104TH CONGRESS
1ST SESSION

S. 1088

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

IN THE SENATE OF THE UNITED STATES

JULY 28 (legislative day, JULY 10), 1995

Mr. COHEN introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

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

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Health Care Fraud and Abuse Prevention Act of 1995''.

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

TITLE I—FRAUD AND ABUSE CONTROL PROGRAM

SEC. 101. FRAUD AND ABUSE CONTROL PROGRAM.

(a) ESTABLISHMENT OF PROGRAM.—

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

(A) to coordinate Federal, State, and local law enforcement programs to control fraud and abuse with respect to the delivery of and payment for health care in the United States,

(B) to conduct investigations, audits, evaluations, and inspections relating to the delivery of and payment for health care in the United States,

(C) to facilitate the enforcement of the provisions of sections 1128, 1128A, and 1128B of the Social Security Act (42 U.S.C. 1320a–7, 1320a–7a, and 1320a–7b) and other statutes applicable to health care fraud and abuse, and

(D) to provide for the modification and establishment of safe harbors and to issue inter-

pretative rulings and special fraud alerts pursuant to section 103.

(2) COORDINATION WITH HEALTH PLANS.—In carrying out the program established under paragraph (1), the Secretary and the Attorney General shall consult with, and arrange for the sharing of data with representatives of health plans.

(3) GUIDELINES.—

(A) IN GENERAL.—The Secretary and the Attorney General shall issue guidelines to carry out the program under paragraph (1). The provisions of sections 553, 556, and 557 of title 5, United States Code, shall not apply in the issuance of such guidelines.

(B) INFORMATION GUIDELINES.—

(i) IN GENERAL.—Such guidelines shall include guidelines relating to the furnishing of information by health plans, providers, and others to enable the Secretary and the Attorney General to carry out the program (including coordination with health plans under paragraph (2)).

(ii) CONFIDENTIALITY.—Such guidelines shall include procedures to assure that such information is provided and uti-

lized in a manner that appropriately protects the confidentiality of the information and the privacy of individuals receiving health care services and items.

(iii) QUALIFIED IMMUNITY FOR PROVIDING INFORMATION.—The provisions of section 1157(a) of the Social Security Act (42 U.S.C. 1320c–6(a)) (relating to limitation on liability) shall apply to a person providing information to the Secretary or the Attorney General in conjunction with their performance of duties under this section.

(4) INVESTIGATORS AND OTHER PERSONNEL.—In addition to any other amounts authorized to be appropriated to the Secretary, the Attorney General, the Director of the Federal Bureau of Investigation, and the Inspectors General of the Departments of Health and Human Services, Defense, Labor, and Veterans Affairs, of the Office of Personnel Management, and of the Railroad Retirement Board, for health care anti-fraud and abuse activities for a fiscal year, there are authorized to be appropriated additional amounts, from the Health Care Fraud and Abuse Control described in subsection (b) of this

section, as may be necessary to enable the Secretary, the Attorney General, and such Inspectors General to conduct investigations and audits of allegations of health care fraud and abuse and otherwise carry out the program established under paragraph (1) in a fiscal year.

(5) ENSURING ACCESS TO DOCUMENTATION.—The Inspector General of the Department of Health and Human Services is authorized to exercise such authority described in paragraphs (3) through (9) of section 6 of the Inspector General Act of 1978 (5 U.S.C. App.) as necessary with respect to the activities under the fraud and abuse control program established under this subsection.

(6) AUTHORITY OF INSPECTOR GENERAL.—Nothing in this Act shall be construed to diminish the authority of any Inspector General, including such authority as provided in the Inspector General Act of 1978 (5 U.S.C. App.).

(b) HEALTH CARE FRAUD AND ABUSE CONTROL.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—There is hereby established the Health Care Fraud and Abuse Control. There are hereby appropriated to the Health Care Fraud and Abuse Control—

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

(ii) such amounts as may be deposited in the Health Care Fraud and Abuse Control as provided in sections 501(b) and 502(b), and title XI of the Social Security Act; and

(iii) such amounts as are transferred to the Health Care Fraud and Abuse Control under subparagraph (C).

(B) AUTHORIZATION TO ACCEPT GIFTS.—The Health Care Fraud and Abuse Control is authorized to accept on behalf of the United States money gifts and bequests made unconditionally to the Health Care Fraud and Abuse Control, for the benefit of the Health Care Fraud and Abuse Control or any activity financed through the Health Care Fraud and Abuse Control.

(C) TRANSFER OF AMOUNTS.—The Secretary of the Treasury shall transfer to the Health Care Fraud and Abuse Control, under rules similar to the rules in section 9601 of the Internal Revenue Code of 1986, an amount equal to the sum of the following:

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

(ii) Administrative penalties and assessments imposed under titles XI, XVIII, and XIX of the Social Security Act (except as otherwise provided by law).

(iii) Amounts resulting from the forfeiture of property by reason of a Federal health care offense.

(iv) Penalties and damages imposed under the False Claims Act (31 U.S.C. 3729 et seq.), in cases involving claims related to the provision of health care items and services (other than funds awarded to a relator or for restitution).

(2) GENERAL USE OF FUNDS.—

(A) IN GENERAL.—Amounts in the Health Care Fraud and Abuse Control shall be available, as provided in appropriation Acts, to cover the costs (including equipment, salaries and benefits, and travel and training) of the administration and operation of the health care fraud

and abuse control program established under subsection (a), including the costs of—

(i) prosecuting health care matters (through criminal, civil, and administrative proceedings);

(ii) investigations;

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

(iv) inspections and other evaluations; and

(v) provider and consumer education regarding compliance with the provisions of this title.

(B) FUNDS USED TO SUPPLEMENT AGENCY APPROPRIATIONS.—It is intended that disbursements made from the Health Care Fraud and Abuse Control to any Federal agency be used to increase and not supplant the recipient agency's appropriated operating budget.

(3) ADDITIONAL USE OF FUNDS BY INSPECTOR GENERAL.—

(A) REIMBURSEMENTS FOR INVESTIGATIONS.—Amounts in the Health Care Fraud and Abuse Control shall be available, as provided in appropriation Acts, to the Inspectors

General of the Departments of Health and Human Services, Defense, Labor, and Veterans Affairs, of the Office of Personnel Management, and of the Railroad Retirement Board, to receive and retain for current use reimbursement for the costs of conducting investigations, when such restitution is ordered by a court, voluntarily agreed to by the payer, or otherwise.

(B) CREDITING.—Funds received by any such Inspector General as reimbursement for costs of conducting investigations shall be deposited to the credit of the appropriation from which initially paid, or to appropriations for similar purposes currently available at the time of deposit, and shall remain available for obligation for 1 year from the date of the deposit of such funds.

(4) ADDITIONAL USE OF FUNDS BY STATE MEDICAID FRAUD CONTROL UNITS FOR INVESTIGATION REIMBURSEMENTS.—Amounts in the Health Care Fraud and Abuse Control shall be available, as provided in appropriation Acts, to the various State medicaid fraud control units to reimburse such units upon request to the Secretary for the costs of the ac-

tivities authorized under section 1903(q) of the Social Security Act (42 U.S.C. 1396c(q).

(5) ANNUAL REPORT.—The Secretary and the Attorney General shall submit jointly an annual report to Congress on the amount of revenue which is generated and disbursed by the Health Care Fraud and Abuse Control in each fiscal year.

(c) HEALTH PLAN DEFINED.—For purposes of this section, the term ''health plan'' means a plan or program that provides health benefits, whether directly, through insurance, or otherwise, and includes—

(1) a policy of health insurance;

(2) a contract of a service benefit organization;

(3) a membership agreement with a health maintenance organization or other prepaid health plan; and

(4) an employee welfare benefit plan or a multiple employer welfare plan (as such terms are defined in section 3 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002).

SEC. 102. APPLICATION OF CERTAIN HEALTH ANTI-FRAUD AND ABUSE SANCTIONS TO FRAUD AND ABUSE AGAINST FEDERAL HEALTH PROGRAMS.

(a) CRIMES.—

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

(A) In the heading, by striking ''MEDICARE OR STATE HEALTH CARE PROGRAMS'' and inserting ''FEDERAL HEALTH CARE PROGRAMS''.

(B) In subsection (a)(1), by striking ''a program under title XVIII or a State health care program (as defined in section 1128(h))'' and inserting ''a Federal health care program''.

(C) In subsection (a)(5), by striking ''a program under title XVIII or a State health care program'' and inserting ''a Federal health care program''.

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

(i) by striking ''a State plan approved under title XIX'' and inserting ''a Federal health care program'', and

(ii) by striking ''the State may at its option (notwithstanding any other provision of that title or of such plan)'' and inserting ''the administrator of such program may at its option (notwithstanding any other provision of such program)''.

(E) In subsection (b), by striking ''title XVIII or a State health care program'' each place it appears and inserting ''a Federal health care program''.

(F) In subsection (c), by inserting ''(as defined in section 1128(h))'' after ''a State health care program''.

(G) By adding at the end the following new subsection:

''(f) For purposes of this section, the term 'Federal health care program' means—

''(1) any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded, in whole or in part, by the United States Government; or

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

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

''(g) The Secretary may—

''(1) in consultation with State and local health care officials, identify opportunities for the satisfaction of community service obligations that a court

may impose upon the conviction of an offense under this section, and

''(2) make information concerning such opportunities available to Federal and State law enforcement officers and State and local health care officials.''.

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

SEC. 103. HEALTH CARE FRAUD AND ABUSE GUIDANCE.

(a) SOLICITATION AND PUBLICATION OF MODIFICATIONS TO EXISTING SAFE HARBORS AND NEW SAFE HARBORS.—

(1) IN GENERAL.—

(A) SOLICITATION OF PROPOSALS FOR SAFE HARBORS.—Not later than January 1, 1996, and not less than annually thereafter, the Secretary shall publish a notice in the Federal Register soliciting proposals, which will be accepted during a 60-day period, for—

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

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

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

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

(B) PUBLICATION OF PROPOSED MODIFICATIONS AND PROPOSED ADDITIONAL SAFE HARBORS.—After considering the proposals described in clauses (i) and (ii) of subparagraph (A), the Secretary, in consultation with the Attorney General, shall publish in the Federal Register proposed modifications to existing safe harbors and proposed additional safe harbors, if appropriate, with a 60-day comment period. After considering any public comments received during this period, the Secretary shall issue final rules modifying the existing safe harbors

and establishing new safe harbors, as appropriate.

(C) REPORT.—The Inspector General of the Department of Health and Human Services (in this section referred to as the ''Inspector General'') shall, in an annual report to Congress or as part of the year-end semiannual report required by section 5 of the Inspector General Act of 1978 (5 U.S.C. App.), describe the proposals received under clauses (i) and (ii) of subparagraph (A) and explain which proposals were included in the publication described in subparagraph (B), which proposals were not included in that publication, and the reasons for the rejection of the proposals that were not included.

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

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

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

(C) An increase or decrease in patient freedom of choice among health care providers.

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

(E) An increase or decrease in the ability of health care facilities to provide services in medically underserved areas or to medically underserved populations.

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

(G) An increase or decrease in the potential overutilization of health care services.

(H) The existence or nonexistence of any potential financial benefit to a health care professional or provider which may vary based on their decisions of—

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

(ii) whether to arrange for a referral of health care items or services to a particular practitioner or provider.

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

(b) INTERPRETIVE RULINGS.—

(1) IN GENERAL.—

(A) REQUEST FOR INTERPRETIVE RULING.—Any person may present, at any time, a request to the Inspector General for a statement of the Inspector General's current interpretation of the meaning of a specific aspect of the application of sections 1128A and 1128B of the Social Security Act (42 U.S.C. 1320a–7a and 1320a–7b) (in this section referred to as an ''interpretive ruling'').

(B) ISSUANCE AND EFFECT OF INTERPRETIVE RULING.—

(i) IN GENERAL.—If appropriate, the Inspector General shall in consultation with the Attorney General, issue an interpretive ruling not later than 90 days after receiving a request described in subparagraph (A). Interpretive rulings shall not have the force of law and shall be treated as an interpretive rule within the meaning

of section 553(b) of title 5, United States Code. All interpretive rulings issued pursuant to this clause shall be published in the Federal Register or otherwise made available for public inspection.

(ii) REASONS FOR DENIAL.—If the Inspector General does not issue an interpretive ruling in response to a request described in subparagraph (A), the Inspector General shall notify the requesting party of such decision not later than 60 days after receiving such a request and shall identify the reasons for such decision.

(2) CRITERIA FOR INTERPRETIVE RULINGS.—

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

(i) whether and to what extent the request identifies an ambiguity within the language of the statute, the existing safe harbors, or previous interpretive rulings; and

(ii) whether the subject of the requested interpretive ruling can be adequately addressed by interpretation of the

language of the statute, the existing safe harbor rules, or previous interpretive rulings, or whether the request would require a substantive ruling (as defined in section 552 of title 5, United States Code) not authorized under this subsection.

(B) NO RULINGS ON FACTUAL ISSUES.—The Inspector General shall not give an interpretive ruling on any factual issue, including the intent of the parties or the fair market value of particular leased space or equipment.

(c) SPECIAL FRAUD ALERTS.—

(1) IN GENERAL.—

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

(B) ISSUANCE AND PUBLICATION OF SPECIAL FRAUD ALERTS.—Upon receipt of a request described in subparagraph (A), the In-

spector General shall investigate the subject matter of the request to determine whether a special fraud alert should be issued. If appropriate, the Inspector General shall issue a special fraud alert in response to the request. All special fraud alerts issued pursuant to this subparagraph shall be published in the Federal Register.

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

(A) whether and to what extent the practices that would be identified in the special fraud alert may result in any of the consequences described in subsection (a)(2); and

(B) the volume and frequency of the conduct that would be identified in the special fraud alert.

TITLE II—REVISIONS TO CURRENT SANCTIONS FOR FRAUD AND ABUSE

SEC. 201. MANDATORY EXCLUSION FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS.

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

(1) IN GENERAL.—Section 1128(a) of the Social Security Act (42 U.S.C. 1320a–7(a)) is amended by adding at the end the following new paragraph:

''(3) FELONY CONVICTION RELATING TO HEALTH CARE FRAUD.—Any individual or entity that has been convicted after the date of the enactment of the Health Care Fraud and Abuse Prevention Act of 1995, under Federal or State law, in connection with the delivery of a health care item or service or with respect to any act or omission in a health care program (other than those specifically described in paragraph (1)) operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement,

breach of fiduciary responsibility, or other financial misconduct.''.

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

''(1) CONVICTION RELATING TO FRAUD.—Any individual or entity that has been convicted after the date of the enactment of the Health Care Fraud and Abuse Prevention Act of 1995, under Federal or State law—

''(A) of a criminal offense consisting of a misdemeanor relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct—

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

''(ii) with respect to any act or omission in a health care program (other than those specifically described in subsection (a)(1)) operated by or financed in whole or in part by any Federal, State, or local government agency; or

''(B) of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct

with respect to any act or omission in a program (other than a health care program) operated by or financed in whole or in part by any Federal, State, or local government agency.''.

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

(1) IN GENERAL.—Section 1128(a) of the Social Security Act (42 U.S.C. 1320a–7(a)), as amended by subsection (a), is amended by adding at the end the following new paragraph:

''(4) FELONY CONVICTION RELATING TO CONTROLLED SUBSTANCE.—Any individual or entity that has been convicted after the date of the enactment of the Health Care Fraud and Abuse Prevention Act of 1995, under Federal or State law, of a criminal offense consisting of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.''.

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

(A) in the heading, by striking ''CONVICTION'' and inserting ''MISDEMEANOR CONVICTION''; and

(B) by striking ''criminal offense'' and inserting ''criminal offense consisting of a misdemeanor''.

SEC. 202. ESTABLISHMENT OF MINIMUM PERIOD OF EXCLUSION FOR CERTAIN INDIVIDUALS AND ENTITIES SUBJECT TO PERMISSIVE EXCLUSION FROM MEDICARE AND STATE HEALTH CARE PROGRAMS.

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

''(D) In the case of an exclusion of an individual or entity under paragraph (1), (2), or (3) of subsection (b), the period of the exclusion shall be 3 years, unless the Secretary determines in accordance with published regulations that a shorter period is appropriate because of mitigating circumstances or that a longer period is appropriate because of aggravating circumstances.

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

''(F) In the case of an exclusion of an individual or entity under subsection (b)(6)(B), the period of the exclusion shall be not less than 1 year.''.

SEC. 203. PERMISSIVE EXCLUSION OF INDIVIDUALS WITH OWNERSHIP OR CONTROL INTEREST IN SANCTIONED ENTITIES.

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

''(15) INDIVIDUALS CONTROLLING A SANCTIONED ENTITY.—Any individual who has a direct or indirect ownership or control interest of 5 percent or more, or an ownership or control interest (as defined in section 1124(a)(3)) in, or who is an officer or managing employee (as defined in section 1126(b)) of, an entity—

''(A) that has been convicted of any offense described in subsection (a) or in paragraph (1), (2), or (3) of this subsection; or

''(B) that has been excluded from participation under a program under title XVIII or under a State health care program.''.

SEC. 204. SANCTIONS AGAINST PRACTITIONERS AND PERSONS FOR FAILURE TO COMPLY WITH STATUTORY OBLIGATIONS.

(a) MINIMUM PERIOD OF EXCLUSION FOR PRACTITIONERS AND PERSONS FAILING TO MEET STATUTORY OBLIGATIONS.—

(1) IN GENERAL.—The second sentence of section 1156(b)(1) of the Social Security Act (42 U.S.C. 1320c–5(b)(1)) is amended by striking ''may prescribe)'' and inserting ''may prescribe, except that such period may not be less than 1 year)''.

(2) CONFORMING AMENDMENT.—Section 1156(b)(2) of such Act (42 U.S.C. 1320c–5(b)(2)) is amended by striking ''shall remain'' and inserting ''shall (subject to the minimum period specified in the second sentence of paragraph (1)) remain''.

(b) REPEAL OF ''UNWILLING OR UNABLE'' CONDITION FOR IMPOSITION OF SANCTION.—Section 1156(b)(1) of the Social Security Act (42 U.S.C. 1320c–5(b)(1)) is amended—

(1) in the second sentence, by striking ''and determines'' and all that follows through ''such obligations,''; and

(2) by striking the third sentence.

SEC. 205. INTERMEDIATE SANCTIONS FOR MEDICARE HEALTH MAINTENANCE ORGANIZATIONS.

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

(1) IN GENERAL.—Section 1876(i)(1) of the Social Security Act (42 U.S.C. 1395mm(i)(1)) is amended by striking ''the Secretary may terminate'' and all that follows and inserting ''in accordance with procedures established under paragraph (9), the Secretary may at any time terminate any such contract or may impose the intermediate sanctions described in paragraph (6)(B) or (6)(C) (whichever is applicable) on the eligible organization if the Secretary determines that the organization—

''(A) has failed substantially to carry out the contract;

''(B) is carrying out the contract in a manner substantially inconsistent with the efficient and effective administration of this section; or

''(C) no longer substantially meets the applicable conditions of subsections (b), (c), (e), and (f).''.

(2) OTHER INTERMEDIATE SANCTIONS FOR MISCELLANEOUS PROGRAM VIOLATIONS.—Section 1876(i)(6) of such Act (42 U.S.C. 1395mm(i)(6)) is

amended by adding at the end the following new subparagraph:

''(C) In the case of an eligible organization for which the Secretary makes a determination under paragraph (1) the basis of which is not described in subparagraph (A), the Secretary may apply the following intermediate sanctions:

''(i) Civil money penalties of not more than $25,000 for each determination under paragraph (1) if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract.

''(ii) Civil money penalties of not more than $10,000 for each week beginning after the initiation of procedures by the Secretary under paragraph (9) during which the deficiency that is the basis of a determination under paragraph (1) exists.

''(iii) Suspension of enrollment of individuals under this section after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the deficiency that is the basis for the determination has been corrected and is not likely to recur.''.

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

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

''(A) the Secretary first provides the organization with the reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under paragraph (1) and the organization fails to develop or implement such a plan;

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

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

''(D) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before imposing any sanction or terminating the contract.''.

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

(b) AGREEMENTS WITH PEER REVIEW ORGANIZATIONS.—

(1) REQUIREMENT FOR WRITTEN AGREEMENT.—Section 1876(i)(7)(A) of the Social Security Act (42 U.S.C. 1395mm(i)(7)(A)) is amended by striking ''an agreement'' and inserting ''a written agreement''.

(2) DEVELOPMENT OF MODEL AGREEMENT.—Not later than July 1, 1996, the Secretary shall develop a model of the agreement that an eligible organization with a risk-sharing contract under section 1876 of the Social Security Act must enter into with an entity providing peer review services with respect to services provided by the organization under section 1876(i)(7)(A) of such Act.

(3) REPORT BY GAO.—

(A) STUDY.—The Comptroller General of the United States shall conduct a study of the costs incurred by eligible organizations with risk-sharing contracts under section 1876(b) of such Act of complying with the requirement of entering into a written agreement with an entity providing peer review services with respect to services provided by the organization, together with an analysis of how information generated by such entities is used by the Secretary to assess the quality of services provided by such eligible organizations.

(B) REPORT TO CONGRESS.—Not later than July 1, 1998, the Comptroller General shall submit a report to the Committee on Ways and Means and the Committee on Commerce of the House of Representatives and the Committee on Finance and the Special Committee on Aging of the Senate on the study conducted under subparagraph (A).

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to contract years beginning on or after January 1, 1996.

SEC. 206. EFFECTIVE DATE.

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

TITLE III—ADMINISTRATIVE AND MISCELLANEOUS PROVISIONS

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

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

(b) REPORTING OF INFORMATION.—

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

(2) INFORMATION TO BE REPORTED.—The information to be reported under paragraph (1) includes:

(A) The name and TIN (as defined in section 7701(a)(41)) of any health care provider, supplier, or practitioner who is the subject of a final adverse action.

(B) The name (if known) of any health care entity with which a health care provider, supplier, or practitioner is affiliated or associated.

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

(D) A description of the acts or omissions and injuries upon which the final adverse action was based, and such other information as the Secretary determines by regulation is required for appropriate interpretation of information reported under this section.

(3) CONFIDENTIALITY.—In determining what information is required, the Secretary shall include procedures to assure that the privacy of individuals receiving health care services is appropriately protected.

(4) TIMING AND FORM OF REPORTING.—The information required to be reported under this subsection shall be reported regularly (but not less often than monthly) and in such form and manner as the

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

(5) TO WHOM REPORTED.—The information required to be reported under this subsection shall be reported to the Secretary.

(c) DISCLOSURE AND CORRECTION OF INFORMATION.—

(1) DISCLOSURE.—With respect to the information about final adverse actions (not including settlements in which no findings of liability have been made) reported to the Secretary under this section respecting a health care provider, supplier, or practitioner, the Secretary shall, by regulation, provide for—

(A) disclosure of the information, upon request, to the health care provider, supplier, or licensed practitioner, and

(B) procedures in the case of disputed accuracy of the information.

(2) CORRECTIONS.—Each Government agency and health plan shall report corrections of information already reported about any final adverse action taken against a health care provider, supplier, or

practitioner, in such form and manner that the Secretary prescribes by regulation.

(d) ACCESS TO REPORTED INFORMATION.—

(1) AVAILABILITY.—The information in this database shall be available to Federal and State government agencies and health plans pursuant to procedures that the Secretary shall provide by regulation.

(2) FEES FOR DISCLOSURE.—The Secretary may establish or approve reasonable fees for the disclosure of information in this database (other than with respect to requests by Federal agencies). The amount of such a fee may not exceed the costs of processing the requests for disclosure and of providing such information. Such fees shall be available to the Secretary or, in the Secretary's discretion to the agency designated under this section to cover such costs.

(e) PROTECTION FROM LIABILITY FOR REPORTING.—No person or entity, including the agency designated by the Secretary in subsection (b)(5) shall be held liable in any civil action with respect to any report made as required by this section, without knowledge of the falsity of the information contained in the report.

(f) DEFINITIONS AND SPECIAL RULES.—For purposes of this section:

(1)(A) The term ''final adverse action'' includes:

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

(ii) Federal or State criminal convictions related to the delivery of a health care item or service.

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

(I) formal or official actions, such as revocation or suspension of a license (and the length of any such suspension), reprimand, censure or probation,

(II) any other loss of license of the provider, supplier, or practitioner, by operation of law, or

(III) any other negative action or finding by such Federal or State agency that is publicly available information.

(iv) Exclusion from participation in Federal or State health care programs.

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

(B) The term does not include any action with respect to a malpractice claim.

(2) The terms ''licensed health care practitioner'', ''licensed practitioner'', and ''practitioner'' mean, with respect to a State, an individual who is licensed or otherwise authorized by the State to provide health care services (or any individual who, without authority holds himself or herself out to be so licensed or authorized).

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

(4) The term ''supplier'' means a supplier of health care items and services described in section 1819(a) and (b), and section 1861 of the Social Security Act.

(5) The term ''Government agency'' shall include:

(A) The Department of Justice.

(B) The Department of Health and Human Services.

(C) Any other Federal agency that either administers or provides payment for the delivery of health care services, including, but not limited to the Department of Defense and the Veterans' Administration.

(D) State law enforcement agencies.

(E) State medicaid fraud and abuse units.

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

(6) The term ''health plan'' has the meaning given such term by section 101(c).

(7) For purposes of paragraph (2), the existence of a conviction shall be determined under paragraph (4) of section 1128(j) of the Social Security Act.

(g) CONFORMING AMENDMENT.—Section 1921(d) of the Social Security Act is amended by inserting ''and section 301 of the Health Care Fraud and Abuse Prevention

Act of 1995'' after ''section 422 of the Health Care Quality Improvement Act of 1986''.

TITLE IV—CIVIL MONETARY PENALTIES

SEC. 401. SOCIAL SECURITY ACT CIVIL MONETARY PENALTIES.

(a) GENERAL CIVIL MONETARY PENALTIES.—Section 1128A of the Social Security Act (42 U.S.C. 1320a–7a) is amended as follows:

(1) In the third sentence of subsection (a), by striking ''programs under title XVIII'' and inserting ''Federal health care programs (as defined in section 1128(f)(1))''.

(2) In subsection (f)—

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

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

''(3) With respect to amounts recovered arising out of a claim under a Federal health care program (as defined in section 1128B(f)), the portion of such amounts as is determined to have been paid by the program shall be repaid to the program, and the portion of such amounts attributable to the amounts recovered under this section by reason of the amend-

ments made by the Health Care Fraud and Abuse Prevention Act of 1995 (as estimated by the Secretary) shall be deposited into the Health Care Fraud and Abuse Control established under section 101(b) of such Act.''.

(3) In subsection (i)—

(A) in paragraph (2), by striking ''title V, XVIII, XIX, or XX of this Act'' and inserting ''a Federal health care program (as defined in section 1128B(f))'',

(B) in paragraph (4), by striking ''a health insurance or medical services program under title XVIII or XIX of this Act'' and inserting ''a Federal health care program (as so defined)'', and

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

(4) By adding at the end the following new subsection:

''(m)(1) For purposes of this section, with respect to a Federal health care program not contained in this Act, references to the Secretary in this section shall be deemed to be references to the Secretary or Administrator of the department or agency with jurisdiction over such program

and references to the Inspector General of the Department of Health and Human Services in this section shall be deemed to be references to the Inspector General of the applicable department or agency.

''(2)(A) The Secretary and Administrator of the departments and agencies referred to in paragraph (1) may include in any action pursuant to this section, claims within the jurisdiction of other Federal departments or agencies as long as the following conditions are satisfied:

''(i) The case involves primarily claims submitted to the Federal health care programs of the department or agency initiating the action.

''(ii) The Secretary or Administrator of the department or agency initiating the action gives notice and an opportunity to participate in the investigation to the Inspector General of the department or agency with primary jurisdiction over the Federal health care programs to which the claims were submitted.

''(B) If the conditions specified in subparagraph (A) are fulfilled, the Inspector General of the department or agency initiating the action is authorized to exercise all powers granted under the Inspector General Act of 1978 with respect to the claims submitted to the other departments or agencies to the same manner and extent as pro-

vided in that Act with respect to claims submitted to such departments or agencies.''.

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

(1) by striking ''or'' at the end of paragraph (1)(D);

(2) by striking '', or'' at the end of paragraph (2) and inserting a semicolon;

(3) by striking the semicolon at the end of paragraph (3) and inserting ''; or''; and

(4) by inserting after paragraph (3) the following new paragraph:

''(4) in the case of a person who is not an organization, agency, or other entity, is excluded from participating in a program under title XVIII or a State health care program in accordance with this subsection or under section 1128 and who, at the time of a violation of this subsection, retains a direct or indirect ownership or control interest of 5 percent or more, or an ownership or control interest (as defined in section 1124(a)(3)) in, or who is an officer or managing employee (as defined in section 1126(b)) of, an entity that is participating in a pro-

gram under title XVIII or a State health care program;''.

(c) MODIFICATIONS OF AMOUNTS OF PENALTIES AND ASSESSMENTS.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)), as amended by subsection (b), is amended in the matter following paragraph (4)—

(1) by striking ''$2,000'' and inserting ''$10,000'';

(2) by inserting ''; in cases under paragraph (4), $10,000 for each day the prohibited relationship occurs'' after ''false or misleading information was given''; and

(3) by striking ''twice the amount'' and inserting ''3 times the amount''.

(d) CLAIM FOR ITEM OR SERVICE BASED ON INCORRECT CODING OR MEDICALLY UNNECESSARY SERVICES.—Section 1128A(a)(1) of the Social Security Act (42 U.S.C. 1320a–7a(a)(1)) is amended—

(1) in subparagraph (A) by striking ''claimed,'' and inserting ''claimed, including any person who engages in a pattern or practice of presenting or causing to be presented a claim for an item or service that is based on a code that the person knows or has reason to know will result in a greater pay-

ment to the person than the code the person knows or has reason to know is applicable to the item or service actually provided,'';

(2) in subparagraph (C), by striking ''or'' at the end;

(3) in subparagraph (D), by striking ''; or'' and inserting '', or''; and

(4) by inserting after subparagraph (D) the following new subparagraph:

''(E) is for a medical or other item or service that a person knows or has reason to know is not medically necessary; or''.

(e) PERMITTING SECRETARY TO IMPOSE CIVIL MONETARY PENALTY.—Section 1128A(b) of the Social Security Act (42 U.S.C. 1320a–7a(a)) is amended by adding the following new paragraph:

''(3) Any person (including any organization, agency, or other entity, but excluding a beneficiary as defined in subsection (i)(5)) who the Secretary determines has violated section 1128B(b) of this title shall be subject to a civil monetary penalty of not more than $10,000 for each such violation. In addition, such person shall be subject to an assessment of not more than twice the total amount of the remuneration offered, paid, solicited, or received in

violation of section 1128B(b). The total amount of remuneration subject to an assessment shall be calculated without regard to whether some portion thereof also may have been intended to serve a purpose other than one proscribed by section 1128B(b).''.

(f) SANCTIONS AGAINST PRACTITIONERS AND PERSONS FOR FAILURE TO COMPLY WITH STATUTORY OBLIGATIONS.—Section 1156(b)(3) of the Social Security Act (42 U.S.C. 1320c–5(b)(3)) is amended by striking ''the actual or estimated cost'' and inserting ''up to $10,000 for each instance''.

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

''(D) The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under subparagraph (A) or (B) in the same manner as they apply to a civil money penalty or proceeding under section 1128A(a).''.

(h) PROHIBITION AGAINST OFFERING INDUCEMENTS TO INDIVIDUALS ENROLLED UNDER PROGRAMS OR PLANS.—

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

(A) by striking ''or'' at the end of paragraph (1)(D);

(B) by striking '', or'' at the end of paragraph (2) and inserting a semicolon;

(C) by striking the semicolon at the end of paragraph (3) and inserting ''; or''; and

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

''(4) offers to or transfers remuneration to any individual eligible for benefits under title XVIII of this Act, or under a State health care program (as defined in section 1128(h)) that such person knows or should know is likely to influence such individual to order or receive from a particular provider, practitioner, or supplier any item or service for which payment may be made, in whole or in part, under title XVIII, or a State health care program;''.

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

''(6) The term 'remuneration' includes the waiver of coinsurance and deductible amounts (or any

part thereof), and transfers of items or services for free or for other than fair market value. The term 'remuneration' does not include—

''(A) the waiver of coinsurance and deductible amounts by a person, if—

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

''(ii) the person does not routinely waive coinsurance or deductible amounts; and

''(iii) the person—

''(I) waives the coinsurance and deductible amounts after determining in good faith that the individual is in financial need;

''(II) fails to collect coinsurance or deductible amounts after making reasonable collection efforts; or

''(III) provides for any permissible waiver as specified in section 1128B(b)(3) or in regulations issued by the Secretary;

''(B) differentials in coinsurance and deductible amounts as part of a benefit plan design as long as the differentials have been dis-

closed in writing to all beneficiaries, third party payors, and providers, to whom claims are presented and as long as the differentials meet the standards as defined in regulations promulgated by the Secretary not later than 180 days after the date of the enactment of the Health Care Fraud and Abuse Prevention Act of 1995; or

''(C) incentives given to individuals to promote the delivery of preventive care as determined by the Secretary in regulations so promulgated.''.

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

TITLE V—AMENDMENTS TO CRIMINAL LAW

SEC. 501. HEALTH CARE FRAUD.

(a) IN GENERAL.—

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

"§ 1347. Health care fraud

''(a) Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice—

''(1) to defraud any health plan or other person, in connection with the delivery of or payment for health care benefits, items, or services; or

''(2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health plan, or person in connection with the delivery of or payment for health care benefits, items, or services;

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

''(b) For purposes of this section, the term 'health plan' has the same meaning given such term in section 101(c) of the Health Care Fraud and Abuse Prevention Act of 1995.''.

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

''1347. Health care fraud.''.

(b) CRIMINAL FINES DEPOSITED IN THE HEALTH CARE FRAUD AND ABUSE CONTROL.—The Secretary of the Treasury shall deposit into the Health Care Fraud and Abuse Control established under section 101(b) an

amount equal to the criminal fines imposed under section 1347 of title 18, United States Code (relating to health care fraud).

SEC. 502. FORFEITURES FOR FEDERAL HEALTH CARE OFFENSES.

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

''(6)(A) The court, in imposing sentence on a person convicted of a Federal health care offense, shall order the person to forfeit property, real or personal, that constitutes or is derived, directly or indirectly, from proceeds traceable to the commission of the offense.

''(B) For purposes of this paragraph, the term 'Federal health care offense' means a violation of, or a criminal conspiracy to violate—

''(i) section 1347 of this title;

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

''(iii) sections 287, 371, 664, 666, 1001, 1027, 1341, 1343, 1920, or 1954 of this title if the violation or conspiracy relates to health care fraud; and

''(iv) section 501 or 511 of the Employee Retirement Income Security Act of 1974, if the violation or conspiracy relates to health care fraud.''.

(b) PROPERTY FORFEITED DEPOSITED IN HEALTH CARE FRAUD AND ABUSE CONTROL.—The Secretary of the Treasury shall deposit into the Health Care Fraud and Abuse Control established under section 101(b) an amount equal to amounts resulting from forfeiture of property by reason of a Federal health care offense pursuant to section 982(a)(6) of title 18, United States Code.

SEC. 503. INJUNCTIVE RELIEF RELATING TO FEDERAL HEALTH CARE OFFENSES.

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

(1) by striking ''or'' at the end of subparagraph (A);

(2) by inserting ''or'' at the end of subparagraph (B); and

(3) by adding at the end the following new subparagraph:

''(C) committing or about to commit a Federal health care offense (as defined in section 982(a)(6)(B) of this title);''.

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

SEC. 504. GRAND JURY DISCLOSURE.

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

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

(2) by inserting after subsection (b) the following new subsection:

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

''(1) received in the course of duty as an attorney for the Government; or

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

may disclose that information to an attorney for the Government to use in any investigation or civil proceeding relating to health care fraud.''.

SEC. 505. FALSE STATEMENTS.

(a) IN GENERAL.—Chapter 47, of title 18, United States Code, is amended by adding at the end the following new section:

"§ 1033. False statements relating to health care matters

''(a) Whoever, in any matter involving a health plan, knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or device a material fact, or makes any

false, fictitious, or fraudulent statements or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry, shall be fined under this title or imprisoned not more than 5 years, or both.

''(b) For purposes of this section, the term 'health plan' has the same meaning given such term in section 101(c) of the Health Care Fraud and Abuse Prevention Act of 1995.''.

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

''1033. False statements relating to health care matters.''.

SEC. 506. OBSTRUCTION OF CRIMINAL INVESTIGATIONS OF FEDERAL HEALTH CARE OFFENSES.

(a) IN GENERAL.—Chapter 73 of title 18, United States Code, is amended by adding at the end the following new section:

''§ 1518. Obstruction of criminal investigations of Federal health care offenses

''(a) IN GENERAL.—Whoever willfully prevents, obstructs, misleads, delays or attempts to prevent, obstruct, mislead, or delay the communication of information or records relating to a Federal health care offense to a criminal investigator shall be fined under this title or imprisoned not more than 5 years, or both.

''(b) FEDERAL HEALTH CARE OFFENSE.—As used in this section the term 'Federal health care offense' has the same meaning given such term in section 982(a)(6)(B) of this title.

''(c) CRIMINAL INVESTIGATOR.—As used in this section the term 'criminal investigator' means any individual duly authorized by a department, agency, or armed force of the United States to conduct or engage in investigations for prosecutions for violations of health care offenses.''.

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

''1518. Obstruction of Criminal Investigations of Federal Health Care Offenses.''.

SEC. 507. THEFT OR EMBEZZLEMENT.

(a) IN GENERAL.—Chapter 31 of title 18, United States Code, is amended by adding at the end the following new section:

''§ 669. Theft or embezzlement in connection with health care

''(a) IN GENERAL.—Whoever willfully embezzles, steals, or otherwise without authority willfully and unlawfully converts to the use of any person other than the rightful owner, or intentionally misapplies any of the moneys, funds, securities, premiums, credits, property, or

other assets of a health plan, shall be fined under this title or imprisoned not more than 10 years, or both.

''(b) HEALTH PLAN.—As used in this section the term 'health plan' has the same meaning given such term in section 101(c) of the Health Care Fraud and Abuse Prevention Act of 1995.''.

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

''669. Theft or Embezzlement in Connection with Health Care.''.

SEC. 508. LAUNDERING OF MONETARY INSTRUMENTS.

Section 1956(c)(7) of title 18, United States Code, is amended by adding at the end the following new subparagraph:

''(F) Any act or activity constituting an offense involving a Federal health care offense as that term is defined in section 982(a)(6)(B) of this title.''.

SEC. 509. AUTHORIZED INVESTIGATIVE DEMAND PROCEDURES.

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

''§ 3486. Authorized investigative demand procedures

''(a) AUTHORIZATION.—

''(1) In any investigation relating to functions set forth in paragraph (2), the Attorney General or designee may issue in writing and cause to be served a subpoena compelling production of any records (including any books, papers, documents, electronic media, or other objects or tangible things), which may be relevant to an authorized law enforcement inquiry, that a person or legal entity may possess or have care, custody, or control. A custodian of records may be required to give testimony concerning the production and authentication of such records. The production of records may be required from any place in any State or in any territory or other place subject to the jurisdiction of the United States at any designated place; except that such production shall not be required more than 500 miles distant from the place where the subpoena is served. Witnesses summoned under this section shall be paid the same fees and mileage that are paid witnesses in the courts of the United States. A subpoena requiring the production of records shall describe the objects required to be produced and prescribe a return date within a reasonable period of time within which the objects can be assembled and made available.

''(2) Investigative demands utilizing an administrative subpoena are authorized for any investigation with respect to any act or activity constituting or involving health care fraud, including a scheme or artifice—

''(A) to defraud any health plan or other person, in connection with the delivery of or payment for health care benefits, items, or services; or

''(B) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control or, any health plan, or person in connection with the delivery of or payment for health care benefits, items, or services.

''(b) SERVICE.—A subpoena issued under this section may be served by any person designated in the subpoena to serve it. Service upon a natural person may be made by personal delivery of the subpoena to such person. Service may be made upon a domestic or foreign association which is subject to suit under a common name, by delivering the subpoena to an officer, to a managing or general agent, or to any other agent authorized by appointment or by law to receive service of process. The affidavit of

the person serving the subpoena entered on a true copy thereof by the person serving it shall be proof of service.

''(c) ENFORCEMENT.—In the case of contumacy by or refusal to obey a subpoena issued to any person, the Attorney General may invoke the aid of any court of the United States within the jurisdiction of which the investigation is carried on or of which the subpoenaed person is an inhabitant, or in which such person carries on business or may be found, to compel compliance with the subpoena. The court may issue an order requiring the subpoenaed person to appear before the Attorney General to produce records, if go ordered, or to give testimony touching the matter under investigation. Any failure to obey the order of the court may be punished by the court as a contempt thereof. All process in any such case may be served in any judicial district in which such person may be found.

''(d) IMMUNITY FROM CIVIL LIABILITY.—Notwithstanding any Federal, State, or local law, any person, including officers, agents, and employees, receiving a subpoena under this section, who complies in good faith with the subpoena and thus produces the materials sought, shall not be liable in any court of any State or the United States to any customer or other person for such produc-

tion or for nondisclosure of that production to the customer.

''(e) USE IN ACTION AGAINST INDIVIDUALS.—

''(1) Health information about an individual that is disclosed under this section may not be used in, or disclosed to any person for use in, any administrative, civil, or criminal action or investigation directed against the individual who is the subject of the information unless the action or investigation arises out of and is directly related to receipt of health care or payment for health care or action involving a fraudulent claim related to health; or if authorized by an appropriate order of a court of competent jurisdiction, granted after application showing good cause therefore.

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

''(3) Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.

''(f) HEALTH PLAN.—As used in this section the term 'health plan' has the same meaning given such term in section 101(c) of the Health Care Fraud and Abuse Prevention Act of 1995.''.

(b) CLERICAL AMENDMENT.—The table of sections for chapter 223 of title 18, United States Code, is amended by inserting after the item relating to section 3405 the following new item:

''§ 3486. Authorized investigative demand procedures''.

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

TITLE VI—STATE HEALTH CARE FRAUD CONTROL UNITS

SEC. 601. STATE HEALTH CARE FRAUD CONTROL UNITS.

(a) EXTENSION OF CONCURRENT AUTHORITY TO INVESTIGATE AND PROSECUTE FRAUD IN OTHER FEDERAL PROGRAMS.—Paragraph (3) of section 1903(q) of the Social Security Act (42 U.S.C. 1396b(q)) is amended—

(1) by inserting ''(A)'' after ''in connection with''; and

(2) by striking ''title.'' and inserting ''title; and

(B) upon the approval of the relevant Federal agen-

cy, any aspect of the provision of health care services and activities of providers of such services under any Federal health care program (as defined in section 1128B(F)(1)).''.

(b) EXTENSION OF AUTHORITY TO INVESTIGATE AND PROSECUTE PATIENT ABUSE IN NON-MEDICAID BOARD AND CARE FACILITIES.—Paragraph (4) of section 1903(q) of the Social Security Act (42 U.S.C. 1396b(q)) is amended to read as follows:

''(4)(A) The entity has—

''(i) procedures for reviewing complaints of abuse or neglect of patients in health care facilities which receive payments under the State plan under this title;

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

''(iii) where appropriate, procedures for acting upon such complaints under the criminal laws of the State or for referring such complaints to other State agencies for action.

''(B) For purposes of this paragraph, the term 'board and care facility' means a residential setting which receives payment from or on behalf of two or

more unrelated adults who reside in such facility, and for whom one or both of the following is provided:

''(i) Nursing care services provided by, or under the supervision of, a registered nurse, licensed practical nurse, or licensed nursing assistant.

''(ii) Personal care services that assist residents with the activities of daily living, including personal hygiene, dressing, bathing, eating, toileting, ambulation, transfer, positioning, self-medication, body care, travel to medical services, essential shopping, meal preparation, laundry, and housework.''.

TITLE VII—MEDICARE BILLING ABUSE PREVENTION

SEC. 701. IMPLEMENTATION OF GENERAL ACCOUNTING OFFICE RECOMMENDATIONS REGARDING MEDICARE CLAIMS PROCESSING.

(a) IN GENERAL.—Not later than 90 days after the date of the enactment of this Act, the Secretary shall, by regulation, contract, change order, or otherwise, require medicare carriers to acquire commercial automatic data processing equipment (in this title referred to as ''ADPE'') meeting the requirements of section 702 to

process medicare part B claims for the purpose of identifying billing code abuse.

(b) SUPPLEMENTATION.—Any ADPE acquired in accordance with subsection (a) shall be used as a supplement to any other ADPE used in claims processing by medicare carriers.

(c) STANDARDIZATION.—In order to ensure uniformity, the Secretary may require that medicare carriers that use a common claims processing system acquire common ADPE in implementing subsection (a).

(d) IMPLEMENTATION DATE.—Any ADPE acquired in accordance with subsection (a) shall be in use by medicare carriers not later than 180 days after the date of the enactment of this Act.

SEC. 702. MINIMUM SOFTWARE REQUIREMENTS.

(a) IN GENERAL.—The requirements described in this section are as follows:

(1) The ADPE shall be a commercial item.

(2) The ADPE shall surpass the capability of ADPE used in the processing of medicare part B claims for identification of code manipulation on the day before the date of the enactment of this Act.

(3) The ADPE shall be capable of being modified to—

(A) satisfy pertinent statutory requirements of the medicare program; and

(B) conform to general policies of the Health Care Financing Administration regarding claims processing.

(b) MINIMUM STANDARDS.—Nothing in this title shall be construed as preventing the use of ADPE which exceeds the minimum requirements described in subsection (a).

SEC. 703. DISCLOSURE.

(a) IN GENERAL.—Notwithstanding any other provision of law, and except as provided in subsection (b), any ADPE or data related thereto acquired by medicare carriers in accordance with section 701(a) shall not be subject to public disclosure.

(b) EXCEPTION.—The Secretary may authorize the public disclosure of any ADPE or data related thereto acquired by medicare carriers in accordance with section 701(a) if the Secretary determines that—

(1) release of such information is in the public interest; and

(2) the information to be released is not protected from disclosure under section 552(b) of title 5, United States Code.

SEC. 704. REVIEW AND MODIFICATION OF REGULATIONS.

Not later than 30 days after the date of the enactment of this Act, the Secretary shall order a review of existing regulations, guidelines, and other guidance governing medicare payment policies and billing code abuse to determine if revision of or addition to those regulations, guidelines, or guidance is necessary to maximize the benefits to the Federal Government of the use of ADPE acquired pursuant to section 701.

SEC. 705. DEFINITIONS.

For purposes of this title—

(1) The term ''automatic data processing equipment'' (ADPE) has the same meaning as in section 111(a)(2) of the Federal Property and Administrative Services Act of 1949 (40 U.S.C. 759(a)(2)).

(2) The term ''billing code abuse'' means the submission to medicare carriers of claims for services that include procedure codes that do not appropriately describe the total services provided or otherwise violate medicare payment policies.

(3) The term ''commercial item'' has the same meaning as in section 4(12) of the Office of Federal Procurement Policy Act (41 U.S.C. 403(12)).

(4) The term ''medicare part B'' means the supplementary medical insurance program author-

ized under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j–1395w–4).

(5) The term ''medicare carrier'' means an entity that has a contract with the Health Care Financing Administration to determine and make medicare payments for medicare part B benefits payable on a charge basis and to perform other related functions.

(6) The term ''payment policies'' means regulations and other rules that govern billing code abuses such as unbundling, global service violations, double billing, and unnecessary use of assistants at surgery.

(7) The term ''Secretary'' means the Secretary of Health and Human Services.

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S 1088 IS——2

S 1088 IS——3

S 1088 IS——4

S 1088 IS——5

S 1088 IS——6