(e) Transfer from trust funds

Amounts equal to the amounts deducted pursuant to this section shall be transferred from the Trust Fund from which the payment to the individual, provider, or other entity would otherwise have been made, to the general fund in the Treasury, and shall be credited as payment of the past-due obligation of the individual from whom (or with respect to whom) the deduction was made.

(Aug. 14, 1935, ch. 531, title XVIII, § 1892, as added Pub. L. 100–203, title IV, § 4052(a), Dec. 22, 1987, 101 Stat. 1330–95; amended Pub. L. 100–360, title IV, § 411(f)(10)(A), (C)(i), July 1, 1988, 102 Stat. 780; Pub. L. 100–485, title VI, § 608(d)(21)(E)–(H), Oct. 13, 1988, 102 Stat. 2420.)

REFERENCES IN TEXT

Section 204(a)(1) of the Public Health Service Amendments of 1987, referred to in subsec. (a)(1)(B), is section 204(a)(1) of Pub. L. 100–177, title II, Dec. 1, 1987, 101 Stat. 1000, which is set out as a note under section 254*o* of this title.

The Public Health Service Act, referred to in subsecs. (a)(1)(B)(iii) and (b), is act July 1, 1944, ch. 373, 58 Stat. 682, as amended. Subpart II of part D of title III of the Act is classified generally to subpart II (§ 254d et seq.) of part D of subchapter II of chapter 6A of this title. Subpart I of part C of title VII of the Act was classified generally to subpart I (§ 294 et seq.) of part C of subchapter V of chapter 6A of this title and was omitted in the general revision of subchapter V by Pub. L. 102–408, title I, § 102, Oct. 13, 1992, 106 Stat. 1994. See subpart I (§ 292 et seq.) of part A of subchapter V of chapter 6A of this title. Subpart III of part F of title VII of the Public Health Service Act (as in effect before October 1, 1976) was classified to subpart III (§ 295g–21 et seq.) of part F of subchapter V of chapter 6A of this title, prior to repeal by Pub. L. 94–484, title IV, § 409(a), Oct. 12, 1976, 90 Stat. 2290. For complete classification of this Act to the Code, see Short Title note set out under section 201 of this title and Tables.

AMENDMENTS

1988—Pub. L. 100–360, § 411(f)(10)(C)(i)(I), substituted ''individuals'' for ''physicians'' and inserted ''and loan'' in section catchline.

Subsec. (a)(1)(A). Pub. L. 100–360, § 411(f)(10)(C)(i)(IV), as amended by Pub. L. 100–485, § 608(d)(21)(H), inserted '', the Physician Shortage Area Scholarship Program, or the Health Education Assistance Loan Program''.

Pub. L. 100–360, § 411(f)(10)(C)(i)(II), as amended by Pub. L. 100–485, § 608(d)(21)(G), substituted ''individual'' for ''physician'' in two places.

Subsec. (a)(1)(B). Pub. L. 100–360, § 411(f)(10)(C)(i)(II), as amended by Pub. L. 100–485, § 608(d)(21)(G), substituted ''an individual'' for ''a physician'' in introductory provisions and ''individual'' for ''physician'' in cls. (i)(I) and (II), (ii), and (iii).

Subsec. (a)(2)(A) to (C). Pub. L. 100–360, § 411(f)(10)(C)(i)(II), as amended by Pub. L. 100–485, § 608(d)(21)(G), substituted ''individual'' for ''physician'' wherever appearing.

Subsec. (a)(2)(C)(ii). Pub. L. 100–360, § 411(f)(10)(A)(i), substituted ''paragraph (4)'' for ''paragraph (3)''.

Subsec. (a)(3). Pub. L. 100–360, § 411(f)(10)(C)(i)(II), as amended by Pub. L. 100–485, § 608(d)(21)(G), substituted ''individual'' for ''physician'' in introductory provisions.

Subsec. (a)(3)(B). Pub. L. 100–360, § 411(f)(10)(C)(i)(II), as amended by Pub. L. 100–485, § 608(d)(21)(G), substituted ''individual'' for ''physician''.

Pub. L. 100–360, § 411(f)(10)(A)(i), substituted ''paragraph (4)'' for ''paragraph (3)''.

Subsec. (a)(4). Pub. L. 100–360, § 411(f)(10)(C)(i)(III), substituted ''community practitioner'' for ''community physician''.

Pub. L. 100–360, § 411(f)(10)(C)(i)(II), as amended by Pub. L. 100–485, § 608(d)(21)(G), substituted ''an individual'' for ''a physician'' and ''such individual'' for ''such physician''.

Pub. L. 100–360, § 411(f)(10)(A)(iii), as amended by Pub. L. 100–360, § 608(d)(21)(E), inserted before period at end ''if a State requests that the individual not be excluded''.

Pub. L. 100–360, § 411(f)(10)(A)(ii), substituted ''exclude'' for ''bar''.

Subsec. (b). Pub. L. 100–360, § 411(f)(10)(C)(i)(V), as amended by Pub. L. 100–485, § 608(d)(21)(F)(i), substituted ''or under subpart III of part F of title VII of such Act (as in effect before October 1, 1976) and which has not been paid by the deadline established by the Secretary pursuant to such respective section'' for '', and (2) which has not been paid by the deadline established by the Secretary pursuant to section 338E of the Public Health Service Act''.

Subsec. (b)(1). Pub. L. 100–360, § 411(f)(10)(C)(i)(II), as amended by Pub. L. 100–485, § 608(d)(21)(G), substituted ''an individual'' for ''a physician''.

Subsec. (b)(2). Pub. L. 100–360, § 411(f)(10)(C)(i)(VI), as amended by Pub. L. 100–485, § 608(d)(21)(F)(i), added par. (2).

Subsec. (d)(1). Pub. L. 100–360, § 411(f)(10)(C)(i)(II), as amended by Pub. L. 100–485, § 608(d)(21)(G), substituted ''an individual'' for ''a physician''.

Subsec. (d)(2). Pub. L. 100–360, § 411(f)(10)(C)(i)(VII), as added by Pub. L. 100–485, § 608(d)(21)(F), substituted ''continues'' for ''continued''.

Pub. L. 100–360, § 411(f)(10)(C)(i)(II), as amended by Pub. L. 100–485, § 608(d)(21)(G), substituted ''individual'' for ''physician'' in three places.

Subsec. (d)(4) to (6). Pub. L. 100–360, § 411(f)(10)(C)(i)(II), as amended by Pub. L. 100–485, § 608(d)(21)(G), substituted ''individual'' for ''physician'' wherever appearing.

Subsec. (e). Pub. L. 100–360, § 411(f)(10)(C)(i)(II), as amended by Pub. L. 100–485, § 608(d)(21)(G), substituted ''individual'' for ''physician'' in two places.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(f)(10)(A) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

Pub. L. 100–360, title IV, § 411(f)(10)(C)(iii), July 1, 1988, 102 Stat. 781, provided that: ''The Amendments made by this subparagraph [amending this section and former section 294f of this title] shall be effective 30 days after the date of the enactment of this Act [July 1, 1988].''

EFFECTIVE DATE

Pub. L. 100–203, title IV, § 4052(c), Dec. 22, 1987, 101 Stat. 1330–97, provided that: ''The amendments made by this section [enacting this section and amending section 254*o* of this title] shall be effective on the date of the enactment of this Act [Dec. 22, 1987].''

§ 1395ddd. Medicare Integrity Program

(a) Establishment of Program

There is hereby established the Medicare Integrity Program (in this section referred to as the ''Program'') under which the Secretary shall promote the integrity of the medicare program by entering into contracts in accordance with this section with eligible entities, or otherwise,

to carry out the activities described in subsection (b).

(b) Activities described

The activities described in this subsection are as follows:

(1) Review of activities of providers of services or other individuals and entities furnishing items and services for which payment may be made under this subchapter (including skilled nursing facilities and home health agencies), including medical and utilization review and fraud review (employing similar standards, processes, and technologies used by private health plans, including equipment and software technologies which surpass the capability of the equipment and technologies used in the review of claims under this subchapter as of August 21, 1996).

(2) Audit of cost reports.

(3) Determinations as to whether payment should not be, or should not have been, made under this subchapter by reason of section 1395y(b) of this title, and recovery of payments that should not have been made.

(4) Education of providers of services, beneficiaries, and other persons with respect to payment integrity and benefit quality assurance issues.

(5) Developing (and periodically updating) a list of items of durable medical equipment in accordance with section 1395m(a)(15) of this title which are subject to prior authorization under such section.

(6) The Medicare-Medicaid Data Match Program in accordance with subsection (g).

(c) Eligibility of entities

An entity is eligible to enter into a contract under the Program to carry out any of the activities described in subsection (b) if—

(1) the entity has demonstrated capability to carry out such activities;

(2) in carrying out such activities, the entity agrees to cooperate with the Inspector General of the Department of Health and Human Services, the Attorney General, and other law enforcement agencies, as appropriate, in the investigation and deterrence of fraud and abuse in relation to this subchapter and in other cases arising out of such activities;

(3) the entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement;

(4) the entity agrees to provide the Secretary and the Inspector General of the Department of Health and Human Services with such performance statistics (including the number and amount of overpayments recovered, the number of fraud referrals, and the return on investment of such activities by the entity) as the Secretary or the Inspector General may request; and

(5) the entity meets such other requirements as the Secretary may impose.

In the case of the activity described in subsection (b)(5), an entity shall be deemed to be eligible to enter into a contract under the Program to carry out the activity if the entity is a carrier with a contract in effect under section 1395u of this title.

(d) Process for entering into contracts

The Secretary shall enter into contracts under the Program in accordance with such procedures as the Secretary shall by regulation establish, except that such procedures shall include the following:

(1) Procedures for identifying, evaluating, and resolving organizational conflicts of interest that are generally applicable to Federal acquisition and procurement.

(2) Competitive procedures to be used—

(A) when entering into new contracts under this section;

(B) when entering into contracts that may result in the elimination of responsibilities of an individual fiscal intermediary or carrier under section 202(b) of the Health Insurance Portability and Accountability Act of 1996; and

(C) at any other time considered appropriate by the Secretary,

except that the Secretary may continue to contract with entities that are carrying out the activities described in this section pursuant to agreements under section 1395h of this title or contracts under section 1395u of this title in effect on August 21, 1996.

(3) Procedures under which a contract under this section may be renewed without regard to any provision of law requiring competition if the contractor has met or exceeded the performance requirements established in the current contract.

The Secretary may enter into such contracts without regard to final rules having been promulgated.

(e) Limitation on contractor liability

The Secretary shall by regulation provide for the limitation of a contractor's liability for actions taken to carry out a contract under the Program, and such regulation shall, to the extent the Secretary finds appropriate, employ the same or comparable standards and other substantive and procedural provisions as are contained in section 1320c–6 of this title.

(f) Recovery of overpayments

(1) Use of repayment plans

(A) In general

If the repayment, within 30 days by a provider of services or supplier, of an overpayment under this subchapter would constitute a hardship (as described in subparagraph (B)), subject to subparagraph (C), upon request of the provider of services or supplier the Secretary shall enter into a plan with the provider of services or supplier for the repayment (through offset or otherwise) of such overpayment over a period of at least 6 months but not longer than 3 years (or not longer than 5 years in the case of extreme hardship, as determined by the Secretary). Interest shall accrue on the balance through the period of repayment. Such plan shall meet terms and conditions determined to be appropriate by the Secretary.

(B) Hardship

(i) In general

For purposes of subparagraph (A), the repayment of an overpayment (or overpay-

ments) within 30 days is deemed to constitute a hardship if—

(I) in the case of a provider of services that files cost reports, the aggregate amount of the overpayments exceeds 10 percent of the amount paid under this subchapter to the provider of services for the cost reporting period covered by the most recently submitted cost report; or

(II) in the case of another provider of services or supplier, the aggregate amount of the overpayments exceeds 10 percent of the amount paid under this subchapter to the provider of services or supplier for the previous calendar year.

(ii) Rule of application

The Secretary shall establish rules for the application of this subparagraph in the case of a provider of services or supplier that was not paid under this subchapter during the previous year or was paid under this subchapter only during a portion of that year.

(iii) Treatment of previous overpayments

If a provider of services or supplier has entered into a repayment plan under subparagraph (A) with respect to a specific overpayment amount, such payment amount under the repayment plan shall not be taken into account under clause (i) with respect to subsequent overpayment amounts.

(C) Exceptions

Subparagraph (A) shall not apply if—

(i) the Secretary has reason to suspect that the provider of services or supplier may file for bankruptcy or otherwise cease to do business or discontinue participation in the program under this subchapter; or

(ii) there is an indication of fraud or abuse committed against the program.

(D) Immediate collection if violation of repayment plan

If a provider of services or supplier fails to make a payment in accordance with a repayment plan under this paragraph, the Secretary may immediately seek to offset or otherwise recover the total balance outstanding (including applicable interest) under the repayment plan.

(E) Relation to no fault provision

Nothing in this paragraph shall be construed as affecting the application of section 1395gg(c) of this title (relating to no adjustment in the cases of certain overpayments).

(2) Limitation on recoupment

(A) In general

In the case of a provider of services or supplier that is determined to have received an overpayment under this subchapter and that seeks a reconsideration by a qualified independent contractor on such determination under section 1395ff(b)(1) of this title, the Secretary may not take any action (or authorize any other person, including any medicare contractor, as defined in subparagraph (C)) to recoup the overpayment until the date the decision on the reconsideration has been rendered. If the provisions of section 1395ff(b)(1) of this title (providing for such a reconsideration by a qualified independent contractor) are not in effect, in applying the previous sentence any reference to such a reconsideration shall be treated as a reference to a redetermination by the fiscal intermediary or carrier involved.

(B) Collection with interest

Insofar as the determination on such appeal is against the provider of services or supplier, interest on the overpayment shall accrue on and after the date of the original notice of overpayment. Insofar as such determination against the provider of services or supplier is later reversed, the Secretary shall provide for repayment of the amount recouped plus interest at the same rate as would apply under the previous sentence for the period in which the amount was recouped.

(C) Medicare contractor defined

For purposes of this subsection, the term ''medicare contractor'' has the meaning given such term in section 1395zz(g) of this title.

(3) Limitation on use of extrapolation

A medicare contractor may not use extrapolation to determine overpayment amounts to be recovered by recoupment, offset, or otherwise unless the Secretary determines that—

(A) there is a sustained or high level of payment error; or

(B) documented educational intervention has failed to correct the payment error.

There shall be no administrative or judicial review under section 1395ff of this title, section 1395*oo* of this title, or otherwise, of determinations by the Secretary of sustained or high levels of payment errors under this paragraph.

(4) Provision of supporting documentation

In the case of a provider of services or supplier with respect to which amounts were previously overpaid, a medicare contractor may request the periodic production of records or supporting documentation for a limited sample of submitted claims to ensure that the previous practice is not continuing.

(5) Consent settlement reforms

(A) In general

The Secretary may use a consent settlement (as defined in subparagraph (D)) to settle a projected overpayment.

(B) Opportunity to submit additional information before consent settlement offer

Before offering a provider of services or supplier a consent settlement, the Secretary shall—

(i) communicate to the provider of services or supplier—

(I) that, based on a review of the medical records requested by the Secretary, a preliminary evaluation of those records indicates that there would be an overpayment;

(II) the nature of the problems identified in such evaluation; and

(III) the steps that the provider of services or supplier should take to address the problems; and

(ii) provide for a 45-day period during which the provider of services or supplier may furnish additional information concerning the medical records for the claims that had been reviewed.

(C) Consent settlement offer

The Secretary shall review any additional information furnished by the provider of services or supplier under subparagraph (B)(ii). Taking into consideration such information, the Secretary shall determine if there still appears to be an overpayment. If so, the Secretary—

(i) shall provide notice of such determination to the provider of services or supplier, including an explanation of the reason for such determination; and

(ii) in order to resolve the overpayment, may offer the provider of services or supplier—

(I) the opportunity for a statistically valid random sample; or

(II) a consent settlement.

The opportunity provided under clause (ii)(I) does not waive any appeal rights with respect to the alleged overpayment involved.

(D) Consent settlement defined

For purposes of this paragraph, the term ''consent settlement'' means an agreement between the Secretary and a provider of services or supplier whereby both parties agree to settle a projected overpayment based on less than a statistically valid sample of claims and the provider of services or supplier agrees not to appeal the claims involved.

(6) Notice of over-utilization of codes

The Secretary shall establish, in consultation with organizations representing the classes of providers of services and suppliers, a process under which the Secretary provides for notice to classes of providers of services and suppliers served by the contractor in cases in which the contractor has identified that particular billing codes may be overutilized by that class of providers of services or suppliers under the programs under this subchapter (or provisions of subchapter XI insofar as they relate to such programs).

(7) Payment audits

(A) Written notice for post-payment audits

Subject to subparagraph (C), if a medicare contractor decides to conduct a post-payment audit of a provider of services or supplier under this subchapter, the contractor shall provide the provider of services or supplier with written notice (which may be in electronic form) of the intent to conduct such an audit.

(B) Explanation of findings for all audits

Subject to subparagraph (C), if a medicare contractor audits a provider of services or supplier under this subchapter, the contractor shall—

(i) give the provider of services or supplier a full review and explanation of the findings of the audit in a manner that is understandable to the provider of services or supplier and permits the development of an appropriate corrective action plan;

(ii) inform the provider of services or supplier of the appeal rights under this subchapter as well as consent settlement options (which are at the discretion of the Secretary);

(iii) give the provider of services or supplier an opportunity to provide additional information to the contractor; and

(iv) take into account information provided, on a timely basis, by the provider of services or supplier under clause (iii).

(C) Exception

Subparagraphs (A) and (B) shall not apply if the provision of notice or findings would compromise pending law enforcement activities, whether civil or criminal, or reveal findings of law enforcement-related audits.

(8) Standard methodology for probe sampling

The Secretary shall establish a standard methodology for medicare contractors to use in selecting a sample of claims for review in the case of an abnormal billing pattern.

(g) Medicare-Medicaid Data Match Program

(1) Expansion of Program

(A) In general

The Secretary shall enter into contracts with eligible entities or otherwise for the purpose of ensuring that, beginning with 2006, the Medicare-Medicaid Data Match Program (commonly referred to as the ''Medi-Medi Program'') is conducted with respect to the program established under this subchapter and State Medicaid programs under subchapter XIX for the purpose of—

(i) identifying program vulnerabilities in the program established under this subchapter and the Medicaid program established under subchapter XIX through the use of computer algorithms to review claims data to look for payment anomalies (including billing or billing patterns identified with respect to provider, service, time, or patient that appear to be suspect or otherwise implausible);

(ii) working with States, the Attorney General, and the Inspector General of the Department of Health and Human Services to coordinate appropriate actions to investigate and recover amounts with respect to suspect claims to protect the Federal and State share of expenditures under the Medicaid program under subchapter XIX, as well as the program established under this subchapter;

(iii) increasing the effectiveness and efficiency of both such programs through cost avoidance, savings, and recoupments of fraudulent, wasteful, or abusive expenditures; and

(iv) furthering the Secretary's design, development, installation, or enhancement

of an automated data system architecture—

(I) to collect, integrate, and assess data for purposes of program integrity, program oversight, and administration, including the Medi-Medi Program; and

(II) that improves the coordination of requests for data from States.

(B) Reporting requirements

The Secretary shall make available in a timely manner any data and statistical information collected by the Medi-Medi Program to the Attorney General, the Director of the Federal Bureau of Investigation, the Inspector General of the Department of Health and Human Services, and the States (including a Medicaid fraud and abuse control unit described in section 1396b(q) of this title). Such information shall be disseminated no less frequently than quarterly.

(2) Limited waiver authority

The Secretary shall waive only such requirements of this section and of subchapters XI and XIX as are necessary to carry out paragraph (1).

(3) Incentives for States

The Secretary shall study and, as appropriate, may specify incentives for States to work with the Secretary for the purposes described in paragraph (1)(A)(ii). The application of the previous sentence may include use of the waiver authority described in paragraph (2).

(h) Use of recovery audit contractors

(1) In general

Under the Program, the Secretary shall enter into contracts with recovery audit contractors in accordance with this subsection for the purpose of identifying underpayments and overpayments and recouping overpayments under this subchapter with respect to all services for which payment is made under this subchapter. Under the contracts—

(A) payment shall be made to such a contractor only from amounts recovered;

(B) from such amounts recovered, payment—

(i) shall be made on a contingent basis for collecting overpayments; and

(ii) may be made in such amounts as the Secretary may specify for identifying underpayments; and

(C) the Secretary shall retain a portion of the amounts recovered which shall be available to the program management account of the Centers for Medicare & Medicaid Services for purposes of activities conducted under the recovery audit program under this subsection.

(2) Disposition of remaining recoveries

The amounts recovered under such contracts that are not paid to the contractor under paragraph (1) or retained by the Secretary under paragraph (1)(C) or paragraph (10) shall be applied to reduce expenditures under this subchapter.

(3) Nationwide coverage

The Secretary shall enter into contracts under paragraph (1) in a manner so as to provide for activities in all States under such a contract by not later than January 1, 2010 (not later than December 31, 2010, in the case of contracts relating to payments made under part C or D).

(4) Audit and recovery periods

Each such contract shall provide that audit and recovery activities may be conducted during a fiscal year with respect to payments made under this subchapter—

(A) during such fiscal year; and

(B) retrospectively (for a period of not more than 4 fiscal years prior to such fiscal year).

(5) Waiver

The Secretary shall waive such provisions of this subchapter as may be necessary to provide for payment of recovery audit contractors under this subsection in accordance with paragraph (1).

(6) Qualifications of contractors

(A) In general

The Secretary may not enter into a contract under paragraph (1) with a recovery audit contractor unless the contractor has staff that has the appropriate clinical knowledge of, and experience with, the payment rules and regulations under this subchapter or the contractor has, or will contract with, another entity that has such knowledgeable and experienced staff.

(B) Ineligibility of certain contractors

The Secretary may not enter into a contract under paragraph (1) with a recovery audit contractor to the extent the contractor is a fiscal intermediary under section 1395h of this title, a carrier under section 1395u of this title, or a medicare administrative contractor under section 1395kk–1 of this title.

(C) Preference for entities with demonstrated proficiency

In awarding contracts to recovery audit contractors under paragraph (1), the Secretary shall give preference to those risk entities that the Secretary determines have demonstrated more than 3 years direct management experience and a proficiency for cost control or recovery audits with private insurers, health care providers, health plans, under the Medicaid program under subchapter XIX, or under this subchapter.

(7) Construction relating to conduct of investigation of fraud

A recovery of an overpayment to a individual or entity by a recovery audit contractor under this subsection shall not be construed to prohibit the Secretary or the Attorney General from investigating and prosecuting, if appropriate, allegations of fraud or abuse arising from such overpayment.

(8) Annual report

The Secretary shall annually submit to Congress a report on the use of recovery audit contractors under this subsection. Each such report shall include information on the per-

formance of such contractors in identifying underpayments and overpayments and recouping overpayments, including an evaluation of the comparative performance of such contractors and savings to the program under this subchapter.

(9) Special rules relating to parts C and D

The Secretary shall enter into contracts under paragraph (1) to require recovery audit contractors to—

(A) ensure that each MA plan under part C has an anti-fraud plan in effect and to review the effectiveness of each such anti-fraud plan;

(B) ensure that each prescription drug plan under part D has an anti-fraud plan in effect and to review the effectiveness of each such anti-fraud plan;

(C) examine claims for reinsurance payments under section 1395w–115(b) of this title to determine whether prescription drug plans submitting such claims incurred costs in excess of the allowable reinsurance costs permitted under paragraph (2) of that section; and

(D) review estimates submitted by prescription drug plans by private plans with respect to the enrollment of high cost beneficiaries (as defined by the Secretary) and to compare such estimates with the numbers of such beneficiaries actually enrolled by such plans.

(10) Use of certain recovered funds

(A) In general

After application of paragraph (1)(C), the Secretary shall retain a portion of the amounts recovered by recovery audit contractors for each year under this section which shall be available to the program management account of the Centers for Medicare & Medicaid Services for purposes of, subject to subparagraph (B), carrying out sections 1395*l*(z),[1] 1935m(*l*)(16), and 1395kk–1(a)(4)(G) of this title, carrying out section 514(b) of the Medicare Access and CHIP Reauthorization Act of 2015, and implementing strategies (such as claims processing edits) to help reduce the error rate of payments under this subchapter. The amounts retained under the preceding sentence shall not exceed an amount equal to 15 percent of the amounts recovered under this subsection, and shall remain available until expended.

(B) Limitation

Except for uses that support claims processing (including edits) or system functionality for detecting fraud, amounts retained under subparagraph (A) may not be used for technological-related infrastructure, capital investments, or information systems.

(C) No reduction in payments to recovery audit contractors

Nothing in subparagraph (A) shall reduce amounts available for payments to recovery audit contractors under this subsection.

[1] See References in Text note below.

(i) Evaluations and annual report

(1) Evaluations

The Secretary shall conduct evaluations of eligible entities which the Secretary contracts with under the Program not less frequently than every 3 years.

(2) Annual report

Not later than 180 days after the end of each fiscal year (beginning with fiscal year 2011), the Secretary shall submit a report to Congress which identifies—

(A) the use of funds, including funds transferred from the Federal Hospital Insurance Trust Fund under section 1395i of this title and the Federal Supplementary Insurance Trust Fund under section 1395t of this title, to carry out this section; and

(B) the effectiveness of the use of such funds.

(Aug. 14, 1935, ch. 531, title XVIII, § 1893, as added Pub. L. 104–191, title II, § 202(a), Aug. 21, 1996, 110 Stat. 1996; amended Pub. L. 108–173, title VII, § 736(c)(7), title IX, § 935(a), Dec. 8, 2003, 117 Stat. 2356, 2407; Pub. L. 109–171, title VI, § 6034(d)(1), Feb. 8, 2006, 120 Stat. 77; Pub. L. 109–432, div. B, title III, § 302(a), Dec. 20, 2006, 120 Stat. 2991; Pub. L. 111–148, title VI, §§ 6402(j)(1), 6411(b), Mar. 23, 2010, 124 Stat. 762, 775; Pub. L. 114–10, title V, §§ 505(b), 510, Apr. 16, 2015, 129 Stat. 167, 170; Pub. L. 114–115, § 9(b), Dec. 28, 2015, 129 Stat. 3135; Pub. L. 114–198, title VII, § 704(c)(1), July 22, 2016, 130 Stat. 749.)

AMENDMENT OF SECTION

Pub. L. 114–198, title VII, § 704(c)(1), (g)(1), July 22, 2016, 130 Stat. 749, 751, provided that, applicable to prescription drug plans (and MA–PD plans) for plan years beginning on or after Jan. 1, 2019, this section is amended by adding at the end the following new subsection:

(j) Expanding activities of Medicare drug integrity contractors (MEDICs)

(1) Access to information

Under contracts entered into under this section with Medicare drug integrity contractors (including any successor entity to a Medicare drug integrity contractor), the Secretary shall authorize such contractors to directly accept prescription and necessary medical records from entities such as pharmacies, prescription drug plans, MA–PD plans, and physicians with respect to an individual in order for such contractors to provide information relevant to the determination of whether such individual is an at-risk beneficiary for prescription drug abuse, as defined in section 1395w–104(c)(5)(C) of this title.

(2) Requirement for acknowledgment of referrals

If a PDP sponsor or MA organization refers information to a contractor described in paragraph (1) in order for such contractor to assist in the determination described in such paragraph, the contractor shall—

(A) acknowledge to the sponsor or organization receipt of the referral; and

(B) in the case that any PDP sponsor or MA organization contacts the contractor requesting to know the determination by the contractor of whether or not an individual has been deter-

mined to be an individual described in such paragraph, shall inform such sponsor or organization of such determination on a date that is not later than 15 days after the date on which the sponsor or organization contacts the contractor.

(3) Making data available to other entities

(A) In general

For purposes of carrying out this subsection, subject to subparagraph (B), the Secretary shall authorize MEDICs to respond to requests for information from PDP sponsors and MA organizations, State prescription drug monitoring programs, and other entities delegated by such sponsors or organizations using available programs and systems in the effort to prevent fraud, waste, and abuse.

(B) HIPAA compliant information only

Information may only be disclosed by a MEDIC under subparagraph (A) if the disclosure of such information is permitted under the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note).

See 2016 Amendment note below.

REFERENCES IN TEXT

Section 202(b) of the Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (d)(2)(B), is section 202(b) of Pub. L. 104–191, which amended sections 1395h and 1395u of this title.

Section 1395*l*(z) of this title, referred to in subsec. (h)(10)(A), probably means the subsec. (z) of section 1395*l* of this title which relates to medical review of spinal subluxation services and was added by Pub. L. 114–10, title V, § 514(a), Apr. 16, 2015, 129 Stat. 171.

Section 514(b) of the Medicare Access and CHIP Reauthorization Act of 2015, referred to in subsec. (h)(10)(A), is section 514(b) of Pub. L. 114–10, which is set out as a note under section 1395*l* of this title.

AMENDMENTS

2016—Subsec. (j). Pub. L. 114–198 added subsec. (j).

2015—Subsec. (g)(1)(A). Pub. L. 114–115, § 9(b)(1), inserted ''or otherwise'' after ''eligible entities'' in introductory provisions.

Subsec. (g)(1)(A)(i). Pub. L. 114–115, § 9(b)(2), inserted ''to review claims data'' after ''algorithms'' and substituted ''provider, service, time, or patient'' for ''service, time, or patient''.

Subsec. (g)(1)(A)(ii). Pub. L. 114–115, § 9(b)(3)(A), inserted ''to investigate and recover amounts with respect to suspect claims'' after ''appropriate actions''.

Subsec. (g)(1)(A)(iv). Pub. L. 114–115, § 9(b)(3)(B)–(5), added cl. (iv).

Subsec. (g)(3). Pub. L. 114–10, § 510, added par. (3).

Subsec. (h)(2). Pub. L. 114–10, § 505(b)(1), inserted ''or paragraph (10)'' after ''paragraph (1)(C)''.

Subsec. (h)(10). Pub. L. 114–10, § 505(b)(2), added par. (10).

2010—Subsec. (a). Pub. L. 111–148, § 6402(j)(1)(C), inserted '', or otherwise,'' after ''entities''.

Subsec. (c)(4), (5). Pub. L. 111–148, § 6402(j)(1)(A), added par. (4) and redesignated former par. (4) as (5)

Subsec. (h)(1). Pub. L. 111–148, § 6411(b)(1), substituted ''this subchapter'' for ''part A or B'' in introductory provisions.

Subsec. (h)(2). Pub. L. 111–148, § 6411(b)(2), substituted ''this subchapter'' for ''parts A and B''.

Subsec. (h)(3). Pub. L. 111–148, § 6411(b)(3), inserted ''(not later than December 31, 2010, in the case of contracts relating to payments made under part C or D)'' after ''2010''.

Subsec. (h)(4). Pub. L. 111–148, § 6411(b)(4), substituted ''this subchapter'' for ''part A or B'' in introductory provisions.

Subsec. (h)(9). Pub. L. 111–148, § 6411(b)(5), added par. (9).

Subsec. (i). Pub. L. 111–148, § 6402(j)(1)(B), added subsec. (i).

2006—Subsec. (b)(6). Pub. L. 109–171, § 6034(d)(1)(A), added par. (6).

Subsec. (g). Pub. L. 109–171, § 6034(d)(1)(B), added subsec. (g).

Subsec. (h). Pub. L. 109–432 added subsec. (h).

2003—Subsec. (a). Pub. L. 108–173, § 736(c)(7), substituted ''medicare program'' for ''Medicare program''.

Subsec. (f). Pub. L. 108–173, § 935(a), added subsec. (f).

EFFECTIVE DATE OF 2016 AMENDMENT

Amendment by Pub. L. 114–198 applicable to prescription drug plans (and MA–PD plans) for plan years beginning on or after Jan. 1, 2019, see section 704(g)(1) of Pub. L. 114–198, set out as a note under section 1395w–101 of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title IX, § 935(b), Dec. 8, 2003, 117 Stat. 2411, provided that:

''(1) USE OF REPAYMENT PLANS.—Section 1893(f)(1) of the Social Security Act [42 U.S.C. 1395ddd(f)(1)], as added by subsection (a), shall apply to requests for repayment plans made after the date of the enactment of this Act [Dec. 8, 2003].

''(2) LIMITATION ON RECOUPMENT.—Section 1893(f)(2) of the Social Security Act [42 U.S.C. 1395ddd(f)(2)], as added by subsection (a), shall apply to actions taken after the date of the enactment of this Act.

''(3) USE OF EXTRAPOLATION.—Section 1893(f)(3) of the Social Security Act [42 U.S.C. 1395ddd(f)(3)], as added by subsection (a), shall apply to statistically valid random samples initiated after the date that is 1 year after the date of the enactment of this Act.

''(4) PROVISION OF SUPPORTING DOCUMENTATION.—Section 1893(f)(4) of the Social Security Act [42 U.S.C. 1395ddd(f)(4)], as added by subsection (a), shall take effect on the date of the enactment of this Act.

''(5) CONSENT SETTLEMENT.—Section 1893(f)(5) of the Social Security Act [42 U.S.C. 1395ddd(f)(5)], as added by subsection (a), shall apply to consent settlements entered into after the date of the enactment of this Act.

''(6) NOTICE OF OVERUTILIZATION.—Not later than 1 year after the date of the enactment of this Act, the Secretary [of Health and Human Services] shall first establish the process for notice of overutilization of billing codes under section 1893A(f)(6) [1893(f)(6)] of the Social Security Act [probably means 42 U.S.C. 1395ddd(f)(6)], as added by subsection (a).

''(7) PAYMENT AUDITS.—Section 1893A(f)(7) [1893(f)(7)] of the Social Security Act [probably means 42 U.S.C. 1395ddd(f)(7)], as added by subsection (a), shall apply to audits initiated after the date of the enactment of this Act.

''(8) STANDARD FOR ABNORMAL BILLING PATTERNS.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall first establish a standard methodology for selection of sample claims for abnormal billing patterns under section 1893(f)(8) of the Social Security Act [42 U.S.C. 1395ddd(f)(8)], as added by subsection (a).''

IMPROVING THE SHARING OF DATA BETWEEN THE FEDERAL GOVERNMENT AND STATE MEDICAID PROGRAMS

Pub. L. 114–115, § 9, Dec. 28, 2015, 129 Stat. 3135, provided that:

''(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall establish a plan to encourage and facilitate the participation of States in the Medicare-Medicaid Data Match Program (commonly referred to as the 'Medi-Medi Program') under section 1893(g) of the Social Security Act (42 U.S.C. 1395ddd(g)).

''(b) PROGRAM REVISIONS TO IMPROVE MEDI-MEDI DATA MATCH PROGRAM PARTICIPATION BY STATES.—[Amended this section.]

''(c) PROVIDING STATES WITH DATA ON IMPROPER PAYMENTS MADE FOR ITEMS OR SERVICES PROVIDED TO DUAL ELIGIBLE INDIVIDUALS.—

''(1) IN GENERAL.—The Secretary shall develop and implement a plan that allows each State agency responsible for administering a State plan for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] access to relevant data on improper or fraudulent payments made under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for health care items or services provided to dual eligible individuals.

''(2) DUAL ELIGIBLE INDIVIDUAL DEFINED.—In this section, the term 'dual eligible individual' means an individual who is entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.), or enrolled for benefits under part B of title XVIII of such Act (42 U.S.C. 1395j et seq.), and is eligible for medical assistance under a State plan under title XIX of such Act (42 U.S.C. 1396 et seq.) or under a waiver of such plan.''

EXTENSION OF TWO-MIDNIGHT RULE

Pub. L. 113–93, title I, § 111, Apr. 1, 2014, 128 Stat. 1044, as amended by Pub. L. 114–10, title V, § 521, Apr. 16, 2015, 129 Stat. 176, provided that:

''(a) CONTINUATION OF CERTAIN MEDICAL REVIEW ACTIVITIES.—The Secretary of Health and Human Services may continue medical review activities described in the notice entitled 'Selecting Hospital Claims for Patient Status Reviews: Admissions On or After October 1, 2013', posted on the Internet website of the Centers for Medicare & Medicaid Services, through through [sic] the end of fiscal year 2015 for such additional hospital claims as the Secretary determines appropriate.

''(b) LIMITATION.—The Secretary of Health and Human Services shall not conduct patient status reviews (as described in such notice) on a post-payment review basis through recovery audit contractors under section 1893(h) of the Social Security Act (42 U.S.C. 1395ddd(h)) for inpatient claims with dates of admission October 1, 2013, through September 30, 2015, unless there is evidence of systematic gaming, fraud, abuse, or delays in the provision of care by a provider of services (as defined in section 1861(u) of such Act (42 U.S.C. 1395x(u))).

''(c) CONSTRUCTION.—Except as provided in subsections (a) and (b), nothing in this section shall be construed as limiting the Secretary's authority to pursue fraud and abuse activities under such section 1893(h) or otherwise.''

ACCESS TO COORDINATION OF BENEFITS CONTRACTOR DATABASE

Pub. L. 109–432, div. B, title III, § 302(b), Dec. 20, 2006, 120 Stat. 2992, provided that: ''The Secretary of Health and Human Services shall provide for access by recovery audit contractors conducting audit and recovery activities under section 1893(h) of the Social Security Act [42 U.S.C. 1395ddd(h)], as added by subsection (a), to the database of the Coordination of Benefits Contractor of the Centers for Medicare & Medicaid Services with respect to the audit and recovery periods described in paragraph (4) of such section 1893(h).''

§ 1395eee. Payments to, and coverage of benefits under, programs of all-inclusive care for elderly (PACE)

(a) Receipt of benefits through enrollment in PACE program; definitions for PACE program related terms

(1) Benefits through enrollment in a PACE program

In accordance with this section, in the case of an individual who is entitled to benefits under part A or enrolled under part B and who is a PACE program eligible individual (as defined in paragraph (5)) with respect to a PACE program offered by a PACE provider under a PACE program agreement—

(A) the individual may enroll in the program under this section; and

(B) so long as the individual is so enrolled and in accordance with regulations—

(i) the individual shall receive benefits under this subchapter solely through such program; and

(ii) the PACE provider is entitled to payment under and in accordance with this section and such agreement for provision of such benefits.

(2) "PACE program" defined

For purposes of this section, the term ''PACE program'' means a program of all-inclusive care for the elderly that meets the following requirements:

(A) Operation

The entity operating the program is a PACE provider (as defined in paragraph (3)).

(B) Comprehensive benefits

The program provides comprehensive health care services to PACE program eligible individuals in accordance with the PACE program agreement and regulations under this section.

(C) Transition

In the case of an individual who is enrolled under the program under this section and whose enrollment ceases for any reason (including that the individual no longer qualifies as a PACE program eligible individual, the termination of a PACE program agreement, or otherwise), the program provides assistance to the individual in obtaining necessary transitional care through appropriate referrals and making the individual's medical records available to new providers.

(3) "PACE provider" defined

(A) In general

For purposes of this section, the term ''PACE provider'' means an entity that—

(i) subject to subparagraph (B), is (or is a distinct part of) a public entity or a private, nonprofit entity organized for charitable purposes under section 501(c)(3) of the Internal Revenue Code of 1986; and

(ii) has entered into a PACE program agreement with respect to its operation of a PACE program.

(B) Treatment of private, for-profit providers

Clause (i) of subparagraph (A) shall not apply—

(i) to entities subject to a demonstration project waiver under subsection (h); and

(ii) after the date the report under section 4804(b) of the Balanced Budget Act of 1997 is submitted, unless the Secretary determines that any of the findings described in subparagraph (A), (B), (C), or (D) of paragraph (2) of such section are true.

(4) "PACE program agreement" defined

For purposes of this section, the term ''PACE program agreement'' means, with re-