The FAST Act: *Fighting Fraud and Abuse to Save Taxpayers' Dollars*

The "FAST" Act of 2010

Section-By-Section

Sec. 1 - TITLE AND CONTENTS.

Sec. 2 - FINDINGS

Sec. 3 - TRACKING BANNED PROVIDERS ACROSS STATE LINES.

- **GREATER COORDINATION**.—HHS must increase coordination between CMS and regional offices to ensure providers and supplier banned in one State are banned in another State.

- **IMPROVED INFORMATION SYSTEMS**.—Enables HHS to improve information systems to allow greater integration between databases under the Medicare program. Gives Secretary ability to share immediate access to information identifying providers and suppliers excluded from participation in Medicare with all Medicare administrative contractors, fiscal intermediaries, SSA, VA, DOD, DOJ, OPM.

- **HHS BUILD ON"ONE PI" DATABASE FOR MEDICARE AND MEDICAID**. (CMS entered into a contract to develop a centralized data repository, known as One Program Integrity System Integrator, "One PI." This database is intended to warehouse Medicare prescription drug data as well as data on inpatient care, physician services, and other services provided under Medicare Parts A and B and Medicaid.") Requires HHS to continue loading data to build One PI. Gives Secretary ability to give stakeholders who combat waste, fraud, and abuse under Federal health care programs access to One PI. Stakeholders may include HHS OIG, FBI, GAO, ZPICs, RACs, Medicare investigators.

- **INCREASED AGENCY ACCESS TO NATIONAL PRACTITIONER DATA BANK**.—Relevant Federal and State agencies (HHS, DOJ, State Medicaid plans and fraud control units) shall have real time access to the National Practitioner Data Bank, as directed by the Secretary. The Secretary may, in consultation with the Inspector General of the Department of Health and Human Services, give such real-time access to State attorneys general and State and local law enforcement agencies.

- **ENSURING DATA IS UPLOADED TO THE IDR ON A DAILY BASIS**.(CMS calls the Integrated Data Repository, "IDR," an "integral part of the CMS data warehouse strategy" because it "ensures a consistent, reliable, secure, enterprise-wide view of data supporting CMS and its partners in more effective delivery of quality health care at lower cost to CMS' beneficiaries through state-of-the-art health informatics.") —All Medicare claims data shall be uploaded into the IDR daily.

- **REAL-TIME ACCESS TO DATA.—**HHS and HHS OIG shall ensure that any data provided is done so on real-time basis, in accordance with protocols established by the Secretary.
    - PROTOCOLS.—HHS shall establish protocols to ensure the secure transfer and storage of any data provided to another entity or individual under the provisions of or amendments made by this section.
    - CONSIDERATION OF HHS OIG RECOMMENDATIONS.—In establishing protocols HHS shall take into account recommendations submitted that address the secure transfer and storage of data.

- **GAO STUDY AND REPORT ON USE OF FEDERATION OF STATE MEDICAL BOARDS TO STRENGTHEN ENROLLMENT INTEGRITY**– The Comptroller General of the United States shall, in consultation with the Federation of State Medical Boards, conduct a study on how the Federation may help strengthen the integrity of processes for enrolling providers of services and suppliers under Federal health care programs.

SEC. 4 - ACCESS FOR PRIVATE SECTOR AND GOVERNMENTAL ENTITIES.

- **EXPANDED ACCESS TO THE NATIONAL PRACTITIONER DATA BANK**—Data shall be available on a real-time basis, in accordance with protocols established by HHS to Federal and State government agencies and health plans, commercial health plans, and

any health care provider, supplier, or practitioner entering an employment or contractual relationship with an individual or entity who has been subject to a final adverse action in the past 10 years, where the contract involves the furnishing of items or services reimbursed by 1 or more Federal health care programs

- PROTOCOLS.—HHS shall establish protocols to ensure the secure transfer and storage of data and shall take into account recommendations submitted from HHS OIG, the National Association of Insurance Commissioners.
- FEES FOR DISCLOSURE.—HHS may establish or approve reasonable fees for the disclosure of information under this section (similar to fees paid by Federal agencies or their fiscal intermediaries and carriers). HHS shall ensure that the total amount of the fees to be collected is equal to the total costs of processing the requests for disclosure and of providing such information.
- FREE ACCESS TO CERTAIN DATA.—For purposes of identifying additional strategies and tools to combat waste, fraud, and abuse, HHS shall—establish protocols to ensure the secure transmission of data under this section and ensure nonprofit academic, policy, and research institutions have access to data from the National Practitioner Data Bank provided free of charge to these institutions within one year.

- **ESTABLISHMENT OF APPEALS PROCESS**.—HHS shall establish a transparent and responsive appeals process under which a provider of services or supplier may have their name removed from the National Practitioner Data Bank. Under such process, appeals shall be conducted in a timely manner (not more than 90 days after the earlier of the date of the listing in the NPDB or the issuance of any penalty involved) in order to minimize the time hat providers of services or suppliers who successfully appeal are excluded from participation.
  - CONSULTATION.—HHS shall consult with the American Colleges of medical practice in the United States, commercial health plans, HHS OIG, and the National Association of Insurance Commissioners in establishing the appeals process.

- **CRIMINAL PENALTY FOR MISUSE OF INFORMATION**.— Whoever knowingly uses information maintained in the NPDB for an illegitimate or criminal purpose other than the legitimate scope of their duties and profession shall be imprisoned for not more than 3 years or fined under title 18, United States Code, or both.

SEC. 5 - LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTORS FOR CLAIMS SUBMITTED BY EXCLUDED PROVIDERS.

- **REIMBURSEMENTS TO SECRETARY FOR AMOUNTS PAID TO EXCLUDED PROVIDERS**.—HHS shall not enter into a contract with a Medicare administrative contractor unless the contractor agrees to reimburse the Secretary for any amounts paid for a service during any period for which the individual or entity is excluded from participation in the health care program, with some exceptions.
  - WAIVER.—HHS may waive the application of clause with respect to a Medicare administrative contractor if the Secretary determines that the contractor would be negatively impacted to the extent that the contractor would be unable to continue to perform its functions under a contract under this section; and otherwise acted in good faith in carrying out its functions under the contract.

- **REQUIREMENT TO REVIEW CLAIMS**.— A Medicare administrative contractor shall review claims submitted to the contractor for payment for services under this title in order to ensure that such services were not furnished by an individual or entity during any period for which the individual or entity is excluded from participation.

- **REPORT ON EFFECTIVENESS AND DEVELOPMENT OF SCORECARD AND MEASUREABLE PERFORMANCE METRICS FOR MEDICARE CONTRACTORS**.— HHS shall submit to Congress a report on the overall effectiveness and potential of Medicare contractors. The report shall include the Secretary's recommendations for the development of measureable performance metrics and a scorecard for Medicare contractors (or, in the case of Medicare administrative contractors, updated and revised measureable performance metrics and a revised scorecard), with recommendations for such legislation and administrative action as the Secretary determines appropriate. HHS shall consult with Medicare contractors, HHS OIG, private sector waste, fraud, and abuse experts, and entities with experience combating and preventing waste, fraud, and abuse, including through the review of Medicare claims. HHS shall take such steps to modify contracts entered into, renewed, or extended prior to the date of enactment of this Act to conform such contracts to the provisions of and amendments made by this section. The term ''Medicare contractor'' means any of the following:
  - Medicare administrative contractor
  - Medicare Program Safeguard Contractor
  - Zone Program Integrity Contractor
  - Medicare Drug Integrity Contractor

SEC. 6 - LIMITING THE DISCHARGE OF DEBTS IN BANKRUPTCY PROCEEDINGS IN CASES WHERE A HEALTH CARE PROVIDER OR A SUPPLIER ENGAGES IN FRAUDULENT ACTIVITY.

- **CIVIL MONETARY PENALTIES**.— Notwithstanding any other provision of law, amounts made payable under this section are not dischargeable under bankruptcy law.

- **RECOVERY OF OVERPAYMENT TO PROVIDERS OF SERVICES UNDER PART A**.—Amounts due to HHS are not dischargeable under the law if the overpayment was the result of fraudulent activity, as defined by HHS.

- **RECOVERY OF OVERPAYMENT OF BENEFITS UNDER PART B**.— Amounts due to HHS are not dischargeable under the law if the overpayment was the result of fraudulent activity, as defined by HHS.

- **COLLECTION OF PAST-DUE OBLIGATIONS ARISING FROM BREACH OF SCHOLARSHIP AND LOAN CONTRACT**.— Amounts due to HHS under this section are not dischargeable under the law.

SEC. 7 - PREVENTION OF WASTE, FRAUD, AND ABUSE IN THE MEDICAID PROGRAM.

- **DETECTION OF FRAUDULENT IDENTIFICATION NUMBERS WITHIN THE MEDICAID PROGRAM**.—CMS and Medicaid State programs shall not pay claims unless the claim for payment for a item or service contains—
    - a valid beneficiary identification number that, for purposes of the individual who received such item or service, has been determined by the State agency to correspond to an individual who is eligible to receive benefits under the State plan or waiver, and
    - a valid National Provider Identifier that, for purposes of the provider that furnished such item or service, has been determined by the State agency to correspond to a participating provider that is eligible to receive payment for furnishing such item or service under the State plan or waiver.''

- **SCREENING REQUIREMENTS FOR MANAGED CARE ENTITIES**.—State shall establish procedures to ensure that any managed care entity under contract with the State shall comply with the following:
    - REQUIRED DATABASE CHECKS.— a licensure check, which may include such checks across States, and database checks (including such checks across States); and coordination of excluded provider lists between the Secretary and the State agency, including exchanges of data regarding excluding providers between Federal and State databases.

SEC. 8 - ILLEGAL DISTRIBUTION OF A MEDICARE OR MEDICAID BENEFICIARY IDENTIFICATION OR BILLING PRIVILEGES.

- Whoever knowingly, intentionally, and with the intent to defraud purchases, sells or distributes, or arranges for the purchase, sale, or distribution of two or more Medicare or Medicaid beneficiary identification numbers or billing privileges shall be imprisoned for not more than 10 years or fined not more than $500,000 ($1,000,000 in the case of a corporation), or both.''.

SEC. 9 - PILOT PROGRAM FOR THE USE OF UNIVERSAL PRODUCT NUMBERS ON CLAIM FORMS FOR REIMBURSEMENT UNDER THE MEDICARE PROGRAM.

- **ESTABLISHMENT OF PILOT PROGRAM -** Not later than January 1, 2013, HHS shall establish a pilot program under which claims for reimbursement under the Medicare program for UPN covered items contain the universal product number of the UPN covered item. The pilot program under this section shall be conducted for a 2-year period. HHS shall take into account the recommendations of GAO in establishing the pilot program under this section.

- **DEVELOPMENT AND IMPLEMENTATION OF PROCEDURES**.— HHS, in consultation with manufacturers and entities with appropriate expertise, shall determine the relevant descriptive information appropriate for inclusion in a universal product number for a UPN covered item under the pilot program. HHS, with interested parties (which shall, at a minimum, include HHS OOG and private sector and health industry experts), shall use information obtained under the pilot program through the use of universal product numbers on claims for reimbursement under the Medicare program to periodically review the UPN covered items.

- **GAO REPORTS TO CONGRESS ON EFFECTIVENESS OF IMPLEMENTATION OF PILOT PROGRAM**.—
    - INITIAL REPORT.—Not later than 6 months after the implementation of the pilot program under this section, GAO shall submit to Congress a report on the effectiveness of such implementation.

- FINAL REPORT.—Not later than 18 months after the completion of the pilot program under this section, GAO shall submit to Congress a report on the effectiveness of the pilot program, together with recommendations regarding the use of universal product numbers and the use of data obtained from the use of such numbers, and recommendations for such legislation and administrative action as GAO determines appropriate.

- USE OF AVAILABLE FUNDING.—HHS shall use amounts available in the CMS Program Management Account or in the Health Care Fraud and Abuse Control Account to carry out the pilot program

SEC. 10 – PROHIBITING SOCIAL SECURITY NUMBERS ON MEDICARE CARDS

- **GENERAL IMPLEMENTATION –** HHS, in consultation with the Commissioner of Social Security, shall establish cost-effective procedures to ensure that a social security account number (or any derivative thereof) is not displayed, coded, or embedded on a senior's Medicare card and that any other identifier displayed on such card is easily identifiable as not being the social security account number.

- **EFFECTIVE DATE**.—This shall apply to Medicare cards issued on and after an effective date specified HHS, but in no case shall such effective date be later than the date that is 24 months after the date adequate fund is provided).

- **REISSUANCE**.—HHS shall provide for the reissuance for such individuals of such a card that complies with such amendment not later than 3 years after the effective date and may permit such individuals to apply for the reissuance of such a card.

- **OUTREACH PROGRAM**.—HHS, in consultation SSA, shall conduct an outreach program to Medicare beneficiaries and providers about the new Medicare card provided under this section.

- **REPORT TO CONGRESS AND LIMITATIONS ON EFFECTIVE DATE**.—Not later than 90 days after the date of the enactment of this Act, HHS and SSA shall submit to Congress a report that includes detailed options regarding the implementation of this section, including line-item estimates of and justifications for the costs associated with such options and estimates of timeframes for each stage of implementation.

SEC. 11 - IMPLEMENTATION.

- **EMPOWERING THE HHS OIG AND GAO**.—HHS shall—(1) carry out the provisions of and amendments made by this Act in consultation with HHS OIG and (2) take into consideration the findings and recommendations of GAO in carrying out such provisions and amendments.

- **FUNDING**.—The Secretary shall provide for the transfer, from the Health Care Fraud and Abuse Control Account under section to the CMS Program Management Account, of such sums as the Secretary determines are for necessary administrative expenses associated with carrying out the provisions of and amendments made by this Act.

- **SAVINGS FROM MEDICARE STAY IN MEDICARE**.—Any savings from the provisions of, and amendments made by, this Act may only be utilized to offset outlays under part A of such title.