

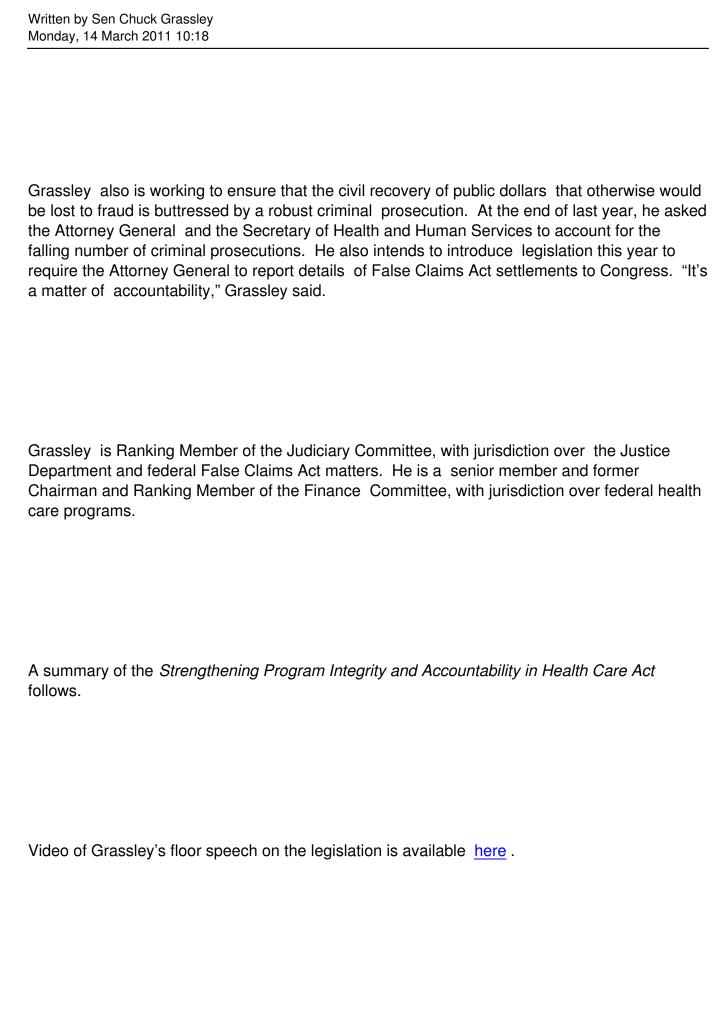
Written by Sen Chuck Grassley Monday, 14 March 2011 10:18

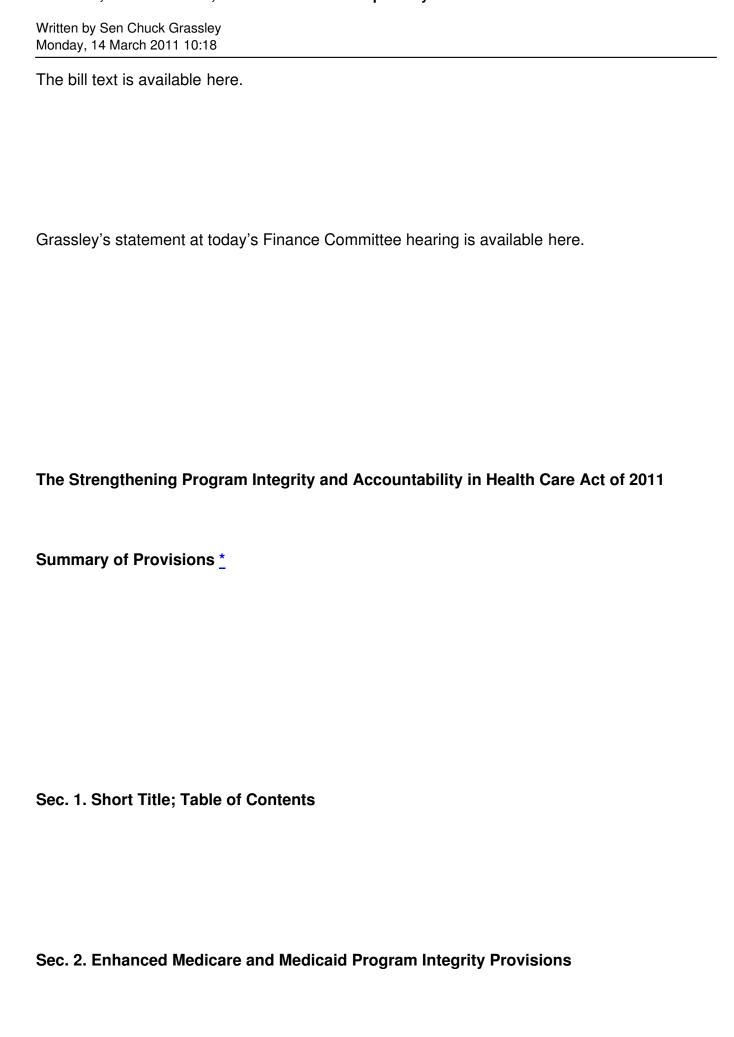
- enhance coordination among federal agencies responsible for fighting medical identity theft, in which thieves use personal and health insurance information to bill for medical treatment and prescription drugs fraudulently;
  - stop payments for illegal, unapproved drugs;
- beef up enforcement capabilities by expanding the range of individuals subject to penalties; and
- require Medicare claims and payment data to be available to the public by provider name for the first time, similar to other federal spending disclosed on <a href="https://www.USAspending.gov">www.USAspending.gov</a>.

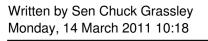
Grassley said the *Strengthening Program Integrity and Accountability in Health Care Act of*2011 is comprised of reforms with bipartisan support. Grassley led the
development of a number of fraud-fighting provisions during the bipartisan work in the Senate
in the last Congress on comprehensive health care legislation. Some of the items were
enacted, but others were not and are included in Grassley's new bill. He also introduced the
Medicare payment reform measure in the last Congress.

The federal government spent \$502 billion on Medicare and \$379 billion on Medicaid in fiscal year 2009. It is estimated between \$40 billion and \$70 billion was lost to fraud that year.

The federal False Claims Act is one of the most effective tools against health care fraud. Grassley authored a major update of this law, in 1986, with Rep. Howard Berman of California. Since then, the law has recovered more than \$28 billion and deterred billions of dollars in additional fraud against the taxpayers. The whistleblower provisions that were created by the 1986 update are among the most successful elements of the False Claims Act. This year, the False Claims Act brought in \$3 billion in recoveries, with \$2.5 billion from health care fraud cases, and nearly \$2.4 billion of the recoveries thanks to the qui tam whistleblower provisions.







**Payment Suspensions** CMS and its contractors currently have the discretionary authority to withhold payment in whole or in part if there is reliable evidence of an overpayment or fraud. CMS regulations stipulate the procedures CMS and its contractors must follow when deciding to suspend payment. The provision would make this discretionary authority mandatory and require

the Secretary to suspend payments to a provider or supplier pending a fraud investigation, except in cases when there is a determination that such a suspension is not supported by good cause.

**Extension of Time to Pay Claims** Under current law, payments must be made for clean claims within 14 to 30 days. This is known as the "prompt payment rule." The provision would require the Secretary to extend the time that Medicare payments must be made to providers if there is a determination of the likelihood of fraud, waste and abuse. OIG would also have to make recommendations at least annually on what categories of providers would warrant an extension of the time period in the prompt payment rule, and CMS would have to respond to these recommendations.

## Sec. 3. Requirements for the Transmission of Management Implication Reports by the HHS OIG

A Management Implication Report (MIR) is a document the HHS Office of Inspector General (OIG) produces identifying systematic weaknesses or vulnerabilities in federal programs to

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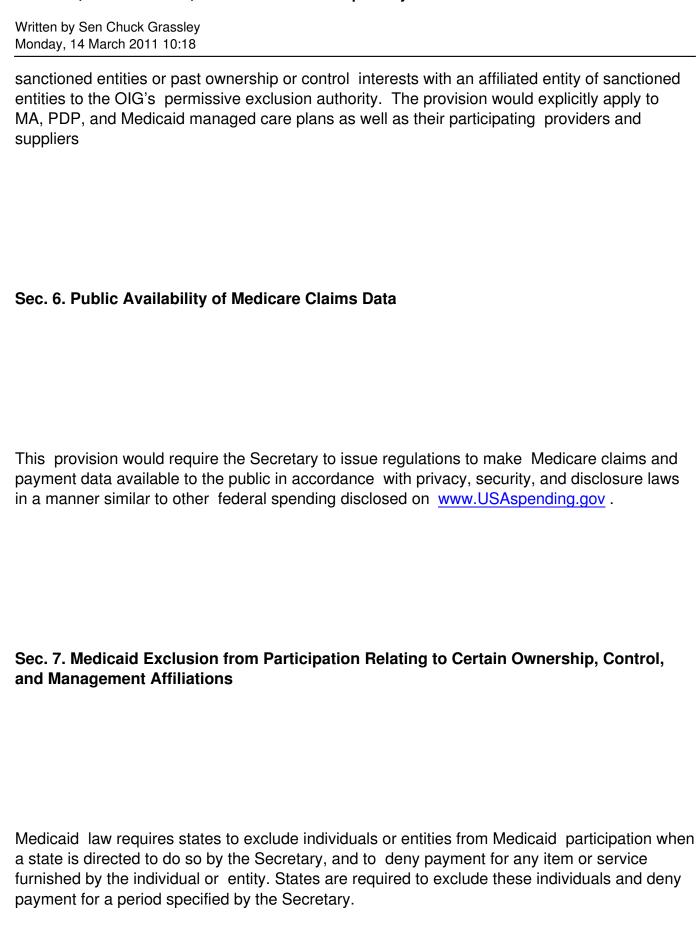
fraud, waste, or abuse, and recommending ways to correct or minimize them. Often detected in the course of an investigation, these identified weaknesses can exceed the parameters of the investigation and represent fraud, waste, or abuse across the federal healthcare system. This provision would require the OIG to inform Congress when it transmits MIRs to the Secretary and requires the Secretary to respond to OIG within 90 days.

## Sec. 4. Medical ID Theft Information Sharing Program and Clearinghouse

Medical identity theft contributes to a significant portion of health care fraud. This provision would require the Secretary to establish an information-sharing program with the Federal Trade Commission (FTC), which maintains identity theft complaints received by both the FTC and the Social Security Administration. The Secretary would be required to establish methods to identify and detect medical identity theft and establish responses to warning signs of medical identity theft.

# Sec. 5. Permissive Exclusion from Federal Health Care Programs Expanded to Individuals and Entities Affiliated with Sanctioned Entities

HHS OIG has the authority to exclude health care providers from participation in Federal health care programs. Exclusions are mandatory under certain circumstances, and permissive in others (*i.e.*, HHS OIG has discretion in whether to exclude an entity or individual). This provision would subject individuals who have had past ownership or control interests with



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The measure would require Medicaid agencies to exclude individuals or entities from Medicaid participation if the entity or individual owns, controls, or manages an entity that: (A) has unpaid or unreturned overpayments during the period as determined by the Secretary or the state; (B) is suspended, excluded, or terminated from participation in any Medicaid program; or (C) is affiliated with an individual or entity that has been suspended, excluded, or terminated from Medicaid participation during the period. This provision would be effective January 1, 2011.

## Sec. 8. Payment for Illegal Unapproved Drugs

This provision would ensure that the Medicaid program does not provide reimbursement for covered outpatient drugs that are not approved by the Food and Drug Administration (FDA) under a new drug application (NDA), an abbreviated new drug application (ANDA), or drugs grandfathered under prior FDA determinations. The Social Security Act currently prohibits the reimbursement of illegal, unapproved drugs which fall outside the definition of a "covered outpatient drug". However, Medicaid continues to make payments for illegal, unapproved drugs. For example, in 2008 it was reported that nearly \$198 million were paid in reimbursements for unapproved drugs from 2004-2007.

This provision would prohibit a state from making a payment for any covered outpatient drug unless the state first verifies with the FDA that such a covered outpatient drug is being legally marketed. It also would require the FDA to establish a public registry of all drugs that are not approved under an NDA or ANDA and include the drug, the person who listed the drug, and the authority that does not require the drug to receive approval via an NDA or ANDA.

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Sec. 9. Requiring Individuals or Entities that Participate in or Conduct Activities under Federal Health Care Programs to Comply with Certain Congressional Requests

This provision would require individuals and entities that participate in federal health care programs to comply with requests for documents, information, or interviews by the chairmen or ranking members of committees of jurisdiction.

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