providers to conduct background checks of direct patient access employees and identify the most efficient, effective, and economical procedures for conducting such background checks;

''(2) assess the costs of conducting such background checks (including start-up and administrative costs);

''(3) consider the benefits and problems associated with requiring employees or facilities or providers to pay the costs of conducting such background checks;

''(4) consider whether the costs of conducting such background checks should be allocated between the medicare and medicaid programs and if so, identify an equitable methodology for doing so;

''(5) determine the extent to which conducting such background checks leads to any unintended consequences, including a reduction in the available workforce for such facilities or providers;

''(6) review forms used by participating States in order to develop, in consultation with the Attorney General, a model form for such background checks;

''(7) determine the effectiveness of background checks conducted by employment agencies; and

''(8) recommend appropriate procedures and payment mechanisms for implementing a national criminal background check program for such facilities and providers.

''(f) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary to carry out the pilot program under this section for the period of fiscal years 2004 through 2007, $25,000,000.

''(g) DEFINITIONS.—In this section:

''(1) CONVICTION FOR A RELEVANT CRIME.—The term 'conviction for a relevant crime' means any Federal or State criminal conviction for—

''(A) any offense described in section 1128(a) of the Social Security Act (42 U.S.C. 1320a–7[(a)]); and

''(B) such other types of offenses as a participating State may specify for purposes of conducting the pilot program in such State.

''(2) DISQUALIFYING INFORMATION.—The term 'disqualifying information' means a conviction for a relevant crime or a finding of patient or resident abuse.

''(3) FINDING OF PATIENT OR RESIDENT ABUSE.—The term 'finding of patient or resident abuse' means any substantiated finding by a State agency under section 1819(g)(1)(C) or 1919(g)(1)(C) of the Social Security Act (42 U.S.C. 1395i–3(g)(1)(C), 1396r(g)(1)(C)) or a Federal agency that a direct patient access employee has committed—

''(A) an act of patient or resident abuse or neglect or a misappropriation of patient or resident property; or

''(B) such other types of acts as a participating State may specify for purposes of conducting the pilot program in such State.

''(4) DIRECT PATIENT ACCESS EMPLOYEE.—The term 'direct patient access employee' means any individual (other than a volunteer) that has access to a patient or resident of a long-term care facility or provider through employment or through a contract with such facility or provider, as determined by a participating State for purposes of conducting the pilot program in such State.

''(5) LONG-TERM CARE FACILITY OR PROVIDER.—

''(A) IN GENERAL.—The term 'long-term care facility or provider' means the following facilities or providers which receive payment for services under title XVIII or XIX of the Social Security Act [42 U.S.C. 1395 et seq., 1396 et seq.]:

''(i) A skilled nursing facility (as defined in section 1819(a) of the Social Security Act) (42 U.S.C. 1395i–3(a)).

''(ii) A nursing facility (as defined in section 1919(a) in such Act) (42 U.S.C. 1396r(a)).

''(iii) A home health agency.

''(iv) A provider of hospice care (as defined in section 1861(dd)(1) of such Act) (42 U.S.C. 1395x(dd)(1)).

''(v) A long-term care hospital (as described in section 1886(d)(1)(B)(iv) of such Act) (42 U.S.C. 1395ww(d)(1)(B)(iv)).

''(vi) A provider of personal care services.

''(vii) A residential care provider that arranges for, or directly provides, long-term care services.

''(viii) An intermediate care facility for the mentally retarded (as defined in section 1905(d) of such Act) [(]42 U.S.C. 1396d(d)).

''(B) ADDITIONAL FACILITIES OR PROVIDERS.—During the first year in which a pilot program under this section is conducted in a participating State, the State may expand the list of facilities or providers under subparagraph (A) (on a phased-in basis or otherwise) to include such other facilities or providers of long-term care services under such titles as the participating State determines appropriate.

''(C) EXCEPTIONS.—Such term does not include—

''(i) any facility or entity that provides, or is a provider of, services described in subparagraph (A) that are exclusively provided to an individual pursuant to a self-directed arrangement that meets such requirements as the participating State may establish in accordance with guidance from the Secretary; or

''(ii) any such arrangement that is obtained by a patient or resident functioning as an employer.

''(6) PARTICIPATING STATE.—The term 'participating State' means a State with an agreement under subsection (c)(1).''

§ 1320a–7m. Use of predictive modeling and other analytics technologies to identify and prevent waste, fraud, and abuse in the Medicare fee-for-service program

(a) Use in the Medicare fee-for-service program

The Secretary shall use predictive modeling and other analytics technologies (in this section referred to as ''predictive analytics technologies'') to identify improper claims for reimbursement and to prevent the payment of such claims under the Medicare fee-for-service program.

(b) Predictive analytics technologies requirements

The predictive analytics technologies used by the Secretary shall—

(1) capture Medicare provider and Medicare beneficiary activities across the Medicare fee-for-service program to provide a comprehensive view across all providers, beneficiaries, and geographies within such program in order to—

(A) identify and analyze Medicare provider networks, provider billing patterns, and beneficiary utilization patterns; and

(B) identify and detect any such patterns and networks that represent a high risk of fraudulent activity;

(2) be integrated into the existing Medicare fee-for-service program claims flow with minimal effort and maximum efficiency;

(3) be able to—

(A) analyze large data sets for unusual or suspicious patterns or anomalies or contain other factors that are linked to the occurrence of waste, fraud, or abuse;

(B) undertake such analysis before payment is made; and

(C) prioritize such identified transactions for additional review before payment is made in terms of the likelihood of potential waste, fraud, and abuse to more efficiently utilize investigative resources;

(4) capture outcome information on adjudicated claims for reimbursement to allow for

refinement and enhancement of the predictive analytics technologies on the basis of such outcome information, including post-payment information about the eventual status of a claim; and

(5) prevent the payment of claims for reimbursement that have been identified as potentially wasteful, fraudulent, or abusive until such time as the claims have been verified as valid.

(c) Implementation requirements

(1) Request for proposals

Not later than January 1, 2011, the Secretary shall issue a request for proposals to carry out this section during the first year of implementation. To the extent the Secretary determines appropriate—

(A) the initial request for proposals may include subsequent implementation years; and

(B) the Secretary may issue additional requests for proposals with respect to subsequent implementation years.

(2) First implementation year

The initial request for proposals issued under paragraph (1) shall require the contractors selected to commence using predictive analytics technologies on July 1, 2011, in the 10 States identified by the Secretary as having the highest risk of waste, fraud, or abuse in the Medicare fee-for-service program.

(3) Second implementation year

Based on the results of the report and recommendation required under subsection (e)(1)(B), the Secretary shall expand the use of predictive analytics technologies on October 1, 2012, to apply to an additional 10 States identified by the Secretary as having the highest risk of waste, fraud, or abuse in the Medicare fee-for-service program, after the States identified under paragraph (2).

(4) Third implementation year

Based on the results of the report and recommendation required under subsection (e)(2), the Secretary shall expand the use of predictive analytics technologies on January 1, 2014, to apply to the Medicare fee-for-service program in any State not identified under paragraph (2) or (3) and the commonwealths and territories.

(5) Fourth implementation year

Based on the results of the report and recommendation required under subsection (e)(3), the Secretary shall expand the use of predictive analytics technologies, beginning April 1, 2015, to apply to Medicaid and CHIP. To the extent the Secretary determines appropriate, such expansion may be made on a phased-in basis.

(6) Option for refinement and evaluation

If, with respect to the first, second, or third implementation year, the Inspector General of the Department of Health and Human Services certifies as part of the report required under subsection (e) for that year no or only nominal actual savings to the Medicare fee-for-service program, the Secretary may impose a moratorium, not to exceed 12 months, on the expansion of the use of predictive analytics technologies under this section for the succeeding year in order to refine the use of predictive analytics technologies to achieve more than nominal savings before further expansion. If a moratorium is imposed in accordance with this paragraph, the implementation dates applicable for the succeeding year or years shall be adjusted to reflect the length of the moratorium period.

(d) Contractor selection, qualifications, and data access requirements

(1) Selection

(A) In general

The Secretary shall select contractors to carry out this section using competitive procedures as provided for in the Federal Acquisition Regulation.

(B) Number of contractors

The Secretary shall select at least 2 contractors to carry out this section with respect to any year.

(2) Qualifications

(A) In general

The Secretary shall enter into a contract under this section with an entity only if the entity—

(i) has leadership and staff who—

(I) have the appropriate clinical knowledge of, and experience with, the payment rules and regulations under the Medicare fee-for-service program; and

(II) have direct management experience and proficiency utilizing predictive analytics technologies necessary to carry out the requirements under subsection (b); or

(ii) has a contract, or will enter into a contract, with another entity that has leadership and staff meeting the criteria described in clause (i).

(B) Conflict of interest

The Secretary may only enter into a contract under this section with an entity to the extent that the entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement.

(3) Data access

The Secretary shall provide entities with a contract under this section with appropriate access to data necessary for the entity to use predictive analytics technologies in accordance with the contract.

(e) Reporting requirements

(1) First implementation year report

Not later than 3 months after the completion of the first implementation year under this section, the Secretary shall submit to the appropriate committees of Congress and make available to the public a report that includes the following:

(A) A description of the implementation of the use of predictive analytics technologies during the year.

(B) A certification of the Inspector General of the Department of Health and Human Services that—

(i) specifies the actual and projected savings to the Medicare fee-for-service program as a result of the use of predictive analytics technologies, including estimates of the amounts of such savings with respect to both improper payments recovered and improper payments avoided;

(ii) the actual and projected savings to the Medicare fee-for-service program as a result of such use of predictive analytics technologies relative to the return on investment for the use of such technologies and in comparison to other strategies or technologies used to prevent and detect fraud, waste, and abuse in the Medicare fee-for-service program; and

(iii) includes recommendations regarding—

(I) whether the Secretary should continue to use predictive analytics technologies;

(II) whether the use of such technologies should be expanded in accordance with the requirements of subsection (c); and

(III) any modifications or refinements that should be made to increase the amount of actual or projected savings or mitigate any adverse impact on Medicare beneficiaries or providers.

(C) An analysis of the extent to which the use of predictive analytics technologies successfully prevented and detected waste, fraud, or abuse in the Medicare fee-for-service program.

(D) A review of whether the predictive analytics technologies affected access to, or the quality of, items and services furnished to Medicare beneficiaries.

(E) A review of what effect, if any, the use of predictive analytics technologies had on Medicare providers.

(F) Any other items determined appropriate by the Secretary.

(2) Second year implementation report

Not later than 3 months after the completion of the second implementation year under this section, the Secretary shall submit to the appropriate committees of Congress and make available to the public a report that includes, with respect to such year, the items required under paragraph (1) as well as any other additional items determined appropriate by the Secretary with respect to the report for such year.

(3) Third year implementation report

Not later than 3 months after the completion of the third implementation year under this section, the Secretary shall submit to the appropriate committees of Congress, and make available to the public, a report that includes[1] with respect to such year, the items required under paragraph (1),[2] as well as any other additional items determined appropriate by the Secretary with respect to the report for such year, and the following:

(A) An analysis of the cost-effectiveness and feasibility of expanding the use of predictive analytics technologies to Medicaid and CHIP.

(B) An analysis of the effect, if any, the application of predictive analytics technologies to claims under Medicaid and CHIP would have on States and the commonwealths and territories.

(C) Recommendations regarding the extent to which technical assistance may be necessary to expand the application of predictive analytics technologies to claims under Medicaid and CHIP, and the type of any such assistance.

(f) Independent evaluation and report

(1) Evaluation

Upon completion of the first year in which predictive analytics technologies are used with respect to claims under Medicaid and CHIP, the Secretary shall, by grant, contract, or interagency agreement, conduct an independent evaluation of the use of predictive analytics technologies under the Medicare fee-for-service program and Medicaid and CHIP. The evaluation shall include an analysis with respect to each such program of the items required for the third year implementation report under subsection (e)(3).

(2) Report

Not later than 18 months after the evaluation required under paragraph (1) is initiated, the Secretary shall submit a report to Congress on the evaluation that shall include the results of the evaluation, the Secretary's response to such results and, to the extent the Secretary determines appropriate, recommendations for legislation or administrative actions.

(g) Waiver authority

The Secretary may waive such provisions of titles XI, XVIII, XIX, and XXI of the Social Security Act [42 U.S.C. 1301 et seq., 1395 et seq., 1396 et seq., 1397aa et seq.], including applicable prompt payment requirements under titles XVIII and XIX of such Act, as the Secretary determines to be appropriate to carry out this section.

(h) Funding

(1) Appropriation

Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary to carry out this section, $100,000,000 for the period beginning January 1, 2011, to remain available until expended.

(2) Reservations

(A) Independent evaluation

The Secretary shall reserve not more than 5 percent of the funds appropriated under paragraph (1) for purposes of conducting the independent evaluation required under subsection (f).

(B) Application to Medicaid and CHIP

The Secretary shall reserve such portion of the funds appropriated under paragraph

[1] So in original. Probably should be followed by a comma.

[2] So in original. The comma probably should not appear.

(1) as the Secretary determines appropriate for purposes of providing assistance to States for administrative expenses in the event of the expansion of predictive analytics technologies to claims under Medicaid and CHIP.

(i) Definitions

In this section:

(1) Commonwealths and territories

The term ''commonwealth and territories'' includes the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, and any other territory or possession of the United States in which the Medicare fee-for-service program, Medicaid, or CHIP operates.

(2) CHIP

The term ''CHIP'' means the Children's Health Insurance Program established under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.).

(3) Medicaid

The term ''Medicaid'' means the program to provide grants to States for medical assistance programs established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(4) Medicare beneficiary

The term ''Medicare beneficiary'' means an individual enrolled in the Medicare fee-for-service program.

(5) Medicare fee-for-service program

The term ''Medicare fee-for-service program'' means the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (42 U.S.C. 1395[c] et seq.[; 1395j et seq.]).

(6) Medicare provider

The term ''Medicare provider'' means a provider of services (as defined in subsection (u) of section 1861 of the Social Security Act (42 U.S.C. 1395x)) and a supplier (as defined in subsection (d) of such section).

(7) Secretary

The term ''Secretary'' means the Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services.

(8) State

The term ''State'' means each of the 50 States and the District of Columbia.

(Pub. L. 111–240, title IV, § 4241, Sept. 27, 2010, 124 Stat. 2599.)

REFERENCES IN TEXT

The Social Security Act, referred to in subsecs. (g) and (i)(2), (3), (5), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Titles XI, XVIII, XIX, and XXI of the Act are classified generally to subchapters XI (§ 1301 et seq.), XVIII (§ 1395 et seq.), XIX (§ 1396 et seq.), and XXI (§ 1397aa et seq.), respectively, of this chapter. Parts A and B of title XVIII of the Act are classified generally to Parts A (§ 1395c et seq.) and B (§ 1395j et seq.) of subchapter XVIII of this chapter. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

CODIFICATION

Section was enacted as part of the Small Business Jobs Act of 2010, and not as part of the Social Security Act which comprises this chapter.

§ 1320a–7n. Disclosure of predictive modeling and other analytics technologies to identify and prevent waste, fraud, and abuse

(a) Reference to predictive modeling technologies requirements

For provisions relating to the use of predictive modeling and other analytics technologies to identify and prevent waste, fraud, and abuse with respect to the Medicare program under subchapter XVIII, the Medicaid program under subchapter XIX, and the Children's Health Insurance Program under subchapter XXI, see section 1320a–7m of this title.

(b) Limiting disclosure of predictive modeling technologies

In implementing such provisions under such section 1320a–7m with respect to covered algorithms (as defined in subsection (c)), the following shall apply:

(1) Nonapplication of FOIA

The covered algorithms used or developed for purposes of such section 1320a–7m (including by the Secretary or a State (or an entity operating under a contract with a State)) shall be exempt from disclosure under section 552(b)(3) of title 5.

(2) Limitation with respect to use and disclosure of information by State agencies

(A) In general

A State agency may not use or disclose covered algorithms used or developed for purposes of such section 1320a–7m except for purposes of administering the State plan (or a waiver of the plan) under the Medicaid program under subchapter XIX or the State child health plan (or a waiver of the plan) under the Children's Health Insurance Program under subchapter XXI, including by enabling an entity operating under a contract with a State to assist the State to identify or prevent waste, fraud, and abuse with respect to such programs.

(B) Information security

A State agency shall have in effect data security and control policies that the Secretary finds adequate to ensure the security of covered algorithms used or developed for purposes of such section 1320a–7m and to ensure that access to such information is restricted to authorized persons for purposes of authorized uses and disclosures described in subparagraph (A).

(C) Procedural requirements

State agencies to which information is disclosed pursuant to such section 1320a–7m shall adhere to uniform procedures established by the Secretary.

(c) Covered algorithm defined

In this section, the term ''covered algorithm''—

(1) means a predictive modeling or other analytics technology, as used for purposes of