S 2964

Strengthening Program Integrity and Accountability in Health Care Act

Congress: 111 (2009–2011, Ended)
Chamber: Senate
Policy Area: Health
Introduced: Jan 28, 2010
Current Status: Read twice and referred to the Committee on Finance.
Latest Action: Read twice and referred to the Committee on Finance. (Jan 28, 2010)
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Sponsor

Name: Sen. Grassley, Chuck [R-IA]
Party: Republican • **State:** IA • **Chamber:** Senate

Cosponsors

No cosponsors are listed for this bill.

Committee Activity

Committee	Chamber	Activity	Date
Finance Committee	Senate	Referred To	Jan 28, 2010

Subjects & Policy Tags

Policy Area:

Health

Related Bills

Bill	Relationship	Last Action
111 HR 3590	Related bill	**Mar 23, 2010:** Became Public Law No: 111-148.

Summary (as of Jan 28, 2010)

Strengthening Program Integrity and Accountability in Health Care Act - Amends title XVIII (Medicare) of the Social Security Act (SSA) to direct the Secretary of Health and Human Services (HHS) to: (1) establish new procedures for screening providers and suppliers under Medicare, Medicaid (SSA title XIX), and the State Children's Health Insurance Program (CHIP, formerly known as SCHIP) (SSA title XXI); and (2) determine the level of screening according to the risk of fraud, waste, and abuse with respect to each category of provider or supplier.

Requires providers and suppliers applying for enrollment or revalidation of enrollment in Medicare, Medicaid, or CHIP to disclose current or previous affiliations with any provider or supplier that has been sanctioned in specified ways.

Requires providers and suppliers to establish a compliance program containing specified core elements.

Directs the Administrator of the Centers for Medicare & Medicaid Services (CMS) to establish a process for making available to each state agency with responsibility for administering a state Medicaid plan or a child health plan under SSA title XXI the identity of any provider or supplier under Medicare or CHIP who is terminated.

Requires CMS to include in the integrated data repository (IDR) claims and payment data from Medicare, Medicaid, CHIP, and health-related programs administered by the Departments of Veterans Affairs (VA) and of Defense (DOD), the Social Security Administration, and the Indian Health Service (IHS).

Directs the Secretary to enter into data-sharing agreements with the Commissioner of Social Security, the VA and DOD Secretaries, and the IHS Director to help identify fraud, waste, and abuse.

Requires that overpayments be reported and returned within a certain period of time.

Directs the Secretary to issue a regulation requiring all Medicare, Medicaid, and CHIP providers to include their National Provider Identifiers on enrollment applications.

Subjects to civil monetary penalties (CMPs) excluded individuals who: (1) order or prescribe an item or service; (2) make false statements on applications or contracts to participate in a federal health care program; or (3) know of an overpayment and do not return it.

Requires the Secretary take into account the volume of billing for a durable medical equipment (DME) supplier or home health agency when determining the size of the supplier's and agency's surety bond.

Requires the Secretary to suspend payment to a provider or supplier pending a fraud investigation.

Extends the number of days in which Medicare claims must be paid if there is a likelihood of fraud involving certain providers or suppliers.

Appropriates additional funds to the Health Care Fraud and Abuse Control Account.

Requires the Medicare Integrity Program and the Medicaid Integrity Program to provide the Secretary and the HHS Office of Inspector General with performance statistics.

Requires the Secretary to furnish the National Practitioner Data Bank with all information reported to the national health care fraud and abuse data collection program on certain final adverse actions taken against health care providers, suppliers, and practitioners.

Reduces from three years to one year the maximum period for submission of Medicare claims.

Requires DME or home health services to be ordered by an enrolled Medicare eligible professional or physician.

Requires a physician, before issuing a certification for home health services, and a physician, a nurse practitioner, a clinical nurse specialist, a certified nurse-midwife, or a physician assistant, before ordering DME, to have a face-to-face encounter with the individual concerned.

Revises certain CMPs for making false statements or delaying inspections.

Requires the Secretary to establish a self-referral disclosure protocol to enable health care providers and suppliers to disclose actual or potential violations of the physician self-referral law.

Requires states to establish contracts with one or more Recovery Audit Contractors (RACs). Directs the Secretary to expand the RAC Program to Medicare parts C (Medicare+Choice) and D (Prescription Drug Program).

Directs the Secretary, acting through the CMS Administrator, to establish: (1) an information sharing program regarding beneficiary medical ID theft under Medicare, Medicaid, and CHIP; and (2) a clearinghouse at the CMS to collect reports of ID theft against beneficiaries.

Amends SSA title XIX (Medicaid) to require states to terminate providers from Medicaid participation if they were terminated from Medicare or another state's Medicaid plan.

Requires Medicaid agencies to exclude individuals or entities from Medicaid participation for a specified period of time if the entity or individual owns, controls, or manages an entity that: (1) has failed to repay overpayments during a specified period; (2) is suspended, excluded, or terminated from participation in any Medicaid program; or (3) is affiliated with an individual or entity that has been suspended, excluded, or terminated from Medicaid participation.

Requires state Medicaid plans to require any billing agents, clearinghouses, or other alternate payees that submit claims on behalf of health care providers to register with the state and the Secretary.

Requires states to submit data elements from the state mechanized claims processing and information retrieval system (under the Medicaid Statistical Information System [MSIS]) that the Secretary determines necessary for program integrity, program oversight, and administration.

Requires a state Medicaid plan to prohibit the state from making any payments for items or services under a Medicaid state plan or a waiver to any financial institution or entity located outside of the United States.

Extends the period for states to recover overpayments from 60 days to one year after discovery of the overpayment.

Requires state mechanized Medicaid claims processing and information retrieval systems to incorporate methodologies compatible with Medicare's National Correct Coding Initiative.

Amends the Federal Food, Drug, and Cosmetic Act to require listing on the Food and Drug Administration (FDA) website of drugs not required to be approved as new drugs or new animal drugs. Prohibits states from making Medicaid payments for any covered outpatient drug without first verifying FDA approval.

Amends SSA title XI to require any individuals or entities participating in or conducting activities under federal health care programs to comply with certain congressional requests for documents, information, or interviews.

Amends the False Claims Act to restrict the statute of limitations for civil actions under the Act to two years after a retaliation occurred. Revises requirements for dismissal of a claim or action based on public disclosure of the same allegations or transactions in other specified venues, including the news media.

Actions Timeline

- **Jan 28, 2010:** Introduced in Senate
- **Jan 28, 2010:** Sponsor introductory remarks on measure. (CR S345-346)
- **Jan 28, 2010:** Read twice and referred to the Committee on Finance.