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111TH CONGRESS
2D SESSION

H. R. 5546

To provide for the establishment of a fraud, waste, and abuse detection and mitigation program for the Medicare Program under title XVIII of the Social Security Act.

IN THE HOUSE OF REPRESENTATIVES

JUNE 16, 2010

Mr. ROSKAM introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To provide for the establishment of a fraud, waste, and abuse detection and mitigation program for the Medicare Program under title XVIII of the Social Security Act.

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

SECTION 1. MEDICARE FRAUD, WASTE, AND ABUSE PREVENTION SOLUTION.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall develop and implement a fraud,

waste, and abuse comprehensive pre-payment review prevention system (in this section referred to as the ''Prevention System'') for reviewing claims for reimbursement under the Medicare Program under title XVIII of the Social Security Act (in this section referred to as the ''Medicare Program'').

(2) IMPLEMENTATION.—The Secretary shall carry out the Prevention System acting through the Center for Program Integrity of the Centers for Medicare & Medicaid Services.

(b) SELECTION OF CLAIMS ACROSS ALL PROVIDER TYPES.—The Prevention System shall cover all types of providers of services and suppliers under the Medicare Program, but may be limited to a subset of claim segments.

(c) SYSTEM DESIGN ELEMENTS.—To the extent practicable, the Prevention System, shall—

(1) be holistic;

(2) be able to view and analyze all provider of services, supplier, and patient activities from multiple providers of services and suppliers under the Medicare Program;

(3) be able to be integrated into the health care claims flow in existence as of the date of the enactment of this Act with minimal effort, time, and cost;

(4) be designed to use technologies, including predictive modeling, that can utilize integrated near real-time transaction risk scoring and referral strategy capabilities to identify transactions, patterns, anomalies, and linkages that are statistically unusual or suspicious and can undertake analysis before payment is made and that prioritizes unusual or suspicious claims in terms of likelihood of potential fraud, waste, or abuse to more efficiently utilize investigative resources;

(5) be designed to—

(A) allow for ease of integration into multiple points along the claims flow under the Medicare Program (pre-adjudication and post-adjudication of such claims) in order to demonstratively show that the system ranks the likelihood of high-risk behavior patterns and of fraud, waste, or abuse; and

(B) utilize experimental design methodology to monitor and measure the performance between the control treatments (which shall be the methods and assessments used as of the day before the date of the enactment of this Act to address fraud, waste, and abuse under the Medicare Program) and test treatments (which

shall be the Prevention System identification of such fraud, waste, and abuse and actions taken pursuant to such system to address such fraud, waste, and abuse); and

(6) be provided through competitively bid contracts using the Federal Acquisition Regulations.

(d) SYSTEM OPERATION.—

(1) SCORING AND NEAR REAL-TIME ANALYSIS.—

(A) IN GENERAL.—The Prevention System shall identify high-risk Medicare claims by scoring all such claims in near real-time, prior to the Centers for Medicare & Medicaid Services making payment on such claims under the Medicare Program.

(B) USE OF SCORES.—The scores under subparagraph (A) shall be communicated to the fraud management system under subsection (f).

(C) NEAR REAL-TIME ANALYSIS.—Under the Prevention System, the near real-time analysis of Medicare claims data shall be conducted in a manner that ensures—

(i) prompt identification of fraud, waste, and abuse; and

(ii) prompt payment of legitimate claims.

(2) PREDICTIVE MODELING.—The Prevention System shall involve the implementation of a statistically sound, empirically derived predictive modeling technology that is designed to prevent fraud, waste, and abuse (by identifying such fraud, waste, and abuse before payment is made under the Medicare Program on related claims). The Prevention System shall use a predictive model to identify fraud, waste, and abuse that is—

(A) based on historical transaction data, from across all markets and regions available, to build and continuously re-develop scoring models that are capable of incorporating external data and external models from other sources into the predictive model; and

(B) regularly updated, through the feedback loop under subsection (g), to provide information and incorporate data on reimbursement claims that is collected through the Prevention System, including information gathered through the investigation of claims for reimbursement under the Medicare Program that the system

identifies as being potentially fraudulent, wasteful, or abusive.

(3) PROTECTIONS FOR PATIENTS AND PROVIDERS.—The identification of an unusual or suspect Medicare claim by the Prevention System shall—

(A) not result in the denial of items or services to an individual under the Medicare Program until such claim is further reviewed by the Secretary; and

(B) not result in a failure to comply with prompt payment requirements under applicable law.

(4) COMPLIANCE WITH HIPAA.—Any data collected, stored, or reviewed under the Prevention System shall be treated in a manner that is in accordance with the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note) and any other applicable law.

(e) TREATMENT OF DATA.—

(1) IN GENERAL.—The Prevention System shall be a high volume, rapid, near real-time information technology solution, which includes data pooling and

scoring capabilities to quickly and accurately capture and evaluate data.

(2) DATA SOURCES.—The Prevention System shall, for purposes of preventing fraud, waste, and abuse under the Medicare Program—

(A) use data from claims for reimbursement under the Medicare Program contained in existing files of Medicare claims data, including the Common Working File of the Centers for Medicare & Medicaid Services; and

(B) to the extent practicable, pool data from all available Government sources (including the Death Master File of the Social Security Administration).

(3) DATA STORAGE.—The Prevention System shall be stored in an industry standard secure data environment that complies with applicable Federal privacy laws for use in building Medicare fraud, waste, and abuse prevention predictive models that have a comprehensive view of provider and supplier activity across all markets, geographic areas, and provider and supplier types.

(f) FRAUD MANAGEMENT SYSTEM.—

(1) IN GENERAL.—The Prevention System shall utilize a fraud management system containing

workflow management and workstation tools to provide the ability to systematically present score, reason codes, and treatment actions for high-risk scored transactions, as determined under subsection (d).

(2) REVIEW OF CLAIMS.—The fraud management system under paragraph (1) shall ensure that analysts who review Medicare claims have the capability to access, review, and research claims efficiently, as well as decline or approve payments on claims in an automated manner.

(g) FEEDBACK LOOP.—

(1) IN GENERAL.—The Prevention System shall utilize a feedback loop to gain access to outcome information on adjudicated Medicare claims so future system enhancements can utilize previous experience.

(2) PURPOSE.—The purpose of the feedback loop under paragraph (1) is to—

(A) enable the Secretary to measure—

(i) the actual amount of fraud, waste, and abuse under the Medicare Program; and

(ii) any savings to the Medicare Program resulting from implementation of the Prevention System; and

(B) provide necessary data to develop future, enhanced models for use in the Prevention System.

(3) ANALYSIS OF FINAL CLAIMS STATUS.—The feedback loop under paragraph (1) shall analyze data from all carriers to provide post-payment information about the eventual status of a Medicare claim as ''Normal'', ''Fraud'', ''Waste'', ''Abuse'', or ''Education required''.

(h) CLAIMS REVIEW PRIOR TO PAYMENT.—

(1) REVIEW BEFORE PAYMENT.—Subject to paragraph (2), if a claim for reimbursement under the Medicare Program is selected for review under the Prevention System, the Secretary shall not make a payment on such claim until such claim has been reviewed under the system. In order to carry out this paragraph, the Secretary shall ensure that appropriate controls and technology are in place to assess and measure the effectiveness of the Prevention System, predictive models used under such system, and the overall strategy for Medicare claims review.

(2) TIMELY REVIEW.—

(A) IN GENERAL.—The review of a claim under the Prevention System shall occur in a timely manner.

(B) APPLICATION OF PROMPT PAYMENT REQUIREMENTS.—The limitation on payment under paragraph (1) shall not interfere with the prompt payment of a Medicare claim in accordance with applicable law.

(3) MANUAL REVIEW.—If automated technology presents a score, reason code, or treatment action for a claim that is scored as ''high-risk,'' the Prevention System shall provide for manual review of medical records related to such claim by both clinical and fraud investigators to ensure accuracy and mitigate false positive events.

(4) SELF-AUDIT REVIEW.—The Secretary may use self-audit practices by providers and suppliers under the Prevention System in a manner such that once high-risk claims are identified through the predictive modeling, providers and suppliers are offered the opportunity to adjust or withdraw their claims.

(5) DENIAL OF PAYMENT FOR FRAUDULENT CLAIMS.—Under the Prevention System, if automated technology of a claim under paragraph (3) and manual review under paragraph (4) confirm fraud has occurred, the Secretary may deny payment of such claim.

(i) ANNUAL ASSESSMENT REPORT.—

(1) IN GENERAL.—Not later than 2 years after the implementation of the Prevention System, the Secretary, through the Office of the Inspector General of the Department of Health and Human Services, shall submit to Congress a report on the implementation of such system.

(2) CONTENTS.—The report submitted under paragraph (1) may contain—

(A) a detailed assessment of the Prevention System's success in identifying fraud, waste, and abuse;

(B) the costs of operating the Prevention System; and

(C) an analysis of the overall return on investment for the Prevention System.

(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary.

(k) EXPANSION.—If the Secretary determines that the Prevention System results in savings to the Medicare Program, the Secretary shall expand the project throughout Federal health programs, including the Medicaid Program under title XIX of the Social Security Act and the

Children's Health Insurance Program under title XXI of such Act.

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