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April 30, 2014

The Honorable Kevin Brady  
Chairman  
Subcommittee on Health  
Committee on Ways & Means  
U.S. House of Representatives  
1102 Longworth House Office Building  
Washington, D.C. 20515

Dear Chairman Brady:

Thank you for the opportunity to provide written comments related to the April 30, 2014, hearing entitled “Ideas to Improve Oversight to Reduce Waste, Fraud and Abuse.” The Academy of Managed Care Pharmacy (AMCP) is pleased to have the opportunity to suggest additional approaches to stemming the growth of Medicare fraud.

The Academy of Managed Care Pharmacy is a national professional association of pharmacists and other health care practitioners who serve society by the application of sound medication management principles and strategies to improve health care for all. The Academy's 7,000 members develop and provide a diversified range of clinical, educational and business management services and strategies on behalf of the more than 200 million Americans covered by a managed care pharmacy benefit. Some of the Academy's members work within managed care organizations in special investigative units to prevent Medicare fraud in the Medicare Part D drug benefit. Others work closely with law enforcement to combat Medicare fraud.

Federal and private-sector estimates of Medicare fraud range from three percent to 10 percent of total expenditures, amounting to between \$68 billion and \$226 billion annually. The substantial size of the dollars lost annually in fraud, waste and abuse in Medicare Parts A, B, C and D have prompted Medicare fraud to be one of the federal government's top priorities. Fraudulent activity within pharmacy benefits can take many forms, including patients acquiring prescriptions under false pretenses, providers writing illegitimate prescriptions and the trafficking of counterfeit drugs.

The Academy strongly supports the premise of stopping the cycle of “paying and chasing” fraudulent activity. The Academy appreciates the inclusion of Section 6402 in the Patient Protection and Affordable Care Act, P.L. 111-148, (the Affordable Care Act, or ACA) that permits the Secretary of the Department of Health and Human Services (HHS) to suspend payments to a provider of services or supplier pending an investigation of a credible allegation of fraud against the provider of services or supplier in Medicare Parts A and B, unless there is good cause not to suspend the payment. Pursuant to this provision, the

Secretary is required to consult with the Inspector General of the Department of Health and Human Services in determining whether there is a credible allegation of fraud.

The Academy strongly recommends that the Committee consider legislation that would extend the authority in the Affordable Care Act to suspend payment of claims wherein there is a credible allegation of fraud in Medicare Part D. Such legislation should provide for an expansion of time in which managed care organizations pay claims believed to be fraudulent. Attached is draft legislation to effectuate this change to Medicare Part D.

The problem faced by managed care pharmacy is exacerbated by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) which adopted a reduced period in which prescription drug plans (PDP) are required to pay pharmacies. As a result, Part D plans are limited to a retrospective analysis of pharmacy claims and provider payment trends which are primarily directed at administration errors, i.e., coding errors, etc.

Generally, a seven to 10-day payment cycle is required to meet MIPPA's 14 day "prompt payment" standard. For instance, a two-day time period between the end of a payment cycle (run on day 11) and the production of payment (run on day 13) obviates any significant prospective opportunity to conduct analysis of claims and reimbursement data prior to payment being sent to the pharmacy provider. As a result, Part D plans must rely on a "pay and chase" approach to recovering suspected fraud once proven. One plan's experience is that since 2006, approximately 9% to 12% of retrospectively reviewed claims have been deemed outliers and warranted additional scrutiny and investigation. However, once the claim is paid, it is unlikely that it can be recovered.

Fraud, waste and abuse are unacceptable within any health care program, especially within health care programs that are financed through taxpayer dollars. In a time of diminishing financial resources, it is more important than ever that Medicare providers, including Part D plan sponsors, are effectively able to combat suspected fraud. AMCP recognizes the seriousness of this problem and is supportive of efforts that would reduce the instance of fraudulent activity.

The Academy would be pleased to work with you to develop legislative language that addresses fraudulent activity in the Medicare Part D drug benefit. Thank you again for the opportunity to provide these written comments. Please do not hesitate to contact Lauren L. Fuller, Vice President, Government Affairs, at 703-683-8416 ext. 625 or [lfuller@amcp.org](mailto:lfuller@amcp.org) if we may be of further assistance.

Sincerely,



Edith A. Rosato, R.Ph., IOM  
Chief Executive Officer

cc: The Honorable Jim McDermott  
Ranking Member

Attachments: Medicare Part D Anti-fraud Act, draft  
Bill Summary

113TH CONGRESS

H.R. \_\_\_\_\_

1ST SESSION

To amend title XVIII of the Social Security Act to permit prescription drug plan sponsors to withhold payments to pharmacies based on credible allegations of fraud, and for other purposes.

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IN THE HOUSE OF THE UNITED STATES

\_\_\_\_\_ introduced the following bill; which was read twice and referred to the Committee on

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## A BILL

To amend title XVIII of the Social Security Act to permit prescription drug plan sponsors to withhold payments to pharmacies based on credible allegations of fraud, and for other purposes.

1           *Be it enacted by the Senate and House of Representa-*  
2           *tives of the United States of America in Congress assembled,*

3           **SECTION 1. SHORT TITLE.**

4           This Act may be cited as the “Medicare Prescription  
5           Drug Anti-Fraud Act of 2013”.

6           **SEC. 2. FINDINGS AND PURPOSES.**

7           (a) FINDINGS.—Congress finds the following:

1           (1) The Secretary of Health and  
2 Human Services may suspend payments to  
3 any Medicare fee-for-service provider  
4 pending an investigation of a credible  
5 allegation of fraud under section 1862(o) of  
6 the Social Security Act.

7           (2) States may suspend payments to  
8 any Medicaid provider pending an  
9 investigation of a credible allegation of fraud  
10 under section 1903(i)(2)(C) of the Social  
11 Security Act.

12           (3) Medicare prescription drug plan  
13 sponsors may not suspend payments to any  
14 pharmacy pending a credible allegation of  
15 fraud because of prompt payment and any  
16 willing pharmacy contracting requirements.

17           (4) Medicare prescription drug plan  
18 sponsors can and should play an important  
19 role in fighting fraud, waste and abuse under  
20 the Medicare prescription drug program  
21 under part D of title XVIII of the Social  
22 Security Act.

23           (5) Greater involvement of  
24 prescription drug plan sponsors will reduce  
25 the incidence of fraud under the medicare  
26 program and result in savings for medicare  
27 beneficiaries and taxpayers.

28           (b) PURPOSES.—The purpose of this Act is to

29 reduce payments for fraudulent claims submitted  
[Confidential Discussion Draft: May 21, 2013]

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1 under part D of the medicare program under title  
2 XVIII of the Social Security Act by establishing  
3 procedures under which prescription drug plan  
4 sponsors may withhold payments to pharmacies  
5 based on credible allegations of fraud.

6 **SEC. 3. AUTHORIZATION OF MEDICARE PRESCRIPTION DRUG**  
7 **PLANS TO SUSPEND PAYMENTS BASED ON CREDIBLE**  
8 **ALLEGATIONS OF FRAUD.**

9 (a) IN GENERAL.—Section 1860D–12(b)(4) of the  
10 Social Security Act (42 U.S.C. 1395w–112(b)(4)) is  
11 amended by adding at the end the following new  
12 subsection:

13 “(H) AUTHORIZATION OF PDP SPONSORS  
14 TO SUSPEND PAYMENTS BASED ON CREDIBLE  
15 ALLEGATIONS OF FRAUD.—

16 “(i) IN GENERAL.—The Secretary  
17 shall establish procedures under  
18 which a PDP sponsor may report to  
19 the Secretary a credible allegation of  
20 fraud relating to a pharmacy or other  
21 supplier furnishing items and services  
22 under the PDP.

23 “(ii) CONSULTATION.—The  
24 procedures under clause (i) shall  
25 provide that the Secretary shall  
26 consult with the Inspector General of  
27 the Department of Health and Human  
28 Services in determining whether there

29 is a credible allegation of fraud  
[Confidential Discussion Draft: May 21, 2013]

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1 against a pharmacy or other supplier.

2 “(iii) AUTHORIZATION TO  
3 SUSPEND PAYMENTS.—If the Secretary  
4 determines there is a credible  
5 allegation of fraud, the Secretary may  
6 authorize the PDP sponsor to suspend  
7 payments to the pharmacy or other  
8 supplier pending an investigation of  
9 such allegation, unless the Secretary  
10 determines there is good cause not to  
11 suspend such payments.

12 “(iv) RELATION TO OTHER  
13 PAYMENT SUSPENSION AUTHORITIES.—  
14 In establishing procedures under this  
15 section, the Secretary shall consider  
16 the procedures established under  
17 sections 1862(o) and 1903(i)(2)(C).

18 “(v) RULE OF CONSTRUCTION.—  
19 Nothing in this paragraph shall be  
20 construed as limiting the authority of  
21 a PDP sponsor to conduct post-claim  
22 payment review.”.

23 **(b) CONFORMING AMENDMENTS.—**

24 (1) PROMPT PAYMENT REQUIREMENTS.—  
25 Section 1860D–12(b)(4)(A)(i) of the Social Security  
26 Act (42 U.S.C. 1395w–112(b)(4)(A)(i)) is amended  
27 by striking “Each contract” and inserting “Subject

28 to subparagraph (H), each contract”.

[Confidential Discussion Draft: May 21, 2013]

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1 (2) ANY WILLING PHARMACY REQUIREMENTS.—  
2 Section 1860D–4(b)(1)(A) of the Social Security Act  
3 (42 U.S.C. 1395w–104(b)(1)(A)) is amended by  
4 striking “A prescription drug plan” and inserting  
5 “Subject to section 1860D–12(b)(4)(H), a  
6 prescription drug plan”.

7 (c) **EFFECTIVE DATE.**—The amendments made by  
8 this section shall apply to plan years beginning on or after  
9 January 1, 2015.

## Academy of Managed Care Pharmacy

### LEGISLATIVE SPECIFICATIONS

## MEDICARE PRESCRIPTION DRUG ANTI-FRAUD ACT OF 2013

The Secretary of Health and Human Services, acting through the Centers for Medicare and Medicaid Services (CMS), should have similar authority to suspend payments under Medicare Part D to pharmacy providers based on credible allegations of fraud as the Secretary has to suspend payments under Medicare Parts A and B under section 1862(o) of the Social Security Act (with necessary adaptations identified below).

Amend Medicare Part D to add a new provision to section 1860D–12 of the Social Security Act as follows:

- Prescription Drug Plan (PDP) sponsors shall report to the Secretary any credible allegation of fraud relating to pharmacy providers and suppliers furnishing items and services under the PDP.
- The Secretary may authorize a PDP sponsor to suspend payments to a pharmacy provider or supplier pending an investigation of a credible allegation of fraud against the pharmacy provider or supplier, unless the Secretary determines there is good cause not to suspend such payments.
- The Secretary shall consult with the Inspector General of the Department of Health and Human Services in determining whether there is a credible allegation of fraud against a pharmacy provider or supplier.
- The process used to determine whether there is a credible allegation of fraud shall be similar to the process established for purposes of administering section 1862(o) of the Social Security Act.
- This provision would supersede the prompt payment requirements, the any willing pharmacy contracting requirements, and any other requirements to make Medicare payments to the subject pharmacy provider or supplier during the period of suspension.
- If the Secretary declines to pursue legal remedies, the Secretary may, in its discretion, establish procedures under which the subject pharmacy provider or supplier together with the PDP it serves may recommend a plan for the pharmacy to meet Medicare Part D requirements, and, if approved by the Secretary, would limit or end the payment suspension.