111TH CONGRESS
1ST SESSION

S. 2128

To provide for the establishment of the Office of Deputy Secretary for Health Care Fraud Prevention.

IN THE SENATE OF THE UNITED STATES

OCTOBER 29, 2009

Mr. LEMIEUX introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

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A BILL

To provide for the establishment of the Office of Deputy Secretary for Health Care Fraud Prevention.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Prevent Health Care Fraud Act of 2009''.

SEC. 2. ESTABLISHMENT OF OFFICE OF DEPUTY SECRETARY FOR HEALTH CARE FRAUD PREVENTION IN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES; APPOINTMENT AND POWERS OF DEPUTY SECRETARY.

(a) IN GENERAL.—There is hereby established in the Department of Health and Human Services the Office of the Deputy Secretary for Health Care Fraud Prevention (referred to in this section as the ''Office'').

(b) DUTIES OF THE OFFICE.—The Office shall—

(1) direct the appropriate implementation within the Department of Health and Human Services of health care fraud prevention and detection recommendations made by Federal Government and private sector antifraud and oversight entities;

(2) routinely consult with the Office of the Inspector General for the Department of Health and Human Services, the Attorney General, and private sector health care antifraud entities to identify emerging health care fraud issues requiring immediate action by the Office;

(3) through a contract entered into with an entity that has experience in designing and implementing antifraud systems in the financial sector, provide for the design, development, and operation of a predictive model antifraud system (in accord-

ance with subsection (d)) to analyze health care claims data in real-time to identify high risk claims activity, develop appropriate rules, processes, and procedures and investigative research approaches, in coordination with the Office of the Inspector General for the Department of Health and Human Services, based on the risk level assigned to claims activity, and develop a comprehensive antifraud database for health care activities carried out or managed by Federal health agencies;

(4) promulgate and enforce regulations relating to the reporting of data claims to the health care antifraud system developed under paragraph (3) by all Federal health agencies;

(5) establish thresholds, in consultation with the Office of the Inspector General of the Department of Health and Human Services and the Department of Justice—

(A) for the amount and extent of claims verified and designated as fraudulent, wasteful, or abusive through the fraud prevention system developed under paragraph (3) for excluding providers or suppliers from participation in Federal health programs; and

(B) for the referral of claims identified through the health care fraud prevention system developed under paragraph (3) to law enforcement entities (such as the Office of the Inspector General, Medicaid Fraud Control Units, and the Department of Justice); and

(6) share antifraud information and best practices with Federal health agencies, health insurance issuers, health care providers, antifraud organizations, antifraud databases, and Federal, State, and local law enforcement and regulatory agencies.

(c) DEPUTY SECRETARY FOR HEALTH CARE FRAUD PREVENTION.—

(1) ESTABLISHMENT.—There is established within the Department of Health and Human Services the position of Deputy Secretary for Health Care Fraud Prevention (referred to in this section as the ''Deputy Secretary''). The Deputy Secretary shall serve as the head of the Office, shall act as the chief health care fraud prevention and detection officer of the United States, and shall consider and direct the appropriate implementation of recommendations to prevent and detect health care fraud, waste, and abuse activities and initiatives within the Department.

(2) APPOINTMENT.—The Deputy Secretary shall be appointed by the President, by and with the advice and consent of the Senate, and serve for a term of 5 years, unless removed prior to the end of such term for cause by the President.

(3) POWERS.—Subject to oversight by the Secretary, the Deputy Secretary shall exercise all powers necessary to carry out this section, including the hiring of staff, entering into contracts, and the delegation of responsibilities to any employee of the Department of Health and Human Services or the Office appropriately designated for such responsibility.

(4) DUTIES.—

(A) IN GENERAL.—The Deputy Secretary shall—

(i) establish and manage the operation of the predictive modeling system developed under subsection (b)(3) to analyze Federal health claims in real-time to identify high risk claims activity and refer risky claims for appropriate verification and investigative research;

(ii) consider and order the appropriate implementation of fraud prevention and detection activities, such as those rec-

ommended by the Office of the Inspector General of the Department of Health and Human Services, the Government Accountability Office, MedPac, and private sector health care antifraud entities;

(iii) not later than 6 months after the date on which he or she is initially appointed, submit to Congress an implementation plan for the health care fraud prevention systems under subsection (d); and

(iv) submit annual performance reports to the Secretary and Congress that, at minimum, shall provide an estimate of the return on investment with respect to the system, for all recommendations made to the Deputy Secretary under this section, a description of whether such recommendations are implemented or not implemented, and contain other relevant performance metrics.

(B) ANALYSIS AND RECOMMENDATIONS.—The Deputy Secretary shall provide required strategies and treatments for claims identified as high risk (including a system of designations for claims, such as ''approve'', ''decline'', ''re-

search'', and ''educate and pay'') to the Centers for Medicare & Medicaid Services, other Federal and State entities responsible for verifying whether claims identified as high risk are payable, should be automatically denied, or require further research and investigation.

(C) LIMITATION.—The Deputy Secretary shall not have any criminal or civil enforcement authority otherwise delegated to the Office of Inspector General of the Department of Health and Human Services or the Attorney General.

(5) REGULATIONS.—The Deputy Secretary shall promulgate and enforce such rules, regulations, orders, and interpretations as the Deputy Secretary determines to be necessary to carry out the purposes of this section. Such authority shall be exercised as provided under section 553 of title 5, United States Code.

(d) HEALTH CARE FRAUD PREVENTION SYSTEM.—

(1) IN GENERAL.—The fraud prevention system established under subsection (b)(3) shall be designed as follows:

(A) IN GENERAL.—The fraud prevention system shall—

(i) be holistic;

(ii) be able to view all provider and patient activities across all Federal health program payers;

(iii) be able to integrate into the existing health care claims flow with minimal effort, time, and cost;

(iv) be modeled after systems used in the Financial Services industry; and

(v) utilize integrated real-time transaction risk scoring and referral strategy capabilities to identify claims that are statistically unusual.

(B) MODULARIZED ARCHITECTURE.—The fraud prevention system shall be designed from an end-to-end modularized perspective to allow for ease of integration into multiple points along a health care claim flow (pre- or post-adjudication), which shall—

(i) utilize a single entity to host, support, manage, and maintain software-based services, predictive models, and solutions from a central location for the customers who access the fraud prevention system;

(ii) allow access through a secure private data connection rather than the in-

stallation of software in multiple information technology infrastructures (and data facilities);

(iii) provide access to the best and latest software without the need for upgrades, data security, and costly installations;

(iv) permit modifications to the software and system edits in a rapid and timely manner;

(v) ensure that all technology and decision components reside within the module; and

(vi) ensure that the third party host of the modular solution is not a party, payer, or stakeholder that reports claims data, accesses the results of the fraud prevention systems analysis, or is otherwise required under this section to verify, research, or investigate the risk of claims.

(C) PROCESSING, SCORING, AND STORAGE.—The platform of the fraud prevention system shall be a high volume, rapid, real-time information technology solution, which includes data pooling, data storage, and scoring capabilities to quickly and accurately capture and

evaluate data from millions of claims per day. Such platform shall be secure and have (at a minimum) data centers that comply with Federal and State privacy laws.

(D) DATA CONSORTIUM.—The fraud prevention system shall provide for the establishment of a centralized data file (referred to as a ''consortium'') that accumulates data from all government health insurance claims data sources. Notwithstanding any other provision of law, Federal health care payers shall provide to the consortium existing claims data, such as Medicare's ''Common Working File'' and Medicaid claims data, for the purpose of fraud and abuse prevention. Such accumulated data shall be transmitted and stored in an industry standard secure data environment that complies with applicable Federal privacy laws for use in building medical waste, fraud, and abuse prevention predictive models that have a comprehensive view of provider activity across all payers (and markets).

(E) MARKET VIEW.—The fraud prevention system shall ensure that claims data from Federal health programs and all markets flows

through a central source so the waste, fraud, and abuse system can look across all markets and geographies in health care to identify fraud and abuse in Medicare, Medicaid, the State Children's Health Program, TRICARE, the Department of Veterans Affairs, and private payers holistically. Such cross-market visibility shall identify unusual provider and patient behavior patterns and fraud and abuse schemes that may not be identified by looking independently at one Federal payer's transactions.

(F) BEHAVIOR ENGINE.—The fraud prevention system shall ensure that the technology used provides real-time ability to identify high-risk behavior patterns across markets, geographies, and specialty group providers to detect waste, fraud, and abuse, and to identify providers that exhibit unusual behavior patterns. Behavior pattern technology that provides the capability to compare a provider's current behavior to their own past behavior and to compare a provider's current behavior to that of other providers in the same specialty group and geographic location shall be used in order to

provide a comprehensive waste, fraud, and abuse prevention solution.

(G) PREDICTIVE MODEL.—The fraud prevention system shall involve the implementation of a statistically sound, empirically derived predictive modeling technology that is designed to prevent (versus post-payment detect) waste, fraud, and abuse. Such prevention system shall utilize historical transaction data, from across all Federal health programs and markets, to build and re-develop scoring models, have the capability to incorporate external data and external models from other sources into the health care predictive waste, fraud, and abuse model, and provide for a feedback loop to provide outcome information on verified claims so future system enhancements can be developed based on previous claims experience.

(H) CHANGE CONTROL.—The fraud prevention system platform shall have the infrastructure to implement new models and attributes in a test environment prior to moving into a production environment. Capabilities shall be developed to quickly make changes to

models, attributes, or strategies to react to changing patterns in waste, fraud, and abuse.

(I) SCORING ENGINE.—The fraud prevention system shall identify high-risk claims by scoring all such claims on a real-time capacity prior to payment. Such scores shall then be communicated to the fraud management system provided for under subparagraph (J).

(J) FRAUD MANAGEMENT SYSTEM.—The fraud prevention system shall utilize a fraud management system, that contains workflow management and workstation tools to provide the ability to systematically present scores, reason codes, and treatment actions for high-risk scored transactions. The fraud prevention system shall ensure that analysts who review claims have the capability to access, review, and research claims efficiently, as well as decline or approve claims (payments) in an automated manner. Workflow management under this subparagraph shall be combined with the ability to utilize principles of experimental design to compare and measure prevention and detection rates between test and control strategies. Such strategy testing shall allow for continuous im-

provement and maximum effectiveness in keeping up with ever changing fraud and abuse patterns. Such system shall provide the capability to test different treatments or actions randomly (typically through use of random digit assignments).

(K) DECISION TECHNOLOGY.—The fraud prevention system shall have the capability to monitor consumer transactions in real-time and monitor provider behavior at different stages within the transaction flow based upon provider, transaction and consumer trends. The fraud prevention system shall provide for the identification of provider and claims excessive usage patterns and trends that differ from similar peer groups, have the capability to trigger on multiple criteria, such as predictive model scores or custom attributes, and be able to segment transaction waste, fraud, and abuse into multiple types for health care categories and business types.

(L) FEEDBACK LOOP.—The fraud prevention system shall have a feedback loop where all Federal health payers provide pre-payment and post-payment information about the eventual

status of a claim designated as ''Normal'', ''Waste'', ''Fraud'', ''Abuse'', or ''Education Required''. Such feedback loop shall enable Federal health agencies to measure the actual amount of waste, fraud, and abuse as well as the savings in the system and provide the ability to retrain future, enhanced models. Such feedback loop shall be an industry file that contains information on previous fraud and abuse claims as well as abuse perpetrated by consumers, providers, and fraud rings, to be used to alert other payers, as well as for subsequent fraud and abuse solution development.

(M) TRACKING AND REPORTING.—The fraud prevention system shall ensure that the infrastructure exists to ascertain system, strategy, and predictive model return on investment. Dynamic model validation and strategy validation analysis and reporting shall be made available to ensure a strategy or predictive model has not degraded over time or is no longer effective. Queue reporting shall be established and made available for population estimates of what claims were flagged, what claims received treatment, and ultimately what results oc-

curred. The capability shall exist to complete tracking and reporting for prevention strategies and actions residing farther upstream in the health care payment flow. The fraud prevention system shall establish a reliable metric to measure the dollars that are never paid due to identification of fraud and abuse, as well as a capability to effectively test and estimate the impact from different actions and treatments utilized to detect and prevent fraud and abuse for legitimate claims. Measuring results shall include waste and abuse.

(N) OPERATING TENET.—The fraud prevention system shall not be designed to deny health care services or to negatively impact prompt-pay laws because assessments are late. The database shall be designed to speed up the payment process. The fraud prevention system shall require the implementation of constant and consistent test and control strategies by stakeholders, with results shared with Federal health program leadership on a quarterly basis to validate improving progress in identifying and preventing waste, fraud, and abuse. Under such implementation, Federal health care pay-

ers shall use standard industry waste, fraud, and abuse measures of success.

(2) COORDINATION.—The Deputy Secretary shall coordinate the operation of the fraud prevention system with the Department of Justice and other related Federal fraud prevention systems.

(3) OPERATION.—The Deputy Secretary shall phase-in the implementation of the system under this subsection beginning not later than 18 months after the date of enactment of this Act, through the analysis of a limited number of Federal health program claims. Not later than 5 years after such date of enactment, the Deputy Secretary shall ensure that such system is fully phased-in and applicable to all Federal health program claims.

(4) NON-PAYMENT OF CLAIMS.—The Deputy Secretary shall promulgate regulations to prohibit the payment of any health care claim that has been identified as potentially ''fraudulent'', ''wasteful'', or ''abusive'' until such time as the claim has been verified as valid.

(5) APPLICATION.—The system under this section shall apply to all Federal health programs, including programs established after the date of enactment of this Act.

(6) REGULATIONS.—The Deputy Secretary shall promulgate regulations providing the maximum appropriate protection of personal privacy consistent with carrying out the Office's responsibilities under this section.

(e) PROTECTING PARTICIPATION IN HEALTH CARE ANTIFRAUD PROGRAMS.—

(1) IN GENERAL.—Notwithstanding any other provision of law, no person providing information to the Secretary under this section shall be held, by reason of having provided such information, to have violated any criminal law, or to be civilly liable under any law of the United States or of any State (or political subdivision thereof) unless such information is false and the person providing it knew, or had reason to believe, that such information was false.

(2) CONFIDENTIALITY.—The Office shall, through the promulgation of regulations, establish standards for—

(A) the protection of confidential information submitted or obtained with regard to suspected or actual health care fraud;

(B) the protection of the ability of representatives the Office to testify in private civil actions concerning any such information; and

(C) the sharing by the Office of any such information related to the medical antifraud programs established under this section.

(f) PROTECTING LEGITIMATE PROVIDERS AND SUPPLIERS.—

(1) INITIAL IMPLEMENTATION.—Not later than 2 years after the date of enactment of this Act, the Secretary shall establish procedures for the implementation of fraud and abuse detection methods under all Federal health programs (including the programs under titles XVIII, XIX, and XXI of the Social Security Act) with respect to items and services furnished by providers of services and suppliers that includes the following:

(A) In the case of a new applicant to be such a provider or supplier, a background check, and in the case of a supplier a site visit prior to approval of participation in the program and random unannounced site visits after such approval.

(B) Not less than 5 years after the date of enactment of this Act, in the case of a provider or supplier who is not a new applicant, re-enrollment under the program, including a new background check and, in the case of a supplier,

a site-visit as part of the application process for such re-enrollment, and random unannounced site visits after such re-enrollment.

(2) REQUIREMENT FOR PARTICIPATION.—In no case may a provider of services or supplier who does not meet the requirements under paragraph (1) participate in any Federal health program.

(3) BACKGROUND CHECKS.—The Secretary shall determine the extent of the background check conducted under paragraph (1), including whether—

(A) a fingerprint check is necessary;

(B) a background check shall be conducted with respect to additional employees, board members, contractors or other interested parties of the provider or supplier; and

(C) any additional national background checks regarding exclusion from participation in Federal health programs (such as the program under titles XVIII, XIX, or XXI of the Social Security Act), including conviction of any felony, crime that involves an act of fraud or false statement, adverse actions taken by State licensing boards, bankruptcies, outstanding taxes, or other indications identified by the In-

spector General of the Department of Health and Human Services are necessary.

(4) LIMITATION.—No payment may be made to a provider of services or supplier under any Federal health program if such provider or supplier fails to obtain a satisfactory background check under this subsection.

(5) FEDERAL HEALTH PROGRAM.—In this subsection, the term ''Federal health program'' means any program that provides Federal payments or reimbursements to providers of health-related items or services, or suppliers of such items, for the provision of such items or services to an individual patient.

(g) DEFINITION.—The term ''Federal health agency'' means the Department of Health and Human Services, the Department of Veterans Affairs, and any Federal agency with oversight or authority regarding the provision of any medical benefit, item, or service for which payment may be made under a Federal health care plan or contract.

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