

104TH CONGRESS
1ST SESSION

S. 245

To provide for enhanced penalties for health care fraud, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JANUARY 19 (legislative day, JANUARY 10), 1995

Mr. COHEN (for himself, Mr. DOLE, Mr. SIMPSON, Mr. STEVENS, Mr. D'AMATO, Mr. GRAHAM, Mr. COATS, Mr. GREGG, Mr. WARNER, Mr. NICKLES, Mr. PRYOR, Mr. BOND, Mr. CHAFEE, Mr. FORD, and Mr. DOMENICI) introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To provide for enhanced penalties for health care fraud,
and for other purposes.

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; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Health Care Fraud Prevention Act of 1995”.

6 (b) TABLE OF CONTENTS.—The table of contents of
7 this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—ALL-PAYER FRAUD AND ABUSE CONTROL PROGRAM

- Sec. 101. All-payer fraud and abuse control program.
- Sec. 102. Application of certain Federal health anti-fraud and abuse sanctions to all fraud and abuse against any health plan.
- Sec. 103. Health care fraud and abuse guidance.
- Sec. 104. Reporting of fraudulent actions under medicare.

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. Intermediate sanctions for medicare health maintenance organizations.
- Sec. 206. Effective date.

TITLE III—ADMINISTRATIVE AND MISCELLANEOUS PROVISIONS

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

TITLE IV—CIVIL MONETARY PENALTIES

- Sec. 401. 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. Voluntary disclosure program.
- Sec. 507. Obstruction of criminal investigations of Federal health care offenses.
- Sec. 508. Theft or embezzlement.
- Sec. 509. Laundering of monetary instruments.

TITLE VI—PAYMENTS FOR STATE HEALTH CARE FRAUD CONTROL UNITS

- Sec. 601. Establishment of State fraud units.
- Sec. 602. Requirements for State fraud units.
- Sec. 603. Scope and purpose.
- Sec. 604. Payments to States.

1 **TITLE I—ALL-PAYER FRAUD AND**
2 **ABUSE CONTROL PROGRAM**

3 **SEC. 101. ALL-PAYER FRAUD AND ABUSE CONTROL PRO-**
4 **GRAM.**

5 (a) ESTABLISHMENT OF PROGRAM.—

6 (1) IN GENERAL.—Not later than January 1,
7 1996, the Secretary of Health and Human Services
8 (in this title referred to as the “Secretary”), acting
9 through the Office of the Inspector General of the
10 Department of Health and Human Services, and the
11 Attorney General shall establish a program—

12 (A) to coordinate Federal, State, and local
13 law enforcement programs to control fraud and
14 abuse with respect to the delivery of and pay-
15 ment for health care in the United States,

16 (B) to conduct investigations, audits, eval-
17 uations, and inspections relating to the delivery
18 of and payment for health care in the United
19 States,

20 (C) to facilitate the enforcement of the
21 provisions of sections 1128, 1128A, and 1128B
22 of the Social Security Act and other statutes
23 applicable to health care fraud and abuse, and

24 (D) to provide for the modification and es-
25 tablishment of safe harbors and to issue inter-

1 pretative rulings and special fraud alerts pursu-
2 ant to section 103.

3 (2) COORDINATION WITH HEALTH PLANS.—In
4 carrying out the program established under para-
5 graph (1), the Secretary and the Attorney General
6 shall consult with, and arrange for the sharing of
7 data with representatives of health plans.

8 (3) REGULATIONS.—

9 (A) IN GENERAL.—The Secretary and the
10 Attorney General shall by regulation establish
11 standards to carry out the program under para-
12 graph (1).

13 (B) INFORMATION STANDARDS.—

14 (i) IN GENERAL.—Such standards
15 shall include standards relating to the fur-
16 nishing of information by health plans,
17 providers, and others to enable the Sec-
18 retary and the Attorney General to carry
19 out the program (including coordination
20 with health plans under paragraph (2)).

21 (ii) CONFIDENTIALITY.—Such stand-
22 ards shall include procedures to assure
23 that such information is provided and uti-
24 lized in a manner that appropriately pro-
25 tects the confidentiality of the information

1 and the privacy of individuals receiving
2 health care services and items.

3 (iii) QUALIFIED IMMUNITY FOR PRO-
4 VIDING INFORMATION.—The provisions of
5 section 1157(a) of the Social Security Act
6 (relating to limitation on liability) shall
7 apply to a person providing information to
8 the Secretary or the Attorney General in
9 conjunction with their performance of du-
10 ties under this section.

11 (C) DISCLOSURE OF OWNERSHIP INFOR-
12 MATION.—

13 (i) IN GENERAL.—Such standards
14 shall include standards relating to the dis-
15 closure of ownership information described
16 in clause (ii) by any entity providing health
17 care services and items.

18 (ii) OWNERSHIP INFORMATION DE-
19 SCRIBED.—The ownership information de-
20 scribed in this clause includes—

21 (I) a description of such items
22 and services provided by such entity;

23 (II) the names and unique physi-
24 cian identification numbers of all phy-
25 sicians with a financial relationship

1 (as defined in section 1877(a)(2) of
2 the Social Security Act) with such en-
3 tity;

4 (III) the names of all other indi-
5 viduals with such an ownership or in-
6 vestment interest in such entity; and

7 (IV) any other ownership and re-
8 lated information required to be dis-
9 closed by such entity under section
10 1124 or section 1124A of the Social
11 Security Act, except that the Sec-
12 retary shall establish procedures
13 under which the information required
14 to be submitted under this subclause
15 will be reduced with respect to health
16 care provider entities that the Sec-
17 retary determines will be unduly bur-
18 dened if such entities are required to
19 comply fully with this subclause.

20 (4) AUTHORIZATION OF APPROPRIATIONS FOR
21 INVESTIGATORS AND OTHER PERSONNEL.—In addi-
22 tion to any other amounts authorized to be appro-
23 priated to the Secretary, the Attorney General, the
24 Director of the Federal Bureau of Investigation, and
25 the Inspectors General of the Departments of De-

1 fense, Labor, and Veterans Affairs and of the Office
2 of Personnel Management, for health care anti-fraud
3 and abuse activities for a fiscal year, there are au-
4 thorized to be appropriated additional amounts,
5 from the Health Care Fraud and Abuse Account de-
6 scribed in subsection (b) of this section, as may be
7 necessary to enable the Secretary, the Attorney Gen-
8 eral, and such Inspectors General to conduct inves-
9 tigations and audits of allegations of health care
10 fraud and abuse and otherwise carry out the pro-
11 gram established under paragraph (1) in a fiscal
12 year.

13 (5) ENSURING ACCESS TO DOCUMENTATION.—
14 The Inspector General of the Department of Health
15 and Human Services is authorized to exercise the
16 authority described in paragraphs (4) and (5) of sec-
17 tion 6 of the Inspector General Act of 1978 (relating
18 to subpoenas and administration of oaths) with re-
19 spect to the activities under the all-payer fraud and
20 abuse control program established under this sub-
21 section to the same extent as such Inspector General
22 may exercise such authorities to perform the func-
23 tions assigned by such Act.

24 (6) AUTHORITY OF INSPECTOR GENERAL.—
25 Nothing in this Act shall be construed to diminish

1 the authority of any Inspector General, including
2 such authority as provided in the Inspector General
3 Act of 1978.

4 (7) HEALTH PLAN DEFINED.—For the purposes
5 of this subsection, the term “health plan” shall have
6 the meaning given such term in section 1128(i) of
7 the Social Security Act.

8 (b) HEALTH CARE FRAUD AND ABUSE CONTROL AC-
9 COUNT.—

10 (1) ESTABLISHMENT.—

11 (A) IN GENERAL.—There is hereby estab-
12 lished an account to be known as the “Health
13 Care Fraud and Abuse Control Account” (in
14 this section referred to as the “Anti-Fraud Ac-
15 count”). The Anti-Fraud Account shall consist
16 of—

17 (i) such gifts and bequests as may be
18 made as provided in subparagraph (B);

19 (ii) such amounts as may be deposited
20 in the Anti-Fraud Account as provided in
21 subsection (a)(4), sections 5441(b) and
22 5442(b), and title XI of the Social Security
23 Act; and

1 (iii) such amounts as are transferred
2 to the Anti-Fraud Account under subpara-
3 graph (C).

4 (B) AUTHORIZATION TO ACCEPT GIFTS.—
5 The Anti-Fraud Account is authorized to accept
6 on behalf of the United States money gifts and
7 bequests made unconditionally to the Anti-
8 Fraud Account, for the benefit of the Anti-
9 Fraud Account or any activity financed through
10 the Anti-Fraud Account.

11 (C) TRANSFER OF AMOUNTS.—

12 (i) IN GENERAL.—The Secretary of
13 the Treasury shall transfer to the Anti-
14 Fraud Account an amount equal to the
15 sum of the following:

16 (I) Criminal fines imposed in
17 cases involving a Federal health care
18 offense (as defined in section
19 982(a)(6)(B) of title 18, United
20 States Code).

21 (ii) Administrative penalties and as-
22 sessments imposed under titles XI, XVIII,
23 and XIX of the Social Security Act (except
24 as otherwise 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 imposed
5 under the False Claims Act (31 U.S.C.
6 3729 et seq.), in cases involving claims re-
7 lated to the provision of health care items
8 and services (other than funds awarded to
9 a relator or for restitution).

10 (2) USE OF FUNDS.—

11 (A) IN GENERAL.—Amounts in the Anti-
12 Fraud Account shall be available to carry out
13 the health care fraud and abuse control pro-
14 gram established under subsection (a) (includ-
15 ing the administration of the program), and
16 may be used to cover costs incurred in operat-
17 ing the program, including costs (including
18 equipment, salaries and benefits, and travel and
19 training) 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 evaluations;
2 and
3 (v) provider and consumer education
4 regarding compliance with the provisions of
5 this title.

6 (B) FUNDS USED TO SUPPLEMENT AGEN-
7 CY APPROPRIATIONS.—It is intended that dis-
8 bursements made from the Anti-Fraud Account
9 to any Federal agency be used to increase and
10 not supplant the recipient agency's appro-
11 priated operating budget.

12 (3) ANNUAL REPORT.—The Secretary and the
13 Attorney General shall submit jointly an annual re-
14 port to Congress on the amount of revenue which is
15 generated and disbursed by the Anti-Fraud Account
16 in each fiscal year.

17 (4) USE OF FUNDS BY INSPECTOR GENERAL.—

18 (A) REIMBURSEMENTS FOR INVESTIGA-
19 TIONS.—The Inspector General is authorized to
20 receive and retain for current use reimburse-
21 ment for the costs of conducting investigations,
22 when such restitution is ordered by a court, vol-
23 untarily agreed to by the payer, or otherwise.

24 (B) CREDITING.—Funds received by the
25 Inspector General or the Inspectors General of

1 the Departments of Defense, Labor, and Veter-
2 ans Affairs and of the Office of Personnel Man-
3 agement, as reimbursement for costs of con-
4 ducting investigations shall be deposited to the
5 credit of the appropriation from which initially
6 paid, or to appropriations for similar purposes
7 currently available at the time of deposit, and
8 shall remain available for obligation for 1 year
9 from the date of their deposit.

10 **SEC. 102. APPLICATION OF CERTAIN FEDERAL HEALTH**
11 **ANTI-FRAUD AND ABUSE SANCTIONS TO**
12 **FRAUD AND ABUSE AGAINST ANY HEALTH**
13 **PLAN.**

14 (a) CRIMES.—

15 (1) SOCIAL SECURITY ACT.—Section 1128B of
16 the Social Security Act (42 U.S.C. 1320a–7b) is
17 amended as follows:

18 (A) In the heading, by adding at the end
19 the following: “OR HEALTH PLANS”.

20 (B) In subsection (a)(1)—

21 (i) by striking “title XVIII or” and
22 inserting “title XVIII,” and

23 (ii) by adding at the end the follow-
24 ing: “or a health plan (as defined in sec-
25 tion 1128(i)),”.

1 (C) In subsection (a)(5), by striking “title
2 XVIII or a State health care program” and in-
3 serting “title XVIII, a State health care pro-
4 gram, or a health plan”.

5 (D) In the second sentence of subsection
6 (a)—

7 (i) by inserting after “title XIX” the
8 following: “or a health plan”, and

9 (ii) by inserting after “the State” the
10 following: “or the plan”.

11 (2) IDENTIFICATION OF COMMUNITY SERVICE
12 OPPORTUNITIES.—Section 1128B of such Act (42
13 U.S.C. 1320a–7b) is further amended by adding at
14 the end the following new subsection:

15 “(f) The Secretary may—

16 “(1) in consultation with State and local health
17 care officials, identify opportunities for the satisfac-
18 tion of community service obligations that a court
19 may impose upon the conviction of an offense under
20 this section, and

21 “(2) make information concerning such oppor-
22 tunities available to Federal and State law enforce-
23 ment officers and State and local health care
24 officials.”.

1 (b) HEALTH PLAN DEFINED.—Section 1128 of the
2 Social Security Act (42 U.S.C. 1320a–7) is amended by
3 redesignating subsection (i) as subsection (j) and by in-
4 serting after subsection (h) the following new subsection:

5 “(i) HEALTH PLAN DEFINED.—For purposes of sec-
6 tions 1128A and 1128B, the term ‘health plan’ means a
7 plan that provides health benefits, whether through di-
8 rectly, through insurance, or otherwise, and includes a pol-
9 icy of health insurance, a contract of a service benefit or-
10 ganization, or a membership agreement with a health
11 maintenance organization or other prepaid health plan,
12 and also includes an employee welfare benefit plan or a
13 multiple employer welfare plan (as such terms are defined
14 in section 3 of the Employee Retirement Income Security
15 Act of 1974).”.

16 (c) EFFECTIVE DATE.—The amendments made by
17 this section shall take effect on January 1, 1996.

18 **SEC. 103. HEALTH CARE FRAUD AND ABUSE GUIDANCE.**

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

22 (1) IN GENERAL.—

23 (A) SOLICITATION OF PROPOSALS FOR
24 SAFE HARBORS.—Not later than January 1,
25 1996, and not less than annually thereafter, the

1 Secretary shall publish a notice in the Federal
2 Register soliciting proposals, which will be ac-
3 cepted during a 60-day period, for—

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

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

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

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

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

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

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

24 (2) CRITERIA FOR MODIFYING AND ESTABLISH-
25 ING SAFE HARBORS.—In modifying and establishing

1 safe harbors under paragraph (1)(B), the Secretary
2 may consider the extent to which providing a safe
3 harbor for the specified payment practice may result
4 in any of the following:

5 (A) An increase or decrease in access to
6 health care services.

7 (B) An increase or decrease in the quality
8 of health care services.

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

11 (D) An increase or decrease in competition
12 among health care providers.

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

17 (F) An increase or decrease in the cost to
18 Government health care programs.

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

21 (H) The existence or nonexistence of any
22 potential financial benefit to a health care pro-
23 fessional or provider which may vary based on
24 their decisions of—

1 (i) whether to order a health care
2 item or service; or

3 (ii) whether to arrange for a referral
4 of health care items or services to a par-
5 ticular practitioner or provider.

6 (I) Any other factors the Secretary deems
7 appropriate in the interest of preventing fraud
8 and abuse in Government health care programs.

9 (b) INTERPRETIVE RULINGS.—

10 (1) IN GENERAL.—

11 (A) REQUEST FOR INTERPRETIVE RUL-
12 ING.—Any person may present, at any time, a
13 request to the Inspector General for a state-
14 ment of the Inspector General’s current inter-
15 pretation of the meaning of a specific aspect of
16 the application of sections 1128A and 1128B of
17 the Social Security Act (hereafter in this sec-
18 tion referred to as an “interpretive ruling”).

19 (B) ISSUANCE AND EFFECT OF INTERPRE-
20 TIVE RULING.—

21 (i) IN GENERAL.—If appropriate, the
22 Inspector General shall in consultation
23 with the Attorney General, issue an inter-
24 pretive ruling in response to a request de-
25 scribed in subparagraph (A). Interpretive

1 rulings shall not have the force of law and
2 shall be treated as an interpretive rule
3 within the meaning of section 553(b) of
4 title 5, United States Code. All interpretive
5 rulings issued pursuant to this provision
6 shall be published in the Federal Register
7 or otherwise made available for public in-
8 spection.

9 (ii) REASONS FOR DENIAL.—If the In-
10 spector General does not issue an interpre-
11 tive ruling in response to a request de-
12 scribed in subparagraph (A), the Inspector
13 General shall notify the requesting party of
14 such decision and shall identify the reasons
15 for such decision.

16 (2) CRITERIA FOR INTERPRETIVE RULINGS.—

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

20 (i) whether and to what extent the re-
21 quest identifies an ambiguity within the
22 language of the statute, the existing safe
23 harbors, or previous interpretive rulings;
24 and

1 (ii) whether the subject of the re-
2 requested interpretive ruling can be ade-
3 quately addressed by interpretation of the
4 language of the statute, the existing safe
5 harbor rules, or previous interpretive rul-
6 ings, or whether the request would require
7 a substantive ruling not authorized under
8 this subsection.

9 (B) NO RULINGS ON FACTUAL ISSUES.—

10 The Inspector General shall not give an inter-
11 pretive ruling on any factual issue, including
12 the intent of the parties or the fair market
13 value of particular leased space or equipment.

14 (c) SPECIAL FRAUD ALERTS.—

15 (1) IN GENERAL.—

16 (A) REQUEST FOR SPECIAL FRAUD
17 ALERTS.—Any person may present, at any
18 time, a request to the Inspector General for a
19 notice which informs the public of practices
20 which the Inspector General considers to be
21 suspect or of particular concern under section
22 1128B(b) of the Social Security Act (42 U.S.C.
23 1320a-7b(b)) (hereafter in this subsection re-
24 ferred to as a “special fraud alert”).

1 (B) ISSUANCE AND PUBLICATION OF SPE-
2 CIAL FRAUD ALERTS.—Upon receipt of a re-
3 quest described in subparagraph (A), the In-
4 spector General shall investigate the subject
5 matter of the request to determine whether a
6 special fraud alert should be issued. If appro-
7 priate, the Inspector General shall in consulta-
8 tion with the Attorney General, issue a special
9 fraud alert in response to the request. All spe-
10 cial fraud alerts issued pursuant to this sub-
11 paragraph shall be published in the Federal
12 Register.

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

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

21 (B) the volume and frequency of the con-
22 duct that would be identified in the special
23 fraud alert.

1 **SEC. 104. REPORTING OF FRAUDULENT ACTIONS UNDER**
 2 **MEDICARE.**

3 Not later than 1 year after the date of the enactment
 4 of this Act, the Secretary shall establish a program
 5 through which individuals entitled to benefits under the
 6 medicare program may report to the Secretary on a con-
 7 fidential basis (at the individual's request) instances of
 8 suspected fraudulent actions arising under the program by
 9 providers of items and services under the program.

10 **TITLE II—REVISIONS TO CUR-**
 11 **RENT SANCTIONS FOR FRAUD**
 12 **AND ABUSE**

13 **SEC. 201. MANDATORY EXCLUSION FROM PARTICIPATION**
 14 **IN MEDICARE AND STATE HEALTH CARE PRO-**
 15 **GRAMS.**

16 (a) INDIVIDUAL CONVICTED OF FELONY RELATING
 17 TO FRAUD.—

18 (1) IN GENERAL.—Section 1128(a) of the So-
 19 cial Security Act (42 U.S.C. 1320a–7(a)) is amend-
 20 ed by adding at the end the following new para-
 21 graph:

22 “(3) FELONY CONVICTION RELATING TO
 23 FRAUD.—Any individual or entity that has been con-
 24 victed after the date of the enactment of the Health
 25 Care Fraud Prevention Act of 1995, under Federal
 26 or State law, in connection with the delivery of a

1 health care item or service or with respect to any act
 2 or omission in a program (other than those specifi-
 3 cally described in paragraph (1)) operated by or fi-
 4 nanced in whole or in part by any Federal, State, or
 5 local government agency, of a criminal offense con-
 6 sisting of a felony relating to fraud, theft, embezzle-
 7 ment, breach of fiduciary responsibility, or other fi-
 8 nancial misconduct.”.

9 (2) CONFORMING AMENDMENT.—Section
 10 1128(b)(1) of such Act (42 U.S.C. 1320a-7(b)(1))
 11 is amended—

12 (A) in the heading, by striking “CONVIC-
 13 TION” and inserting “MISDEMEANOR CONVIC-
 14 TION”; and

15 (B) by striking “criminal offense” and in-
 16 serting “criminal offense consisting of a mis-
 17 demeanor”.

18 (b) INDIVIDUAL CONVICTED OF FELONY RELATING
 19 TO CONTROLLED SUBSTANCE.—

20 (1) IN GENERAL.—Section 1128(a) of the So-
 21 cial Security Act (42 U.S.C. 1320a-7(a)), as amend-
 22 ed by subsection (a), is amended by adding at the
 23 end the following new paragraph:

24 “(4) FELONY CONVICTION RELATING TO CON-
 25 TROLLED SUBSTANCE.—Any individual or entity

1 that has been convicted after the date of the enact-
2 ment of the Health Care Fraud Prevention Act of
3 1995, under Federal or State law, of a criminal of-
4 fense consisting of a felony relating to the unlawful
5 manufacture, distribution, prescription, or dispens-
6 ing of a controlled substance.”.

7 (2) CONFORMING AMENDMENT.—Section
8 1128(b)(3) of such Act (42 U.S.C. 1320a-7(b)(3))
9 is amended—

10 (A) in the heading, by striking “CONVIC-
11 TION” and inserting “MISDEMEANOR CONVIC-
12 TION”; and

13 (B) by striking “criminal offense” and in-
14 serting “criminal offense consisting of a mis-
15 demeanor”.

16 **SEC. 202. ESTABLISHMENT OF MINIMUM PERIOD OF EX-**
17 **CLUSION FOR CERTAIN INDIVIDUALS AND**
18 **ENTITIES SUBJECT TO PERMISSIVE EXCLU-**
19 **SION FROM MEDICARE AND STATE HEALTH**
20 **CARE PROGRAMS.**

21 Section 1128(c)(3) of the Social Security Act (42
22 U.S.C. 1320a-7(c)(3)) is amended by adding at the end
23 the following new subparagraphs:

24 “(D) In the case of an exclusion of an individual or
25 entity under paragraph (1), (2), or (3) of subsection (b),

1 the period of the exclusion shall be 3 years, unless the
2 Secretary determines in accordance with published regula-
3 tions that a shorter period is appropriate because of miti-
4 gating circumstances or that a longer period is appro-
5 priate because of aggravating circumstances.

6 “(E) In the case of an exclusion of an individual or
7 entity under subsection (b)(4) or (b)(5), the period of the
8 exclusion shall not be less than the period during which
9 the individual’s or entity’s license to provide health care
10 is revoked, suspended, or surrendered, or the individual
11 or the entity is excluded or suspended from a Federal or
12 State health care program.

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

16 **SEC. 203. PERMISSIVE EXCLUSION OF INDIVIDUALS WITH**
17 **OWNERSHIP OR CONTROL INTEREST IN**
18 **SANCTIONED ENTITIES.**

19 Section 1128(b) of the Social Security Act (42 U.S.C.
20 1320a-7(b)) is amended by adding at the end the follow-
21 ing new paragraph:

22 “(15) INDIVIDUALS CONTROLLING A SANC-
23 TIONED ENTITY.—Any individual who has a direct
24 or indirect ownership or control interest of 5 percent
25 or more, or an ownership or control interest (as de-

1 fined in section 1124(a)(3)) in, or who is an officer,
 2 director, agent, or managing employee (as defined in
 3 section 1126(b)) of, an entity—

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

7 “(B) against which a civil monetary pen-
 8 alty has been assessed under section 1128A; or

9 “(C) that has been excluded from partici-
 10 pation under a program under title XVIII or
 11 under a State health care program.”.

12 **SEC. 204. SANCTIONS AGAINST PRACTITIONERS AND PER-**
 13 **SONS FOR FAILURE TO COMPLY WITH STATU-**
 14 **TORY OBLIGATIONS.**

15 (a) MINIMUM PERIOD OF EXCLUSION FOR PRACTI-
 16 TIONERS AND PERSONS FAILING TO MEET STATUTORY
 17 OBLIGATIONS.—

18 (1) IN GENERAL.—The second sentence of sec-
 19 tion 1156(b)(1) of the Social Security Act (42
 20 U.S.C. 1320c-5(b)(1)) is amended by striking “may
 21 prescribe)” and inserting “may prescribe, except
 22 that such period may not be less than 1 year)”.

23 (2) CONFORMING AMENDMENT.—Section
 24 1156(b)(2) of such Act (42 U.S.C. 1320c-5(b)(2)) is
 25 amended by striking “shall remain” and inserting

1 “shall (subject to the minimum period specified in
2 the second sentence of paragraph (1)) remain”.

3 (b) REPEAL OF “UNWILLING OR UNABLE” CONDI-
4 TION FOR IMPOSITION OF SANCTION.—Section 1156(b)(1)
5 of the Social Security Act (42 U.S.C. 1320c-5(b)(1)) is
6 amended—

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

10 (2) by striking the third sentence.

11 **SEC. 205. INTERMEDIATE SANCTIONS FOR MEDICARE**
12 **HEALTH MAINTENANCE ORGANIZATIONS.**

13 (a) APPLICATION OF INTERMEDIATE SANCTIONS FOR
14 ANY PROGRAM VIOLATIONS.—

15 (1) IN GENERAL.—Section 1876(i)(1) of the
16 Social Security Act (42 U.S.C. 1395mm(i)(1)) is
17 amended by striking “the Secretary may terminate”
18 and all that follows and inserting the following: “in
19 accordance with procedures established under para-
20 graph (9), the Secretary may at any time terminate
21 any such contract or may impose the intermediate
22 sanctions described in paragraph (6)(B) or (6)(C)
23 (whichever is applicable) on the eligible organization
24 if the Secretary determines that the organization—

1 “(A) has failed substantially to carry out
2 the contract;

3 “(B) is carrying out the contract in a man-
4 ner inconsistent with the efficient and effective
5 administration of this section; or

6 “(C) no longer substantially meets the ap-
7 plicable conditions of subsections (b), (c), (e),
8 and (f).”.

9 (2) OTHER INTERMEDIATE SANCTIONS FOR
10 MISCELLANEOUS PROGRAM VIOLATIONS.—Section
11 1876(i)(6) of such Act (42 U.S.C. 1395mm(i)(6)) is
12 amended by adding at the end the following new
13 subparagraph:

14 “(C) In the case of an eligible organization for which
15 the Secretary makes a determination under paragraph (1)
16 the basis of which is not described in subparagraph (A),
17 the Secretary may apply the following intermediate sanc-
18 tions:

19 “(i) Civil money penalties of not more than
20 \$25,000 for each determination under paragraph (1)
21 if the deficiency that is the basis of the determina-
22 tion has directly adversely affected (or has the sub-
23 stantial likelihood of adversely affecting) an individ-
24 ual covered under the organization’s contract.

1 “(ii) Civil money penalties of not more than
2 \$10,000 for each week beginning after the initiation
3 of procedures by the Secretary under paragraph (9)
4 during which the deficiency that is the basis of a de-
5 termination under paragraph (1) exists.

6 “(iii) Suspension of enrollment of individuals
7 under this section after the date the Secretary noti-
8 fies the organization of a determination under para-
9 graph (1) and until the Secretary is satisfied that
10 the deficiency that is the basis for the determination
11 has been corrected and is not likely to recur.”.

12 (3) PROCEDURES FOR IMPOSING SANCTIONS.—
13 Section 1876(i) of such Act (42 U.S.C. 1395mm(i))
14 is amended by adding at the end the following new
15 paragraph:

16 “(9) The Secretary may terminate a contract with an
17 eligible organization under this section or may impose the
18 intermediate sanctions described in paragraph (6) on the
19 organization in accordance with formal investigation and
20 compliance procedures established by the Secretary under
21 which—

22 “(A) the Secretary provides the organization
23 with the opportunity to develop and implement a
24 corrective action plan to correct the deficiencies that

1 were the basis of the Secretary's determination
2 under paragraph (1);

3 “(B) in deciding whether to impose sanctions,
4 the Secretary considers aggravating factors such as
5 whether an entity has a history of deficiencies or has
6 not taken action to correct deficiencies the Secretary
7 has brought to their attention;

8 “(C) there are no unreasonable or unnecessary
9 delays between the finding of a deficiency and the
10 imposition of sanctions; and

11 “(D) the Secretary provides the organization
12 with reasonable notice and opportunity for hearing
13 (including the right to appeal an initial decision) be-
14 fore imposing any sanction or terminating the con-
15 tract.”.

16 (4) CONFORMING AMENDMENTS.—Section
17 1876(i)(6)(B) of such Act (42 U.S.C.
18 1395mm(i)(6)(B)) is amended by striking the sec-
19 ond sentence.

20 (b) AGREEMENTS WITH PEER REVIEW ORGANIZA-
21 TIONS.—

22 (1) REQUIREMENT FOR WRITTEN AGREE-
23 MENT.—Section 1876(i)(7)(A) of the Social Security
24 Act (42 U.S.C. 1395mm(i)(7)(A)) is amended by

1 striking “an agreement” and inserting “a written
2 agreement”.

3 (2) DEVELOPMENT OF MODEL AGREEMENT.—

4 Not later than July 1, 1996, the Secretary shall de-
5 velop a model of the agreement that an eligible orga-
6 nization with a risk-sharing contract under section
7 1876 of the Social Security Act must enter into with
8 an entity providing peer review services with respect
9 to services provided by the organization under sec-
10 tion 1876(i)(7)(A) of such Act.

11 (3) REPORT BY GAO.—

12 (A) STUDY.—The Comptroller General of
13 the United States shall conduct a study of the
14 costs incurred by eligible organizations with
15 risk-sharing contracts under section 1876(b) of
16 such Act of complying with the requirement of
17 entering into a written agreement with an en-
18 tity providing peer review services with respect
19 to services provided by the organization, to-
20 gether with an analysis of how information gen-
21 erated by such entities is used by the Secretary
22 to assess the quality of services provided by
23 such eligible organizations.

24 (B) REPORT TO CONGRESS.—Not later
25 than July 1, 1998, the Comptroller General

1 shall submit a report to the Committee on
2 Ways and Means and the Committee on Energy
3 and Commerce of the House of Representatives
4 and the Committee on Finance and the Special
5 Committee on Aging of the Senate on the study
6 conducted under subparagraph (A).

7 (c) EFFECTIVE DATE.—The amendments made by
8 this section shall apply with respect to contract years be-
9 ginning on or after January 1, 1996.

10 **SEC. 206. EFFECTIVE DATE.**

11 The amendments made by this part shall take effect
12 January 1, 1996.

13 **TITLE III—ADMINISTRATIVE**
14 **AND MISCELLANEOUS PROVI-**
15 **SIONS**

16 **SEC. 301. ESTABLISHMENT OF THE HEALTH CARE FRAUD**
17 **AND ABUSE DATA COLLECTION PROGRAM.**

18 (a) GENERAL PURPOSE.—Not later than January 1,
19 1996, the Secretary shall establish a national health care
20 fraud and abuse data collection program for the reporting
21 of final adverse actions (not including settlements in which
22 no findings of liability have been made) against health
23 care providers, suppliers, or practitioners as required by
24 subsection (b), with access as set forth in subsection (c).

25 (b) REPORTING OF INFORMATION.—

1 (1) IN GENERAL.—Each government agency
2 and health plan shall report any final adverse action
3 (not including settlements in which no findings of li-
4 ability have been made) taken against a health care
5 provider, supplier, or practitioner.

6 (2) INFORMATION TO BE REPORTED.—The in-
7 formation to be reported under paragraph (1) in-
8 cludes:

9 (A) The name of any health care provider,
10 supplier, or practitioner who is the subject of a
11 final adverse action.

12 (B) The name (if known) of any health
13 care entity with which a health care provider,
14 supplier, or practitioner is affiliated or associ-
15 ated.

16 (C) The nature of the final adverse action.

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 prescribes. Such information shall first be
8 required to be reported on a date specified by the
9 Secretary.

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

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

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

22 (A) disclosure of the information, upon re-
23 quest, to the health care provider, supplier, or
24 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 this
11 database shall be available to Federal and State gov-
12 ernment agencies and health plans pursuant to pro-
13 cedures that the Secretary shall provide by regula-
14 tion.

15 (2) FEES FOR DISCLOSURE.—The Secretary
16 may establish or approve reasonable fees for the dis-
17 closure of information in this database. The amount
18 of such a fee may not exceed the costs of processing
19 the requests for disclosure and of providing such in-
20 formation. Such fees shall be available to the Sec-
21 retary or, in the Secretary's discretion to the agency
22 designated under this section to cover such costs.

23 (e) PROTECTION FROM LIABILITY FOR REPORT-
24 ING.—No person or entity, including the agency des-
25 ignated by the Secretary in subsection (b)(5) shall be held

1 liable in any civil action with respect to any report made
2 as required by this section, without knowledge of the fal-
3 sity of the information contained in the report.

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

6 (1) The term “final adverse action” includes:

7 (A) Civil judgments against a health care
8 provider in Federal or State court related to the
9 delivery of a health care item or service.

10 (B) Federal or State criminal convictions
11 related to the delivery of a health care item or
12 service.

13 (C) Actions by Federal or State agencies
14 responsible for the licensing and certification of
15 health care providers, suppliers, and licensed
16 health care practitioners, including—

17 (i) formal or official actions, such as
18 revocation or suspension of a license (and
19 the length of any such suspension), rep-
20 rimand, censure or probation,

21 (ii) any other loss of license of the
22 provider, supplier, or practitioner, by oper-
23 ation of law, or

1 (iii) any other negative action or find-
2 ing by such Federal or State agency that
3 is publicly available information.

4 (D) Exclusion from participation in Fed-
5 eral or State health care programs.

6 (E) Any other adjudicated actions or deci-
7 sions that the Secretary shall establish by regu-
8 lation.

9 (2) The terms “licensed health care practi-
10 tioner”, “licensed practitioner”, and “practitioner”
11 mean, with respect to a State, an individual who is
12 licensed or otherwise authorized by the State to pro-
13 vide health care services (or any individual who,
14 without authority holds himself or herself out to be
15 so licensed or authorized).

16 (3) The term “health care provider” means a
17 provider of services as defined in section 1861(u) of
18 the Social Security Act, and any entity, including a
19 health maintenance organization, group medical
20 practice, or any other entity listed by the Secretary
21 in regulation, that provides health care services.

22 (4) The term “supplier” means a supplier of
23 health care items and services described in section
24 1819(a) and (b), and section 1861 of the Social Se-
25 curity Act.

1 (5) The term “Government agency” shall in-
2 clude:

3 (A) The Department of Justice.

4 (B) The Department of Health and
5 Human Services.

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

11 (D) State law enforcement agencies.

12 (E) State medicaid fraud and abuse units.

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

16 (6) The term “health plan” has the meaning
17 given to such term by section 1128(i) of the Social
18 Security Act.

19 (7) For purposes of paragraph (2), the exist-
20 ence of a conviction shall be determined under para-
21 graph (4) of section 1128(j) of the Social Security
22 Act.

23 (g) CONFORMING AMENDMENT.—Section 1921(d) of
24 the Social Security Act is amended by inserting “and sec-
25 tion 301 of the Health Care Fraud Prevention Act of

1 1995” after “section 422 of the Health Care Quality Im-
2 provement Act of 1986”.

3 **TITLE IV—CIVIL MONETARY**
4 **PENALTIES**

5 **SEC. 401. CIVIL MONETARY PENALTIES.**

6 (a) GENERAL CIVIL MONETARY PENALTIES.—Sec-
7 tion 1128A of the Social Security Act (42 U.S.C. 1320a-
8 7a) is amended as follows:

9 (1) In subsection (a)(1), by inserting “or of any
10 health plan (as defined in section 1128(i)),” after
11 “subsection (i)(1),”.

12 (2) In subsection (f)—

13 (A) by redesignating paragraph (3) as
14 paragraph (4); and

15 (B) by inserting after paragraph (2) the
16 following new paragraphs:

17 “(3) With respect to amounts recovered arising
18 out of a claim under a health plan, the portion of
19 such amounts as is determined to have been paid by
20 the plan shall be repaid to the plan, and the portion
21 of such amounts attributable to the amounts recov-
22 ered under this section by reason of the amendments
23 made by the Health Care Fraud Prevention Act of
24 1995 (as estimated by the Secretary) shall be depos-
25 ited into the Health Care Fraud and Abuse Control

1 Account established under section 101(b) of such
2 Act.”.

3 (3) In subsection (i)—

4 (A) in paragraph (2), by inserting “or
5 under a health plan” before the period at the
6 end, and

7 (B) in paragraph (5), by inserting “or
8 under a health plan” after “or XX”.

9 (b) EXCLUDED INDIVIDUAL RETAINING OWNERSHIP
10 OR CONTROL INTEREST IN PARTICIPATING ENTITY.—
11 Section 1128A(a) of the Social Security Act (42 U.S.C.
12 1320a–7a(a)) is amended—

13 (1) by striking “or” at the end of paragraph
14 (1)(D);

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

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

19 (4) by inserting after paragraph (3) the follow-
20 ing new paragraph:

21 “(4) in the case of a person who is not an orga-
22 nization, agency, or other entity, is excluded from
23 participating in a program under title XVIII or a
24 State health care program in accordance with this
25 subsection or under section 1128 and who, at the

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

9 (c) MODIFICATIONS OF AMOUNTS OF PENALTIES
10 AND ASSESSMENTS.—Section 1128A(a) of the Social Se-
11 curity Act (42 U.S.C. 1320a–7a(a)), as amended by sub-
12 section (b), is amended in the matter following paragraph
13 (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 (d) CLAIM FOR ITEM OR SERVICE BASED ON INCOR-
23 RECT CODING OR MEDICALLY UNNECESSARY SERV-
24 ICES.—Section 1128A(a)(1) of the Social Security Act (42
25 U.S.C. 1320a–7a(a)(1)) is amended—

1 (1) in subparagraph (A) by striking “claimed,”
2 and inserting the following: “claimed, including any
3 person who repeatedly presents or causes to be pre-
4 sented a claim for an item or service that is based
5 on a code that the person knows or should know will
6 result in a greater payment to the person than the
7 code the person knows or should know is applicable
8 to the item or service actually provided,”;

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

11 (3) in subparagraph (D), by striking “; or” and
12 inserting “, or”;

13 (4) by inserting after subparagraph (D) the fol-
14 lowing new subparagraph:

15 “(E) is for a medical or other item or serv-
16 ice that a person repeatedly knows or should
17 know is not medically necessary; or”.

18 (e) PERMITTING SECRETARY TO IMPOSE CIVIL MON-
19 ETARY PENALTY.—Section 1128A(b) of the Social Secu-
20 rity Act (42 U.S.C. 1320a–7a(a)) is amended by adding
21 the following new paragraph:

22 “(3) Any person (including any organization,
23 agency, or other entity, but excluding a beneficiary
24 as defined in subsection (i)(5)) who the Secretary
25 determines has violated section 1128B(b) of this

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

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

18 (g) PROCEDURAL PROVISIONS.—Section 1876(i)(6)
19 of such Act (42 U.S.C. 1395mm(i)(6)) is further amended
20 by adding at the end the following new subparagraph:

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

1 (h) EFFECTIVE DATE.—The amendments made by
2 this section shall take effect January 1, 1996.

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

6 (1) OFFER OF REMUNERATION.—Section
7 1128A(a) of the Social Security Act (42 U.S.C.
8 1320a-7a(a)) is amended—

9 (A) by striking “or” at the end of para-
10 graph (1)(D);

11 (B) by striking “, or” at the end of para-
12 graph (2) and inserting a semicolon;

13 (C) by striking the semicolon at the end of
14 paragraph (3) and inserting “; or”; and

15 (D) by inserting after paragraph (3) the
16 following new paragraph:

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

1 (2) REMUNERATION DEFINED.—Section
2 1128A(i) of such Act (42 U.S.C. 1320a–7a(i)) is
3 amended by 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 third party payors to
7 whom claims are presented and as long as the
8 differentials meet the standards as defined in
9 regulations promulgated by the Secretary; or

10 “(C) incentives given to individuals to pro-
11 mote the delivery of preventive care as deter-
12 mined by the Secretary in regulations.”.

13 **TITLE V—AMENDMENTS TO**
14 **CRIMINAL LAW**

15 **SEC. 501. HEALTH CARE FRAUD.**

16 (a) IN GENERAL.—

17 (1) FINES AND IMPRISONMENT FOR HEALTH
18 CARE FRAUD VIOLATIONS.—Chapter 63 of title 18,
19 United States Code, is amended by adding at the
20 end the following new section:

21 **“§ 1347. Health care fraud**

22 “(a) Whoever knowingly executes, or attempts to exe-
23 cute, a scheme or artifice—

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

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

10 shall be fined under this title or imprisoned not more than
11 10 years, or both. If the violation results in serious bodily
12 injury (as defined in section 1365(g)(3) of this title), such
13 person shall be imprisoned for any term of years.

14 “(b) For purposes of this section, the term ‘health
15 plan’ has the same meaning given such term in section
16 1128(i) of the Social Security Act.”.

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

“1347. Health care fraud.”.

21 (b) CRIMINAL FINES DEPOSITED IN THE HEALTH
22 CARE FRAUD AND ABUSE CONTROL ACCOUNT.—The Sec-
23 retary of the Treasury shall deposit into the Health Care
24 Fraud and Abuse Control Account established under sec-
25 tion 101(b) an amount equal to the criminal fines imposed

1 under section 1347 of title 18, United States Code (relat-
2 ing to health care fraud).

3 **SEC. 502. FORFEITURES FOR FEDERAL HEALTH CARE OF-**
4 **FENSES.**

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

8 “(6)(A) The court, in imposing sentence on a person
9 convicted of a Federal health care offense, shall order the
10 person to forfeit property, real or personal, that—

11 “(i) is used in the commission of the offense if
12 the offense results in a financial loss or gain of
13 \$50,000 or more; or

14 “(ii) constitutes or is derived from proceeds
15 traceable to the commission of the offense.

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

19 “(i) section 1347 of this title;

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

21 “(iii) sections 287, 371, 664, 666, 1001, 1027,
22 1341, 1343, or 1954 of this title if the violation or
23 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:

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

24 (b) **FREEZING OF ASSETS.**—Section 1345(a)(2) of
25 title 18, United States Code, is amended by inserting “or

1 a Federal health care offense (as defined in section
2 982(a)(6)(B))” after “title”.

3 **SEC. 504. GRAND JURY DISCLOSURE.**

4 Section 3322 of title 18, United States Code, is
5 amended—

6 (1) by redesignating subsections (c) and (d) as
7 subsections (d) and (e), respectively; and

8 (2) by inserting after subsection (b) the follow-
9 ing:

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

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

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

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

20 **SEC. 505. FALSE STATEMENTS.**

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

1 **“§ 1033. False statements relating to health care mat-**
2 **ters**

3 “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) CLERICAL AMENDMENT.—The table of sections
12 at the beginning of chapter 47 of title 18, United States
13 Code, in amended by adding at the end the following:

“1033. False statements relating to health care matters.”.

14 **SEC. 506. VOLUNTARY DISCLOSURE PROGRAM.**

15 In consultation with the Attorney General of the
16 United States, the Secretary of Health and Human Serv-
17 ices shall publish proposed regulations not later than 9
18 months after the date of enactment of this Act, and final
19 regulations not later than 18 months after such date of
20 enactment, establishing a program of voluntary disclosure
21 that would facilitate the enforcement of sections 1128A
22 and 1128B of the Social Security Act (42 U.S.C. 1320a-
23 7a and 1320a-7b) and other relevant provisions of Fed-
24 eral law relating to health care fraud and abuse. Such pro-
25 gram should promote and provide incentives for disclo-

1 sures of potential violations of such sections and provi-
2 sions by providing that, under certain circumstances, the
3 voluntary disclosure of wrongdoing would result in the im-
4 position of penalties and punishments less substantial
5 than those that would be assessed for the same wrong-
6 doing if voluntary disclosure did not occur.

7 **SEC. 507. OBSTRUCTION OF CRIMINAL INVESTIGATIONS OF**
8 **FEDERAL HEALTH CARE OFFENSES.**

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

12 **“§ 1518. Obstruction of Criminal Investigations of**
13 **Federal Health Care Offenses.**

14 “(a) IN GENERAL.—Whoever willfully prevents, ob-
15 structs, misleads, delays or attempts to prevent, obstruct,
16 mislead, or delay the communication of information or
17 records relating to a Federal health care offense to a
18 criminal investigator shall be fined under this title or im-
19 prisoned not more than 5 years, or both.

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

24 “(c) CRIMINAL INVESTIGATOR.—As used in this sec-
25 tion the term ‘criminal investigator’ means any individual

1 duly authorized by a department, agency, or armed force
2 of the United States to conduct or engage in investigations
3 for prosecutions for violations of health care offenses.”.

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

“1518. Obstruction of Criminal Investigations of Federal Health Care Of-
fenses.”.

7 **SEC. 508. THEFT OR EMBEZZLEMENT.**

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

11 **“§ 669. Theft or Embezzlement in Connection with**
12 **Health Care.**

13 “(a) IN GENERAL.—Whoever willfully embezzles,
14 steals, or otherwise without authority willfully and unlaw-
15 fully converts to the use of any person other than the
16 rightful owner, or intentionally misapplies any of the mon-
17 eys, funds, securities, premiums, credits, property, or
18 other assets of a health care benefit program, shall be
19 fined under this title or imprisoned not more than 10
20 years, or both.

21 “(b) FEDERAL HEALTH CARE OFFENSE.—As used
22 in this section the term ‘Federal health care offense’ has
23 the same meaning given such term in section 982(a)(6)(B)
24 of this title.”.

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

“669. Theft or Embezzlement in Connection with Health Care.”.

4 **SEC. 509. LAUNDERING OF MONETARY INSTRUMENTS.**

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

8 “(F) Any act or activity constituting an of-
 9 fense involving a Federal health care offense as
 10 that term is defined in section 982(a)(6)(B) of
 11 this title.”.

12 **TITLE VI—PAYMENTS FOR**
 13 **STATE HEALTH CARE FRAUD**
 14 **CONTROL UNITS**

15 **SEC. 601. ESTABLISHMENT OF STATE FRAUD UNITS.**

16 (a) ESTABLISHMENT OF HEALTH CARE FRAUD AND
 17 ABUSE CONTROL UNIT.—The Governor of each State
 18 shall, consistent with State law, establish and maintain in
 19 accordance with subsection (b) a State agency to act as
 20 a Health Care Fraud and Abuse Control Unit for purposes
 21 of this part.

22 (b) DEFINITION.—In this section, a “State Fraud
 23 Unit” means a Health Care Fraud and Abuse Control
 24 Unit designated under subsection (a) that the Secretary
 25 certifies meets the requirements of this part.

1 **SEC. 602. REQUIREMENTS FOR STATE FRAUD UNITS.**

2 (a) IN GENERAL.—The State Fraud Unit must—

3 (1) be a single identifiable entity of the State
4 government;

5 (2) be separate and distinct from any State
6 agency with principal responsibility for the adminis-
7 tration of any Federally-funded or mandated health
8 care program;

9 (3) meet the other requirements of this section.

10 (b) SPECIFIC REQUIREMENTS DESCRIBED.—The
11 State Fraud Unit shall—

12 (1) be a Unit of the office of the State Attorney
13 General or of another department of State govern-
14 ment which possesses statewide authority to pros-
15 ecute individuals for criminal violations;

16 (2) if it is in a State the constitution of which
17 does not provide for the criminal prosecution of indi-
18 viduals by a statewide authority and has formal pro-
19 cedures, (A) assure its referral of suspected criminal
20 violations to the appropriate authority or authorities
21 in the State for prosecution, and (B) assure its as-
22 sistance of, and coordination with, such authority or
23 authorities in such prosecutions; or

24 (3) have a formal working relationship with the
25 office of the State Attorney General or the appro-
26 priate authority or authorities for prosecution and

1 have formal procedures (including procedures for its
2 referral of suspected criminal violations to such of-
3 fice) which provide effective coordination of activities
4 between the Fraud Unit and such office with respect
5 to the detection, investigation, and prosecution of
6 suspected criminal violations relating to any Feder-
7 ally-funded or mandated health care programs.

8 (c) STAFFING REQUIREMENTS.—The State Fraud
9 Unit shall—

10 (1) employ attorneys, auditors, investigators
11 and other necessary personnel; and

12 (2) be organized in such a manner and provide
13 sufficient resources as is necessary to promote the
14 effective and efficient conduct of State Fraud Unit
15 activities.

16 (d) COOPERATIVE AGREEMENTS; MEMORANDA OF
17 UNDERSTANDING.—The State Fraud Unit shall have co-
18 operative agreements with—

19 (1) Federally-funded or mandated health care
20 programs;

21 (2) similar Fraud Units in other States, as ex-
22 emplified through membership and participation in
23 the National Association of Medicaid Fraud Control
24 Units or its successor; and

25 (3) the Secretary.

1 (e) REPORTS.—The State Fraud Unit shall submit
2 to the Secretary an application and an annual report con-
3 taining such information as the Secretary determines to
4 be necessary to determine whether the State Fraud Unit
5 meets the requirements of this section.

6 (f) FUNDING SOURCE; PARTICIPATION IN ALL-
7 PAYER PROGRAM.—In addition to those sums expended
8 by a State under section 604(a) for purposes of determin-
9 ing the amount of the Secretary's payments, a State
10 Fraud Unit may receive funding for its activities from
11 other sources, the identity of which shall be reported to
12 the Secretary in its application or annual report. The
13 State Fraud Unit shall participate in the all-payer fraud
14 and abuse control program established under section 101.

15 **SEC. 603. SCOPE AND PURPOSE.**

16 The State Fraud Unit shall carry out the following
17 activities:

18 (1) The State Fraud Unit shall conduct a state-
19 wide program for the investigation and prosecution
20 (or referring for prosecution) of violations of all ap-
21 plicable state laws regarding any and all aspects of
22 fraud in connection with any aspect of the adminis-
23 tration and provision of health care services and ac-
24 tivities of providers of such services under any Fed-
25 erally-funded or mandated health care programs;

1 (2) The State Fraud Unit shall have procedures
2 for reviewing complaints of the abuse or neglect of
3 patients of facilities (including patients in residential
4 facilities and home health care programs) that re-
5 ceive payments under any Federally-funded or man-
6 dated health care programs, and, where appropriate,
7 to investigate and prosecute such complaints under
8 the criminal laws of the State or for referring the
9 complaints to other State agencies for action.

10 (3) The State Fraud Unit shall provide for the
11 collection, or referral for collection to the appro-
12 priate agency, of overpayments that are made under
13 any Federally-funded or mandated health care pro-
14 gram and that are discovered by the State Fraud
15 Unit in carrying out its activities.

16 **SEC. 604. PAYMENTS TO STATES.**

17 (a) MATCHING PAYMENTS TO STATES.—Subject to
18 subsection (c), for each year for which a State has a State
19 Fraud Unit approved under section 602(b) in operation
20 the Secretary shall provide for a payment to the State for
21 each quarter in a fiscal year in an amount equal to the
22 applicable percentage of the sums expended during the
23 quarter by the State Fraud Unit.

24 (b) APPLICABLE PERCENTAGE DEFINED.—

1 (1) IN GENERAL.—In subsection (a), the “ap-
2 plicable percentage” with respect to a State for a
3 fiscal year is—

4 (A) 90 percent, for quarters occurring dur-
5 ing the first 3 years for which the State Fraud
6 Unit is in operation; or

7 (B) 75 percent, for any other quarters.

8 (2) TREATMENT OF STATES WITH MEDICAID
9 FRAUD CONTROL UNITS.—In the case of a State
10 with a State medicaid fraud control in operation
11 prior to or as of the date of the enactment of this
12 Act, in determining the number of years for which
13 the State Fraud Unit under this part has been in
14 operation, there shall be included the number of
15 years for which such State medicaid fraud control
16 unit was in operation.

17 (c) LIMIT ON PAYMENT.—Notwithstanding sub-
18 section (a), the total amount of payments made to a State
19 under this section for a fiscal year may not exceed the
20 amounts as authorized pursuant to section 1903(b)(3) of
21 the Social Security Act.

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S 245 IS—2

S 245 IS—3

S 245 IS—4

S 245 IS—5