



September 1, 2014

The Honorable Kevin Brady  
301 Cannon House Office Building  
United States House of Representatives  
Washington, D.C. 20515

**RE: Protecting Integrity in Medicare Act of 2014 (PIMA)**

Dear Representative Brady:

Thank you for providing the National Health Care Anti-Fraud Association (NHCAA) with the opportunity to review the discussion draft of your legislation, the “Protecting Integrity in Medicare Act of 2014” (PIMA).

Established in 1985, NHCAA is the leading national organization focused exclusively on combating health care fraud and abuse in both the private and public sectors. NHCAA has been a private-public partnership since its founding, making it unique among associations. Our members comprise more than 80 of the nation’s most prominent private health insurers joined together with nearly 120 federal, state and local government law enforcement and regulatory agencies that participate in NHCAA as law enforcement liaisons.

NHCAA supports Congressional efforts to address health care fraud in our public programs. Based on the bipartisan measures introduced in both the House and Senate over the last two years, we believe broad support exists for taking the steps necessary to protect the Medicare Trust Fund and the millions of our seniors it serves. We are generally supportive of the Protecting Integrity in Medicare Act of 2014 and offer to you specific comments about several of the bill’s sections:

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

For many years now valid arguments have been made that Social Security numbers should be removed from Medicare cards. We agree and believe this should be a priority, particularly since the Government Accountability Office (GAO) made this recommendation more than a decade ago<sup>1</sup> and revisited the issue as recently as last September<sup>2</sup>.

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<sup>1</sup> U.S. Government Accountability Office. Social Security Numbers: Government Benefits from SSN Use but Could Provide Better Safeguards. GAO-02-352. Washington, D.C.: United States Government Printing Office, May 2002.

<sup>2</sup> U.S. Government Accountability Office. Medicare Information Technology: Centers for Medicare and Medicaid Services Needs to Pursue a Solution for Removing Social Security Numbers from Cards. GAO-13-761. Washington, D.C.: United States Government Printing Office, September 2013.

Social Security numbers are very powerful unique identifiers which are extremely attractive and valuable to those individuals intent on committing health care fraud, including medical identity theft. Having Social Security numbers printed on Medicare cards which are carried around by millions of seniors in wallets and purses makes them quite vulnerable. We believe that the Centers for Medicare & Medicaid Services (CMS) is already taking steps to ultimately achieve this objective and we commend your legislation for including a funding mechanism to enable this goal to be realized.

#### **Section 4 – Measures Regarding Medicare Beneficiary Smart Cards**

The use of smart card technology for Medicare has been discussed with increasing regularity and NHCAA agrees that employing such a tool would promote program integrity. Some of the potential benefits include increased quality of care, improved accuracy and efficiency in billing, reduced identity theft, as well as reduced fraud, waste and abuse. We're aware of no fewer than nine legislative measures introduced in the last two Congresses aimed at establishing pilot projects to use smart card technology in the Medicare program—HR 2828, HR 2925, HR 3024, HR 3399, HR 3474, S 676, S 1251, S 1551, and S 2586. Despite the apparent interest, none of these measures have been enacted.

NHCAA supports the use of smart card technology in Medicare if it is demonstrated that it is cost effective and technologically viable to do so.

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

The Affordable Care Act (ACA) mandates face-to-face encounter requirements for certain items of durable medical equipment (DME). The final rule that implements the requirements was published on November 16, 2012, although CMS has delayed enforcement of the face-to-face encounter requirements until further notice.<sup>3</sup>

The law requires that a physician must document that either a physician, nurse practitioner, physician assistant or clinical nurse specialist has had a face-to-face encounter with the patient. Section 5 of PIMA aims to expand who can document these face-to-face encounters to include physician assistants, practitioners, and specialists. Although NHCAA understands the rationale for this provision, we are concerned that any expansion of the number and type of health care providers who can document the face-to-face encounter increases the risk of potential fraud and abuse. DME fraud has been a serious problem in both Medicare and Medicaid for many years and we believe the current face-to-face encounter requirements assist in minimizing the fraud and abuse risk.

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<sup>3</sup> Centers for Medicare & Medicaid Services. *Face-to-Face Encounter Requirement for Certain Durable Medical Equipment: Additional Time to Establish Protocols for Newly Required Face-to-Face Encounters for Durable Medical Equipment (DME)*. <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/FacetoFaceEncounterRequirementforCertainDurableMedicalEquipment.html> Last accessed 8/25/2014; Last modified 8/20/2014.

## **Section 6 – Reducing Improper Medicare Payments**

The establishment of improper payment outreach and education programs for providers of services and suppliers under Medicare and administered by Medicare Administrative Contractors (MACs) is a worthwhile concept. NHCAA is founded on the idea that education and the sharing of information are critical tools necessary to effectively fight health care fraud and abuse and this provision would employ both concepts.

We note that Section 6 specifies that the information to be provided under the MAC-administered programs would need to be determined as appropriate by the HHS Secretary, and we strongly agree. The bill offers several examples of the categories and types of information that could be provided, all of which sound potentially valuable. However, it is important that the Secretary be able to limit information that could be sensitive or compromise ongoing program integrity efforts.

NHCAA is supportive of the provision stating that the Secretary shall provide MACs, on a quarterly basis, with a complete list of the types of improper payments identified by recovery audit contractors (RACs). The types of information to be shared (i.e. providers that have the highest rate of improper payments, providers that have the greatest total dollar amounts of improper payments, etc.) would yield value in helping stem the tide of improper payments under Medicare. Providing useful information to other interested parties that share responsibility for safeguarding Medicare promotes the overall integrity of our nation’s health care system.

NHCAA also supports the provision allowing the Secretary to retain a portion, not exceeding 15 percent, of the amounts recovered by RACs to implement corrective action plans. NHCAA believes that investment in anti-fraud efforts must be ongoing and we appreciate that this provision could enable long-term, dependable funding for efforts expressly aimed at reducing improper payments.

## **Section 10 – Expansion of the Senior Medicare Patrol (SMP)**

For many years, NHCAA has extolled the work of the Senior Medicare Patrol. In fact, a few years ago, the SMP was honored with our coveted Excellence in Public Awareness Award. The SMP program does important work and holds great promise, and we support efforts to strengthen it. The suggestion of revising the SMP incentive program to include enhanced reporting rewards and extending the incentive program to the Medicaid program also are welcome concepts.

## **Section 16 – Sharing Funds Recouped Through Medicare-Medicaid Data Match Program with States**

NHCAA fully supports this section which would direct the HHS Secretary to develop incentives for states to join the Medicare-Medicaid Data Match Program (Medi-Medi). NHCAA clearly understands the value in having program safeguard contractors (PSCs) and state and federal agencies working collaboratively to analyze billing trends across both programs.

Health care fraud does not discriminate between types of medical coverage. To be sure, the same fraud schemes are regularly employed to defraud both Medicare and Medicaid, and it makes sense to incentivize participation in the Medi-Medi program.

Cross-agency collaboration aimed at identifying suspect billing trends is vital because fraudsters bank on the assumption that payers are not working together to collectively connect the dots and uncover the true breadth of a scheme. It is precisely this reason why the sharing of preventive and investigative information among payers is crucial for successfully identifying and preventing health care fraud. Payers, whether private or public, who limit the scope of their anti-fraud information to data from their own organization or agency are taking an uncoordinated and piecemeal approach to the problem. NHCAA's experience as a champion and facilitator of anti-fraud information exchange for nearly three decades has taught us that it is very effective in combating health care fraud.

### **Section 17 – Program to Prevent Prescription Drug Abuse Under Medicare Part D**

In the fall of 2011, the Government Accountability Office (GAO) issued a report declaring the Part D Program to be vulnerable to prescription drug abuse. This bill provision acknowledges the GAO finding, recognizing prescription drug fraud as a serious issue with severe patient harm risks.

NHCAA supports the plan envisioned by this section to create a high-risk beneficiary drug management program under the supervision of Medicare Part D Plan (PDP) sponsors. This would essentially be what we consider to be a “lock-in” or “restricted recipient” program, limiting high-risk beneficiaries to one physician or one pharmacy for certain opioids and other high-risk drugs.

NHCAA has been a proponent of adopting lock-in programs for years, and we believe it would be a very powerful anti-fraud tool under Part D that also works to protect patients. Many of our insurer members as well as several state Medicaid programs have adopted lock-in programs with great success. In October 2011, NHCAA testified before a subcommittee of the U.S. Senate Committee on Homeland Security & Governmental Affairs<sup>4</sup> highlighting some of these successes and specifically encouraging the application of lock-in programs under Part D.

Overdoses resulting from the abuse of prescription drugs are sadly commonplace and in many cases the drugs taken were obtained by filing false claims. In response to this growing problem, NHCAA has seen that insurers are devoting increased attention and resources, devising new and innovative ways to detect possible drug diversion and doctor shopping and taking appropriate steps to stop it, while also trying to help patients in need of intervention and treatment. The drug

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<sup>4</sup> National Health Care Anti-Fraud Association hearing testimony. “Costs of Prescription Drug Abuse in the Medicare Part D Program”

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Costs of Prescription Drug Abuse in the Medicare Part D Program. October 4, 2011

management program that this section would implement under Part D would be a great step towards stemming the costly effects of prescription drug abuse.

We also support the greater involvement by Medicare Drug Integrity Contractors (MEDICs) in addressing prescription drug abuse envisioned by this section. Monthly reports on provider and supplier services will be submitted to MEDICs by PDP sponsors and MEDICs are required to acknowledge receipt of referrals. In addition, the MEDIC will respond to PDP sponsor requests seeking information about whether or not an individual beneficiary has been identified as “high-risk” and locked-in by another plan.

While we do not have specific comments to offer regarding the following sections of PIMA, NHCAA is supportive of them:

Section 3 – Preventing Wrongful Medicare Payments

Section 7 – Medicaid Fraud Control Units

Section 8 – Improved Use of Funds by HHS Inspector General

Section 9 – Strengthening the Medicaid Program

Section 11 – Requiring Valid Prescriber National Provider Identifiers on Pharmacy Claims

Section 12 – Improving Claims Processing and Detection of Fraud within the Medicaid and CHIP Programs

Section 13 – Alternative Sections for Technical Noncompliance

Section 14 – Electronic Medicare Summary Notice Option

Section 19 – Exclusion from Medicare Program Those Convicted for Defrauding Such Program

Section 21 – Modification of Medicare Home Health Surety Bond Condition of Participation Requirement

Section 22 – Requirement for Prior Authorization for Chiropractic Visits for Spinal Manipulation Reimbursement After 12 Visits

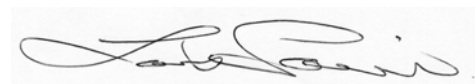
Section 23 – Limiting Payments for Vacuum Erection Systems for Medicare Beneficiaries

Section 24 – Requiring Prior Authorization for Reimbursement of Blepharoplasty and Eye Brow Surgeries

Section 25 – Non Expansion of Prior Authorization Demonstration Programs for Repetitive Scheduled Non-Emergent Ambulance Transport

NHCAA appreciates the opportunity to review your discussion draft and applauds your efforts to address the serious problem of fraud in our government health care programs. We hope the PIMA Act will stimulate serious discussions about health care fraud and receive favorable consideration among your colleagues. Please let us know if we can be of additional assistance.

Sincerely,



Louis Saccoccio  
Chief Executive Officer