

111<sup>TH</sup> CONGRESS  
1<sup>ST</sup> SESSION

# S. 2128

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

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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.

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, the De-  
6 partment of Veterans Affairs, and private pay-  
7 ers holistically. Such cross-market visibility  
8 shall identify unusual provider and patient be-  
9 havior patterns and fraud and abuse schemes  
10 that may not be identified by looking independ-  
11 ently at one Federal 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 apply to all Federal health programs, in-  
24          cluding programs established after the date of enact-  
25          ment of this Act.

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

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

8           (1) IN GENERAL.—Notwithstanding any other  
9 provision of law, no person providing information to  
10 the Secretary under this section shall be held, by  
11 reason of having provided such information, to have  
12 violated any criminal law, or to be civilly liable under  
13 any law of the United States or of any State (or po-  
14 litical subdivision thereof) unless such information is  
15 false and the person providing it knew, or had rea-  
16 son to believe, that such information was false.

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

20                   (A) the protection of confidential informa-  
21 tion submitted or obtained with regard to sus-  
22 pected or actual health care fraud;

23                   (B) the protection of the ability of rep-  
24 resentatives the Office to testify in private civil  
25 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.

○