

and State expenditures under the Medicare and Medicaid programs. Nothing in this section shall be construed as requiring the Secretary to conduct an independent review of each long-term care insurance policy offered under or in connection with such a partnership.

(2) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary of Health and Human Services, \$1,000,000 for the period of fiscal years 2006 through 2010 to carry out paragraph (1).

(d) NATIONAL CLEARINGHOUSE FOR LONG-TERM CARE INFORMATION.—

(1) ESTABLISHMENT.—The Secretary of Health and Human Services shall establish a National Clearinghouse for Long-Term Care Information. The Clearinghouse may be established through a contract or interagency agreement.

(2) DUTIES.—

(A) IN GENERAL.—The National Clearinghouse for Long-Term Care Information shall—

(i) educate consumers with respect to the availability and limitations of coverage for long-term care under the Medicaid program and provide contact information for obtaining State-specific information on long-term care coverage, including eligibility and estate recovery requirements under State Medicaid programs;

(ii) provide objective information to assist consumers with the decisionmaking process for determining whether to purchase long-term care insurance or to pursue other private market alternatives for purchasing long-term care and provide contact information for additional objective resources on planning for long-term care needs; and

(iii) maintain a list of States with State long-term care insurance partnerships under the Medicaid program that provide reciprocal recognition of long-term care insurance policies issued under such partnerships.

(B) REQUIREMENT.—In providing information to consumers on long-term care in accordance with this subsection, the National Clearinghouse for Long-Term Care Information shall not advocate in favor of a specific long-term care insurance provider or a specific long-term care insurance policy.

(3) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out this subsection, \$3,000,000 for each of fiscal years 2006 through 2010.

### **CHAPTER 3—ELIMINATING FRAUD, WASTE, AND ABUSE IN MEDICAID**

#### **SEC. 6031. ENCOURAGING THE ENACTMENT OF STATE FALSE CLAIMS ACTS.**

42 USC 1396h.

(a) IN GENERAL.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by inserting after section 1908A the following:

“STATE FALSE CLAIMS ACT REQUIREMENTS FOR INCREASED STATE  
SHARE OF RECOVERIES

“SEC. 1909. (a) IN GENERAL.—Notwithstanding section 1905(b), if a State has in effect a law relating to false or fraudulent claims that meets the requirements of subsection (b), the Federal medical assistance percentage with respect to any amounts recovered under a State action brought under such law, shall be decreased by 10 percentage points.

“(b) REQUIREMENTS.—For purposes of subsection (a), the requirements of this subsection are that the Inspector General of the Department of Health and Human Services, in consultation with the Attorney General, determines that the State has in effect a law that meets the following requirements:

“(1) The law establishes liability to the State for false or fraudulent claims described in section 3729 of title 31, United States Code, with respect to any expenditure described in section 1903(a).

“(2) The law contains provisions that are at least as effective in rewarding and facilitating qui tam actions for false or fraudulent claims as those described in sections 3730 through 3732 of title 31, United States Code.

“(3) The law contains a requirement for filing an action under seal for 60 days with review by the State Attorney General.

“(4) The law contains a civil penalty that is not less than the amount of the civil penalty authorized under section 3729 of title 31, United States Code.

“(c) DEEMED COMPLIANCE.—A State that, as of January 1, 2007, has a law in effect that meets the requirements of subsection (b) shall be deemed to be in compliance with such requirements for so long as the law continues to meet such requirements.

“(d) NO PRECLUSION OF BROADER LAWS.—Nothing in this section shall be construed as prohibiting a State that has in effect a law that establishes liability to the State for false or fraudulent claims described in section 3729 of title 31, United States Code, with respect to programs in addition to the State program under this title, or with respect to expenditures in addition to expenditures described in section 1903(a), from being considered to be in compliance with the requirements of subsection (a) so long as the law meets such requirements.”

(b) EFFECTIVE DATE.—Except as provided in section 6035(e), the amendments made by this section take effect on January 1, 2007.

42 USC 1396h  
note.

**SEC. 6032. EMPLOYEE EDUCATION ABOUT FALSE CLAIMS RECOVERY.**

(a) IN GENERAL.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(1) in paragraph (66), by striking “and” at the end;

(2) in paragraph (67) by striking the period at the end and inserting “; and”; and

(3) by inserting after paragraph (67) the following:

“(68) provide that any entity that receives or makes annual payments under the State plan of at least \$5,000,000, as a condition of receiving such payments, shall—

“(A) establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about

Procedures.

the False Claims Act established under sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1128B(f));

“(B) include as part of such written policies, detailed provisions regarding the entity’s policies and procedures for detecting and preventing fraud, waste, and abuse; and

“(C) include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of employees to be protected as whistleblowers, and the entity’s policies and procedures for detecting and preventing fraud, waste, and abuse.”

42 USC 1396a  
note.

(b) **EFFECTIVE DATE.**—Except as provided in section 6035(e), the amendments made by subsection (a) take effect on January 1, 2007.

**SEC. 6033. PROHIBITION ON RESTOCKING AND DOUBLE BILLING OF PRESCRIPTION DRUGS.**

(a) **IN GENERAL.**—Section 1903(i)(10) of the Social Security Act (42 U.S.C. 1396b(i)), as amended by section 6002(b), is amended—

(1) in subparagraph (B), by striking “and” at the end;

(2) in subparagraph (C), by striking “; or” at the end and inserting “, and”; and

(3) by adding at the end the following:

“(D) with respect to any amount expended for reimbursement to a pharmacy under this title for the ingredient cost of a covered outpatient drug for which the pharmacy has already received payment under this title (other than with respect to a reasonable restocking fee for such drug); or”

42 USC 1396b  
note.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) take effect on the first day of the first fiscal year quarter that begins after the date of enactment of this Act.

**SEC. 6034. MEDICAID INTEGRITY PROGRAM.**

(a) **ESTABLISHMENT OF MEDICAID INTEGRITY PROGRAM.**—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended—

42 USC 1396v.

(1) by redesignating section 1936 as section 1937; and

(2) by inserting after section 1935 the following:

“MEDICAID INTEGRITY PROGRAM

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42 USC 1396u–6.

“SEC. 1936. (a) **IN GENERAL.**—There is hereby established the Medicaid Integrity Program (in this section referred to as the ‘Program’) under which the Secretary shall promote the integrity of the program under this title by entering into contracts in accordance with this section with eligible entities to carry out the activities described in subsection (b).

“(b) **ACTIVITIES DESCRIBED.**—Activities described in this subsection are as follows:

“(1) Review of the actions of individuals or entities furnishing items or services (whether on a fee-for-service, risk, or other basis) for which payment may be made under a State

plan approved under this title (or under any waiver of such plan approved under section 1115) to determine whether fraud, waste, or abuse has occurred, is likely to occur, or whether such actions have any potential for resulting in an expenditure of funds under this title in a manner which is not intended under the provisions of this title.

“(2) Audit of claims for payment for items or services furnished, or administrative services rendered, under a State plan under this title, including—

“(A) cost reports;

“(B) consulting contracts; and

“(C) risk contracts under section 1903(m).

“(3) Identification of overpayments to individuals or entities receiving Federal funds under this title.

“(4) Education of providers of services, managed care entities, beneficiaries, and other individuals with respect to payment integrity and quality of care.

“(c) ELIGIBLE ENTITY AND CONTRACTING REQUIREMENTS.—

“(1) IN GENERAL.—An entity is eligible to enter into a contract under the Program to carry out any of the activities described in subsection (b) if the entity satisfies the requirements of paragraphs (2) and (3).

“(2) ELIGIBILITY REQUIREMENTS.—The requirements of this paragraph are the following:

“(A) The entity has demonstrated capability to carry out the activities described in subsection (b).

“(B) 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 title and in other cases arising out of such activities.

“(C) The entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement.

“(D) The entity meets such other requirements as the Secretary may impose.

“(3) CONTRACTING REQUIREMENTS.—The entity has contracted with the Secretary in accordance with such procedures as the Secretary shall by regulation establish, except that such procedures shall include the following:

Regulations.

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

“(B) Competitive procedures to be used—

“(i) when entering into new contracts under this section;

“(ii) when entering into contracts that may result in the elimination of responsibilities under section 202(b) of the Health Insurance Portability and Accountability Act of 1996; and

“(iii) at any other time considered appropriate by the Secretary.

“(C) 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.

Regulations.

“(4) 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 1157.

“(d) COMPREHENSIVE PLAN FOR PROGRAM INTEGRITY.—

“(1) 5-YEAR PLAN.—With respect to the 5-fiscal year period beginning with fiscal year 2006, and each such 5-fiscal year period that begins thereafter, the Secretary shall establish a comprehensive plan for ensuring the integrity of the program established under this title by combatting fraud, waste, and abuse.

“(2) CONSULTATION.—Each 5-fiscal year plan established under paragraph (1) shall be developed by the Secretary in consultation with the Attorney General, the Director of the Federal Bureau of Investigation, the Comptroller General of the United States, the Inspector General of the Department of Health and Human Services, and State officials with responsibility for controlling provider fraud and abuse under State plans under this title.

“(e) APPROPRIATION.—

“(1) IN GENERAL.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated to carry out the Medicaid Integrity Program under this section, without further appropriation—

“(A) for fiscal year 2006, \$5,000,000;

“(B) for each of fiscal years 2007 and 2008, \$50,000,000;

and

“(C) for each fiscal year thereafter, \$75,000,000.

“(2) AVAILABILITY.—Amounts appropriated pursuant to paragraph (1) shall remain available until expended.

“(3) INCREASE IN CMS STAFFING DEVOTED TO PROTECTING MEDICAID PROGRAM INTEGRITY.—From the amounts appropriated under paragraph (1), the Secretary shall increase by 100 the number of full-time equivalent employees whose duties consist solely of protecting the integrity of the Medicaid program established under this section by providing effective support and assistance to States to combat provider fraud and abuse.

“(4) ANNUAL REPORT.—Not later than 180 days after the end of each fiscal year (beginning with fiscal year 2006), the Secretary shall submit a report to Congress which identifies—

“(A) the use of funds appropriated pursuant to paragraph (1); and

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

(b) STATE REQUIREMENT TO COOPERATE WITH INTEGRITY PROGRAM EFFORTS.—Section 1902(a) of such Act (42 U.S.C. 1396a(a)), as amended by section 6033(a), is amended—

(1) in paragraph (67), by striking “and” at the end;

(2) in paragraph (68), by striking the period at the end and inserting “; and”; and

(3) by inserting after paragraph (68), the following:

“(69) provide that the State must comply with any requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program established under section 1936.”.

(c) INCREASED FUNDING FOR MEDICAID FRAUD AND ABUSE CONTROL ACTIVITIES.—

(1) IN GENERAL.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated to the Office of the Inspector General of the Department of Health and Human Services, without further appropriation, \$25,000,000 for each of fiscal years 2006 through 2010, for activities of such Office with respect to the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(2) AVAILABILITY; AMOUNTS IN ADDITION TO OTHER AMOUNTS APPROPRIATED FOR SUCH ACTIVITIES.—Amounts appropriated pursuant to paragraph (1) shall—

(A) remain available until expended; and

(B) be in addition to any other amounts appropriated or made available to the Office of the Inspector General of the Department of Health and Human Services for activities of such Office with respect to the Medicaid program.

(3) ANNUAL REPORT.—Not later than 180 days after the end of each fiscal year (beginning with fiscal year 2006), the Inspector General of the Department of Health and Human Services shall submit a report to Congress which identifies—

(A) the use of funds appropriated pursuant to paragraph (1); and

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

(d) NATIONAL EXPANSION OF THE MEDICARE-MEDICAID (MEDI-MEDI) DATA MATCH PILOT PROGRAM.—

(1) REQUIREMENT OF THE MEDICARE INTEGRITY PROGRAM.—Section 1893 of the Social Security Act (42 U.S.C. 1395ddd) is amended—

(A) in subsection (b), by adding at the end the following:

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

(B) by adding at the end the following:

“(g) MEDICARE-MEDICAID DATA MATCH PROGRAM.—

“(1) EXPANSION OF PROGRAM.—

“(A) IN GENERAL.—The Secretary shall enter into contracts with eligible entities 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 title and State Medicaid programs under title XIX for the purpose of—

“(i) identifying program vulnerabilities in the program established under this title and the Medicaid program established under title XIX through the use of computer algorithms to look for payment anomalies (including billing or billing patterns identified with respect to 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

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and Human Services to coordinate appropriate actions to protect the Federal and State share of expenditures under the Medicaid program under title XIX, as well as the program established under this title; and

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

Deadline.

“(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 1903(q)). 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 titles XI and XIX as are necessary to carry out paragraph (1).”

(2) FUNDING.—Section 1817(k)(4) of such Act (42 U.S.C. 1395i(k)(4)), as amended by section 5204 of this Act, is amended—

(A) in subparagraph (A), by striking “subparagraph (B)” and inserting “subparagraphs (B), (C), and (D)”; and

(B) by adding at the end the following:

“(D) EXPANSION OF THE MEDICARE-MEDICAID DATA MATCH PROGRAM.—The amount appropriated under subparagraph (A) for a fiscal year is further increased as follows for purposes of carrying out section 1893(b)(6) for the respective fiscal year:

“(i) \$12,000,000 for fiscal year 2006.

“(ii) \$24,000,000 for fiscal year 2007.

“(iii) \$36,000,000 for fiscal year 2008.

“(iv) \$48,000,000 for fiscal year 2009.

“(v) \$60,000,000 for fiscal year 2010 and each fiscal year thereafter.”

42 USC 1396a  
note.

(e) DELAYED EFFECTIVE DATE FOR CHAPTER.—Except as otherwise provided in this chapter, in the case of a State plan under title XIX of the Social Security Act which the Secretary determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by a provision of this chapter, the State plan shall not be regarded as failing to comply with the requirements of such Act solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature.

**SEC. 6035. ENHANCING THIRD PARTY IDENTIFICATION AND PAYMENT.**

(a) CLARIFICATION OF THIRD PARTIES LEGALLY RESPONSIBLE FOR PAYMENT OF A CLAIM FOR A HEALTH CARE ITEM OR SERVICE.—Section 1902(a)(25) of the Social Security Act (42 U.S.C. 1396a(a)(25)) is amended—

- (1) in subparagraph (A), in the matter preceding clause (i)—
- (A) by inserting “, self-insured plans” after “health insurers”; and
- (B) by striking “and health maintenance organizations” and inserting “managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service”; and
- (2) in subparagraph (G)—
- (A) by inserting “a self-insured plan,” after “1974,”; and
- (B) by striking “and a health maintenance organization” and inserting “a managed care organization, a pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service”.
- (b) REQUIREMENT FOR THIRD PARTIES TO PROVIDE THE STATE WITH COVERAGE ELIGIBILITY AND CLAIMS DATA.—Section 1902(a)(25) of such Act (42 U.S.C. 1396a(a)(25)) is amended—
- (1) in subparagraph (G), by striking “and” at the end;
- (2) in subparagraph (H), by adding “and” after the semicolon at the end; and
- (3) by inserting after subparagraph (H), the following:
- “(I) that the State shall provide assurances satisfactory to the Secretary that the State has in effect laws requiring health insurers, including self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service, as a condition of doing business in the State, to—
- “(i) provide, with respect to individuals who are eligible for, or are provided, medical assistance under the State plan, upon the request of the State, information to determine during what period the individual or their spouses or their dependents may be (or may have been) covered by a health insurer and the nature of the coverage that is or was provided by the health insurer (including the name, address, and identifying number of the plan) in a manner prescribed by the Secretary;
- “(ii) accept the State’s right of recovery and the assignment to the State of any right of an individual or other entity to payment from the party for an item or service for which payment has been made under the State plan;
- “(iii) respond to any inquiry by the State regarding a claim for payment for any health care item or service that is submitted not later than 3 years after the date of the provision of such health care item or service; and
- “(iv) agree not to deny a claim submitted by the State solely on the basis of the date of submission of the claim, the type or format of the claim form,

or a failure to present proper documentation at the point-of-sale that is the basis of the claim, if—

“(I) the claim is submitted by the State within the 3-year period beginning on the date on which the item or service was furnished; and

“(II) any action by the State to enforce its rights with respect to such claim is commenced within 6 years of the State’s submission of such claim;”.

42 USC 1396a  
note.

(c) **EFFECTIVE DATE.**—Except as provided in section 6035(e), the amendments made by this section take effect on January 1, 2006.

**SEC. 6036. IMPROVED ENFORCEMENT OF DOCUMENTATION REQUIREMENTS.**

(a) **IN GENERAL.**—Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended—

(1) in subsection (i), as amended by section 104 of Public Law 109–91—

(A) by striking “or” at the end of paragraph (20);

(B) by striking the period at the end of paragraph (21) and inserting “; or”; and

(C) by inserting after paragraph (21) the following new paragraph:

“(22) with respect to amounts expended for medical assistance for an individual who declares under section 1137(d)(1)(A) to be a citizen or national of the United States for purposes of establishing eligibility for benefits under this title, unless the requirement of subsection (x) is met.”; and

(2) by adding at the end the following new subsection:

“(x)(1) For purposes of subsection (i)(23), the requirement of this subsection is, with respect to an individual declaring to be a citizen or national of the United States, that, subject to paragraph (2), there is presented satisfactory documentary evidence of citizenship or nationality (as defined in paragraph (3)) of the individual.

“(2) The requirement of paragraph (1) shall not apply to an alien who is eligible for medical assistance under this title—

“(A) and is entitled to or enrolled for benefits under any part of title XVIII;

“(B) on the basis of receiving supplemental security income benefits under title XVI; or

“(C) on such other basis as the Secretary may specify under which satisfactory documentary evidence of citizenship or nationality had been previously presented.

“(3)(A) For purposes of this subsection, the term ‘satisfactory documentary evidence of citizenship or nationality’ means—

“(i) any document described in subparagraph (B); or

“(ii) a document described in subparagraph (C) and a document described in subparagraph (D).

“(B) The following are documents described in this subparagraph:

“(i) A United States passport.

“(ii) Form N–550 or N–570 (Certificate of Naturalization).

“(iii) Form N–560 or N–561 (Certificate of United States Citizenship).

“(iv) A valid State-issued driver’s license or other identity document described in section 274A(b)(1)(D) of the Immigration