Summary of the Discussion Draft of "Protecting the Integrity of Medicare Act 2014"

Section 1- Short Title and Table of Contents

Section 2 – Prohibition of Inclusion of Social Security Account Numbers on Medicare Cards

This provision requires the Secretary of the Department of Health and Human Services (HHS) (the Secretary) to ensure that a Social Security number (SSN) is not displayed, encoded, or embedded on an individual's Medicare card. $320 million in funding is provided to the Centers for Medicare & Medicaid Services (CMS), the Social Security Administration, and the Railroad Retirement Board to implement this provision. HHS shall make available assistance to beneficiaries and providers as these changes are implemented.

This change follows recommendations from the Government Accountability Office (GAO) and the Social Security Administration (SSA) Inspector General.

Section 3 – Preventing Wrongful Medicare Payments and for Other Purposes

Beginning in 2015, this provision prevents wrongful Medicare payments for incarcerated, not lawfully present, and deceased individuals. Any payments made in error will be reviewed and recouped by Recovery Audit Contractors (RACs). The HHS Office of Inspector General (OIG) will review and report on these activities.

The HHS OIG has issued reports in the past few years highlighting the improper payments made for these ineligible populations: Deceased, Not Lawfully Present, and Incarcerated.

Section 4 – Measures Regarding Medicare Beneficiary Smart Cards

The Consolidated Appropriations Act of 2014 mandated that GAO report on the use of smart card technology in the Medicare program. Once that report is released, this provision requires the Secretary to examine the cost-effectiveness and technological viability of using such cards.

Section 5 – Modification of Face-to-Face Encounter Documentation Requirement

This provision allows professionals who can perform the face-to-face encounter for Medicare durable medical equipment prescriptions, including nurse practitioners and physician assistants, as allowed by state law, to also document those encounters.

Section 6 – Reducing Improper Medicare Payments

This provision requires the Secretary to direct each MAC to establish an improper payment outreach and education program to provide information to providers of services and suppliers in the contractor's region. The information will include the provider's or supplier's most frequent and expensive payment errors, a notice of new topics that have been approved for audits by RACs, as well as specific instructions to correct and avoid errors and audit issues.

The Secretary will retain a portion, not exceeding 15 percent, of the recovered amounts to implement corrective actions to help reduce the error rate of payments. The Secretary will use these funds to implement the programs in this section and other sections of this bill.

Section 7 – Expansion of the Senior Medicare Patrol (SMP)

This provision requires the Secretary to develop a plan to encourage greater participation by individuals to report Medicare fraud and abuse. The plan shall include: recommendations for ways to enhance rewards for individuals reporting under the SMP incentive program; how to extend the program to Medicaid; and 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.

Section 8 – Requiring Valid Prescriber National Provider Identifiers on Pharmacy Claims.

This provision requires that CMS use the National Prescriber Identifiers (NPIs) as the only allowed prescriber identifier for the Medicare prescription drug program and requires that all subscriber claims be submitted with a valid prescriber NPI.

Section 9 – Electronic Medicare Summary Notice Option

This provision provides existing beneficiaries the option to receive a Medicare summary notice (MSN) electronically beginning in 2016. After 2017, new beneficiaries will be notified of their right to receive their summary statements electronically at the time of their enrollment. A beneficiary who elects to receive electronic notices may rescind their decision and return to paper notices at least once. The Secretary is encouraged to expand the electronic option to other Medicare statements and notifications using a similar process.

Section 10 – Renewal of MAC Contracts

This provision allows the Secretary to bid MAC contracts every 10 years instead of five years. Currently, MAC contracts are for one guaranteed year and four option years, subject to yearly reviews by the Secretary for performance and efficiency. The five-year contract period limits the Secretary's ability to replace poor performing MACs mid-cycle, as prospective bidders can only win the contract for the years that remain in the cycle before having to go through the entire bidding process all over again.

Contracts will continue to be subject to annual renewal, with one guaranteed year and nine option years based on MAC performance. The Secretary also shall increase transparency around MAC performance standards and scores.

Section 11 – Sharing Funds Recouped Through Medicare-Medicaid (Medi-Medi) Data Match Program with States

This provision requires the Secretary to develop incentives for states to participate in the Medi-Medi program.

Section 12 – Programs to Prevent Prescription Drug Abuse Under Medicare Part D

This provision creates a drug management program for beneficiaries at risk of prescription drug abuse starting January 1, 2017.

Beneficiaries determined to be at-risk for prescription drug abuse can be limited to one or more physicians and one or more pharmacies for certain opioids and similar drugs. The section does not apply to other prescription drugs; beneficiaries may still access these medications from the prescribers and pharmacies of their choice. Beneficiaries will be removed from the drug management program if it is concluded that they are no longer at risk.

Plan Sponsors (PDP's) shall adhere to beneficiary requests regarding their preferred pharmacy (or pharmacies) and provider(s) to the extent feasible. PDPs are also required to notify at-risk beneficiaries prior to including them in a drug management program, and provide them with information regarding resources available to address prescription drug abuse.

This section also provides for the MEDIC program to act as the mechanism for state-by-state contact for which the providers and their delegated entities can exchange beneficiary information to verify whether they have been locked-in by another plan, in conjunction with state prescription drug monitoring programs (PDMPs), and to confirm that the beneficiary meets the eligibility criteria and is not exempted from the program. States shall be given the authority to share information in an effort to prevent prescription drug abuse across state lines.

The Secretary shall convene stakeholders for guidance on issues including an expedited appeals process ensuring affordability and access to medications, excepted conditions and drug classes, and definitions. The Secretary shall promulgate rules based on this guidance by January 1, 2016.

Section 13 – Application of Common Rule to Clinical Data Registries

This provision requires that the Secretary publish guidance clarifying how the "Common Rule," which provides protection for individuals involved in research, applies to information reported to clinical data registries for quality improvement purposes. The guidance must be issued no later than one year after enactment.

Section 14 – Eliminating Certain Civil Money Penalties; Gainsharing Study and Report

This provision would eliminate civil money penalties for inducements to physicians to limit services that are not medically necessary. Further, it requires the Secretary to issue a report describing how a permanent physician-hospital gainsharing program can best be established. The report is due no later than one year after enactment.

Section 15 – Modification of Medicare Home Health Surety Bond Condition of Participation Requirement

This provision requires home health agencies to obtain a surety bond in the amount of no less than $50,000 as a condition of participation in the Medicare program.

Section 16 – Requirement for Prior Authorization for Chiropractic Visits for Spinal Manipulation Reimbursement After 12 Visits

This provision requires chiropractors with aberrant billing patterns or high denial rates to request prior authorization prior to furnishing services. The Secretary may remove chiropractors from prior authorization if billing patterns demonstrate a low denial rate. This targeted approach, along with the requirement that the Secretary make a prior authorization decision within 14 days, ensures beneficiaries have access to needed services. The Secretary will work with chiropractors and Medicare administrative contractors to improve documentation of services.

An OIG report highlights misuse of the chiropractor billing codes that has resulted in millions of dollars of improper payments.

Section 17 – Limiting Payments for Vacuum Erection Systems for Medicare Beneficiaries

This provision requires that the Secretary include vacuum erection systems (VES) in the Durable Medical Equipment Competitive Bidding Program by 2016. Establishing a competitively bid rate will correct the excessive amount that Medicare currently pays for VES.

An OIG report documents overpayment for these products.

Section 18 – National Expansion of Prior Authorization Demonstration Program for Repetitive Scheduled Non-Emergent Ambulance Transport

This provision requires the Secretary to expand the prior authorization process for "repetitive scheduled non-emergent ambulance transports" that CMS is currently implementing in three states through the Center for Medicare & Medicaid Innovation (CMMI). The provision expands that program to additional states in 2016 and establishes a national program starting in 2017.

The HHS OIG and the Medicare Payment Advisory Commission have highlighted a high billing error rate for these services.

Section 19 – Repealing Duplicative Medicare Secondary Payor Provision

This provision, derived from H.R. 5201, the Medicare Employer Relief Act of 2014, repeals the requirement for employer disclosure of information regarding the health care coverage of employees who are Medicare beneficiaries.

Section 20 – Expanding Data in Annual CERT Report

Not later than March 25, 2015, the Secretary shall submit to the Senate Finance Committee, the Energy and Commerce Committee and the Committee on Ways and Means a plan for including data annually on services (or groupings of services) where the fee schedule amount is in excess of $250 and where the error rate is in excess of 20 percent in the annual report of the Comprehensive Error Rate Testing (CERT) program.

Section 21 – Rule of Construction

This provision provides a rule of construction that nothing in this Act shall prevent the Secretary from using notice-and-comment rulemaking to implement this legislation.