” as reported.

S. 861 would increase revenues by \$20 million over the 2016–2025 period. Because the legislation would affect revenues, pay-as-you-go procedures apply. Enacting the legislation would not affect direct spending.

S. 861—Preventing and Reducing Improper Medicare and Medicaid Expenditures Act of 2015

Summary: S. 861 would aim to reduce improper payments in the Medicare and Medicaid programs. CBO estimates that enacting the bill would increase revenues by \$20 million over the 2016–2025 period. Because the legislation would affect revenues, pay-as-you-go procedures apply. Enacting the legislation would not affect direct spending.

S. 861 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA).

Estimated cost to the Federal Government: The estimated budgetary effects of S. 861 are shown in the following table.

	By fiscal year, in millions of dollars—														2016–2020	2016–2025	
	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025							
	CHANGES IN REVENUES																
Estimated Revenues	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	10	20

Basis of estimate: CBO assumes that S. 861 will be enacted by the end of fiscal year 2015.

S. 861 would direct the Secretary of Health and Human Services (HHS) to establish incentives for Medicare administrative contractors (MACs), which process and pay claims, to reduce the improper payment rate in that program.⁶ Funding for MACs is subject to appropriation. The Secretary would be allowed to make bonus payments to MACs with low improper payment rates and reduce payments to those MACs with high improper payment rates. CBO expects the Secretary would set the payment reductions and bonus payments so that they would leave total spending unchanged. Therefore, CBO estimates that implementing this provision would not have a significant effect on discretionary costs.

The bill also would provide the Secretary with additional flexibility to administer the Medicaid Integrity Program by removing a limit on the number and type of staff that the Secretary may hire to conduct integrity activities under the program. In addition, S.

⁶In general, improper payments are any payments in an incorrect amount (whether an under- or overpayment) or to the wrong person or entity. Some improper payments may be fraudulent, but others arise from human error, mistakes in documentation, waste, or abuse. Federal agencies are required to calculate improper payment rates for programs within their jurisdiction.

861 would require the Secretary to establish a plan to encourage and facilitate the participation of states in the Medicare-Medicaid Data Match Program. Funding for both the Medicaid Integrity Program and the Data Match Program is mandatory, the amounts available (\$83 million and \$60 million, respectively, for fiscal year 2015) are specified in statute, and CBO expects those amounts would all be spent under current law. CBO estimates that while these provisions would increase flexibility, total spending would not change.

S. 861 would permit HHS to impose financial penalties for misuse of personally identifiable data of individuals who receive health care through Medicare, Medicaid, or the Children’s Health Insurance Program. The same penalties could be levied on individuals who misuse provider billing information. The bill also would allow violators to be incarcerated for not more than 10 years for those offenses. Based on information about the frequency of such crimes, CBO estimates that \$2 million in penalties would be assessed annually, thus increasing federal revenues by \$20 million over the 2016–2025 period.

Pay-As-You-Go considerations: The Statutory Pay-As-You-Go Act of 2010 establishes budget-reporting and enforcement procedures for legislation affecting direct spending or revenues. The net changes in revenues that are subject to those pay-as-you-go procedures are shown in the following table.

CBO ESTIMATE OF PAY-AS-YOU-GO EFFECTS FOR S. 861 AS ORDERED REPORTED BY THE SENATE COMMITTEE ON FINANCE ON JUNE 24, 2015

	By fiscal year, in millions of dollars—													
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2015– 2020	2015– 2025	
	NET DECREASE IN THE DEFICIT													
Statutory Pay-As-You-Go Impact	0	2	2	2	2	2	2	2	2	2	2	10	20	

Intergovernmental and private-sector impact: S. 861 contains no intergovernmental or private-sector mandates as defined in UMRA and would impose no costs on state, local, or tribal governments.

Estimate prepared by: Federal costs: Lara Robillard and Lisa Ramirez-Branum; Impact on state, local, and tribal governments: J’nell Blanco Suchy; Impact on the private sector: Amy Petz.

Estimate approved by: Holly Harvey, Deputy Assistant Director for Budget Analysis.

B. BUDGET AUTHORITY

Budget authority

In compliance with section 308(a)(1) of the Congressional Budget and Impoundment Control Act of 1974 (“Budget Act”),⁷ the Committee states that the bill as reported involves increased budget authority (see Part A, above).

⁷ Pub. L. No 93–344.

Tax expenditures

In compliance with section 308(a)(1) of the Budget Act, the Committee states that the bill does not involve increased tax expenditures.

C. CONSULTATION WITH CONGRESSIONAL BUDGET OFFICE

In accordance with section 403 of the Budget Act, the Committee advises that the Congressional Budget Office has submitted a statement on the bill.

IV. VOTES OF THE COMMITTEE

In compliance with paragraph 7(b) of rule XXVI of the Standing Rules of the Senate, the Committee states that, with a majority present, “Preventing and Reducing Improper Medicare and Medicaid Expenditures Act” as modified, was ordered favorably reported on June 24, 2015.

V. REGULATORY IMPACT AND OTHER MATTERS

A. REGULATORY IMPACT

Pursuant to paragraph 11(b) of rule XXVI of the Standing Rules of the Senate, the Committee makes the following statement concerning the regulatory impact that might be incurred in carrying out the provisions of the bill.

Impact on individuals and businesses, personal privacy and paperwork

The bill is not expected to impose additional administrative requirements or regulatory burdens on individuals. The bill is expected to reduce administrative requirements and regulatory burdens on some businesses.

The provisions of the bill do not impact personal privacy.

B. UNFUNDED MANDATES STATEMENT

This information is provided in accordance with section 423 of the Unfunded Mandates Reform Act of 1995.⁸

The Committee has determined that the bill does not contain any private sector mandates. The Committee has determined that the bill contains no intergovernmental mandate.

VI. CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In the opinion of the Committee, it is necessary in order to expedite the business of the Senate, to dispense with the requirements of paragraph 12 of rule XXVI of the Standing Rules of the Senate (relating to the showing of changes in existing law made by the bill as reported by the Committee).

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⁸Pub. L. No. 104-4.