I

111TH CONGRESS
1ST SESSION

H. R. 4222

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

IN THE HOUSE OF REPRESENTATIVES

DECEMBER 8, 2009

Ms. GINNY BROWN-WAITE of Florida (for herself, Mrs. EMERSON, Mr. SOUDER, Mr. ROONEY, Mr. BUCHANAN, Mr. ROSKAM, Mr. LINCOLN DIAZ-BALART of Florida, Mr. PUTNAM, Mr. MARIO DIAZ-BALART of Florida, and Mr. MACK) introduced the following bill; which was referred to the Committee on Energy and Commerce

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A BILL

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

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 ''Prevent Health Care
5 Fraud Act of 2009''.

1 **SEC. 2. ESTABLISHMENT OF OFFICE OF DEPUTY SEC-**
2 **RETARY FOR HEALTH CARE FRAUD PREVEN-**
3 **TION IN THE DEPARTMENT OF HEALTH AND**
4 **HUMAN SERVICES; APPOINTMENT AND POW-**
5 **ERS OF DEPUTY SECRETARY.**

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

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

11 (1) direct the appropriate implementation with-
12 in the Department of Health and Human Services of
13 health care fraud prevention and detection rec-
14 ommendations made by Federal Government and
15 private sector antifraud and oversight entities;

16 (2) routinely consult with the Office of the In-
17 spector General for the Department of Health and
18 Human Services, the Attorney General, and private
19 sector health care antifraud entities to identify
20 emerging health care fraud issues requiring imme-
21 diate action by the Office;

22 (3) through a contract entered into with an en-
23 tity that has experience in designing and imple-
24 menting antifraud systems in the financial sector,
25 provide for the design, development, and operation
26 of a predictive model antifraud system (in accord-

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

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

15 (5) establish thresholds, in consultation with
16 the Office of the Inspector General of the Depart-
17 ment of Health and Human Services and the De-
18 partment of Justice—

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

1 (B) for the referral of claims identified
2 through the health care fraud prevention sys-
3 tem developed under paragraph (3) to law en-
4 forcement entities (such as the Office of the In-
5 spector General, Medicaid Fraud Control Units,
6 and the Department of Justice); and
7 (6) share antifraud information and best prac-
8 tices with Federal health agencies, health insurance
9 issuers, health care providers, antifraud organiza-
10 tions, antifraud databases, and Federal, State, and
11 local law enforcement and regulatory agencies.
12 (c) DEPUTY SECRETARY FOR HEALTH CARE FRAUD
13 PREVENTION.—
14 (1) ESTABLISHMENT.—There is established
15 within the Department of Health and Human Serv-
16 ices the position of Deputy Secretary for Health
17 Care Fraud Prevention (referred to in this section as
18 the ''Deputy Secretary''). The Deputy Secretary
19 shall serve as the head of the Office, shall act as the
20 chief health care fraud prevention and detection offi-
21 cer of the United States, and shall consider and di-
22 rect the appropriate implementation of recommenda-
23 tions to prevent and detect health care fraud, waste,
24 and abuse activities and initiatives within the De-
25 partment.

1 (2) APPOINTMENT.—The Deputy Secretary
2 shall be appointed by the President, by and with the
3 advice and consent of the Senate, and serve for a
4 term of 5 years, unless removed prior to the end of
5 such term for cause by the President.
6 (3) POWERS.—Subject to oversight by the Sec-
7 retary, the Deputy Secretary shall exercise all pow-
8 ers necessary to carry out this section, including the
9 hiring of staff, entering into contracts, and the dele-
10 gation of responsibilities to any employee of the De-
11 partment of Health and Human Services or the Of-
12 fice appropriately designated for such responsibility.
13 (4) DUTIES.—
14 (A) IN GENERAL.—The Deputy Secretary
15 shall—
16 (i) establish and manage the operation
17 of the predictive modeling system devel-
18 oped under subsection (b)(3) to analyze
19 Federal health claims in real-time to iden-
20 tify high risk claims activity and refer
21 risky claims for appropriate verification
22 and investigative research;
23 (ii) consider and order the appropriate
24 implementation of fraud prevention and
25 detection activities, such as those rec-

1 ommended by the Office of the Inspector
2 General of the Department of Health and
3 Human Services, the Government Account-
4 ability Office, MedPac, and private sector
5 health care antifraud entities;
6 (iii) not later than 6 months after the
7 date on which he or she is initially ap-
8 pointed, submit to Congress an implemen-
9 tation plan for the health care fraud pre-
10 vention systems under subsection (d); and
11 (iv) submit annual performance re-
12 ports to the Secretary and Congress that,
13 at minimum, shall provide an estimate of
14 the return on investment with respect to
15 the system, for all recommendations made
16 to the Deputy Secretary under this section,
17 a description of whether such recommenda-
18 tions are implemented or not implemented,
19 and contain other relevant performance
20 metrics.
21 (B) ANALYSIS AND RECOMMENDATIONS.—
22 The Deputy Secretary shall provide required
23 strategies and treatments for claims identified
24 as high risk (including a system of designations
25 for claims, such as ''approve'', ''decline'', ''re-

1 search'', and ''educate and pay'') to the Centers
2 for Medicare & Medicaid Services, other Fed-
3 eral and State entities responsible for verifying
4 whether claims identified as high risk are pay-
5 able, should be automatically denied, or require
6 further research and investigation.

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

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

19 (d) HEALTH CARE FRAUD PREVENTION SYSTEM.—

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

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

25 (i) be holistic;

1 (ii) be able to view all provider and
2 patient activities across all Federal health
3 program payers;
4 (iii) be able to integrate into the exist-
5 ing health care claims flow with minimal
6 effort, time, and cost;
7 (iv) be modeled after systems used in
8 the Financial Services industry; and
9 (v) utilize integrated real-time trans-
10 action risk scoring and referral strategy
11 capabilities to identify claims that are sta-
12 tistically unusual.
13 (B) MODULARIZED ARCHITECTURE.—The
14 fraud prevention system shall be designed from
15 an end-to-end modularized perspective to allow
16 for ease of integration into multiple points
17 along a health care claim flow (pre- or post-ad-
18 judication), which shall—
19 (i) utilize a single entity to host, sup-
20 port, manage, and maintain software-based
21 services, predictive models, and solutions
22 from a central location for the customers
23 who access the fraud prevention system;
24 (ii) allow access through a secure pri-
25 vate data connection rather than the in-

1 stallation of software in multiple informa-
2 tion technology infrastructures (and data
3 facilities);
4 (iii) provide access to the best and lat-
5 est software without the need for upgrades,
6 data security, and costly installations;
7 (iv) permit modifications to the soft-
8 ware and system edits in a rapid and time-
9 ly manner;
10 (v) ensure that all technology and de-
11 cision components reside within the mod-
12 ule; and
13 (vi) ensure that the third party host
14 of the modular solution is not a party,
15 payer, or stakeholder that reports claims
16 data, accesses the results of the fraud pre-
17 vention systems analysis, or is otherwise
18 required under this section to verify, re-
19 search, or investigate the risk of claims.
20 (C) PROCESSING, SCORING, AND STOR-
21 AGE.—The platform of the fraud prevention
22 system shall be a high volume, rapid, real-time
23 information technology solution, which includes
24 data pooling, data storage, and scoring capabili-
25 ties to quickly and accurately capture and

1 evaluate data from millions of claims per day.
2 Such platform shall be secure and have (at a
3 minimum) data centers that comply with Fed-
4 eral and State privacy laws.

5 (D) DATA CONSORTIUM.—The fraud pre-
6 vention system shall provide for the establish-
7 ment of a centralized data file (referred to as
8 a ''consortium'') that accumulates data from all
9 government health insurance claims data
10 sources. Notwithstanding any other provision of
11 law, Federal health care payers shall provide to
12 the consortium existing claims data, such as
13 Medicare's ''Common Working File'' and Med-
14 icaid claims data, for the purpose of fraud and
15 abuse prevention. Such accumulated data shall
16 be transmitted and stored in an industry stand-
17 ard secure data environment that complies with
18 applicable Federal privacy laws for use in build-
19 ing medical waste, fraud, and abuse prevention
20 predictive models that have a comprehensive
21 view of provider activity across all payers (and
22 markets).

23 (E) MARKET VIEW.—The fraud prevention
24 system shall ensure that claims data from Fed-
25 eral health programs and all markets flows

1 through a central source so the waste, fraud,
2 and abuse system can look across all markets
3 and geographies in health care to identify fraud
4 and abuse in Medicare, Medicaid, the State
5 Children's Health Program, TRICARE, and the
6 Department of Veterans Affairs holistically.
7 Such cross-market visibility shall identify un-
8 usual provider and patient behavior patterns
9 and fraud and abuse schemes that may not be
10 identified by looking independently at one Fed-
11 eral payer's transactions.
12 (F) BEHAVIOR ENGINE.—The fraud pre-
13 vention system shall ensure that the technology
14 used provides real-time ability to identify high-
15 risk behavior patterns across markets, geog-
16 raphies, and specialty group providers to detect
17 waste, fraud, and abuse, and to identify pro-
18 viders that exhibit unusual behavior patterns.
19 Behavior pattern technology that provides the
20 capability to compare a provider's current be-
21 havior to their own past behavior and to com-
22 pare a provider's current behavior to that of
23 other providers in the same specialty group and
24 geographic location shall be used in order to

1 provide a comprehensive waste, fraud, and
2 abuse prevention solution.
3 (G) PREDICTIVE MODEL.—The fraud pre-
4 vention system shall involve the implementation
5 of a statistically sound, empirically derived pre-
6 dictive modeling technology that is designed to
7 prevent (versus post-payment detect) waste,
8 fraud, and abuse. Such prevention system shall
9 utilize historical transaction data, from across
10 all Federal health programs and markets, to
11 build and re-develop scoring models, have the
12 capability to incorporate external data and ex-
13 ternal models from other sources into the health
14 care predictive waste, fraud, and abuse model,
15 and provide for a feedback loop to provide out-
16 come information on verified claims so future
17 system enhancements can be developed based
18 on previous claims experience.
19 (H) CHANGE CONTROL.—The fraud pre-
20 vention system platform shall have the infra-
21 structure to implement new models and at-
22 tributes in a test environment prior to moving
23 into a production environment. Capabilities
24 shall be developed to quickly make changes to

1 models, attributes, or strategies to react to
2 changing patterns in waste, fraud, and abuse.
3 (I) SCORING ENGINE.—The fraud preven-
4 tion system shall identify high-risk claims by
5 scoring all such claims on a real-time capacity
6 prior to payment. Such scores shall then be
7 communicated to the fraud management system
8 provided for under subparagraph (J).
9 (J) FRAUD MANAGEMENT SYSTEM.—The
10 fraud prevention system shall utilize a fraud
11 management system, that contains workflow
12 management and workstation tools to provide
13 the ability to systematically present scores, rea-
14 son codes, and treatment actions for high-risk
15 scored transactions. The fraud prevention sys-
16 tem shall ensure that analysts who review
17 claims have the capability to access, review, and
18 research claims efficiently, as well as decline or
19 approve claims (payments) in an automated
20 manner. Workflow management under this sub-
21 paragraph shall be combined with the ability to
22 utilize principles of experimental design to com-
23 pare and measure prevention and detection
24 rates between test and control strategies. Such
25 strategy testing shall allow for continuous im-

1 provement and maximum effectiveness in keep-
2 ing up with ever changing fraud and abuse pat-
3 terns. Such system shall provide the capability
4 to test different treatments or actions randomly
5 (typically through use of random digit assign-
6 ments).
7 (K) DECISION TECHNOLOGY.—The fraud
8 prevention system shall have the capability to
9 monitor consumer transactions in real-time and
10 monitor provider behavior at different stages
11 within the transaction flow based upon pro-
12 vider, transaction and consumer trends. The
13 fraud prevention system shall provide for the
14 identification of provider and claims excessive
15 usage patterns and trends that differ from simi-
16 lar peer groups, have the capability to trigger
17 on multiple criteria, such as predictive model
18 scores or custom attributes, and be able to seg-
19 ment transaction waste, fraud, and abuse into
20 multiple types for health care categories and
21 business types.
22 (L) FEEDBACK LOOP.—The fraud preven-
23 tion system shall have a feedback loop where all
24 Federal health payers provide pre-payment and
25 post-payment information about the eventual

1 status of a claim designated as ''Normal'',
2 ''Waste'', ''Fraud'', ''Abuse'', or ''Education
3 Required''. Such feedback loop shall enable
4 Federal health agencies to measure the actual
5 amount of waste, fraud, and abuse as well as
6 the savings in the system and provide the abil-
7 ity to retrain future, enhanced models. Such
8 feedback loop shall be an industry file that con-
9 tains information on previous fraud and abuse
10 claims as well as abuse perpetrated by con-
11 sumers, providers, and fraud rings, to be used
12 to alert other payers, as well as for subsequent
13 fraud and abuse solution development.
14 (M) TRACKING AND REPORTING.—The
15 fraud prevention system shall ensure that the
16 infrastructure exists to ascertain system, strat-
17 egy, and predictive model return on investment.
18 Dynamic model validation and strategy valida-
19 tion analysis and reporting shall be made avail-
20 able to ensure a strategy or predictive model
21 has not degraded over time or is no longer ef-
22 fective. Queue reporting shall be established
23 and made available for population estimates of
24 what claims were flagged, what claims received
25 treatment, and ultimately what results oc-

1 curred. The capability shall exist to complete
2 tracking and reporting for prevention strategies
3 and actions residing farther upstream in the
4 health care payment flow. The fraud prevention
5 system shall establish a reliable metric to meas-
6 ure the dollars that are never paid due to iden-
7 tification of fraud and abuse, as well as a capa-
8 bility to effectively test and estimate the impact
9 from different actions and treatments utilized
10 to detect and prevent fraud and abuse for legiti-
11 mate claims. Measuring results shall include
12 waste and abuse.

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

1 ers shall use standard industry waste, fraud,
2 and abuse measures of success.
3 (2) COORDINATION.—The Deputy Secretary
4 shall coordinate the operation of the fraud preven-
5 tion system with the Department of Justice and
6 other related Federal fraud prevention systems.
7 (3) OPERATION.—The Deputy Secretary shall
8 phase-in the implementation of the system under
9 this subsection beginning not later than 18 months
10 after the date of enactment of this Act, through the
11 analysis of a limited number of Federal health pro-
12 gram claims. Not later than 5 years after such date
13 of enactment, the Deputy Secretary shall ensure
14 that such system is fully phased-in and applicable to
15 all Federal health program claims.
16 (4) NON-PAYMENT OF CLAIMS.—The Deputy
17 Secretary shall promulgate regulations to prohibit
18 the payment of any health care claim that has been
19 identified as potentially ‘‘fraudulent’’, ‘‘wasteful’’, or
20 ‘‘abusive’’ until such time as the claim has been
21 verified as valid.
22 (5) APPLICATION.—The system under this sec-
23 tion shall only apply to all Federal health programs,
24 including programs established after the date of en-
25 actment 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

1 (C) the sharing by the Office of any such
2 information related to the medical antifraud
3 programs established under this section.
4 (f) PROTECTING LEGITIMATE PROVIDERS AND SUP-
5 PLIERS.—
6 (1) INITIAL IMPLEMENTATION.—Not later than
7 2 years after the date of enactment of this Act, the
8 Secretary shall establish procedures for the imple-
9 mentation of fraud and abuse detection methods
10 under all Federal health programs (including the
11 programs under titles XVIII, XIX, and XXI of the
12 Social Security Act) with respect to items and serv-
13 ices furnished by providers of services and suppliers
14 that includes the following:
15 (A) In the case of a new applicant to be
16 such a provider or supplier, a background
17 check, and in the case of a supplier a site visit
18 prior to approval of participation in the pro-
19 gram and random unannounced site visits after
20 such approval.
21 (B) Not less than 5 years after the date of
22 enactment of this Act, in the case of a provider
23 or supplier who is not a new applicant, re-en-
24 rollment under the program, including a new
25 background check and, in the case of a supplier,

1 a site-visit as part of the application process for
2 such re-enrollment, and random unannounced
3 site visits after such re-enrollment.
4 (2) REQUIREMENT FOR PARTICIPATION.—In no
5 case may a provider of services or supplier who does
6 not meet the requirements under paragraph (1) par-
7 ticipate in any Federal health program.
8 (3) BACKGROUND CHECKS.—The Secretary
9 shall determine the extent of the background check
10 conducted under paragraph (1), including whether—
11 (A) a fingerprint check is necessary;
12 (B) a background check shall be conducted
13 with respect to additional employees, board
14 members, contractors or other interested parties
15 of the provider or supplier; and
16 (C) any additional national background
17 checks regarding exclusion from participation in
18 Federal health programs (such as the program
19 under titles XVIII, XIX, or XXI of the Social
20 Security Act), including conviction of any fel-
21 ony, crime that involves an act of fraud or false
22 statement, adverse actions taken by State li-
23 censing boards, bankruptcies, outstanding
24 taxes, or other indications identified by the In-

1 spector General of the Department of Health
2 and Human Services are necessary.
3 (4) LIMITATION.—No payment may be made to
4 a provider of services or supplier under any Federal
5 health program if such provider or supplier fails to
6 obtain a satisfactory background check under this
7 subsection.
8 (5) FEDERAL HEALTH PROGRAM.—In this sub-
9 section, the term ''Federal health program'' means
10 any program that provides Federal payments or re-
11 imbursements to providers of health-related items or
12 services, or suppliers of such items, for the provision
13 of such items or services to an individual patient.
14 (g) DEFINITION.—The term ''Federal health agency''
15 means the Department of Health and Human Services,
16 the Department of Veterans Affairs, and any Federal
17 agency with oversight or authority regarding the provision
18 of any medical benefit, item, or service for which payment
19 may be made under a Federal health care plan or contract.

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