

104TH CONGRESS  
2D SESSION

# S. 1858

To provide for improved coordination, communication, and enforcement related to health care fraud, waste, and abuse.

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IN THE SENATE OF THE UNITED STATES

JUNE 11, 1996

Mr. GRAHAM (for himself, Mr. BAUCUS, and Mr. PRYOR) introduced the following bill; which was read twice and referred to the Committee on Finance

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## A BILL

To provide for improved coordination, communication, and enforcement related to health care fraud, waste, and abuse.

1 *Be it enacted by the Senate and House of Representa-*  
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; REFERENCES IN ACT; TABLE OF**  
4 **CONTENTS.**

5 (a) SHORT TITLE.—This Act may be cited as the  
6 “Medicare Antifraud Act of 1996”.

7 (b) AMENDMENTS TO SOCIAL SECURITY ACT.—Ex-  
8 cept as otherwise specifically provided, whenever in this  
9 Act an amendment is expressed in terms of an amendment  
10 to, or repeal of, a section or other provision, the reference

1 shall be considered to be made to that section or other  
 2 provision of the Social Security Act.

3 (c) TABLE OF CONTENTS.—The table of contents of  
 4 this Act is as follows:

Sec. 1. Short title; references in act; table of contents.

#### TITLE I—FRAUD AND ABUSE CONTROL PROGRAM

Sec. 101. Fraud and abuse control program.

Sec. 102. Medicare benefit integrity system.

Sec. 103. Application of certain health antifraud and abuse sanctions to fraud  
 and abuse against Federal health programs.

Sec. 104. Health care fraud and abuse provider guidance.

Sec. 105. Medicare/medicaid beneficiary protection program.

Sec. 106. Ensuring the integrity of the Federal Hospital Insurance Trust  
 Fund.

#### TITLE II—REVISIONS TO CURRENT SANCTIONS FOR FRAUD AND ABUSE

Sec. 201. Mandatory exclusion from participation in medicare and State health  
 care programs.

Sec. 202. Establishment of minimum period of exclusion for certain individuals  
 and entities subject to permissive exclusion from medicare and  
 State health care programs.

Sec. 203. Permissive exclusion of individuals with ownership or control interest  
 in sanctioned entities.

Sec. 204. Sanctions against practitioners and persons for failure to comply with  
 statutory obligations.

Sec. 205. Sanctions against providers for excessive fees or prices.

Sec. 206. Applicability of the Bankruptcy Code to program sanctions.

Sec. 207. Intermediate sanctions for medicare health maintenance organiza-  
 tions.

Sec. 208. Liability of medicare carriers and fiscal intermediaries and States for  
 claims submitted by excluded providers.

Sec. 209. Effective date.

#### TITLE III—ADMINISTRATIVE AND MISCELLANEOUS PROVISIONS

Sec. 301. Establishment of the health care fraud and abuse data collection pro-  
 gram.

Sec. 302. Inspector General access to national practitioner data bank.

Sec. 303. Corporate whistleblower program.

Sec. 304. Home health billing, payment, and cost limit calculation to be based  
 on site where service is furnished.

Sec. 305. Application of inherent reasonableness.

Sec. 306. Clarification of time and filing limitations.

Sec. 307. Clarification of liability of third party administrators.

Sec. 308. Clarification of payment amounts to medicare.

Sec. 309. Increased flexibility in contracting for medicare claims processing.

#### TITLE IV—CIVIL MONETARY PENALTIES

Sec. 401. Social Security Act civil monetary penalties.

TITLE V—AMENDMENTS TO CRIMINAL LAW

Sec. 501. Health care fraud.

Sec. 502. Forfeitures for Federal health care offenses.

Sec. 503. Injunctive relief relating to Federal health care offenses.

Sec. 504. Grand jury disclosure.

Sec. 505. False statements.

Sec. 506. Obstruction of criminal investigations, audits, or inspections of Federal health care offenses.

Sec. 507. Theft or embezzlement.

Sec. 508. Laundering of monetary instruments.

Sec. 509. Authorized investigative demand procedures.

TITLE VI—STATE HEALTH CARE FRAUD CONTROL UNITS

Sec. 601. State health care fraud control units.

TITLE VII—MEDICARE/MEDICAID BILLING ABUSE PREVENTION

Sec. 701. Uniform medicare/medicaid application process.

Sec. 702. Standards for uniform claims.

Sec. 703. Unique provider identification code.

Sec. 704. Use of new procedures.

Sec. 705. Nondischargeability of certain medicare debts.

1       **TITLE I—FRAUD AND ABUSE**  
 2               **CONTROL PROGRAM**

3   **SEC. 101. FRAUD AND ABUSE CONTROL PROGRAM.**

4       (a) ESTABLISHMENT OF PROGRAM.—Title XI (42  
 5 U.S.C. 1301 et seq.) is amended by inserting after section  
 6 1128B the following new section:

7               “FRAUD AND ABUSE CONTROL PROGRAM

8               “SEC. 1128C. (a) ESTABLISHMENT OF PROGRAM.—

9               “(1) IN GENERAL.—Not later than January 1,  
 10               1997, the Secretary, acting through the Office of the  
 11               Inspector General of the Department of Health and  
 12               Human Services, and the Attorney General shall es-  
 13               tablish a program—

1           “(A) to coordinate Federal, State, and  
2 local law enforcement programs to control fraud  
3 and abuse with respect to health plans,

4           “(B) to conduct investigations, audits,  
5 evaluations, and inspections relating to the de-  
6 livery of and payment for health care in the  
7 United States,

8           “(C) to facilitate the enforcement of the  
9 provisions of sections 1128, 1128A, and 1128B  
10 and other statutes applicable to health care  
11 fraud and abuse,

12           “(D) to provide for the modification and  
13 establishment of safe harbors and to issue advi-  
14 sory opinions and special fraud alerts pursuant  
15 to section 104 of the Medicare Antifraud Act of  
16 1996, and

17           “(E) to provide for the reporting and dis-  
18 closure of certain final adverse actions against  
19 health care providers, suppliers, or practitioners  
20 pursuant to the data collection system estab-  
21 lished under section 301 of such Act.

22           “(2) COORDINATION WITH HEALTH PLANS.—In  
23 carrying out the program established under para-  
24 graph (1), the Secretary and the Attorney General

1 shall consult with, and arrange for the sharing of  
2 data with representatives of health plans.

3 “(3) GUIDELINES.—

4 “(A) IN GENERAL.—The Secretary and the  
5 Attorney General shall issue guidelines to carry  
6 out the program under paragraph (1). The pro-  
7 visions of sections 553, 556, and 557 of title 5,  
8 United States Code, shall not apply in the issu-  
9 ance of such guidelines.

10 “(B) INFORMATION GUIDELINES.—

11 “(i) IN GENERAL.—Guidelines issued  
12 under subparagraph (A) shall include  
13 guidelines relating to the furnishing of in-  
14 formation by health plans, providers, and  
15 others to enable the Secretary and the At-  
16 torney General to carry out the program  
17 (including coordination with health plans  
18 under paragraph (2)).

19 “(ii) CONFIDENTIALITY.—Guidelines  
20 issued under subparagraph (A) shall in-  
21 clude procedures to assure that such infor-  
22 mation is provided and utilized in a man-  
23 ner that appropriately protects the con-  
24 fidentiality of the information and the pri-

1 vacy of individuals receiving health care  
2 services and items.

3 “(iii) QUALIFIED IMMUNITY FOR PRO-  
4 VIDING INFORMATION.—The provisions of  
5 section 1157(a) (relating to limitation on  
6 liability) shall apply to a person providing  
7 information to the Secretary or the Attor-  
8 ney General in conjunction with their per-  
9 formance of duties under this section.

10 “(4) ENSURING ACCESS TO DOCUMENTATION.—  
11 The Inspector General of the Department of Health  
12 and Human Services is authorized to exercise such  
13 authority described in paragraphs (3) through (9) of  
14 section 6 of the Inspector General Act of 1978 (5  
15 U.S.C. App.) as necessary with respect to the activi-  
16 ties under the fraud and abuse control program es-  
17 tablished under this subsection.

18 “(5) AUTHORITY OF INSPECTOR GENERAL.—  
19 Nothing in this Act shall be construed to diminish  
20 the authority of any Inspector General, including  
21 such authority as is provided in the Inspector Gen-  
22 eral Act of 1978 (5 U.S.C. App.).

23 “(b) ADDITIONAL USE OF FUNDS BY INSPECTOR  
24 GENERAL.—

1           “(1) REIMBURSEMENTS FOR INVESTIGA-  
2           TIONS.—The Inspector General of the Department  
3           of Health and Human Services is authorized to re-  
4           ceive and retain for current use reimbursement for  
5           the costs of conducting investigations and audits and  
6           for monitoring compliance plans when such costs are  
7           ordered by a court, voluntarily agreed to by the  
8           payor, or otherwise.

9           “(2) CREDITING.—Funds received by the In-  
10          spector General under paragraph (1) as reimburse-  
11          ment for costs of conducting investigations shall be  
12          deposited to the credit of the appropriation from  
13          which initially paid, or to appropriations for similar  
14          purposes currently available at the time of deposit,  
15          and shall remain available for obligation for 1 year  
16          from the date of the deposit of such funds.

17          “(c) HEALTH PLAN DEFINED.—For purposes of this  
18          section, the term ‘health plan’ means a plan or program  
19          that provides health benefits, whether directly, through in-  
20          surance, or otherwise, and includes—

21                 “(1) a policy of health insurance;

22                 “(2) a contract of a service benefit organiza-  
23          tion; and

1           “(3) a membership agreement with a health  
2           maintenance organization or other prepaid health  
3           plan.”.

4           (b) ESTABLISHMENT OF HEALTH CARE FRAUD AND  
5 ABUSE CONTROL ACCOUNT IN FEDERAL HOSPITAL IN-  
6 SURANCE TRUST FUND.—Section 1817 (42 U.S.C. 1395i)  
7 is amended by adding at the end the following new sub-  
8 section:

9           “(k) HEALTH CARE FRAUD AND ABUSE CONTROL  
10 ACCOUNT.—

11           “(1) ESTABLISHMENT.—There is hereby estab-  
12           lished in the Trust Fund an expenditure account to  
13           be known as the ‘Health Care Fraud and Abuse  
14           Control Account’ (in this subsection referred to as  
15           the ‘Account’).

16           “(2) APPROPRIATED AMOUNTS TO TRUST  
17 FUND.—

18           “(A) IN GENERAL.—There are hereby ap-  
19           propriated to the Trust Fund—

20                   “(i) such gifts and bequests as may be  
21                   made as provided in subparagraph (B);

22                   “(ii) such amounts as may be depos-  
23                   ited in the Trust Fund as provided in title  
24                   XI; and

1                   “(iii) such amounts as are transferred  
2                   to the Trust Fund under subparagraph  
3                   (C).

4                   “(B) AUTHORIZATION TO ACCEPT GIFTS.—  
5                   The Trust Fund is authorized to accept, on be-  
6                   half of the United States, money gifts and be-  
7                   quests made unconditionally to the Trust Fund,  
8                   for the benefit of the Account or any activity fi-  
9                   nanced through the Account.

10                   “(C) TRANSFER OF AMOUNTS.—The Man-  
11                   aging Trustee shall transfer to the Trust Fund,  
12                   under rules similar to the rules in section 9601  
13                   of the Internal Revenue Code of 1986, an  
14                   amount equal to the sum of the following:

15                   “(i) Criminal fines recovered in cases  
16                   involving a Federal health care offense (as  
17                   defined in section 982(a)(6)(B) of title 18,  
18                   United States Code).

19                   “(ii) Civil monetary penalties and as-  
20                   sessments imposed in health care cases, in-  
21                   cluding amounts recovered under titles XI,  
22                   XVIII, and XIX, and chapter 38 of title  
23                   31, United States Code (except as other-  
24                   wise provided by law).

1           “(iii) Amounts resulting from the for-  
2           feiture of property by reason of a Federal  
3           health care offense.

4           “(iv) Penalties and damages obtained  
5           and otherwise creditable to miscellaneous  
6           receipts of the general fund of the Treas-  
7           ury obtained under sections 3729 through  
8           3733 of title 31, United States Code  
9           (known as the False Claims Act), in cases  
10          involving claims related to the provision of  
11          health care items and services (other than  
12          funds awarded to a relator, for restitution  
13          or otherwise authorized by law).

14           “(3) APPROPRIATED AMOUNTS TO ACCOUNT  
15          FOR FRAUD AND ABUSE CONTROL PROGRAM, ETC.—

16           “(A) DEPARTMENTS OF HEALTH AND  
17          HUMAN SERVICES AND JUSTICE.—

18           “(i) IN GENERAL.—There are hereby  
19          appropriated to the Account from the  
20          Trust Fund such sums as the Secretary  
21          and the Attorney General certify are nec-  
22          essary to carry out the purposes described  
23          in subparagraph (C), to be available with-  
24          out further appropriation, in an amount  
25          not to exceed—

1                   “(I) for fiscal year 1997,  
2                   \$104,000,000;

3                   “(II) for each of the fiscal years  
4                   1998 through 2003, the limit for the  
5                   preceding fiscal year, increased by 15  
6                   percent; and

7                   “(III) for each fiscal year after  
8                   fiscal year 2003, the limit for fiscal  
9                   year 2003.

10                  “(ii) MEDICARE AND MEDICAID AC-  
11                  TIVITIES.—For each fiscal year, of the  
12                  amount appropriated in clause (i), the fol-  
13                  lowing amounts shall be available only for  
14                  the purposes of the activities of the Office  
15                  of the Inspector General of the Depart-  
16                  ment of Health and Human Services with  
17                  respect to the medicare and medicaid pro-  
18                  grams—

19                         “(I) for fiscal year 1997, not less  
20                         than \$60,000,000 and not more than  
21                         \$70,000,000;

22                         “(II) for fiscal year 1998, not  
23                         less than \$80,000,000 and not more  
24                         than \$90,000,000;

1                   “(III) for fiscal year 1999, not  
2                   less than \$90,000,000 and not more  
3                   than \$100,000,000;

4                   “(IV) for fiscal year 2000, not  
5                   less than \$110,000,000 and not more  
6                   than \$120,000,000;

7                   “(V) for fiscal year 2001, not  
8                   less than \$120,000,000 and not more  
9                   than \$130,000,000;

10                  “(VI) for fiscal year 2002, not  
11                  less than \$140,000,000 and not more  
12                  than \$150,000,000; and

13                  “(VII) for each fiscal year after  
14                  fiscal year 2002, not less than  
15                  \$150,000,000 and not more than  
16                  \$160,000,000.

17                  “(B) FEDERAL BUREAU OF INVESTIGA-  
18                  TION.—There are hereby appropriated from the  
19                  general fund of the United States Treasury and  
20                  hereby appropriated to the Account for transfer  
21                  to the Federal Bureau of Investigation to carry  
22                  out the purposes described in subparagraph  
23                  (C), to be available without further appropria-  
24                  tion—

25                  “(i) for fiscal year 1997, \$47,000,000;

1           “(ii) for fiscal year 1998,  
2           \$56,000,000;

3           “(iii) for fiscal year 1999,  
4           \$66,000,000;

5           “(iv) for fiscal year 2000,  
6           \$76,000,000;

7           “(v) for fiscal year 2001,  
8           \$88,000,000;

9           “(vi) for fiscal year 2002,  
10          \$101,000,000; and

11          “(vii) for each fiscal year after fiscal  
12          year 2002, \$114,000,000.

13          “(C) USE OF FUNDS.—The purposes de-  
14          scribed in this subparagraph are to cover the  
15          costs (including equipment, salaries, benefits,  
16          travel, and training) of the administration and  
17          operation of the health care fraud and abuse  
18          control program established under section  
19          1128C(a), including the costs of—

20                 “(i) prosecuting health care matters  
21                 (through criminal, civil, and administrative  
22                 proceedings);

23                 “(ii) investigations;

24                 “(iii) financial and performance audits  
25                 of health care programs and operations;

1           “(iv) inspections and other evalua-  
2           tions; and

3           “(v) provider and consumer education  
4           regarding compliance with the provisions of  
5           title XI.

6           “(4) APPROPRIATED AMOUNTS TO ACCOUNT  
7           FOR MEDICARE BENEFIT INTEGRITY SYSTEM.—

8           “(A) IN GENERAL.—There are hereby ap-  
9           propriated to the Account from the Trust Fund  
10          for each fiscal year such amounts as are nec-  
11          essary to carry out the Medicare Benefit Integ-  
12          rity System under section 1889, subject to sub-  
13          paragraph (B), to be available without further  
14          appropriation.

15          “(B) AMOUNTS SPECIFIED.—The amount  
16          appropriated under subparagraph (A) for a fis-  
17          cal year is as follows:

18               “(i) For fiscal year 1997, such  
19               amount shall be not less than  
20               \$430,000,000 and not more than  
21               \$440,000,000.

22               “(ii) For fiscal year 1998, such  
23               amount shall be not less than  
24               \$490,000,000 and not more than  
25               \$500,000,000.

1           “(iii) For fiscal year 1999, such  
2           amount shall be not less than  
3           \$550,000,000 and not more than  
4           \$560,000,000.

5           “(iv) For fiscal year 2000, such  
6           amount shall be not less than  
7           \$620,000,000 and not more than  
8           \$630,000,000.

9           “(v) For fiscal year 2001, such  
10          amount shall be not less than  
11          \$670,000,000 and not more than  
12          \$680,000,000.

13          “(vi) For fiscal year 2002, such  
14          amount shall be not less than  
15          \$690,000,000 and not more than  
16          \$700,000,000.

17          “(vii) For each fiscal year after fiscal  
18          year 2002, such amount shall be not less  
19          than \$710,000,000 and not more than  
20          \$720,000,000.

21                 “(5) ANNUAL REPORT.—The Secretary and the  
22          Attorney General shall submit jointly an annual re-  
23          port to Congress on the amount of revenue which is  
24          generated and disbursed, and the justification for

1 such disbursements, by the Account in each fiscal  
2 year.”.

3 **SEC. 102. MEDICARE BENEFIT INTEGRITY SYSTEM.**

4 Part C of title XVIII (42 U.S.C. 1395 et seq.) is  
5 amended by inserting after section 1888 the following new  
6 section:

7 “MEDICARE BENEFIT INTEGRITY CONTRACTS

8 “SEC. 1889. (a) AUTHORITY TO CONTRACT.—

9 “(1) IN GENERAL.—In order to improve the ef-  
10 fectiveness of benefit quality assurance activities re-  
11 lating to programs under this title, and to enhance  
12 the Secretary’s capability of carrying out program  
13 safeguard functions and related education activities  
14 to avoid the improper expenditure of assets of the  
15 Federal Hospital Insurance Trust Fund and the  
16 Federal Supplementary Medical Insurance Trust  
17 Fund, the Secretary shall enter into contracts with  
18 organizations or other entities having demonstrated  
19 the capability to carry out one or more benefit qual-  
20 ity assurance activities. The provisions of sections  
21 1816 and 1842 shall be inapplicable to contracts  
22 under this section.

23 “(2) NUMBER OF CONTRACTS.—The Secretary  
24 shall determine the number of separate contracts  
25 which are necessary to achieve, with the maximum  
26 degree of efficiency and cost-effectiveness, the objec-

1 tives of this section. The Secretary may enter into  
2 contracts under this section at such time or times as  
3 are appropriate so long as not later than the fiscal  
4 year beginning October 1, 1998, and for each fiscal  
5 year thereafter, there are in effect contracts that,  
6 considered collectively, provide for benefit quality as-  
7 surance activities with respect to all payments under  
8 this title.

9 “(b) CONTRACT REQUIREMENTS.—A benefit quality  
10 assurance contract entered into under subsection (a) must  
11 provide for one or more benefit quality assurance program  
12 activities. Each such contract shall include an agreement  
13 by the contractor to cooperate with the Inspector General  
14 of the Department of Health and Human Services, and  
15 the Attorney General, and other law enforcement agencies,  
16 as appropriate, in the investigation and deterrence of  
17 fraud and abuse in relation to this title and in other cases  
18 arising out of the activities described in such section, and  
19 shall contain such other provisions as the Secretary finds  
20 necessary or appropriate to achieve the purposes of this  
21 part. The provisions of section 1153(e)(1) shall apply to  
22 contracts and contracting authority under this section, ex-  
23 cept that competitive procedures must be used when enter-  
24 ing into new contracts under this section, or at any other  
25 time when it is in the best interests of the United States.

1 A contract under this section may be renewed from term  
2 to term without regard to any provision of law requiring  
3 competition if the contractor has met or exceeded the per-  
4 formance requirements established in the current contract.

5 “(c) LIMITATIONS.—

6 “(1) IN GENERAL.—In carrying out this sec-  
7 tion, the Secretary may not enter into a contract  
8 with an organization or other entity if the Secretary  
9 determines that such organization’s or entity’s finan-  
10 cial holdings, interests, or relationships would inter-  
11 fere with its ability to perform the functions to be  
12 required by the contract in an effective and impar-  
13 tial manner.

14 “(2) LIMITATION OF LIABILITY.—The Sec-  
15 retary shall by regulation provide for the limitation  
16 of a contractor’s liability for actions taken to carry  
17 out a contract under this section, and such regula-  
18 tions shall, to the extent the Secretary finds appro-  
19 priate, employ the same or comparable standards  
20 and other substantive and procedural provisions as  
21 are contained in section 1157.”.

1 **SEC. 103. APPLICATION OF CERTAIN HEALTH ANTIFRAUD**  
2 **AND ABUSE SANCTIONS TO FRAUD AND**  
3 **ABUSE AGAINST FEDERAL HEALTH PRO-**  
4 **GRAMS.**

5 (a) CRIMES.—

6 (1) SOCIAL SECURITY ACT.—Section 1128B (42  
7 U.S.C. 1320a–7b) is amended as follows:

8 (A) In the heading, by striking “MEDICARE  
9 OR STATE HEALTH CARE PROGRAMS” and in-  
10 serting “FEDERAL HEALTH CARE PROGRAMS”.

11 (B) In subsection (a)(1), by striking “a  
12 program under title XVIII or a State health  
13 care program (as defined in section 1128(h))”  
14 and inserting “a Federal health care program  
15 (as defined in subsection (f))”.

16 (C) In subsection (a)(5), by striking “a  
17 program under title XVIII or a State health  
18 care program” and inserting “a Federal health  
19 care program (as defined in subsection (f))”.

20 (D) In the second sentence of subsection  
21 (a)—

22 (i) by striking “a State plan approved  
23 under title XIX” and inserting “a Federal  
24 health care program (as defined in sub-  
25 section (f))”; and

1           (ii) by striking “the State may at its  
2 option (notwithstanding any other provi-  
3 sion of that title or of such plan)” and in-  
4 serting “the administrator of such program  
5 may at its option (notwithstanding any  
6 other provision of such program)”.

7 (E) In subsection (b)—

8           (i) by striking “and willfully” each  
9 place it appears;

10           (ii) by striking “\$25,000” each place  
11 it appears and inserting “\$50,000”;

12           (iii) by striking “title XVIII or a  
13 State health care program” each place it  
14 appears and inserting “Federal health care  
15 program (as defined in subsection (f))”;

16           (iv) in paragraph (1) in the matter  
17 preceding subparagraph (A), by striking  
18 “kind—” and inserting “kind with intent  
19 to be influenced—”;

20           (v) in paragraph (1)(A), by striking  
21 “in return for referring” and inserting “to  
22 refer”;

23           (vi) in paragraph (1)(B), by striking  
24 “in return for purchasing, leasing, order-  
25 ing, or arranging for or recommending”

1 and inserting “to purchase, lease, order, or  
2 arrange for or recommend”;

3 (vii) in paragraph (2) in the matter  
4 preceding subparagraph (A), by striking  
5 “to induce such person” and inserting  
6 “with intent to influence such person”;

7 (viii) by adding at the end of para-  
8 graphs (1) and (2) the following sentence:  
9 “A violation exists under this paragraph if  
10 one or more purposes of the remuneration  
11 is unlawful under this paragraph.”;

12 (ix) by redesignating paragraph (3) as  
13 paragraph (4);

14 (x) in paragraph (4) (as redesignated)  
15 in the matter preceding subparagraph (A),  
16 by striking “Paragraphs (1) and (2)” and  
17 inserting “Paragraphs (1), (2), and (3)”;  
18 and

19 (xi) by inserting after paragraph (2)  
20 the following new paragraph:

21 “(3)(A) The Attorney General may bring an action  
22 in the district courts to impose upon any person who car-  
23 ries out any activity in violation of this subsection a civil  
24 penalty of not less than \$25,000 and not more than

1 \$50,000 for each such violation, plus three times the total  
2 remuneration offered, paid, solicited, or received.

3 “(B) A violation exists under this paragraph if one  
4 or more purposes of the remuneration is unlawful, and the  
5 damages shall be the full amount of such remuneration.

6 “(C) Section 3731 of title 31, United States Code,  
7 and the Federal Rules of Civil Procedure shall apply to  
8 actions brought under this paragraph.

9 “(D) The provisions of this paragraph do not affect  
10 the availability of other criminal and civil remedies for  
11 such violations.”.

12 (F) In subsection (e), by inserting “(as de-  
13 fined in section 1128(h))” after “a State health  
14 care program”.

15 (G) By adding at the end the following  
16 new subsections:

17 “(f) For purposes of this section, the term ‘Federal  
18 health care program’ means—

19 “(1) any plan or program that provides health  
20 benefits, whether directly, through insurance, or oth-  
21 erwise, which is funded, in whole or in part, by the  
22 United States Government; or

23 “(2) any State health care program, as defined  
24 in section 1128(h).

1       “(g)(1) The Inspector General of the departments  
2 and agencies with a Federal health care program may con-  
3 duct an investigation or audit relating to violations of this  
4 section and claims within the jurisdiction of other Federal  
5 departments or agencies if the following conditions are  
6 satisfied:

7           “(A) The investigation or audit involves pri-  
8 marily claims submitted to the Federal health care  
9 programs of the department or agency conducting  
10 the investigation or audit.

11          “(B) The Inspector General of the department  
12 or agency conducting the investigation or audit gives  
13 notice and an opportunity to participate in the inves-  
14 tigation or audit to the Inspector General of the de-  
15 partment or agency with primary jurisdiction over  
16 the Federal health care programs to which the  
17 claims were submitted.

18       “(2) If the conditions specified in paragraph (1) are  
19 fulfilled, the Inspector General of the department or agen-  
20 cy conducting the investigation or audit may exercise all  
21 powers granted under the Inspector General Act of 1978  
22 (5 U.S.C. App.) with respect to the claims submitted to  
23 the other departments or agencies to the same manner  
24 and extent as provided in that Act with respect to claims  
25 submitted to such departments or agencies.”.

1           (2) IDENTIFICATION OF COMMUNITY SERVICE  
 2 OPPORTUNITIES.—Section 1128B (42 U.S.C.  
 3 1320a–7b), as amended by paragraph (1), is amend-  
 4 ed by adding at the end the following new sub-  
 5 section:

6           “(h) The Secretary may—

7                 “(1) in consultation with State and local health  
 8 care officials, identify opportunities for the satisfac-  
 9 tion of community service obligations that a court  
 10 may impose upon the conviction of an offense under  
 11 this section; and

12                 “(2) make information concerning such oppor-  
 13 tunities available to Federal and State law enforce-  
 14 ment officers and State and local health care offi-  
 15 cials.”.

16           (b) EFFECTIVE DATE.—The amendments made by  
 17 this section shall take effect on January 1, 1997.

18 **SEC. 104. HEALTH CARE FRAUD AND ABUSE PROVIDER**

19 **GUIDANCE.**

20           (a) SOLICITATION AND PUBLICATION OF MODIFICA-  
 21 TIONS TO EXISTING SAFE HARBORS AND NEW SAFE  
 22 HARBORS.—

23                 (1) IN GENERAL.—

24                         (A) SOLICITATION OF PROPOSALS FOR  
 25 SAFE HARBORS.—Not later than January 1,

1 1997, and not less than annually thereafter, the  
2 Secretary shall publish a notice in the Federal  
3 Register soliciting proposals, which will be ac-  
4 cepted during a 60-day period, for—

5 (i) modifications to existing safe har-  
6 bors issued pursuant to section 14(a) of  
7 the Medicare Patient and Program Protec-  
8 tion Act of 1987 (42 U.S.C. 1320a–7b  
9 note);

10 (ii) additional safe harbors specifying  
11 payment practices that shall not be treated  
12 as a criminal offense under section  
13 1128B(b) of the Social Security Act (42  
14 U.S.C. 1320a–7b(b)) and shall not serve  
15 as the basis for an exclusion under section  
16 1128(b)(7) of such Act (42 U.S.C. 1320a–  
17 7(b)(7));

18 (iii) interpretive rulings to be issued  
19 pursuant to subsection (b); and

20 (iv) special fraud alerts to be issued  
21 pursuant to subsection (c).

22 (B) PUBLICATION OF PROPOSED MODI-  
23 FICATIONS AND PROPOSED ADDITIONAL SAFE  
24 HARBORS.—After considering the proposals de-  
25 scribed in clauses (i) and (ii) of subparagraph

1 (A), the Secretary, in consultation with the At-  
2 torney General, shall publish in the Federal  
3 Register proposed modifications to existing safe  
4 harbors and proposed additional safe harbors, if  
5 appropriate, with a 60-day comment period.  
6 After considering any public comments received  
7 during this period, the Secretary shall issue  
8 final rules modifying the existing safe harbors  
9 and establishing new safe harbors, as appro-  
10 priate.

11 (C) REPORT.—The Inspector General of  
12 the Department of Health and Human Services  
13 (in this section referred to as the “Inspector  
14 General”) shall, in an annual report to Con-  
15 gress or as part of the year-end semiannual re-  
16 port required by section 5 of the Inspector Gen-  
17 eral Act of 1978 (5 U.S.C. App.), describe the  
18 proposals received under clauses (i) and (ii) of  
19 subparagraph (A) and explain which proposals  
20 were included in the publication described in  
21 subparagraph (B), which proposals were not in-  
22 cluded in that publication, and the reasons for  
23 the rejection of the proposals that were not in-  
24 cluded.

1           (2) CRITERIA FOR MODIFYING AND ESTABLISH-  
2           ING SAFE HARBORS.—In modifying and establishing  
3           safe harbors under paragraph (1)(B), the Secretary  
4           may consider the extent to which providing a safe  
5           harbor for the specified payment practice may result  
6           in any of the following:

7                   (A) An increase or decrease in access to  
8                   health care services.

9                   (B) An increase or decrease in the quality  
10                  of health care services.

11                  (C) An increase or decrease in patient free-  
12                  dom of choice among health care providers.

13                  (D) An increase or decrease in competition  
14                  among health care providers.

15                  (E) An increase or decrease in the ability  
16                  of health care facilities to provide services in  
17                  medically underserved areas or to medically un-  
18                  derserved populations.

19                  (F) An increase or decrease in the cost to  
20                  Federal health care programs (as defined in  
21                  section 1128B(f) of the Social Security Act (42  
22                  U.S.C. 1320a–7b(f)).

23                  (G) An increase or decrease in the poten-  
24                  tial overutilization of health care services.

1 (H) The existence or nonexistence of any  
2 potential financial benefit to a health care pro-  
3 fessional or provider which may vary based on  
4 their decisions of—

5 (i) whether to order a health care  
6 item or service; or

7 (ii) whether to arrange for a referral  
8 of health care items or services to a par-  
9 ticular practitioner or provider.

10 (I) Any other factors the Secretary deems  
11 appropriate in the interest of preventing fraud  
12 and abuse in Federal health care programs (as  
13 so defined).

14 (b) INTERPRETIVE RULINGS.—

15 (1) IN GENERAL.—

16 (A) REQUEST FOR INTERPRETIVE RUL-  
17 ING.—Any person may present, at any time, a  
18 request to the Inspector General for a state-  
19 ment of the Inspector General’s current inter-  
20 pretation of the meaning of a specific aspect of  
21 the application of sections 1128A and 1128B of  
22 the Social Security Act (42 U.S.C. 1320a–7a  
23 and 1320a–7b) (in this section referred to as an  
24 “interpretive ruling”).

1 (B) ISSUANCE AND EFFECT OF INTERPRE-  
2 TIVE RULING.—

3 (i) IN GENERAL.—If appropriate, the  
4 Inspector General shall in consultation  
5 with the Attorney General, issue an inter-  
6 pretive ruling not later than 120 days after  
7 receiving a request described in subpara-  
8 graph (A). Interpretive rulings shall not  
9 have the force of law and shall be treated  
10 as an interpretive rule within the meaning  
11 of section 553(b) of title 5, United States  
12 Code. All interpretive rulings issued pursu-  
13 ant to this clause shall be published in the  
14 Federal Register or otherwise made avail-  
15 able for public inspection.

16 (ii) REASONS FOR DENIAL.—If the In-  
17 spector General does not issue an interpre-  
18 tive ruling in response to a request de-  
19 scribed in subparagraph (A), the Inspector  
20 General shall notify the requesting party of  
21 such decision not later than 120 days after  
22 receiving such a request and shall identify  
23 the reasons for such decision.

24 (2) CRITERIA FOR INTERPRETIVE RULINGS.—

1 (A) IN GENERAL.—In determining whether  
2 to issue an interpretive ruling under paragraph  
3 (1)(B), the Inspector General may consider—

4 (i) whether and to what extent the re-  
5 quest identifies an ambiguity within the  
6 language of the statute, the existing safe  
7 harbors, or previous interpretive rulings;  
8 and

9 (ii) whether the subject of the re-  
10 quested interpretive ruling can be ade-  
11 quately addressed by interpretation of the  
12 language of the statute, the existing safe  
13 harbor rules, or previous interpretive rul-  
14 ings, or whether the request would require  
15 a substantive ruling (as defined in section  
16 552 of title 5, United States Code) not au-  
17 thorized under this subsection.

18 (B) NO RULINGS ON FACTUAL ISSUES.—

19 The Inspector General shall not give an inter-  
20 pretive ruling on any factual issue, including  
21 the intent of the parties or the fair market  
22 value of particular leased space or equipment.

23 (c) SPECIAL FRAUD ALERTS.—

24 (1) IN GENERAL.—

1           (A) REQUEST FOR SPECIAL FRAUD  
2 ALERTS.—Any person may present, at any  
3 time, a request to the Inspector General for a  
4 notice which informs the public of practices  
5 which the Inspector General considers to be  
6 suspect or of particular concern under section  
7 1128B(b) of the Social Security Act (42 U.S.C.  
8 1320a–7b(b)) (in this subsection referred to as  
9 a “special fraud alert”).

10           (B) ISSUANCE AND PUBLICATION OF SPE-  
11 CIAL FRAUD ALERTS.—Upon receipt of a re-  
12 quest described in subparagraph (A), the In-  
13 spector General shall investigate the subject  
14 matter of the request to determine whether a  
15 special fraud alert should be issued. If appro-  
16 priate, the Inspector General shall issue a spe-  
17 cial fraud alert in response to the request. All  
18 special fraud alerts issued pursuant to this sub-  
19 paragraph shall be published in the Federal  
20 Register.

21           (2) CRITERIA FOR SPECIAL FRAUD ALERTS.—  
22 In determining whether to issue a special fraud alert  
23 upon a request described in paragraph (1), the In-  
24 spector General may consider—

1 (A) whether and to what extent the prac-  
2 tices that would be identified in the special  
3 fraud alert may result in any of the con-  
4 sequences described in subsection (a)(2); and

5 (B) the volume and frequency of the con-  
6 duct that would be identified in the special  
7 fraud alert.

8 **SEC. 105. MEDICARE/MEDICAID BENEFICIARY PROTECTION**  
9 **PROGRAM.**

10 (a) ESTABLISHMENT OF PROGRAM.—Not later than  
11 January 1, 1997, the Secretary (through the Adminis-  
12 trator of the Health Care Financing Administration and  
13 the Inspector General of the Department of Health and  
14 Human Services) shall establish the Medicare/Medicaid  
15 Beneficiary Protection Program. Under such program the  
16 Secretary shall—

17 (1) educate medicare and medicaid beneficiaries  
18 regarding—

19 (A) medicare and medicaid program cov-  
20 erage;

21 (B) fraudulent and abusive practices;

22 (C) medically unnecessary health care  
23 items and services; and

24 (D) substandard health care items and  
25 services;



1 XVIII of the Social Security Act (42 U.S.C. 1395 et  
2 seq.) to combat health care waste, fraud, and abuse,  
3 which do not relate to the administration of the  
4 medicare program; and

5 (2) the amount of funds deposited into such ac-  
6 count of such trust fund during such fiscal year that  
7 were attributable to enforcement activities that were  
8 intended to combat health care waste, fraud, and  
9 abuse, which do not relate to the administration of  
10 the medicare program.

11 (b) CERTIFICATION.—If the portion determined  
12 under paragraph (1) of subsection (a) exceeds the amount  
13 determined under paragraph (2) of such subsection, the  
14 Secretary and the Attorney General shall certify to the  
15 Secretary of the Treasury the amount, which shall be  
16 equal to the amount of such excess, which should be trans-  
17 ferred from the General Fund of the Treasury to such  
18 trust fund, in order to ensure that such trust fund is fully  
19 reimbursed for any expenditures made from the account  
20 described in subsection (a) that are not related to the ad-  
21 ministration of the medicare program under title XVIII  
22 of the Social Security Act.

23 (c) TRANSFER OF FUNDS.—The Secretary of the  
24 Treasury shall transfer to such trust fund from the Gen-  
25 eral Fund of the Treasury, out of any funds in the General

1 Fund that are not otherwise appropriated, an amount  
2 equal to the amount certified under subsection (b).

3 **TITLE II—REVISIONS TO CUR-**  
4 **RENT SANCTIONS FOR FRAUD**  
5 **AND ABUSE**

6 **SEC. 201. MANDATORY EXCLUSION FROM PARTICIPATION**  
7 **IN MEDICARE AND STATE HEALTH CARE PRO-**  
8 **GRAMS.**

9 (a) INDIVIDUAL CONVICTED OF FELONY RELATING  
10 TO HEALTH CARE FRAUD.—

11 (1) IN GENERAL.—Section 1128(a) (42 U.S.C.  
12 1320a-7(a)) is amended by adding at the end the  
13 following new paragraph:

14 “(3) FELONY CONVICTION RELATING TO  
15 HEALTH CARE FRAUD.—Any individual or entity  
16 that has been convicted after the date of the enact-  
17 ment of the Medicare Antifraud Act of 1996, under  
18 Federal or State law, in connection with the delivery  
19 of a health care item or service or with respect to  
20 any act or omission in a health care program (other  
21 than those specifically described in paragraph (1))  
22 operated by or financed in whole or in part by any  
23 Federal, State, or local government agency, of a  
24 criminal offense consisting of a felony relating to

1 fraud, theft, embezzlement, breach of fiduciary re-  
2 sponsibility, or other financial misconduct.”.

3 (2) CONFORMING AMENDMENT.—Paragraph (1)  
4 of section 1128(b) (42 U.S.C. 1320a–7(b)) is  
5 amended to read as follows:

6 “(1) CONVICTION RELATING TO FRAUD.—Any  
7 individual or entity that has been convicted after the  
8 date of the enactment of the Medicare Antifraud Act  
9 of 1996, under Federal or State law—

10 “(A) of a criminal offense consisting of a  
11 misdemeanor relating to fraud, theft, embezzle-  
12 ment, breach of fiduciary responsibility, or  
13 other financial misconduct—

14 “(i) in connection with the delivery of  
15 a health care item or service, or

16 “(ii) with respect to any act or omis-  
17 sion in a health care program (other than  
18 those specifically described in subsection  
19 (a)(1)) operated by or financed in whole or  
20 in part by any Federal, State, or local gov-  
21 ernment agency; or

22 “(B) of a criminal offense relating to  
23 fraud, theft, embezzlement, breach of fiduciary  
24 responsibility, or other financial misconduct  
25 with respect to any act or omission in a pro-

1           gram (other than a health care program) oper-  
2           ated by or financed in whole or in part by any  
3           Federal, State, or local government agency.”.

4           (b) INDIVIDUAL CONVICTED OF FELONY RELATING  
5 TO CONTROLLED SUBSTANCE.—

6           (1) IN GENERAL.—Section 1128(a) (42 U.S.C.  
7           1320a-7(a)), as amended by subsection (a), is  
8           amended by adding at the end the following new  
9           paragraph:

10           “(4) FELONY CONVICTION RELATING TO CON-  
11           TROLLED SUBSTANCE.—Any individual or entity  
12           that has been convicted after the date of the enact-  
13           ment of the Medicare Antifraud Act of 1996, under  
14           Federal or State law, of a criminal offense consisting  
15           of a felony relating to the unlawful manufacture,  
16           distribution, prescription, or dispensing of a con-  
17           trolled substance.”.

18           (2) CONFORMING AMENDMENT.—Section  
19           1128(b)(3) (42 U.S.C. 1320a-7(b)(3)) is amended—

20           (A) in the heading, by striking “CONVIC-  
21           TION” and inserting “MISDEMEANOR CONVIC-  
22           TION”; and

23           (B) by striking “criminal offense” and in-  
24           serting “criminal offense consisting of a mis-  
25           demeanor”.

1 **SEC. 202. ESTABLISHMENT OF MINIMUM PERIOD OF EX-**  
2 **CLUSION FOR CERTAIN INDIVIDUALS AND**  
3 **ENTITIES SUBJECT TO PERMISSIVE EXCLU-**  
4 **SION FROM MEDICARE AND STATE HEALTH**  
5 **CARE PROGRAMS.**

6 Section 1128(c)(3) (42 U.S.C. 1320a-7(e)(3)) is  
7 amended by adding at the end the following new subpara-  
8 graphs:

9 “(D) In the case of an exclusion of an individual or  
10 entity under paragraph (1), (2), or (3) of subsection (b),  
11 the period of the exclusion shall be 3 years, unless the  
12 Secretary determines in accordance with published regula-  
13 tions that a shorter period is appropriate because of miti-  
14 gating circumstances or that a longer period is appro-  
15 priate because of aggravating circumstances.

16 “(E) In the case of an exclusion of an individual or  
17 entity under paragraph (4) or (5) of subsection (b), the  
18 period of the exclusion shall not be less than the period  
19 during which the individual’s or entity’s license to provide  
20 health care is revoked, suspended, or surrendered, or the  
21 individual or the entity is excluded or suspended from a  
22 Federal or State health care program.

23 “(F) In the case of an exclusion of an individual or  
24 entity under subsection (b)(6)(B), the period of the exclu-  
25 sion shall be not less than 1 year.”.

1 **SEC. 203. PERMISSIVE EXCLUSION OF INDIVIDUALS WITH**  
 2 **OWNERSHIP OR CONTROL INTEREST IN**  
 3 **SANCTIONED ENTITIES.**

4 Section 1128(b) (42 U.S.C. 1320a–7(b)) is amended  
 5 by adding at the end the following new paragraph:

6 “(15) INDIVIDUALS CONTROLLING A SANC-  
 7 TIONED ENTITY.—Any individual who has a direct  
 8 or indirect ownership or control interest of 5 percent  
 9 or more, or an ownership or control interest (as de-  
 10 fined in section 1124(a)(3)) in, or who is an officer  
 11 or managing employee (as defined in section  
 12 1126(b)) of, an entity—

13 “(A) that has been convicted of any of-  
 14 fense described in subsection (a) or in para-  
 15 graph (1), (2), or (3) of this subsection; or

16 “(B) that has been excluded from partici-  
 17 pation under a program under title XVIII or  
 18 under a State health care program (as defined  
 19 in subsection (h)).”.

20 **SEC. 204. SANCTIONS AGAINST PRACTITIONERS AND PER-**  
 21 **SONS FOR FAILURE TO COMPLY WITH STATU-**  
 22 **TORY OBLIGATIONS.**

23 (a) MINIMUM PERIOD OF EXCLUSION FOR PRACTI-  
 24 TIONERS AND PERSONS FAILING TO MEET STATUTORY  
 25 OBLIGATIONS.—

1           (1) IN GENERAL.—The second sentence of sec-  
 2           tion 1156(b)(1) (42 U.S.C. 1320e–5(b)(1)) is  
 3           amended by striking “may prescribe)” and inserting  
 4           “may prescribe, except that such period may not be  
 5           less than 1 year)”.

6           (2) CONFORMING AMENDMENT.—Section  
 7           1156(b)(2) (42 U.S.C. 1320e–5(b)(2)) is amended  
 8           by striking “shall remain” and inserting “shall (sub-  
 9           ject to the minimum period specified in the second  
 10          sentence of paragraph (1)) remain”.

11          (b) REPEAL OF “UNWILLING OR UNABLE” CONDI-  
 12          TION FOR IMPOSITION OF SANCTION.—Section 1156(b)(1)  
 13          (42 U.S.C. 1320e–5(b)(1)) is amended—

14                 (1) in the second sentence, by striking “and de-  
 15                 termines” and all that follows through “such obliga-  
 16                 tions,”; and

17                 (2) by striking the third sentence.

18          **SEC. 205. SANCTIONS AGAINST PROVIDERS FOR EXCESSIVE**

19                         **FEES OR PRICES.**

20          Section 1128(b)(6)(A) (42 U.S.C. 1320a–7(b)(6)(A))  
 21          is amended—

22                 (1) by inserting “(as specified by the Secretary  
 23                 in regulations)” after “substantially in excess of  
 24                 such individual’s or entity’s usual charges”; and

1           (2) by striking “(or, in applicable cases, sub-  
2           stantially in excess of such individual’s or entity’s  
3           costs)” and inserting “, costs or fees”.

4 **SEC. 206. APPLICABILITY OF THE BANKRUPTCY CODE TO**  
5 **PROGRAM SANCTIONS.**

6           (a) EXCLUSION OF INDIVIDUALS AND ENTITIES  
7 FROM PARTICIPATION IN FEDERAL HEALTH CARE PRO-  
8 GRAMS.—Section 1128 (42 U.S.C. 1320a–7) is amended  
9 by adding at the end the following new subsection:

10           “(j) APPLICABILITY OF BANKRUPTCY PROVISIONS.—  
11 An exclusion imposed under this section is not subject to  
12 the automatic stay imposed under section 362 of title 11,  
13 United States Code.”.

14           (b) CIVIL MONETARY PENALTIES.—Section  
15 1128A(a) (42 U.S.C. 1320a–7a(a)) is amended by adding  
16 at the end the following sentence: “An exclusion imposed  
17 under this subsection is not subject to the automatic stay  
18 imposed under section 362 of title 11, United States Code,  
19 and any penalties and assessments imposed under this sec-  
20 tion shall be nondischargeable under the provisions of such  
21 title.”.

22           (c) OFFSET OF PAYMENTS TO INDIVIDUALS.—Sec-  
23 tion 1892(a)(4) (42 U.S.C. 1395ccc(a)(4)) is amended by  
24 adding at the end the following sentence: “An exclusion  
25 imposed under paragraph (2)(C)(ii) or paragraph (3)(B)

1 is not subject to the automatic stay imposed under section  
2 362 of title 11, United States Code.”.

3 **SEC. 207. INTERMEDIATE SANCTIONS FOR MEDICARE**  
4 **HEALTH MAINTENANCE ORGANIZATIONS.**

5 (a) APPLICATION OF INTERMEDIATE SANCTIONS FOR  
6 PROGRAM VIOLATIONS.—

7 (1) IN GENERAL.—Section 1876(i)(1) (42  
8 U.S.C. 1395mm(i)(1)) is amended by striking “the  
9 Secretary may terminate” and all that follows and  
10 inserting “in accordance with procedures established  
11 under paragraph (9), the Secretary may at any time  
12 terminate any such contract or may impose the in-  
13 termediate sanctions described in paragraph (6)(B)  
14 or (6)(C) (whichever is applicable) on the eligible or-  
15 ganization if the Secretary determines that the orga-  
16 nization—

17 “(A) has failed substantially to carry out  
18 the contract;

19 “(B) is carrying out the contract in a man-  
20 ner substantially inconsistent with the efficient  
21 and effective administration of this section; or

22 “(C) no longer substantially meets the ap-  
23 plicable conditions of subsections (b), (c), (e),  
24 and (f).”.

1           (2) OTHER INTERMEDIATE SANCTIONS FOR  
2 MISCELLANEOUS PROGRAM VIOLATIONS.—Section  
3 1876(i)(6) (42 U.S.C. 1395mm(i)(6)) is amended by  
4 adding at the end the following new subparagraph:  
5       “(C) In the case of an eligible organization for which  
6 the Secretary makes a determination under paragraph (1),  
7 the basis of which is not described in subparagraph (A),  
8 the Secretary may apply the following intermediate sanc-  
9 tions:

10           “(i) Civil money penalties of not more than  
11 \$25,000 for each determination under paragraph (1)  
12 if the deficiency that is the basis of the determina-  
13 tion has directly adversely affected (or has the sub-  
14 stantial likelihood of adversely affecting) an individ-  
15 ual covered under the organization’s contract.

16           “(ii) Civil money penalties of not more than  
17 \$10,000 for each week beginning after the initiation  
18 of procedures by the Secretary under paragraph (9)  
19 during which the deficiency that is the basis of a de-  
20 termination under paragraph (1) exists.

21           “(iii) Suspension of enrollment of individuals  
22 under this section after the date the Secretary noti-  
23 fies the organization of a determination under para-  
24 graph (1) and until the Secretary is satisfied that

1 the deficiency that is the basis for the determination  
2 has been corrected and is not likely to recur.”.

3 (3) PROCEDURES FOR IMPOSING SANCTIONS.—

4 Section 1876(i) (42 U.S.C. 1395mm(i)) is amended  
5 by adding at the end the following new paragraph:

6 “(9) The Secretary may terminate a contract with an  
7 eligible organization under this section or may impose the  
8 intermediate sanctions described in paragraph (6) on the  
9 organization in accordance with formal investigation and  
10 compliance procedures established by the Secretary under  
11 which—

12 “(A) the Secretary first provides the organiza-  
13 tion with the reasonable opportunity to develop and  
14 implement a corrective action plan to correct the de-  
15 ficiencies that were the basis of the Secretary’s de-  
16 termination under paragraph (1) and the organiza-  
17 tion fails to develop or implement such a plan;

18 “(B) in deciding whether to impose sanctions,  
19 the Secretary considers aggravating factors such as  
20 whether an entity has a history of deficiencies or has  
21 not taken action to correct deficiencies the Secretary  
22 has brought to their attention;

23 “(C) there are no unreasonable or unnecessary  
24 delays between the finding of a deficiency and the  
25 imposition of sanctions; and

1           “(D) the Secretary provides the organization  
2 with reasonable notice and opportunity for hearing  
3 (including the right to appeal an initial decision) be-  
4 fore imposing any sanction or terminating the con-  
5 tract.”.

6           (4) CONFORMING AMENDMENTS.—Section  
7 1876(i)(6)(B) (42 U.S.C. 1395mm(i)(6)(B)) is  
8 amended by striking the second sentence.

9           (b) AGREEMENTS WITH PEER REVIEW ORGANIZA-  
10 TIONS.—

11           (1) REQUIREMENT FOR WRITTEN AGREE-  
12 MENT.—Section 1876(i)(7)(A) (42 U.S.C.  
13 1395mm(i)(7)(A)) is amended by striking “an agree-  
14 ment” and inserting “a written agreement”.

15           (2) DEVELOPMENT OF MODEL AGREEMENT.—  
16 Not later than July 1, 1997, the Secretary shall de-  
17 velop a model of the agreement that an eligible orga-  
18 nization with a risk-sharing contract under section  
19 1876 of the Social Security Act (42 U.S.C.  
20 1395mm) must enter into with an entity providing  
21 peer review services with respect to services provided  
22 by the organization under section 1876(i)(7)(A) of  
23 such Act (42 U.S.C. 1395mm(i)(7)(A)).

24           (3) REPORT BY GAO.—

1           (A) STUDY.—The Comptroller General of  
2 the United States shall conduct a study of the  
3 costs incurred by eligible organizations with  
4 risk-sharing contracts under section 1876 of  
5 such Act (42 U.S.C. 1395mm(b)) of complying  
6 with the requirement of entering into a written  
7 agreement with an entity providing peer review  
8 services with respect to services provided by the  
9 organization, together with an analysis of how  
10 information generated by such entities is used  
11 by the Secretary to assess the quality of serv-  
12 ices provided by such eligible organizations.

13           (B) REPORT TO CONGRESS.—Not later  
14 than July 1, 1998, the Comptroller General  
15 shall submit a report to the Committee on  
16 Ways and Means and the Committee on Com-  
17 merce of the House of Representatives and the  
18 Committee on Finance and the Special Commit-  
19 tee on Aging of the Senate on the study con-  
20 ducted under subparagraph (A).

21 **SEC. 208. LIABILITY OF MEDICARE CARRIERS AND FISCAL**  
22 **INTERMEDIARIES AND STATES FOR CLAIMS**  
23 **SUBMITTED BY EXCLUDED PROVIDERS.**

24           (a) REIMBURSEMENT TO THE SECRETARY FOR  
25 AMOUNTS PAID TO EXCLUDED PROVIDERS.—

1           (1)       REQUIREMENTS       FOR       FISCAL  
2       INTERMEDIARIES.—

3           (A)    IN   GENERAL.—Section   1816   (42  
4       U.S.C. 1395h), is amended by adding at the  
5       end the following new subsection:

6       “(l) An agreement with an agency or organization  
7   under this section shall require that such agency or orga-  
8   nization reimburse the Secretary for any amounts paid for  
9   a service under this title which is furnished, directed, or  
10   prescribed by an individual or entity during any period  
11   for which the individual or entity is excluded pursuant to  
12   section 1128, 1128A, or 1156, from participation in the  
13   program under this title, if the amounts are paid after  
14   the Secretary notifies the agency or organization of the  
15   exclusion.”.

16           (B)   CONFORMING   AMENDMENT.—Section  
17       1816(i) (42 U.S.C. 1395h(i)) is amended by  
18       adding at the end the following new paragraph:

19       “(4) Nothing in this subsection shall be con-  
20   strued to prohibit reimbursement by an agency or  
21   organization under subsection (l).”.

22           (2)   REQUIREMENTS   FOR   CARRIERS.—Section  
23       1842(b)(3) (42 U.S.C. 1395u(b)(3)) is amended—

24           (A)   by striking “and” at the end of sub-  
25       paragraph (I); and

1 (B) by inserting after subparagraph (I) the  
2 following new subparagraph:

3 “(J) will reimburse the Secretary for any  
4 amounts paid for an item or service under this part  
5 which is furnished, directed, or prescribed by an in-  
6 dividual or entity during any period for which the in-  
7 dividual or entity is excluded pursuant to section  
8 1128, 1128A, or 1156 from participation in the pro-  
9 gram under this title, if the amounts are paid after  
10 the Secretary notifies the carrier of the exclusion;  
11 and”.

12 (3) REQUIREMENTS FOR STATES.—Section  
13 1902(a)(39) (42 U.S.C. 1396a(a)(39)) is amended  
14 by striking the semicolon at the end and inserting “,  
15 and provide further for reimbursement to the Sec-  
16 retary of any payments made under the plan for any  
17 item or service furnished, directed, or prescribed by  
18 the excluded individual or entity during such period,  
19 after the Secretary notifies the State of such exclu-  
20 sion;”.

21 (b) CONFORMING REPEAL OF MANDATORY PAYMENT  
22 RULE.—Section 1862(e)(2) (42 U.S.C. 1395y(e)(2)) is  
23 amended to read as follows:

24 “(2) No individual or entity may bill (or collect any  
25 amount from) any individual for any item or service for

1 which payment is denied under paragraph (1). No person  
 2 is liable for payment of any amounts billed for such an  
 3 item or service in violation of the previous sentence.”.

4 **SEC. 209. EFFECTIVE DATE.**

5 The amendments made by this title shall take effect  
 6 January 1, 1997.

7 **TITLE III—ADMINISTRATIVE**  
 8 **AND MISCELLANEOUS PROVI-**  
 9 **SIONS**

10 **SEC. 301. ESTABLISHMENT OF THE HEALTH CARE FRAUD**  
 11 **AND ABUSE DATA COLLECTION PROGRAM.**

12 (a) GENERAL PURPOSE.—Not later than January 1,  
 13 1997, the Secretary shall establish a national health care  
 14 fraud and abuse data collection program for the reporting  
 15 of final adverse actions (not including settlements in which  
 16 no findings of liability have been made) against health  
 17 care providers, suppliers, or practitioners as required by  
 18 subsection (b), with access as set forth in subsection (c),  
 19 and shall maintain a database of the information collected  
 20 under this section.

21 (b) REPORTING OF INFORMATION.—

22 (1) IN GENERAL.—Each Government agency  
 23 and health plan shall report any final adverse action  
 24 (not including settlements in which no findings of li-

1 ability have been made) taken against a health care  
2 provider, supplier, or practitioner.

3 (2) INFORMATION TO BE REPORTED.—The in-  
4 formation to be reported under paragraph (1) in-  
5 cludes the following:

6 (A) The name and TIN (as defined in sec-  
7 tion 7701(a)(41) of the Internal Revenue Code  
8 of 1986) of any health care provider, supplier,  
9 or practitioner who is the subject of a final ad-  
10 verse action.

11 (B) The name (if known) of any health  
12 care entity with which a health care provider,  
13 supplier, or practitioner, who is the subject of  
14 a final adverse action, is affiliated or associated.

15 (C) The nature of the final adverse action  
16 and whether such action is on appeal.

17 (D) A description of the acts or omissions  
18 and injuries upon which the final adverse action  
19 was based, and such other information as the  
20 Secretary determines by regulation is required  
21 for appropriate interpretation of information re-  
22 ported under this section.

23 (3) CONFIDENTIALITY.—In determining what  
24 information is required, the Secretary shall include  
25 procedures to assure that the privacy of individuals

1 receiving health care services is appropriately pro-  
2 tected.

3 (4) TIMING AND FORM OF REPORTING.—The  
4 information required to be reported under this sub-  
5 section shall be reported regularly (but not less often  
6 than monthly) and in such form and manner as the  
7 Secretary of Health and Human Services (in this  
8 section referred to as the “Secretary”) prescribes.  
9 Such information shall first be required to be re-  
10 ported on a date specified by the Secretary.

11 (5) TO WHOM REPORTED.—The information re-  
12 quired to be reported under this subsection shall be  
13 reported to the Secretary.

14 (c) DISCLOSURE AND CORRECTION OF INFORMA-  
15 TION.—

16 (1) DISCLOSURE.—With respect to the informa-  
17 tion about final adverse actions (not including settle-  
18 ments in which no findings of liability have been  
19 made) reported to the Secretary under this section  
20 with respect to a health care provider, supplier, or  
21 practitioner, the Secretary shall, by regulation, pro-  
22 vide for—

23 (A) disclosure of the information, upon re-  
24 quest, to the health care provider, supplier, or  
25 licensed practitioner, and

1 (B) procedures in the case of disputed ac-  
2 curacy of the information.

3 (2) CORRECTIONS.—Each Government agency  
4 and health plan shall report corrections of informa-  
5 tion already reported about any final adverse action  
6 taken against a health care provider, supplier, or  
7 practitioner, in such form and manner that the Sec-  
8 retary prescribes by regulation.

9 (d) ACCESS TO REPORTED INFORMATION.—

10 (1) AVAILABILITY.—The information in the  
11 database maintained under this section shall be  
12 available to Federal and State government agencies,  
13 health plans, and the public pursuant to procedures  
14 that the Secretary shall provide by regulation.

15 (2) FEES FOR DISCLOSURE.—The Secretary  
16 may establish or approve reasonable fees for the dis-  
17 closure of information in such database (other than  
18 with respect to requests by Federal agencies). The  
19 amount of such a fee may be sufficient to recover  
20 the full costs of carrying out the provisions of this  
21 section, including reporting, disclosure, and adminis-  
22 tration. Such fees shall be available to the Secretary  
23 or, in the Secretary's discretion to the agency des-  
24 ignated under this section to cover such costs.

1 (e) PROTECTION FROM LIABILITY FOR REPORT-  
2 ING.—No person or entity shall be held liable in any civil  
3 action with respect to any report made as required by this  
4 section, without knowledge of the falsity of the informa-  
5 tion contained in the report.

6 (f) DEFINITIONS AND SPECIAL RULES.—For pur-  
7 poses of this section:

8 (1) FINAL ADVERSE ACTION.—

9 (A) IN GENERAL.—The term “final ad-  
10 verse action” includes the following:

11 (i) Civil judgments against a health  
12 care provider or practitioner in Federal or  
13 State court related to the delivery of a  
14 health care item or service.

15 (ii) Federal or State criminal convic-  
16 tions related to the delivery of a health  
17 care item or service.

18 (iii) Actions by Federal or State agen-  
19 cies responsible for the licensing and cer-  
20 tification of health care providers, suppli-  
21 ers, and licensed health care practitioners,  
22 including—

23 (I) formal or official actions,  
24 such as revocation or suspension of a  
25 license (and the length of any such

1 suspension), reprimand, censure, or  
2 probation,

3 (II) any other loss of license, or  
4 the right to apply for or renew a li-  
5 cense of the provider, supplier, or  
6 practitioner, whether by operation of  
7 law, voluntary surrender, nonrenew-  
8 ability, or otherwise, or

9 (III) any other negative action or  
10 finding by such Federal or State  
11 agency that is publicly available infor-  
12 mation.

13 (iv) Exclusion from participation in  
14 Federal or State health care programs (as  
15 defined in section 1128B(f) and 1128(h),  
16 respectively).

17 (v) Any other adjudicated actions or  
18 decisions that the Secretary shall establish  
19 by regulation.

20 (B) EXCLUSION.—The term does not in-  
21 clude any action with respect to a malpractice  
22 claim.

23 (C) SPECIAL RULE.—For purposes of this  
24 paragraph, the existence of a conviction shall be

1           determined under section 1128(i) of the Social  
2           Security Act (42 U.S.C. 1320a–7(i)).

3           (2) LICENSED HEALTH CARE PRACTITIONER.—  
4           The terms “licensed health care practitioner”, “li-  
5           censed practitioner”, and “practitioner” mean, with  
6           respect to a State, an individual who is licensed or  
7           otherwise authorized by the State to provide health  
8           care services (or any individual who, without author-  
9           ity holds himself or herself out to be so licensed or  
10          authorized).

11          (3) HEALTH CARE PROVIDER.—The term  
12          “health care provider” means a provider of services  
13          as defined in section 1861(u) of the Social Security  
14          Act (42 U.S.C. 1395x(u)), and any person or entity,  
15          including a health maintenance organization, group  
16          medical practice, or any other entity listed by the  
17          Secretary in regulation, that provides health care  
18          services.

19          (4) SUPPLIER.—The term “supplier” means a  
20          supplier of health care items and services described  
21          in subsections (a) and (b) of section 1819, and sec-  
22          tion 1861 of the Social Security Act (42 U.S.C.  
23          1395i–3 (a) and (b), and 1395x).

24          (5) GOVERNMENT AGENCY.—The term “Gov-  
25          ernment agency” shall include the following:

1 (A) The Department of Justice.

2 (B) The Department of Health and  
3 Human Services.

4 (C) Any other Federal agency that either  
5 administers or provides payment for the deliv-  
6 ery of health care services, including, but not  
7 limited to the Department of Defense and the  
8 Veterans' Administration.

9 (D) State law enforcement agencies.

10 (E) State medicaid fraud and abuse units.

11 (F) Federal or State agencies responsible  
12 for the licensing and certification of health care  
13 providers and licensed health care practitioners.

14 (6) HEALTH PLAN.—The term “health plan”  
15 has the meaning given such term by section  
16 1128C(c) of the Social Security Act, as added by  
17 section 101(a) of this Act.

18 (g) CONFORMING AMENDMENT.—Section 1921(d)  
19 (42 U.S.C. 1396r–2(d)) is amended by inserting “and sec-  
20 tion 301 of the Medicare Antifraud Act of 1996” after  
21 “section 422 of the Health Care Quality Improvement Act  
22 of 1986”.

1 **SEC. 302. INSPECTOR GENERAL ACCESS TO NATIONAL**  
2 **PRACTITIONER DATA BANK.**

3 Section 427 of the Health Care Quality Improvement  
4 Act of 1986 (42 U.S.C. 11137) is amended—

5 (1) in subsection (a), by adding at the end the  
6 following sentence: “Information reported under this  
7 part shall also be made available, upon request, to  
8 the Inspector General of the Departments of Health  
9 and Human Services, Defense, and Labor, the Office  
10 of Personnel Management, and the Railroad Retirement  
11 Board.”; and

12 (2) by amending subsection (b)(4) to read as  
13 follows:

14 “(4) FEES.—The Secretary may impose fees for  
15 the disclosure of information under this part suffi-  
16 cient to recover the full costs of carrying out the  
17 provisions of this part, including reporting, disclo-  
18 sure, and administration, except that a fee may not  
19 be imposed for requests made by the Inspector Gen-  
20 eral of the Department of Health and Human Serv-  
21 ices. Such fees shall remain available to the Sec-  
22 retary (or, in the Secretary’s discretion, to the agen-  
23 cy designated in section 424(b)) until expended.”.

1 **SEC. 303. CORPORATE WHISTLEBLOWER PROGRAM.**

2 Title XI (42 U.S.C. 1301 et seq.), as amended by  
3 section 101(a), is amended by inserting after section  
4 1128C the following new section:

5 “CORPORATE WHISTLEBLOWER PROGRAM

6 “SEC. 1128D. (a) ESTABLISHMENT OF PROGRAM.—

7 The Secretary, through the Inspector General of the De-  
8 partment of Health and Human Services, shall establish  
9 a procedure whereby corporations, partnerships, and other  
10 legal entities specified by the Secretary, may voluntarily  
11 disclose instances of unlawful conduct and seek to resolve  
12 liability for such conduct through means specified by the  
13 Secretary.

14 “(b) LIMITATION.—No person may bring an action  
15 under section 3730(b) of title 31, United States Code, if,  
16 on the date of filing—

17 “(1) the matter set forth in the complaint has  
18 been voluntarily disclosed to the United States by  
19 the proposed defendant and the defendant has been  
20 accepted into the voluntary disclosure program es-  
21 tablished pursuant to subsection (a); and

22 “(2) any new information provided in the com-  
23 plaint under such section does not add substantial  
24 grounds for additional recovery beyond those encom-  
25 passed within the scope of the voluntary disclo-  
26 sure.”.

1 **SEC. 304. HOME HEALTH BILLING, PAYMENT, AND COST**  
2 **LIMIT CALCULATION TO BE BASED ON SITE**  
3 **WHERE SERVICE IS FURNISHED.**

4 (a) **CONDITIONS OF PARTICIPATION.**—Section 1891  
5 (42 U.S.C. 1395bbb) is amended by adding at the end  
6 the following new subsection:

7 “(g) A home health agency shall submit claims for  
8 payment of home health services under this title only on  
9 the basis of the geographic location at which the service  
10 is furnished, as determined by the Secretary.”.

11 (b) **WAGE ADJUSTMENT.**—Section 1861(v)(1)(L)(iii)  
12 (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended by striking  
13 “agency is located” and inserting “service is furnished”.

14 **SEC. 305. APPLICATION OF INHERENT REASONABLENESS.**

15 (a) **IN GENERAL.**—Section 1834(a)(10)(B) (42  
16 U.S.C. 1395m(a)(10)(B)) is amended—

17 (1) in the first sentence, by striking “apply the  
18 provisions” and all that follows through the period  
19 and inserting “describe by regulation the factors to  
20 be used in determining the cases (or particular  
21 items) in which the application of this subsection re-  
22 sults in the determination of an amount that, by  
23 reason of its being grossly excessive or grossly defi-  
24 cient, is not inherently reasonable, and to provide in  
25 such cases for the factors that will be considered in

1 establishing an amount that is realistic and equi-  
2 table.”; and

3 (2) in the second sentence, by striking “apply-  
4 ing such provisions” and inserting “applying the  
5 previous provisions of this subsection”.

6 (b) CONFORMING AMENDMENT.—Section 1834(i)  
7 (42 U.S.C. 1395m(i)) is amended by adding at the end  
8 the following new paragraph:

9 “(3) ADJUSTMENT FOR INHERENT REASON-  
10 ABLENESS.—The provisions of subsection (a)(10)(B)  
11 shall apply to payment for surgical dressings under  
12 this subsection.”.

13 **SEC. 306. CLARIFICATION OF TIME AND FILING LIMITA-**  
14 **TIONS.**

15 (a) IN GENERAL.—Section 1862(b)(2)(B) (42 U.S.C.  
16 1395y(b)(2)(B)) is amended by adding at the end the fol-  
17 lowing new clause:

18 “(v) TIME, FILING, AND RELATED  
19 PROVISIONS UNDER PRIMARY PLAN.—Re-  
20 quirements under a primary plan as to the  
21 filing of a claim, time limitations for the  
22 filing of a claim, information not main-  
23 tained by the Secretary, or notification or  
24 pre-admission review, shall not apply to a

1 claim by the United States under clause  
2 (ii) or (iii).”.

3 (b) EFFECTIVE DATE.—The amendment made by  
4 subsection (a) applies to items and services furnished after  
5 1990.

6 **SEC. 307. CLARIFICATION OF LIABILITY OF THIRD PARTY**  
7 **ADMINISTRATORS.**

8 (a) IN GENERAL.—Section 1862(b)(2)(B)(ii) (42  
9 U.S.C. 1395y(b)(2)(B)(ii)) is amended by inserting “, or  
10 which determines claims under the primary plan” after  
11 “primary plan”.

12 (b) CLAIMS BETWEEN PARTIES OTHER THAN THE  
13 UNITED STATES.—Section 1862(b)(2)(B) (42 U.S.C.  
14 1395y(b)(2)(B)), as amended by section 306(a) of this  
15 Act, is amended by adding at the end the following new  
16 clause:

17 “(vi) CLAIMS BETWEEN PARTIES  
18 OTHER THAN THE UNITED STATES.—A  
19 claim by the United States under clause  
20 (ii) or (iii) shall not preclude claims be-  
21 tween other parties.”.

22 (c) EFFECTIVE DATE.—The amendments made by  
23 this section shall apply to items and services furnished  
24 after 1990.

1 **SEC. 308. CLARIFICATION OF PAYMENT AMOUNTS TO MEDI-**  
2 **CARE.**

3 (a) IN GENERAL.—Section 1862(b)(2)(B)(i) (42  
4 U.S.C. 1395y(b)(2)(B)(i)) is amended to read as follows:

5 “(i) REPAYMENT REQUIRED.—

6 “(I) IN GENERAL.—Any payment  
7 under this title, with respect to any  
8 item or service for which payment by  
9 a primary plan is required under the  
10 preceding provisions of this sub-  
11 section, shall be conditioned on reim-  
12 bursement to the appropriate Trust  
13 Fund established by this title when  
14 notice or other information is received  
15 that payment for that item or service  
16 has been or should have been made  
17 under those provisions. If reimburse-  
18 ment is not made to the appropriate  
19 Trust Fund before the expiration of  
20 the 60-day period that begins on the  
21 date such notice or other information  
22 is received, the Secretary may charge  
23 interest (beginning with the date on  
24 which the notice or other information  
25 is received) on the amount of the re-  
26 imbursement until reimbursement is

1           made (at a rate determined by the  
2           Secretary in accordance with regula-  
3           tions of the Secretary of the Treasury  
4           applicable to charges for late pay-  
5           ments).

6                           “(II)     DETERMINATION     OF  
7           AMOUNT OWED.—The amount owed  
8           by a primary plan under the first sen-  
9           tence of subclause (I) is the lesser of  
10          the full primary payment required (if  
11          that amount is readily determinable)  
12          and the amount paid under this title  
13          for that item or service.”.

14       (b) CONFORMING AND TECHNICAL AMENDMENTS.—

15           (1) Subparagraphs (A)(i)(I) and (B)(i) of sec-  
16          tion 1862(b)(1) (42 U.S.C. 1395y(b)(1)) are each  
17          amended by inserting “(or eligible to be covered)”  
18          after “covered”.

19           (2) Section 1862(b)(1)(C)(ii) (42 U.S.C.  
20          1395y(b)(1)(C)(ii)) is amended by striking “covered  
21          by such plan”.

22           (3) The matter in section 1862(b)(2)(A) (42  
23          U.S.C. 1395y(b)(2)(A)) preceding clause (i) is  
24          amended by striking “, except as provided in sub-  
25          paragraph (B),”.

1 (c) EFFECTIVE DATE.—The amendments made by  
 2 this section shall apply to items and services furnished  
 3 after 1990.

4 **SEC. 309. INCREASED FLEXIBILITY IN CONTRACTING FOR**  
 5 **MEDICARE CLAIMS PROCESSING.**

6 (a) CARRIERS TO INCLUDE ENTITIES THAT ARE  
 7 NOT INSURANCE COMPANIES.—The matter in section  
 8 1842(a) (42 U.S.C. 1395u(a)) preceding paragraph (1) is  
 9 amended by striking “with carriers” and inserting “with  
 10 agencies and organizations (referred to as carriers)”.

11 (b) REPEAL.—Section 1842(f) (42 U.S.C. 1395u(f))  
 12 is repealed.

13 **TITLE IV—CIVIL MONETARY**  
 14 **PENALTIES**

15 **SEC. 401. SOCIAL SECURITY ACT CIVIL MONETARY PEN-**  
 16 **ALTIES.**

17 (a) GENERAL CIVIL MONETARY PENALTIES.—Sec-  
 18 tion 1128A (42 U.S.C. 1320a–7a) is amended as follows:

19 (1) In the third sentence of subsection (a), by  
 20 striking “programs under title XVIII” and inserting  
 21 “Federal health care programs (as defined in section  
 22 1128B(f))”.

23 (2) In subsection (f)—

24 (A) by redesignating paragraph (3) as  
 25 paragraph (4); and

1 (B) by inserting after paragraph (2) the  
2 following new paragraph:

3 “(3) With respect to amounts recovered arising  
4 out of a claim under a Federal health care program  
5 (as defined in section 1128B(f)), the portion of such  
6 amounts as is determined to have been paid by the  
7 program shall be repaid to the program, and the  
8 portion of such amounts attributable to the amounts  
9 recovered under this section by reason of the amend-  
10 ments made by the Medicare Antifraud Act of 1996  
11 (as estimated by the Secretary) shall be deposited  
12 into the Health Care Fraud and Abuse Control Ac-  
13 count established under section 101(b) of such  
14 Act.”.

15 (3) In subsection (i)—

16 (A) in paragraph (2), by striking “title V,  
17 XVIII, XIX, or XX of this Act” and inserting  
18 “a Federal health care program (as defined in  
19 section 1128B(f))”;

20 (B) in paragraph (4), by striking “a health  
21 insurance or medical services program under  
22 title XVIII or XIX of this Act” and inserting  
23 “a Federal health care program (as so de-  
24 fined)”; and

1 (C) in paragraph (5), by striking “title V,  
2 XVIII, XIX, or XX” and inserting “a Federal  
3 health care program (as so defined)”.

4 (4) By adding at the end the following new sub-  
5 section:

6 “(m)(1) For purposes of this section, with respect to  
7 a Federal health care program not contained in this Act,  
8 references to the Secretary in this section shall be deemed  
9 to be references to the Secretary or Administrator of the  
10 department or agency with jurisdiction over such program  
11 and references to the Inspector General of the Department  
12 of Health and Human Services in this section shall be  
13 deemed to be references to the Inspector General of the  
14 applicable department or agency.

15 “(2)(A) The Secretary and Administrator of the de-  
16 partments and agencies referred to in paragraph (1) may  
17 include in any action pursuant to this section, claims with-  
18 in the jurisdiction of other Federal departments or agen-  
19 cies as long as the following conditions are satisfied:

20 “(i) The case primarily involves claims submit-  
21 ted to the Federal health care programs of the de-  
22 partment or agency initiating the action.

23 “(ii) The Secretary or Administrator of the de-  
24 partment or agency initiating the action gives notice  
25 and an opportunity to participate in the investiga-

1       tion to the Inspector General of the department or  
2       agency with primary jurisdiction over the Federal  
3       health care programs to which the claims were sub-  
4       mitted.

5       “(B) If the conditions specified in subparagraph (A)  
6       are fulfilled, the Inspector General of the department or  
7       agency initiating the action is authorized to exercise all  
8       powers granted under the Inspector General Act of 1978  
9       (5 U.S.C. App.) with respect to the claims submitted to  
10      the other departments or agencies to the same manner  
11      and extent as provided in that Act with respect to claims  
12      submitted to such departments or agencies.”.

13      (b) EXCLUDED INDIVIDUAL RETAINING OWNERSHIP  
14      OR CONTROL INTEREST IN PARTICIPATING ENTITY.—  
15      Section 1128A(a) (42 U.S.C. 1320a–7a(a)) is amended—

16              (1) by striking “or” at the end of paragraph  
17              (1)(D);

18              (2) by striking “, or” at the end of paragraph  
19              (2) and inserting a semicolon;

20              (3) by striking the semicolon at the end of  
21              paragraph (3) and inserting “; or”; and

22              (4) by inserting after paragraph (3) the follow-  
23              ing new paragraph:

24              “(4) in the case of a person who is not an orga-  
25              nization, agency, or other entity, is excluded from

1 participating in a program under title XVIII or a  
2 State health care program in accordance with this  
3 subsection or under section 1128 and who, at the  
4 time of a violation of this subsection, retains a direct  
5 or indirect ownership or control interest of 5 percent  
6 or more, or an ownership or control interest (as de-  
7 fined in section 1124(a)(3)) in, or who is an officer  
8 or managing employee (as defined in section  
9 1126(b)) of, an entity that is participating in a pro-  
10 gram under title XVIII or a State health care pro-  
11 gram;”.

12 (c) EMPLOYER BILLING FOR SERVICES FURNISHED,  
13 DIRECTED, OR PRESCRIBED BY AN EXCLUDED EM-  
14 PLOYEE.—Section 1128A(a)(1) (42 U.S.C. 1320a-  
15 7a(a)(1)), as amended by subsection (b), is amended—

16 (1) by striking “or” at the end of subparagraph  
17 (C);

18 (2) by striking the semicolon at the end of sub-  
19 paragraph (D) and inserting “, or”; and

20 (3) by adding at the end the following new sub-  
21 paragraph:

22 “(E) is for a medical or other item or serv-  
23 ice furnished, directed, or prescribed by an indi-  
24 vidual who is an employee or agent of the per-  
25 son during a period in which such employee or

1 agent was excluded from the program under  
2 which the claim was made on any of the  
3 grounds for exclusion described in subpara-  
4 graph (D);”.

5 (d) CIVIL MONEY PENALTIES FOR ITEMS OR SERV-  
6 ICES FURNISHED, DIRECTED, OR PRESCRIBED BY AN EX-  
7 CLUDED INDIVIDUAL.—Section 1128A(a)(1)(D) (42  
8 U.S.C. 1320a–7a(a)(1)(D)) is amended by inserting “, di-  
9 rected, or prescribed” after “furnished”.

10 (e) MODIFICATIONS OF AMOUNTS OF PENALTIES  
11 AND ASSESSMENTS.—Section 1128A(a) (42 U.S.C.  
12 1320a–7a(a)), as amended by subsection (b), is amended  
13 in the matter following paragraph (4)—

14 (1) by striking “\$2,000” and inserting  
15 “\$10,000”;

16 (2) by inserting “; in cases under paragraph  
17 (4), \$10,000 for each day the prohibited relationship  
18 occurs” after “false or misleading information was  
19 given”; and

20 (3) by striking “twice the amount” and insert-  
21 ing “3 times the amount”.

22 (f) CLAIM FOR ITEM OR SERVICE BASED ON INCOR-  
23 RECT CODING OR MEDICALLY UNNECESSARY SERV-  
24 ICES.—Section 1128A(a)(1) (42 U.S.C. 1320a–7a(a)(1)),  
25 as amended by subsection (c), is amended—

1           (1) in subparagraph (A) by striking “claimed,”  
2           and inserting “claimed, including any person who  
3           engages in a pattern or practice of presenting or  
4           causing to be presented a claim for an item or serv-  
5           ice that is based on a code that the person knows  
6           or has reason to know will result in a greater pay-  
7           ment to the person than the code the person knows  
8           or has reason to know is applicable to the item or  
9           service actually provided,”;

10           (2) in subparagraph (D), by striking “or” at  
11           the end;

12           (3) in subparagraph (E), by striking the semi-  
13           colon and inserting “, or”; and

14           (4) by inserting after subparagraph (E) the fol-  
15           lowing new subparagraph:

16                   “(F) is for a medical or other item or serv-  
17           ice that a person knows or has reason to know  
18           is not medically necessary;”.

19           (g) PERMITTING SECRETARY TO IMPOSE CIVIL MON-  
20           ETARY PENALTY FOR KICKBACK VIOLATIONS.—Section  
21           1128A(b) (42 U.S.C. 1320a–7a(a)) is amended by adding  
22           the following new paragraph:

23                   “(3) Any person (including any organization,  
24           agency, or other entity, but excluding a beneficiary  
25           as defined in subsection (i)(5)) who the Secretary

1 determines has violated section 1128B(b) of this  
2 title shall be subject to a civil monetary penalty of  
3 not more than \$10,000 for each such violation. In  
4 addition, such person shall be subject to an assess-  
5 ment of not more than twice the total amount of the  
6 remuneration offered, paid, solicited, or received in  
7 violation of section 1128B(b). The total amount of  
8 remuneration subject to an assessment shall be cal-  
9 culated without regard to whether some portion  
10 thereof also may have been intended to serve a pur-  
11 pose other than one proscribed by section  
12 1128B(b).”.

13 (h) SANCTIONS AGAINST PRACTITIONERS AND PER-  
14 SONS FOR FAILURE TO COMPLY WITH STATUTORY OBLI-  
15 GATIONS.—Section 1156(b)(3) (42 U.S.C. 1320c-5(b)(3))  
16 is amended by striking “the actual or estimated cost” and  
17 inserting “up to \$10,000 for each instance”.

18 (i) PROCEDURAL PROVISIONS.—Section 1876(i)(6)  
19 (42 U.S.C. 1395mm(i)(6)), as amended by section  
20 207(a)(2), is amended by adding at the end the following  
21 new subparagraph:

22 “(D) The provisions of section 1128A (other than  
23 subsections (a) and (b)) shall apply to a civil money pen-  
24 alty under subparagraph (A) or (B) in the same manner

1 as they apply to a civil money penalty or proceeding under  
2 section 1128A(a).”.

3 (j) PROHIBITION AGAINST OFFERING INDUCEMENTS  
4 TO INDIVIDUALS ENROLLED UNDER PROGRAMS OR  
5 PLANS.—

6 (1) OFFER OF REMUNERATION.—Section  
7 1128A(a) (42 U.S.C. 1320a–7a(a)), as amended by  
8 subsection (b), is amended—

9 (A) by striking “, or” at the end of para-  
10 graph (3) and inserting a semicolon;

11 (B) by striking the semicolon at the end of  
12 paragraph (4) and inserting “; or”; and

13 (C) by inserting after paragraph (4) the  
14 following new paragraph:

15 “(5) offers to or transfers remuneration to any  
16 individual eligible for benefits under title XVIII of  
17 this Act, or under a State health care program (as  
18 defined in section 1128(h)) that such person knows  
19 or should know is likely to influence such individual  
20 to order or receive from a particular provider, practi-  
21 tioner, or supplier any item or service for which pay-  
22 ment may be made, in whole or in part, under title  
23 XVIII, or a State health care program (as so de-  
24 fined);”.

1           (2)     REMUNERATION     DEFINED.—Section  
2     1128A(i) (42 U.S.C. 1320a–7a(i)) is amended by  
3     adding the following new paragraph:

4           “(6) The term ‘remuneration’ includes the waiv-  
5     er of coinsurance and deductible amounts (or any  
6     part thereof), and transfers of items or services for  
7     free or for other than fair market value. The term  
8     ‘remuneration’ does not include—

9           “(A) the waiver of coinsurance and deduct-  
10     ible amounts by a person, if—

11           “(i) the waiver is not offered as part  
12     of any advertisement or solicitation;

13           “(ii) the person does not routinely  
14     waive coinsurance or deductible amounts;  
15     and

16           “(iii) the person—

17           “(I) waives the coinsurance and  
18     deductible amounts after determining  
19     in good faith that the individual is in  
20     financial need;

21           “(II) fails to collect coinsurance  
22     or deductible amounts after making  
23     reasonable collection efforts; or

24           “(III) provides for any permis-  
25     sible waiver as specified in section

1                   1128B(b)(3) or in regulations issued  
2                   by the Secretary;

3                   “(B) differentials in coinsurance and de-  
4                   ductible amounts as part of a benefit plan de-  
5                   sign as long as the differentials have been dis-  
6                   closed in writing to all beneficiaries, third party  
7                   payors, and providers, to whom claims are pre-  
8                   sented and as long as the differentials meet the  
9                   standards as defined in regulations promulgated  
10                  by the Secretary not later than 180 days after  
11                  the date of the enactment of the Medicare Anti-  
12                  fraud Act of 1996; or

13                  “(C) incentives given to individuals to pro-  
14                  mote the delivery of preventive care as deter-  
15                  mined by the Secretary in regulations so pro-  
16                  mulgated.”.

17                  (k) EFFECTIVE DATE.—The amendments made by  
18 this section shall take effect January 1, 1997.

19                  **TITLE V—AMENDMENTS TO**  
20                  **CRIMINAL LAW**

21                  **SEC. 501. HEALTH CARE FRAUD.**

22                  (a) IN GENERAL.—

23                  (1) FINES AND IMPRISONMENT FOR HEALTH  
24                  CARE FRAUD VIOLATIONS.—Chapter 63 of title 18,

1 United States Code, is amended by adding at the  
2 end the following new section:

3 **“§ 1347. Health care fraud**

4 “(a) Whoever knowingly and willfully executes, or at-  
5 tempts to execute, a scheme or artifice—

6 “(1) to defraud any health plan or other per-  
7 son, in connection with the delivery of or payment  
8 for health care benefits, items, or services; or

9 “(2) to obtain, by means of false or fraudulent  
10 pretenses, representations, or promises, any of the  
11 money or property owned by, or under the custody  
12 or control of, any health plan, or person in connec-  
13 tion with the delivery of or payment for health care  
14 benefits, items, or services;

15 shall be fined under this title or imprisoned not more than  
16 10 years, or both. If the violation results in serious bodily  
17 injury (as defined in section 1365(g)(3) of this title), such  
18 person may be imprisoned for any term of years.

19 “(b) For purposes of this section, the term ‘health  
20 plan’ has the same meaning given such term in section  
21 1128C(c) of the Social Security Act.”.

22 (2) CLERICAL AMENDMENT.—The table of sec-  
23 tions at the beginning of chapter 63 of title 18,  
24 United States Code, is amended by adding at the  
25 end the following:

“1347. Health care fraud.”.

1 (b) CRIMINAL FINES DEPOSITED IN THE HEALTH  
 2 CARE FRAUD AND ABUSE CONTROL ACCOUNT.—The Sec-  
 3 retary of the Treasury shall deposit into the Health Care  
 4 Fraud and Abuse Control Account established under sec-  
 5 tion 101(b) an amount equal to the criminal fines imposed  
 6 under section 1347 of title 18, United States Code (relat-  
 7 ing to health care fraud).

8 **SEC. 502. FORFEITURES FOR FEDERAL HEALTH CARE OF-**  
 9 **FENSES.**

10 (a) IN GENERAL.—Section 982(a) of title 18, United  
 11 States Code, is amended by adding after paragraph (5)  
 12 the following new paragraph:

13 “(6)(A) The court, in imposing sentence on a person  
 14 convicted of a Federal health care offense, shall order the  
 15 person to forfeit property, real or personal, that con-  
 16 stitutes or is derived, directly or indirectly, from proceeds  
 17 traceable to the commission of the offense.

18 “(B) For purposes of this paragraph, the term ‘Fed-  
 19 eral health care offense’ means a violation of, or a criminal  
 20 conspiracy to violate—

21 “(i) section 1347 of this title;

22 “(ii) section 1128B of the Social Security Act;

23 “(iii) section 287, 371, 664, 666, 1001, 1027,  
 24 1341, 1343, 1920, or 1954 of this title if the viola-  
 25 tion or conspiracy relates to health care fraud; and

1           “(iv) section 501 or 511 of the Employee Re-  
2           tirement Income Security Act of 1974, if the viola-  
3           tion or conspiracy relates to health care fraud.”.

4           (b) **PROPERTY FORFEITED DEPOSITED IN HEALTH**  
5 **CARE FRAUD AND ABUSE CONTROL ACCOUNT.**—The Sec-  
6           retary of the Treasury shall deposit into the Health Care  
7           Fraud and Abuse Control Account established under sec-  
8           tion 101(b) an amount equal to amounts resulting from  
9           forfeiture of property by reason of a Federal health care  
10          offense pursuant to section 982(a)(6) of title 18, United  
11          States Code.

12 **SEC. 503. INJUNCTIVE RELIEF RELATING TO FEDERAL**  
13 **HEALTH CARE OFFENSES.**

14          (a) **IN GENERAL.**—Section 1345(a)(1) of title 18,  
15          United States Code, is amended—

16               (1) by striking “or” at the end of subparagraph  
17               (A);

18               (2) by inserting “or” at the end of subpara-  
19               graph (B); and

20               (3) by adding at the end the following new sub-  
21               paragraph:

22                       “(C) committing or about to commit a  
23                       Federal health care offense (as defined in sec-  
24                       tion 982(a)(6)(B) of this title);”.

1 (b) FREEZING OF ASSETS.—Section 1345(a)(2) of  
2 title 18, United States Code, is amended by inserting “or  
3 a Federal health care offense (as defined in section  
4 982(a)(6)(B))” after “title”.

5 **SEC. 504. GRAND JURY DISCLOSURE.**

6 Section 3322 of title 18, United States Code, is  
7 amended—

8 (1) by redesignating subsections (c) and (d) as  
9 subsections (d) and (e), respectively; and

10 (2) by inserting after subsection (b) the follow-  
11 ing new subsection:

12 “(c) A person who is privy to grand jury information  
13 concerning a Federal health care offense (as defined in  
14 section 982(a)(6)(B))—

15 “(1) received in the course of duty as an attor-  
16 ney for the Government; or

17 “(2) disclosed under rule 6(e)(3)(A)(ii) of the  
18 Federal Rules of Criminal Procedure;

19 may disclose that information to an attorney for the Gov-  
20 ernment to use in any investigation or civil proceeding re-  
21 lating to health care fraud.”.

22 **SEC. 505. FALSE STATEMENTS.**

23 (a) IN GENERAL.—Chapter 47, of title 18, United  
24 States Code, is amended by adding at the end the follow-  
25 ing new section:

1 **“§ 1035. False statements relating to health care mat-**  
 2 **ters**

3 “(a) Whoever, in any matter involving a health plan,  
 4 knowingly and willfully falsifies, conceals, or covers up by  
 5 any trick, scheme, or device a material fact, or makes any  
 6 false, fictitious, or fraudulent statements or representa-  
 7 tions, or makes or uses any false writing or document  
 8 knowing the same to contain any false, fictitious, or fraud-  
 9 ulent statement or entry, shall be fined under this title  
 10 or imprisoned not more than 5 years, or both.

11 “(b) For purposes of this section, the term ‘health  
 12 plan’ has the same meaning given such term in section  
 13 1128C(c) of the Social Security Act.”.

14 (b) CLERICAL AMENDMENT.—The table of sections  
 15 at the beginning of chapter 47 of title 18, United States  
 16 Code, is amended by adding at the end the following:

“1035. False statements relating to health care matters.”.

17 **SEC. 506. OBSTRUCTION OF CRIMINAL INVESTIGATIONS,**  
 18 **AUDITS, OR INSPECTIONS OF FEDERAL**  
 19 **HEALTH CARE OFFENSES.**

20 (a) IN GENERAL.—Chapter 73 of title 18, United  
 21 States Code, is amended by adding at the end the follow-  
 22 ing new section:

1 **“§ 1518. Obstruction of criminal investigations, au-**  
2 **dits, or inspections of Federal health care**  
3 **offenses**

4       “(a) IN GENERAL.—Whoever willfully prevents, ob-  
5 structs, misleads, delays or attempts to prevent, obstruct,  
6 mislead, or delay the communication of information or  
7 records relating to a Federal health care offense to a Fed-  
8 eral agent or employee involved in an investigation, audit,  
9 inspection, or other activity related to such an offense,  
10 shall be fined under this title or imprisoned not more than  
11 5 years, or both.

12       “(b) FEDERAL HEALTH CARE OFFENSE.—As used  
13 in this section the term ‘Federal health care offense’ has  
14 the same meaning given such term in section 982(a)(6)(B)  
15 of this title.

16       “(c) CRIMINAL INVESTIGATOR.—As used in this sec-  
17 tion the term ‘criminal investigator’ means any individual  
18 duly authorized by a department, agency, or armed force  
19 of the United States to conduct or engage in investigations  
20 for prosecutions for violations of health care offenses.”.

21       (b) CLERICAL AMENDMENT.—The table of sections  
22 at the beginning of chapter 73 of title 18, United States  
23 Code, is amended by adding at the end the following:

“1518. Obstruction of criminal investigations, audits, or inspections of Federal  
health care offenses.”.

1 **SEC. 507. THEFT OR EMBEZZLEMENT.**

2 (a) IN GENERAL.—Chapter 31 of title 18, United  
3 States Code, is amended by adding at the end the follow-  
4 ing new section:

5 **“§ 669. Theft or embezzlement in connection with**  
6 **health care**

7 “(a) IN GENERAL.—Whoever willfully embezzles,  
8 steals, or otherwise without authority willfully and unlaw-  
9 fully converts to the use of any person other than the  
10 rightful owner, or intentionally misapplies any of the mon-  
11 eys, funds, securities, premiums, credits, property, or  
12 other assets of a health plan, shall be fined under this  
13 title or imprisoned not more than 10 years, or both.

14 “(b) HEALTH PLAN.—As used in this section the  
15 term ‘health plan’ has the same meaning given such term  
16 in section 1128C(c) of the Social Security Act.”.

17 (b) CLERICAL AMENDMENT.—The table of sections  
18 at the beginning of chapter 31 of title 18, United States  
19 Code, is amended by adding at the end the following:

“669. Theft or embezzlement in connection with health care.”.

20 **SEC. 508. LAUNDERING OF MONETARY INSTRUMENTS.**

21 Section 1956(c)(7) of title 18, United States Code,  
22 is amended by adding at the end the following new sub-  
23 paragraph:

24 “(F) Any act or activity constituting an of-  
25 fense involving a Federal health care offense as

1           that term is defined in section 982(a)(6)(B) of  
2           this title.”.

3 **SEC. 509. AUTHORIZED INVESTIGATIVE DEMAND PROCE-**  
4                                   **DURES.**

5           (a) IN GENERAL.—Chapter 233 of title 18, United  
6 States Code, is amended by adding after section 3485 the  
7 following new section:

8 **“§ 3486. Authorized investigative demand procedures**

9           “(a) AUTHORIZATION.—

10           “(1) In any investigation relating to functions  
11 set forth in paragraph (2), the Attorney General or  
12 designee may issue in writing and cause to be served  
13 a subpoena compelling production of any records (in-  
14 cluding any books, papers, documents, electronic  
15 media, or other objects or tangible things), which  
16 may be relevant to an authorized law enforcement  
17 inquiry, that a person or legal entity may possess or  
18 have care, custody, or control. A custodian of  
19 records may be required to give testimony concern-  
20 ing the production and authentication of such  
21 records. The production of records may be required  
22 from any place in any State or in any territory or  
23 other place subject to the jurisdiction of the United  
24 States at any designated place, except that such pro-  
25 duction shall not be required more than 500 miles

1 distant from the place where the subpoena is served.  
2 Witnesses summoned under this section shall be paid  
3 the same fees and mileage that are paid witnesses  
4 in the courts of the United States. A subpoena re-  
5 quiring the production of records shall describe the  
6 objects required to be produced and prescribe a re-  
7 turn date within a reasonable period of time within  
8 which the objects can be assembled and made avail-  
9 able.

10 “(2) Investigative demands utilizing an admin-  
11 istrative subpoena are authorized for any investiga-  
12 tion with respect to any act or activity constituting  
13 or involving health care fraud, including a scheme or  
14 artifice—

15 “(A) to defraud any health plan or other  
16 person, in connection with the delivery of or  
17 payment for health care benefits, items, or serv-  
18 ices; or

19 “(B) to obtain, by means of false or fraud-  
20 ulent pretenses, representations, or promises,  
21 any of the money or property owned by, or  
22 under the custody or control or, any health  
23 plan, or person in connection with the delivery  
24 of or payment for health care benefits, items, or  
25 services.

1       “(b) SERVICE.—A subpoena issued under this section  
2 may be served by any person designated in the subpoena  
3 to serve it. Service upon a natural person may be made  
4 by personal delivery of the subpoena to such person. Serv-  
5 ice may be made upon a domestic or foreign association  
6 which is subject to suit under a common name, by deliver-  
7 ing the subpoena to an officer, to a managing or general  
8 agent, or to any other agent authorized by appointment  
9 or by law to receive service of process. The affidavit of  
10 the person serving the subpoena entered on a true copy  
11 thereof by the person serving it shall be proof of service.

12       “(c) ENFORCEMENT.—In the case of contumacy by  
13 or refusal to obey a subpoena issued to any person, the  
14 Attorney General may invoke the aid of any court of the  
15 United States within the jurisdiction of which the inves-  
16 tigation is carried on or of which the subpoenaed person  
17 is an inhabitant, or in which such person carries on busi-  
18 ness or may be found, to compel compliance with the sub-  
19 poena. The court may issue an order requiring the subpoenaed  
20 person to appear before the Attorney General to  
21 produce records, if so ordered, or to give testimony touch-  
22 ing the matter under investigation. Any failure to obey  
23 the order of the court may be punished by the court as  
24 a contempt thereof. All process in any such case may be

1 served in any judicial district in which such person may  
2 be found.

3       “(d) IMMUNITY FROM CIVIL LIABILITY.—Notwith-  
4 standing any Federal, State, or local law, any person, in-  
5 cluding officers, agents, and employees, receiving a sub-  
6 poena under this section, who complies in good faith with  
7 the subpoena and thus produces the materials sought,  
8 shall not be liable in any court of any State or the United  
9 States to any customer or other person for such produc-  
10 tion or for nondisclosure of that production to the cus-  
11 tomer.

12       “(e) USE IN ACTION AGAINST INDIVIDUALS.—

13           “(1) Health information about an individual  
14 that is disclosed under this section may not be used  
15 in, or disclosed to any person for use in, any admin-  
16 istrative, civil, or criminal action or investigation di-  
17 rected against the individual who is the subject of  
18 the information unless the action or investigation  
19 arises out of and is directly related to receipt of  
20 health care or payment for health care or action in-  
21 volving a fraudulent claim related to health, or if au-  
22 thorized by an appropriate order of a court of com-  
23 petent jurisdiction, granted after application showing  
24 good cause therefore.

1           “(2) In assessing good cause, the court shall  
2 weigh the public interest and the need for disclosure  
3 against the injury to the patient, to the physician-  
4 patient relationship, and to the treatment services.

5           “(3) Upon the granting of such order, the  
6 court, in determining the extent to which any disclo-  
7 sure of all or any part of any record is necessary,  
8 shall impose appropriate safeguards against unau-  
9 thorized disclosure.

10          “(f) HEALTH PLAN.—As used in this section, the  
11 term ‘health plan’ has the same meaning given such term  
12 in section 1128C(c) of the Social Security Act.”.

13          (b) CLERICAL AMENDMENT.—The table of sections  
14 for chapter 223 of title 18, United States Code, is amend-  
15 ed by inserting after the item relating to section 3485 the  
16 following new item:

“3486. Authorized investigative demand procedures.”.

17          (c) CONFORMING AMENDMENT.—Section  
18 1510(b)(3)(B) of title 18, United States Code, is amended  
19 by inserting “or a Department of Justice subpoena (issued  
20 under section 3486),” after “subpoena”.

21       **TITLE VI—STATE HEALTH CARE**  
22               **FRAUD CONTROL UNITS**

23       **SEC. 601. STATE HEALTH CARE FRAUD CONTROL UNITS.**

24          (a) EXTENSION OF CONCURRENT AUTHORITY TO IN-  
25 VESTIGATE AND PROSECUTE FRAUD IN OTHER FEDERAL

1 PROGRAMS.—Section 1903(q)(3) (42 U.S.C. 1396b(q)(3))  
2 is amended—

3 (1) by inserting “(A)” after “in connection  
4 with”; and

5 (2) by striking “title.” and inserting “title; and  
6 (B) in cases where the entity’s function is also de-  
7 scribed by subparagraph (A), and upon the approval  
8 of the relevant Federal agency, any aspect of the  
9 provision of health care services and activities of  
10 providers of such services under any Federal health  
11 care program (as defined in section 1128B(b)(1)).”.

12 (b) EXTENSION OF AUTHORITY TO INVESTIGATE  
13 AND PROSECUTE PATIENT ABUSE IN NON-MEDICAID  
14 BOARD AND CARE FACILITIES.—Section 1903(q)(4) (42  
15 U.S.C. 1396b(q)(4)) is amended to read as follows:

16 “(4)(A) The entity has—

17 “(i) procedures for reviewing complaints of  
18 abuse or neglect of patients in health care fa-  
19 cilities which receive payments under the State  
20 plan under this title;

21 “(ii) at the option of the entity, procedures  
22 for reviewing complaints of abuse or neglect of  
23 patients residing in board and care facilities;  
24 and

1           “(iii) procedures for acting upon such com-  
2           plaints under the criminal laws of the State or  
3           for referring such complaints to other State  
4           agencies for action.

5           “(B) For purposes of this paragraph, the term  
6           ‘board and care facility’ means a residential setting  
7           which receives payment from or on behalf of two or  
8           more unrelated adults who reside in such facility,  
9           and for whom one or both of the following is pro-  
10          vided:

11           “(i) Nursing care services provided by, or  
12           under the supervision of, a registered nurse, li-  
13           censed practical nurse, or licensed nursing as-  
14           sistant.

15           “(ii) Personal care services that assist resi-  
16           dents with the activities of daily living, includ-  
17           ing personal hygiene, dressing, bathing, eating,  
18           toileting, ambulation, transfer, positioning, self-  
19           medication, body care, travel to medical serv-  
20           ices, essential shopping, meal preparation, laun-  
21           dry, and housework.”.

1 **TITLE VII—MEDICARE/MEDICAID**  
2 **BILLING ABUSE PREVENTION**

3 **SEC. 701. UNIFORM MEDICARE/MEDICAID APPLICATION**  
4 **PROCESS.**

5 Not later than 1 year after the date of the enactment  
6 of this Act, the Secretary of Health and Human Services  
7 (in this title referred to as the “Secretary”) shall establish  
8 procedures and a uniform application form for use by any  
9 individual or entity that seeks to participate in the pro-  
10 grams under titles XVIII and XIX of the Social Security  
11 Act (42 U.S.C. 1395 et seq.; 42 U.S.C. 1396 et seq.). The  
12 procedures established shall include the following:

13 (1) Execution of a standard authorization form  
14 by all individuals and entities prior to submission of  
15 claims for payment which shall include the social se-  
16 curity number of the beneficiary and the TIN (as  
17 defined in section 7701(a)(41) of the Internal Reve-  
18 nue Code of 1986) of any health care provider, sup-  
19 plier, or practitioner providing items or services  
20 under the claim.

21 (2) Assumption of responsibility and liability  
22 for all claims submitted.

23 (3) A right of access by the Secretary to pro-  
24 vider records relating to items and services rendered  
25 to beneficiaries of such programs.

1 (4) Retention of source documentation.

2 (5) Provision of complete and accurate docu-  
3 mentation to support all claims for payment.

4 (6) A statement of the legal consequences for  
5 the submission of false or fraudulent claims for pay-  
6 ment.

7 **SEC. 702. STANDARDS FOR UNIFORM CLAIMS.**

8 (a) ESTABLISHMENT OF STANDARDS.—Not later  
9 than 1 year after the date of the enactment of this Act,  
10 the Secretary shall establish standards for the form and  
11 submission of claims for payment under the medicare pro-  
12 gram under title XVIII of the Social Security Act (42  
13 U.S.C. 1395 et seq.) and the medicaid program under title  
14 XIX of such Act (42 U.S.C. 1396 et seq.).

15 (b) ENSURING PROVIDER RESPONSIBILITY.—In es-  
16 tablishing standards under subsection (a), the Secretary,  
17 in consultation with appropriate agencies including the  
18 Department of Justice, shall include such methods of en-  
19 suring provider responsibility and accountability for claims  
20 submitted as necessary to control fraud and abuse.

21 (c) USE OF ELECTRONIC MEDIA.—The Secretary  
22 shall develop specific standards which govern the submis-  
23 sion of claims through electronic media in order to control  
24 fraud and abuse in the submission of such claims.

1 **SEC. 703. UNIQUE PROVIDER IDENTIFICATION CODE.**

2 (a) ESTABLISHMENT OF SYSTEM.—Not later than 1  
3 year after the date of the enactment of this Act, the Sec-  
4 retary shall establish a system which provides for the issu-  
5 ance of a unique identifier code for each individual or en-  
6 tity furnishing items or services for which payment may  
7 be made under title XVIII or XIX of the Social Security  
8 (42 U.S.C. 1395 et seq.; 1396 et seq.), and the notation  
9 of such unique identifier codes on all claims for payment.

10 (b) APPLICATION FEE.—The Secretary shall require  
11 an individual applying for a unique identifier code under  
12 subsection (a) to submit a fee in an amount determined  
13 by the Secretary to be sufficient to cover the cost of inves-  
14 tigating the information on the application and the indi-  
15 vidual’s suitability for receiving such a code.

16 **SEC. 704. USE OF NEW PROCEDURES.**

17 No payment may be made under either title XVIII  
18 or XIX of the Social Security Act (42 U.S.C. 1395 et seq.;  
19 42 U.S.C. 1396 et seq.) for any item or service furnished  
20 by an individual or entity unless the requirements of sec-  
21 tions 702 and 703 are satisfied.

22 **SEC. 705. NONDISCHARGEABILITY OF CERTAIN MEDICARE**  
23 **DEBTS.**

24 (a) PAYMENT TO PROVIDERS.—Section 1815(d) (42  
25 U.S.C. 1395g(d)) is amended by adding at the end thereof  
26 the following new sentence: “Notwithstanding any other

1 provision of law, amounts due to the program under this  
2 subsection are not dischargeable under any provision of  
3 title 11, United States Code.”.

4 (b) PAYMENT OF BENEFITS.—Section 1833(j) (42  
5 U.S.C. 1395l(j)) is amended by adding at the end thereof  
6 the following new sentence: “Notwithstanding any other  
7 provision of law, amounts due to the program under this  
8 subsection are not dischargeable under any provision of  
9 title 11, United States Code.”.

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