

111TH CONGRESS
2D SESSION

S. 3900

To reduce waste, fraud, and abuse under the Medicare, Medicaid, and CHIP programs, and for other purposes.

IN THE SENATE OF THE UNITED STATES

SEPTEMBER 29, 2010

Mr. COBURN introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To reduce waste, fraud, and abuse under the Medicare, Medicaid, and CHIP programs, 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; TABLE OF CONTENTS.**

4 (a) **SHORT TITLE.**—This Act may be cited as the
5 “Fighting Fraud and Abuse to Save Taxpayers’ Dollars
6 Act” or the “FAST Act”.

7 (b) **TABLE OF CONTENTS.**—The table of contents of
8 this Act is as follows:

- Sec. 1. Short title; table of contents.
- Sec. 2. Findings.
- Sec. 3. Tracking excluded providers across State lines.
- Sec. 4. Access for private sector and governmental entities.

- Sec. 5. Liability of Medicare administrative contractors for claims submitted by excluded providers.
- Sec. 6. Limiting the discharge of debts in bankruptcy proceedings in cases where a health care provider or a supplier engages in fraudulent activity.
- Sec. 7. Prevention of waste, fraud, and abuse in the Medicaid and CHIP programs.
- Sec. 8. Illegal distribution of a Medicare, Medicaid, or CHIP beneficiary identification or billing privileges.
- Sec. 9. Pilot program for the use of universal product numbers on claim forms for reimbursement under the Medicare program.
- Sec. 10. Prohibition of inclusion of social security account numbers on Medicare cards.
- Sec. 11. Implementation.

1 **SEC. 2. FINDINGS.**

2 Congress makes the following findings:

3 (1) The Medicare program loses an estimated
4 \$60,000,000,000 annually to wasted and fraudulent
5 payments.

6 (2) The Medicaid program also suffers from
7 rampant fraud. As the Office of the Inspector Gen-
8 eral of the Department of Health and Human Serv-
9 ices noted in 2009, in an analysis of the only source
10 of nationwide Medicaid claims and beneficiary eligi-
11 bility information, the Medicaid Statistical Informa-
12 tion System, the Federal Government does not have
13 “timely, accurate, or comprehensive information for
14 fraud, waste, and abuse detection” in the Medicaid
15 program.

16 (3) Absent comprehensive estimates, the Med-
17 icaid program’s improper payment rate may be the
18 most objective measure of taxpayer dollars lost to
19 fraud. The national average improper payment rate

1 ranges between 8.7 percent and 10.5 percent, but
2 many States have much higher improper payment
3 rates.

4 (4) The new Federal health reform law substan-
5 tially expands the Medicaid program, significantly
6 changes the Medicare program, creates new man-
7 dates and regulations, and will send hundreds of bil-
8 lions of dollars to insurance companies.

9 (5) It is the duty of public officials and public
10 servants in Congress and the Administration to pro-
11 tect the American public's taxpayer dollars. Con-
12 gress and the Administration must continue to ag-
13 gressively combat waste, fraud, and abuse in public
14 health care programs.

15 (6) The Inspector General of the Department of
16 Health and Human Services has stated that "swift
17 and effective detection of and response to waste,
18 fraud, and abuse remain an essential program integ-
19 rity strategy". Furthermore, the Inspector General
20 noted that "effective use of Medicare and Medicaid
21 data is critical to the success of the Government's
22 efforts to reduce waste, fraud, and abuse".

23 (7) The loss of taxpayer dollars due to waste
24 and fraud under the Medicare and Medicaid pro-
25 grams not only threatens the financial viability of

1 those programs, it erodes the public trust. American
2 taxpayers should not be expected to tolerate ramp-
3 ant waste, fraud, and abuse in publicly funded
4 health care programs.

5 (8) Congress supports the commitment of the
6 Office of the Inspector General of the Department of
7 Health and Human Services to “enhancing existing
8 data analysis and mining capabilities and employing
9 advanced techniques such as predictive analytics and
10 social network analysis, to counter new and existing
11 fraud schemes”.

12 (9) Congress supports the use of predictive
13 modeling and other smart technologies that can
14 transform the current “pay and chase” payment cul-
15 tures under the Medicare and Medicaid programs
16 and prevent taxpayer dollars from being lost to
17 waste, fraud, and abuse.

18 **SEC. 3. TRACKING EXCLUDED PROVIDERS ACROSS STATE**
19 **LINES.**

20 (a) GREATER COORDINATION.—In order to ensure
21 that providers of services and suppliers that have operated
22 in one State and are excluded from participation in the
23 Medicare program are unable to begin operation and par-
24 ticipation in other Federal health care programs in an-

1 other State, the Secretary shall provide for increased co-
2 ordination between the following:

3 (1) The Administrator of the Centers for Medi-
4 care & Medicaid Services.

5 (2) Regional offices of the Centers for Medicare
6 & Medicaid Services.

7 (3) Medicare administrative contractors, fiscal
8 intermediaries, and carriers.

9 (4) State health agencies, State plans under
10 title XIX of the Social Security Act (42 U.S.C. 1396
11 et seq.), State plans under title XXI of such Act (42
12 U.S.C. 1397aa et seq.), and entities that contract
13 with such agencies and plans, as directed by the
14 Secretary.

15 (5) The Federation of State Medical Boards.

16 (b) IMPROVED INFORMATION SYSTEMS.—

17 (1) IN GENERAL.—The Secretary shall improve
18 information systems to allow greater integration be-
19 tween databases under the Medicare program so
20 that—

21 (A) Medicare administrative contractors,
22 fiscal intermediaries, and carriers have imme-
23 diate access to information identifying providers
24 and suppliers excluded from participation in the
25 Medicare program, the Medicaid program under

1 title XIX of the Social Security Act, the State
2 Children's Health Insurance Program under
3 title XXI of such Act, and other Federal health
4 care programs; and

5 (B) such information can be shared on a
6 real-time basis, in accordance with protocols es-
7 tablished under subsection (g)(2)—

8 (i) across Federal health care pro-
9 grams and agencies, including between the
10 Department of Health and Human Serv-
11 ices, the Social Security Administration,
12 the Department of Veterans Affairs, the
13 Department of Defense, the Department of
14 Justice, and the Office of Personnel Man-
15 agement; and

16 (ii) with State health agencies, State
17 plans under title XIX of the Social Secu-
18 rity Act (42 U.S.C. 1396 et seq.), State
19 child health plans under title XXI of such
20 Act (42 U.S.C. 1397aa et seq.), and enti-
21 ties that contract with such agencies and
22 plans, as directed by the Secretary.

23 (2) SHARING OF INFORMATION IN ADDITION TO
24 HEAT EFFORTS.—The information shared under
25 paragraph (1) shall be in addition to, and shall not

1 replace, activities of the Health Care Fraud Preven-
2 tion and Enforcement Action Team (HEAT) estab-
3 lished by the Attorney General and the Department
4 of Health and Human Services.

5 (3) APPROPRIATE COORDINATION.—In imple-
6 menting this subsection, the Secretary shall provide
7 for the maximum appropriate coordination with the
8 process established under section 6401(b)(2) of the
9 Patient Protection and Affordable Care Act (Public
10 Law 111–148).

11 (c) “ONE PI” DATABASE FOR MEDICARE, MEDICAID,
12 AND CHIP.—

13 (1) IN GENERAL.—The Secretary shall—

14 (A) continue to upload Medicare claims,
15 provider, and beneficiary data into the Inte-
16 grated Data Repository under section
17 1128J(a)(1) of the Social Security Act, as
18 added by section 6402(a) of the Patient Protec-
19 tion and Affordable Care Act until such time as
20 the Secretary determines that the Integrated
21 Data Repository is completed; and

22 (B) fully implement the waste, fraud, and
23 abuse detection solution of the Centers for
24 Medicare & Medicaid Services, called the “One
25 PI project” (in this subsection referred to as

1 the “project”) by not later than January 1,
2 2013.

3 (2) ACCESS.—The Secretary, in consultation
4 with Inspector General of the Department of Health
5 and Human Services, may allow stakeholders who
6 combat, or could assist in combating, waste, fraud,
7 and abuse under Federal health care programs to
8 have access to the One PI system established under
9 the project. Such stakeholders may include the Di-
10 rector of the Federal Bureau of Investigation, the
11 Comptroller General of the United States, Medicare
12 administrative contractors, fiscal intermediaries, and
13 carriers.

14 (d) FEDERAL AND STATE AGENCY ACCESS TO NA-
15 TIONAL PRACTITIONER DATA BANK.—For purposes of
16 enhancing data sharing in order to identify programmatic
17 weaknesses and improving the timeliness of analysis and
18 actions to prevent waste, fraud, and abuse, relevant Fed-
19 eral and State agencies, including the Department of
20 Health and Human Services, the Department of Justice,
21 State departments of health, State Medicaid plans under
22 title XIX of the Social Security Act, State child health
23 plans under title XXI of such Act, and State medicaid
24 fraud control units (as described in section 1903(q) of the
25 Social Security Act (42 U.S.C. 1396b(q))), shall have real-

1 time access to the National Practitioner Data Bank, as
2 directed by the Secretary. The Secretary may, in consulta-
3 tion with the Inspector General of the Department of
4 Health and Human Services, give such real-time access
5 to State attorneys general and State and local law enforce-
6 ment agencies.

7 (e) ACCESS TO CLAIMS AND PAYMENT DATA-
8 BASES.—Section 1128J(a)(2) of the Social Security Act,
9 as added by section 6402(a) of the Patient Protection and
10 Affordable Care Act (Public Law 111–148) is amended—

11 (1) by striking “DATABASES.—For purposes”
12 and inserting “DATABASES.—

13 “(A) ACCESS FOR THE CONDUCT OF LAW
14 ENFORCEMENT AND OVERSIGHT ACTIVITIES.—
15 For purposes”;

16 (2) in subparagraph (A), as added by para-
17 graph (1), by inserting “, including the Integrated
18 Data Repository under paragraph (1)” before the
19 period at the end; and

20 (3) by adding at the end the following new sub-
21 paragraph:

22 “(B) ACCESS TO REDUCE WASTE, FRAUD,
23 AND ABUSE.—For purposes of reducing waste,
24 fraud, and abuse, and to the extent consistent
25 with applicable information, privacy, security,

1 and disclosure laws, including the regulations
2 promulgated under the Health Insurance Port-
3 ability and Accountability Act of 1996 and sec-
4 tion 552a of title 5, United States Code, and
5 subject to any information systems security re-
6 quirements under such laws or otherwise re-
7 quired by the Secretary, the Secretary, in con-
8 sultation with the Inspector General of the De-
9 partment of Health and Human Services, may
10 allow State Medicaid fraud control units and
11 State and local law enforcement officials to
12 have access to claims and payment data of the
13 Department of Health and Human Services and
14 its contractors related to titles XVIII, XIX, and
15 XXI, including the Integrated Data Repository
16 under paragraph (1).”.

17 (f) ENSURING DATA IS UPLOADED TO THE IDR ON
18 A DAILY BASIS.—Section 1128J(a)(1) of the Social Secu-
19 rity Act, as added by section 6402(a) of the Patient Pro-
20 tection and Affordable Care Act (Public Law 111–148)
21 is amended by adding at the end the following new sub-
22 paragraph:

23 “(C) UPLOADING OF MEDICARE CLAIMS
24 DATA ON A DAILY BASIS.—All Medicare claims

1 data shall be uploaded into the Integrated Data
2 Repository on a daily basis.”.

3 (g) REAL-TIME ACCESS TO DATA.—

4 (1) IN GENERAL.—The Secretary shall ensure
5 that any data provided to an entity or individual
6 under the provisions of or amendments made by this
7 section is provided to such entity or individual on a
8 real-time basis, in accordance with protocols estab-
9 lished by the Secretary under paragraph (2). The
10 Secretary shall consult with the Inspector General of
11 the Department of Health and Human Services
12 prior to implementing this subsection.

13 (2) PROTOCOLS.—

14 (A) IN GENERAL.—The Secretary shall es-
15 tablish protocols to ensure the secure transfer
16 and storage of any data provided to another en-
17 tity or individual under the provisions of or
18 amendments made by this section.

19 (B) CONSIDERATION OF HHS OIG REC-
20 OMMENDATIONS.—In establishing protocols
21 under subparagraph (A), the Secretary shall
22 take into account recommendations submitted
23 to the Secretary by the Inspector General of the
24 Department of Health and Human Services

1 with respect to the secure transfer and storage
2 of such data.

3 (h) GAO STUDY AND REPORT ON USE OF FEDERA-
4 TION OF STATE MEDICAL BOARDS TO STRENGTHEN EN-
5 ROLLMENT INTEGRITY PROCESSES.—

6 (1) STUDY.—The Comptroller General of the
7 United States shall, in consultation with the Federa-
8 tion of State Medical Boards, conduct a study on
9 whether and, if so, to what degree, such Federation
10 may be useful to the Secretary in further strength-
11 ening the integrity of processes for enrolling pro-
12 viders of services and suppliers under Federal health
13 care programs.

14 (2) REPORT.—Not later than 1 year after the
15 date of enactment of this Act, the Comptroller Gen-
16 eral of the United States shall submit to Congress
17 a report containing the results of the study con-
18 ducted under paragraph (1), together with rec-
19 ommendations for such legislation and administra-
20 tive action as the Comptroller General determines
21 appropriate.

22 (i) DEFINITIONS.—In this section:

23 (1) ADMINISTRATOR.—The term “Adminis-
24 trator” means the Administrator of the Centers for
25 Medicare & Medicaid Services.

1 (2) CHIP.—The term “CHIP” means the
2 State Children’s Health Insurance Program under
3 title XXI of the Social Security Act (42 U.S.C.
4 1397aa et seq.).

5 (3) FEDERAL HEALTH CARE PROGRAM.—The
6 term “Federal health care program” has the mean-
7 ing given such term in section 1128B(f) of the So-
8 cial Security Act (42 U.S.C. 1320a–7b(f)).

9 (4) HHS OIG.—The term “HHS OIG” means
10 the Inspector General of the Department of Health
11 and Human Services.

12 (5) MEDICARE ADMINISTRATIVE CONTRACTORS,
13 FISCAL INTERMEDIARIES, AND CARRIERS.—The
14 term “Medicare administrative contractors, fiscal
15 intermediaries, and carriers” includes zone program
16 integrity contractors, program safeguard or integrity
17 contractors, recovery audit contractors under section
18 1893(h) of the Social Security Act (42 U.S.C.
19 1395ddd(h)), and special investigative units at Medi-
20 care contractors (as defined in section 1889(g) of
21 the Social Security Act (42 U.S.C. 1395zz(g))).

22 (6) MEDICARE PROGRAM.—The term “Medicare
23 program” means the program under title XVIII of
24 the Social Security Act (42 U.S.C. 1395 et seq.).

1 1986 (42 U.S.C. 11101 et seq.) may be available on
2 a real-time basis, in accordance with protocols estab-
3 lished by the Secretary under subsection (b), to—

4 “(A) Federal and State government agen-
5 cies and health plans, commercial health plans,
6 and any health care provider, supplier, or prac-
7 titioner entering an employment or contractual
8 relationship with an individual or entity who
9 has been subject to a final adverse action in the
10 past 10 years, where the contract involves the
11 furnishing of items or services reimbursed by 1
12 or more Federal health care programs (regard-
13 less of whether the individual or entity is paid
14 by the programs directly, or whether the items
15 or services are reimbursed directly or indirectly
16 through the claims of a direct provider); and

17 “(B) utilization and quality control peer
18 review organizations and accreditation entities
19 as defined by the Secretary, including but not
20 limited to organizations described in part B of
21 this title and in section 1154(a)(4)(C).

22 “(2) NO EFFECT ON ACCESS UNDER OTHER AP-
23 PPLICABLE LAW; APPROPRIATE COORDINATION.—
24 Nothing in this section shall affect the availability of
25 information in the National Practitioner Data Bank

1 under other applicable law, including the availability
2 of such information to entities or individuals under
3 part B of the Health Care Quality Improvement Act
4 of 1986 (42 U.S.C. 11131 et seq.). In implementing
5 this section, the Secretary shall provide for the max-
6 imum appropriate coordination with such part.

7 “(b) PROTOCOLS.—The Secretary shall establish pro-
8 tocols to ensure the secure transfer and storage of data
9 made available under this section. In establishing such
10 protocols the Secretary shall take into account rec-
11 ommendations submitted to the Secretary by the Inspector
12 General of the Department of Health and Human Services
13 and the National Association of Insurance Commissioners
14 with respect to the secure transfer and storage of such
15 data, the establishment or approval of a fee structure
16 under subsection (c), and the establishment of user access
17 protocols.

18 “(c) FEES FOR DISCLOSURE.—

19 “(1) IN GENERAL.—

20 “(A) FEES.—Subject to paragraph (2), the
21 Secretary may establish or approve reasonable
22 fees for the disclosure of information under this
23 section, including with respect to requests by
24 Federal agencies or other entities, such as fiscal

1 intermediaries and carriers, acting under con-
2 tract on behalf of such agencies.

3 “(B) ESTABLISHMENT OR APPROVAL OF
4 FEE AMOUNTS.—In establishing or approving
5 the amount of such fees, the Secretary shall en-
6 sure that the total amount of the fees to be col-
7 lected is equal to the total costs of processing
8 the requests for disclosure and of providing
9 such information. Such fees shall be available to
10 the Secretary to cover such costs.

11 “(C) FOR-PROFIT ENTITIES.—The Sec-
12 retary may allow for-profit entities to receive
13 data under this section for a fee that is com-
14 parable to the fee charged to a Federal agency
15 or other entity under subparagraph (A) with re-
16 spect to a similar request.

17 “(2) FREE ACCESS TO CERTAIN DATA.—

18 “(A) IN GENERAL.—Not later than 1 year
19 after the date of enactment of the Fighting
20 Fraud and Abuse to Save Taxpayers’ Dollars
21 Act, for purposes of identifying additional strat-
22 egies and tools to combat waste, fraud, and
23 abuse, the Secretary—

1 “(i) establish protocols to ensure the
2 secure transmission of data under this sec-
3 tion; and

4 “(ii) may ensure nonprofit academic,
5 policy, and research institutions have ac-
6 cess to data from the National Practitioner
7 Data Bank.

8 “(B) ACCESS FREE OF CHARGE.—Data
9 shall be provided under subparagraph (A)(ii)
10 free of charge to academic, policy, and research
11 institutions.

12 “(C) REQUIREMENT.—Any academic, pol-
13 icy, or research institution that is provided data
14 under subparagraph (A)(ii) shall, as a condition
15 of receiving such data, be required to share
16 with the Secretary any findings using such data
17 to combat waste, fraud, and abuse (in a form
18 and manner of the academic, policy, or research
19 institution’s choosing).

20 “(d) ESTABLISHMENT OF APPEALS PROCESS.—

21 “(1) IN GENERAL.—The Secretary shall estab-
22 lish a transparent and responsive appeals process
23 under which a provider of services or supplier may
24 have their name removed from the National Practi-
25 tioner Data Bank. Under such process, appeals shall

1 be conducted in a timely manner (not more than 90
2 days after the earlier of the date of the listing in the
3 National Practitioner Data Bank or the issuance of
4 any penalty involved) in order to minimize the time
5 that providers of services or suppliers who success-
6 fully appeal are excluded from participation under
7 the programs under titles XVIII and XIX.

8 “(2) CONSULTATION.—The Secretary shall con-
9 sult with major colleges of medical practice in the
10 United States, commercial health plans, the Inspec-
11 tor General of the Department of Health and
12 Human Services, the National Association of Insur-
13 ance Commissioners, and the Federation of State
14 Medical Boards in establishing the appeals process
15 under paragraph (1).

16 “(e) DEFINITIONS.—In this section:

17 “(1) COMMERCIAL HEALTH PLAN.—The term
18 ‘commercial health plan’ means health insurance
19 coverage (as defined in section 2791 of the Public
20 Health Service Act and including group health
21 plans).

22 “(2) FINAL ADVERSE ACTION.—The term ‘final
23 adverse action’ means one or more of the following
24 actions:

1 “(A) A Medicare-imposed revocation of any
2 Medicare billing privileges.

3 “(B) Suspension or revocation of a license
4 to provide health care by any State licensing
5 authority.

6 “(C) A conviction of a Federal or State fel-
7 ony offense within the last 10 years preceding
8 enrollment, revalidation, or re-enrollment.

9 “(D) An exclusion or debarment from par-
10 ticipation in a Federal or State health care pro-
11 gram.”.

12 (b) CRIMINAL PENALTY FOR MISUSE OF INFORMA-
13 TION DISCLOSED.—Section 1128B(b) of the Social Secu-
14 rity Act (42 U.S.C. 1320a–7b(b)) is amended by adding
15 at the end the following:

16 “(4) Whoever knowingly uses information dis-
17 closed from the National Practitioner Data Bank
18 under section 1128K for a purpose other than those
19 authorized under that section shall be imprisoned for
20 not more than 3 years or fined under title 18,
21 United States Code, or both.”.

22 (c) EFFECTIVE DATE.—The amendments made by
23 this section shall take effect on the date of enactment of
24 this Act.

1 **SEC. 5. LIABILITY OF MEDICARE ADMINISTRATIVE CON-**
2 **TRACTORS FOR CLAIMS SUBMITTED BY EX-**
3 **CLUDED PROVIDERS.**

4 (a) REIMBURSEMENT TO THE SECRETARY FOR
5 AMOUNTS PAID TO EXCLUDED PROVIDERS.—Section
6 1874A(b) of the Social Security Act (42 U.S.C.
7 1395kk(b)) is amended by adding at the end the following
8 new paragraph:

9 “(6) REIMBURSEMENTS TO SECRETARY FOR
10 AMOUNTS PAID TO EXCLUDED PROVIDERS.—

11 “(A) LIMITATION.—

12 “(i) IN GENERAL.—Except as pro-
13 vided in clause (ii), the Secretary shall not
14 enter into a contract with a Medicare ad-
15 ministrative contractor under this section
16 unless the contractor agrees to reimburse
17 the Secretary for any amounts paid by the
18 contractor for with respect to any item or
19 service (other than an emergency item or
20 service, not including items or services fur-
21 nished in an emergency room of a hospital)
22 which is furnished—

23 “(I) by an individual or entity
24 during the period when such indi-
25 vidual or entity is excluded pursuant
26 to section 1128, 1128A, 1156 or

1 1842(j)(2) from participation in the
2 program under this title; or

3 “(II) at the medical direction or
4 on the prescription of a physician dur-
5 ing the period when he is excluded
6 pursuant to section 1128, 1128A,
7 1156 or 1842(j)(2) from participation
8 in the program under this title and
9 when the person furnishing such item
10 or service knew or had reason to know
11 of the exclusion (after a reasonable
12 time period after reasonable notice
13 has been furnished to the person).

14 “(ii) EXCEPTION.—Where a Medicare
15 administrative contractor pays a claim for
16 payment for items or services furnished by
17 an individual or entity excluded from par-
18 ticipation in the programs under this title,
19 pursuant to section 1128, 1128A, 1156, or
20 1866, and such Medicare administrative
21 contractor did not know or have reason to
22 know that such individual or entity was so
23 excluded, then, to the extent permitted by
24 this title, and notwithstanding such exclu-
25 sion, the contractor shall not be required

1 to reimburse the Secretary under clause (i)
2 for any amounts paid with respect to such
3 items or services. In each such case the
4 Secretary shall notify the contractor of the
5 exclusion of the individual or entity fur-
6 nishing the items or services. A Medicare
7 administrative contractor shall not make
8 payment for items or services furnished by
9 an excluded individual or entity to a bene-
10 ficiary after a reasonable time (as deter-
11 mined by the Secretary in regulations)
12 after the Secretary has notified the con-
13 tractor of the exclusion of that individual
14 or entity.

15 “(B) REQUIREMENT TO REVIEW CLAIMS.—
16 A Medicare administrative contractor shall re-
17 view claims submitted to the contractor for pay-
18 ment for services under this title in order to en-
19 sure that such services were not furnished by
20 an individual or entity during any period for
21 which the individual or entity is excluded from
22 such participation (as described in subpara-
23 graph (A)).”

1 (b) REPORT ON EFFECTIVENESS AND DEVELOP-
2 MENT OF SCORECARD AND MEASURABLE PERFORMANCE
3 METRICS FOR MEDICARE CONTRACTORS.—

4 (1) REPORT.—

5 (A) IN GENERAL.—Not later than 12
6 months after the date of enactment of this Act,
7 the Secretary of Health and Human Services
8 shall submit to Congress a report on the overall
9 effectiveness and potential of Medicare contrac-
10 tors.

11 (B) CONTENTS OF REPORT.—The report
12 submitted under subparagraph (A) shall include
13 the Secretary's recommendations for the devel-
14 opment of measurable performance metrics and
15 a scorecard for Medicare contractors (or, in the
16 case of Medicare administrative contractors, up-
17 dated and revised measurable performance
18 metrics and a revised scorecard), together with
19 recommendations for such legislation and ad-
20 ministrative action as the Secretary determines
21 appropriate

22 (2) CONSULTATION.—The Secretary shall con-
23 sult with Medicare contractors, the Inspector Gen-
24 eral of the Department of Health and Human Serv-
25 ices, private sector waste, fraud, and abuse experts,

1 and entities with experience combating and pre-
2 venting waste, fraud, and abuse, including through
3 the review of Medicare claims, in preparing the re-
4 port submitted under paragraph (1).

5 (3) **MEDICARE CONTRACTORS DEFINED.**—In
6 this subsection, the term “Medicare contractor”
7 means any of the following:

8 (A) A Medicare administrative contractor
9 under section 1874A of the Social Security Act.

10 (B) A Medicare Program Safeguard Con-
11 tractor.

12 (C) A Zone Program Integrity Contractor.

13 (D) A Medicare Drug Integrity Contractor.

14 (c) **EFFECTIVE DATE.**—

15 (1) **IN GENERAL.**—The amendments made by
16 subsection (a) shall apply to claims for reimburse-
17 ment submitted on or after the date of enactment of
18 this Act.

19 (2) **CONTRACT MODIFICATION.**—The Secretary
20 of Health and Human Services shall take such steps
21 as may be necessary to modify contracts entered
22 into, renewed, or extended prior to the date of enact-
23 ment of this Act to conform such contracts to the
24 provisions of and amendments made by this section.

1 **SEC. 6. LIMITING THE DISCHARGE OF DEBTS IN BANK-**
2 **RUPTCY PROCEEDINGS IN CASES WHERE A**
3 **HEALTH CARE PROVIDER OR A SUPPLIER EN-**
4 **GAGES IN FRAUDULENT ACTIVITY.**

5 (a) IN GENERAL.—

6 (1) CIVIL MONETARY PENALTIES.—Section
7 1128A(a) of the Social Security Act (42 U.S.C.
8 1320a–7a(a)) is amended by adding at the end the
9 following: “Notwithstanding any other provision of
10 law, amounts made payable under this section are
11 not dischargeable under section 727, 944, 1141,
12 1228, or 1328 of title 11, United States Code, or
13 any other provision of such title.”.

14 (2) RECOVERY OF OVERPAYMENT TO PRO-
15 VIDERS OF SERVICES UNDER PART A.—Section
16 1815(d) of the Social Security Act (42 U.S.C.
17 1395g(d)) is amended—

18 (A) by inserting “(1)” after “(d)”; and

19 (B) by adding at the end the following:

20 “(2) Notwithstanding any other provision of
21 law, amounts due to the Secretary under this section
22 are not dischargeable under section 727, 944, 1141,
23 1228, or 1328 of title 11, United States Code, or
24 any other provision of such title if the overpayment
25 was the result of fraudulent activity, as may be de-
26 fined by the Secretary.”.

1 (3) RECOVERY OF OVERPAYMENT OF BENEFITS
2 UNDER PART B.—Section 1833(j) of the Social Secu-
3 rity Act (42 U.S.C. 1395l(j)) is amended—

4 (A) by inserting “(1)” after “(j)”; and

5 (B) by adding at the end the following:

6 “(2) Notwithstanding any other provision of
7 law, amounts due to the Secretary under this section
8 are not dischargeable under section 727, 944, 1141,
9 1228, or 1328 of title 11, United States Code, or
10 any other provision of such title if the overpayment
11 was the result of fraudulent activity, as may be de-
12 fined by the Secretary.”.

13 (4) COLLECTION OF PAST-DUE OBLIGATIONS
14 ARISING FROM BREACH OF SCHOLARSHIP AND LOAN
15 CONTRACT.—Section 1892(a) of the Social Security
16 Act (42 U.S.C. 1395ccc(a)) is amended by adding at
17 the end the following:

18 “(5) Notwithstanding any other provision of
19 law, amounts due to the Secretary under this section
20 are not dischargeable under section 727, 944, 1141,
21 1228, or 1328 of title 11, United States Code, or
22 any other provision of such title.”.

23 (b) EFFECTIVE DATE.—The amendments made by
24 subsection (a) shall apply to bankruptcy petitions filed
25 after the date of enactment of this Act.

1 **SEC. 7. PREVENTION OF WASTE, FRAUD, AND ABUSE IN**
2 **THE MEDICAID AND CHIP PROGRAMS.**

3 (a) DETECTION OF FRAUDULENT IDENTIFICATION
4 NUMBERS WITHIN THE MEDICAID AND CHIP PRO-
5 GRAMS.—

6 (1) MEDICAID.—Section 1903(i) of the Social
7 Security Act (42 U.S.C. 1396b(i)), as amended by
8 section 2001(a)(2)(B) of the Patient Protection and
9 Affordable Care Act (Public Law 111–148), is
10 amended—

11 (A) in paragraph (25), by striking “or” at
12 the end;

13 (B) in paragraph (26), by striking the pe-
14 riod and inserting “; or”; and

15 (C) by adding at the end the following new
16 paragraph:

17 “(27) with respect to amounts expended for an
18 item or service for which medical assistance is pro-
19 vided under the State plan or under a waiver of such
20 plan unless the claim for payment for such item or
21 service contains—

22 “(A) a valid beneficiary identification num-
23 ber that, for purposes of the individual who re-
24 ceived such item or service, has been deter-
25 mined by the State agency to correspond to an

1 individual who is eligible to receive benefits
2 under the State plan or waiver; and

3 “(B) a valid National Provider Identifier
4 that, for purposes of the provider that fur-
5 nished such item or service, has been deter-
6 mined by the State agency to correspond to a
7 participating provider that is eligible to receive
8 payment for furnishing such item or service
9 under the State plan or waiver.”.

10 (2) CHIP.—Section 2107(e)(1)(I) of the Social
11 Security Act (42 U.S.C. 1397gg(e)(1)(I)) is amend-
12 ed by striking “and (17)” and inserting “(17), and
13 (27)”.

14 (b) SCREENING REQUIREMENTS FOR MANAGED
15 CARE ENTITIES.—

16 (1) IN GENERAL.—Section 1902 of the Social
17 Security Act (42 U.S.C. 1396a) is amended—

18 (A) by redesignating the second subsection
19 (ii), as added by section 6401(b)(1)(B) of the
20 Patient Protection and Affordable Care Act, as
21 subsection (kk) of such section; and

22 (B) in subsection (kk), as so redesign-
23 ated—

24 (i) by redesignating paragraph (8) as
25 paragraph (9); and

1 (ii) by inserting after paragraph (7)
2 the following new paragraph:

3 “(8) MANAGED CARE ENTITIES.—The State es-
4 tablishes procedures to ensure that any managed
5 care entity (as defined in section 1932(a)(1)(B))
6 under contract with the State complies with all ap-
7 plicable requirements under this subsection.”.

8 (2) MEDICAID MANAGED CARE ORGANIZA-
9 TIONS.—Section 1903(m)(2)(A) of the Social Secu-
10 rity Act (42 U.S.C. 1396b(m)(2)(A)) is amended—

11 (A) in clause (xii), by striking “and” at
12 the end;

13 (B) in clause (xiii), by striking the period
14 and inserting “; and”; and

15 (C) by adding at the end the following new
16 clause:

17 “(xiv) such contract requires that the
18 entity comply with any applicable screen-
19 ing, oversight, and reporting requirements
20 under section 1902(kk).”.

21 (3) MANAGED CARE ENTITIES.—Section
22 1932(d) of the Social Security Act (42 U.S.C.
23 1396u–2(d)) is amended by adding at the end the
24 following new paragraph:

1 “(5) COMPLIANCE WITH SCREENING, OVER-
2 SIGHT, AND REPORTING REQUIREMENTS.—A man-
3 aged care entity shall comply with any applicable
4 screening, oversight, and reporting requirements
5 under section 1902(kk).”.

6 (c) REQUIRED DATABASE CHECKS.—Clause (i) of
7 section 1866(j)(2)(B) of the Social Security Act (42
8 U.S.C. 1395cc(j)(2)(B)) is amended to read as follows:

9 “(i) shall include—

10 “(I) a licensure check, which may
11 include such checks across States; and

12 “(II) for purposes of the Med-
13 icaid program under title XIX—

14 “(aa) database checks (in-
15 cluding such checks across
16 States), which shall include—

17 “(AA) the Medicaid
18 Statistical Information Sys-
19 tem (as described in section
20 1903(r)(1)(F)); and

21 “(BB) any relevant
22 medical databases that are
23 maintained by the State
24 agencies, as determined by
25 the Secretary in consultation

1 with the directors of the
2 State agencies; and
3 “(bb) coordination of ex-
4 cluded provider lists between the
5 Secretary and the State agency,
6 including exchanges of data re-
7 garding excluding providers be-
8 tween Federal and State data-
9 bases; and”.

10 (d) TECHNICAL CORRECTIONS.—Section 1902 of the
11 Social Security Act (42 U.S.C. 1396a), as amended by
12 subsection (b)(1), is further amended—

13 (1) in subsection (a)—

14 (A) in paragraph (23), by striking “sub-
15 section (ii)(4)” and inserting “subsection
16 (kk)(4)”; and

17 (B) in paragraph (77), by striking “sub-
18 section (ii)” and inserting “subsection (kk)”;
19 and

20 (2) in subsection (kk), by striking “section
21 1886” each place it appears and inserting “section
22 1866”.

1 **SEC. 8. ILLEGAL DISTRIBUTION OF A MEDICARE, MED-**
2 **ICAID, OR CHIP BENEFICIARY IDENTIFICA-**
3 **TION OR BILLING PRIVILEGES.**

4 Section 1128B(b) of the Social Security Act (42
5 U.S.C. 1320a-7b(b)), as amended by section 4(b), is
6 amended by adding at the end the following:

7 “(5) Whoever knowingly, intentionally, and with
8 the intent to defraud purchases, sells or distributes,
9 or arranges for the purchase, sale, or distribution of
10 a Medicare, Medicaid, or CHIP beneficiary identi-
11 fication number or billing privileges under title
12 XVIII, title XIX, or title XXI shall be imprisoned
13 for not more than 10 years or fined not more than
14 \$500,000 (\$1,000,000 in the case of a corporation),
15 or both.”.

16 **SEC. 9. PILOT PROGRAM FOR THE USE OF UNIVERSAL**
17 **PRODUCT NUMBERS ON CLAIM FORMS FOR**
18 **REIMBURSEMENT UNDER THE MEDICARE**
19 **PROGRAM.**

20 (a) ESTABLISHMENT.—

21 (1) IN GENERAL.—Not later than January 1,
22 2013, the Secretary shall establish a pilot program
23 under which claims for reimbursement under the
24 Medicare program for UPN covered items contain
25 the universal product number of the UPN covered
26 item.

1 (2) DURATION.—The pilot program under this
2 section shall be conducted for a 2-year period.

3 (3) CONSIDERATION OF GAO RECOMMENDA-
4 TIONS.—The Secretary shall take into account the
5 recommendations of the Comptroller General of the
6 United States in establishing the pilot program
7 under this section.

8 (b) DEVELOPMENT AND IMPLEMENTATION OF PRO-
9 CEDURES.—

10 (1) INFORMATION INCLUDED IN UPN.—The
11 Secretary, in consultation with manufacturers and
12 entities with appropriate expertise, shall determine
13 the relevant descriptive information appropriate for
14 inclusion in a universal product number for a UPN
15 covered item under the pilot program.

16 (2) REVIEW OF PROCEDURE.—The Secretary,
17 in consultation with interested parties (which shall,
18 at a minimum, include the Inspector General of the
19 Department of Health and Human Services and pri-
20 vate sector and health industry experts), shall use
21 information obtained under the pilot program
22 through the use of universal product numbers on
23 claims for reimbursement under the Medicare pro-
24 gram to periodically review the UPN covered items
25 billed under the Health Care Financing Administra-

1 tion Common Procedure Coding System and adjust
2 such coding system to ensure that functionally
3 equivalent UPN covered items are billed and reim-
4 bursed under the same codes.

5 (c) GAO REPORTS TO CONGRESS ON EFFECTIVE-
6 NESS OF IMPLEMENTATION OF PILOT PROGRAM.—

7 (1) INITIAL REPORT.—Not later than 6 months
8 after the implementation of the pilot program under
9 this section, the Comptroller General of the United
10 States shall submit to Congress a report on the ef-
11 fectiveness of such implementation.

12 (2) FINAL REPORT.—Not later than 18 months
13 after the completion of the pilot program under this
14 section, the Comptroller General of the United
15 States shall submit to Congress a report on the ef-
16 fectiveness of the pilot program, together with rec-
17 ommendations regarding the use of universal prod-
18 uct numbers and the use of data obtained from the
19 use of such numbers, and recommendations for such
20 legislation and administrative action as the Comp-
21 troller General determines appropriate.

22 (d) USE OF AVAILABLE FUNDING.—The Secretary
23 shall use amounts available in the Centers for Medicare
24 & Medicaid Services Program Management Account or in
25 the Health Care Fraud and Abuse Control Account under

1 section 1817(k) of the Social Security Act (42 U.S.C.
2 1395i(k)) to carry out the pilot program under this sec-
3 tion.

4 (e) DEFINITIONS.—In this section:

5 (1) MEDICARE PROGRAM.—The term “Medicare
6 program” means the program under title XVIII of
7 the Social Security Act (42 U.S.C. 1395 et seq.).

8 (2) SECRETARY.—The term “Secretary” means
9 the Secretary of Health and Human Services.

10 (3) UNIVERSAL PRODUCT NUMBER.—The term
11 “universal product number” means a number that
12 is—

13 (A) affixed by the manufacturer to each in-
14 dividual UPN covered item that uniquely identi-
15 fies the item at each packaging level; and

16 (B) based on commercially acceptable iden-
17 tification standards such as, but not limited to,
18 standards established by the Uniform Code
19 Council—International Article Numbering Sys-
20 tem or the Health Industry Business Commu-
21 nication Council.

22 (4) UPN COVERED ITEM.—

23 (A) IN GENERAL.—Except as provided in
24 subparagraph (B), the term “UPN covered
25 item” means—

1 (i) a covered item as that term is de-
2 fined in section 1834(a)(13) of the Social
3 Security Act (42 U.S.C. 1395m(a)(13));

4 (ii) an item described in paragraph
5 (8) or (9) of section 1861(s) of such Act
6 (42 U.S.C. 1395x);

7 (iii) an item described in paragraph
8 (5) of such section 1861(s); and

9 (iv) any other item for which payment
10 is made under this title that the Secretary
11 determines to be appropriate.

12 (B) EXCLUSION.—The term “UPN cov-
13 ered item” does not include a customized item
14 for which payment is made under this title.

15 **SEC. 10. PROHIBITION OF INCLUSION OF SOCIAL SECURITY**

16 **ACCOUNT NUMBERS ON MEDICARE CARDS.**

17 (a) IN GENERAL.—Section 205(c)(2)(C) of the Social
18 Security Act (42 U.S.C. 405(c)(2)(C)), as amended by
19 section 1414(a)(2) of the Patient Protection and Afford-
20 able Care Act (Public Law 111–148), is amended by add-
21 ing at the end the following new clause:

22 “(xi) The Secretary of Health and Human Services,
23 in consultation with the Commissioner of Social Security,
24 shall establish cost-effective procedures to ensure that a
25 social security account number (or any derivative thereof)

1 is not displayed, coded, or embedded on the Medicare card
2 issued to an individual who is entitled to benefits under
3 part A of title XVIII or enrolled under part B of title
4 XVIII and that any other identifier displayed on such card
5 is easily identifiable as not being the social security ac-
6 count number (or a derivative thereof).”.

7 (b) EFFECTIVE DATE.—

8 (1) IN GENERAL.—The amendment made by
9 subsection (a) shall apply with respect to Medicare
10 cards issued on and after an effective date specified
11 by the Secretary of Health and Human Services, but
12 in no case shall such effective date be later than the
13 date that is 24 months after the date adequate fund-
14 ing is provided pursuant to subsection (d)(2).

15 (2) REISSUANCE.—Subject to subsection (d)(2),
16 in the case of individuals who have been issued such
17 cards before such date, the Secretary of Health and
18 Human Services—

19 (A) shall provide for the reissuance for
20 such individuals of such a card that complies
21 with such amendment not later than 3 years
22 after the effective date specified under para-
23 graph (1); and

24 (B) may permit such individuals to apply
25 for the reissuance of such a card that complies

1 with such amendment before the date of
2 reissuance otherwise provided under subpara-
3 graph (A) in such exceptional circumstances as
4 the Secretary may specify.

5 (c) OUTREACH PROGRAM.—Subject to subsection
6 (d)(2), the Secretary of Health and Human Services, in
7 consultation with the Commissioner of Social Security,
8 shall conduct an outreach program to Medicare bene-
9 ficiaries and providers about the new Medicare card pro-
10 vided under this section.

11 (d) REPORT TO CONGRESS AND LIMITATIONS ON EF-
12 FECTIVE DATE.—

13 (1) REPORT.—Not later than 90 days after the
14 date of the enactment of this Act, the Secretary of
15 Health and Human Services, acting through the Ad-
16 ministrator of the Centers for Medicare & Medicaid
17 Services and in consultation with the Commissioner
18 of Social Security, shall submit to Congress a report
19 that includes detailed options regarding the imple-
20 mentation of this section, including line-item esti-
21 mates of and justifications for the costs associated
22 with such options and estimates of timeframes for
23 each stage of implementation. In recommending
24 such options, the Secretary shall take into consider-

1 ation, among other factors, cost-effectiveness and
2 beneficiary outreach and education.

3 (2) LIMITATION; MODIFICATION OF DEAD-
4 LINES.—With respect to the amendment made by
5 subsection (a), and the requirements of subsections
6 (b) and (c)—

7 (A) such amendment and requirements
8 shall not apply until adequate funding is trans-
9 ferred pursuant to section 11(b) to implement
10 the provisions of this section, as determined by
11 Congress; and

12 (B) any deadlines otherwise established
13 under this section for such amendment and re-
14 quirements are contingent upon the receipt of
15 adequate funding (as determined in subpara-
16 graph (A)) for such implementation.

17 The previous sentence shall not affect the timely
18 submission of the report required under paragraph
19 (1).

20 **SEC. 11. IMPLEMENTATION.**

21 (a) EMPOWERING THE HHS OIG AND GAO.—Ex-
22 cept as otherwise provided, to the extent practicable, the
23 Secretary of Health and Human Services (in this section
24 referred to as the “Secretary”) shall—

1 (1) carry out the provisions of and amendments
2 made by this Act in consultation with the Inspector
3 General of the Department of Health and Human
4 Services; and

5 (2) take into consideration the findings and rec-
6 ommendations of the Comptroller General of the
7 United States in carrying out such provisions and
8 amendments.

9 (b) FUNDING.—The Secretary shall provide for the
10 transfer, from the Health Care Fraud and Abuse Control
11 Account under section 1817(k) of the Social Security Act
12 (42 U.S.C. 1395i(k)), to the Centers for Medicare & Med-
13 icaid Services Program Management Account, of such
14 sums, provided such sums are fully offset, as the Secretary
15 determines are for necessary administrative expenses asso-
16 ciated with carrying out the provisions of and amendments
17 made by this Act (other than section 9). Amounts trans-
18 ferred under the preceding sentence shall remain available
19 until expended.

20 (c) SAVINGS.—Any reduction in outlays under the
21 Medicare program under title XVIII of the Social Security
22 Act under the provisions of, and amendments made by,
23 this Act may only be utilized to offset outlays under part
24 A of such title.

○