

104<sup>TH</sup> CONGRESS  
1<sup>ST</sup> SESSION

# H. R. 2408

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

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## IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 27, 1995

Mr. COBURN introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committees on Ways and Means, the Judiciary, and Government Reform and Oversight, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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## 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 Anti-Fraud 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—FRAUD AND ABUSE CONTROL PROGRAM

- Sec. 101. Creation of Health Care Anti-Fraud Task Force.
- Sec. 102. Employees of task force.
- Sec. 103. Fraud and abuse control program.
- Sec. 104. Court-imposed obligations upon health anti-fraud and abuse convictions.
- Sec. 105. Health care fraud and abuse guidance.

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—MONETARY PENALTIES

- Sec. 401. Social Security Act civil monetary penalties.
- Sec. 402. Other Social Security Act civil penalties.
- Sec. 403. Social Security Act criminal penalties.

TITLE V—AMENDMENTS TO ANTI-KICKBACK LAW

- Sec. 501. Clarification of standards.
- Sec. 502. Clarifications and additions to anti-kickback exceptions.
- Sec. 503. Clarification of safe harbor authority in anti-kickback provisions.

TITLE VI—AMENDMENTS TO THE PHYSICIAN SELF-REFERRAL LAW

- Sec. 601. Financial relationship defined.
- Sec. 602. Self-referrals for physician services.
- Sec. 603. Risk-sharing arrangements.
- Sec. 604. Physician Ownership
- Sec. 605. Shared facility services.
- Sec. 606. Payer directed care.
- Sec. 607. Self-referrals for certain designated health services.
- Sec. 608. Definition of direct supervision.
- Sec. 609. Effective date.

TITLE VII—MEDICARE BILLING ABUSE PREVENTION

- Sec. 701. Implementation of General Accounting Office recommendations regarding Medicare claims processing.
- Sec. 702. Minimum software requirements.



1           (2) to work fully and effectively with State and  
2 local law enforcement agencies;

3           (3) to promote a coordinated health care fraud  
4 enforcement effort and to encourage maximum co-  
5 operation among all Federal agencies; and

6           (4) to make full use of financial investigative  
7 techniques, including tax law enforcement and, in  
8 order identify and convict individuals and sanction  
9 entities that engage in health care fraud.

10       (c) PARTICIPANTS.—The Federal agencies that shall  
11 participate in the health care fraud task force are—

12           (1) the Department of Justice (including the  
13 Federal Bureau of Investigation);

14           (2) the Department of Health and Human  
15 Services (including the Office of the Inspector Gen-  
16 eral);

17           (3) the Department of Defense (CHAMPUS);

18           (4) the Veteran’s Administration;

19           (5) the Railroad Retirement Board;

20           (6) the United States Postal Inspection Service;

21       and

22           (7) the Internal Revenue Service.

23       (d) The President shall designate one of the members  
24 as chair. The chair serves a term concurrent with that

1 of the President. The chair shall serve as the chief execu-  
2 tive officer of the task force.

3 **SEC. 102. EMPLOYEES OF THE TASK FORCE.**

4 (a) Effective January 1, 1996, the following employ-  
5 ees of the Government of the United States shall be as-  
6 signed to the task force but shall remain as employees of  
7 their former Government employer for purposes of salary,  
8 compensation, benefits and all related matters:

9 (1) Employees of the Department of Health  
10 and Human Services whose primary duties related to  
11 health care fraud.

12 (2) Employees of the Department of Justice  
13 whose primary duties relate to health care fraud to  
14 include employees of the Federal Bureau of Inves-  
15 tigation and the Office for United States Attorneys;  
16 and

17 (3) Any other employee of the Federal Govern-  
18 ment selected by the Commission for assignment to  
19 the task force.

20 (b) The number of employees assigned to the task  
21 force pursuant to subsection (a) shall be sufficient to allow  
22 the task force to perform its objectives; provided, however,  
23 that the total number of individuals does not exceed fifty  
24 (50).

1 (c) OBJECTIVES.—The objectives of the task force  
2 shall be—

3 (1) to target, investigate, and prosecute individ-  
4 uals who organize, direct, finance, or are otherwise  
5 engaged in health care fraud;

6 (2) to promote a coordinated health care fraud  
7 enforcement effort, and to encourage maximum co-  
8 operation among all Federal agencies; and

9 (3) to work fully and effectively with State and  
10 local law enforcement agencies.

11 **SEC. 103. FRAUD AND ABUSE CONTROL PROGRAM.**

12 (a) ESTABLISHMENT OF PROGRAM.—

13 (1) IN GENERAL.—Not later than January 1,  
14 1996, the Secretary of Health and Human Services  
15 (in this title referred to as the “Secretary”), acting  
16 through the Office of the Inspector General of the  
17 Department of Health and Human Services, and the  
18 Attorney General shall, after consultation with the  
19 task force, establish a program—

20 (A) to coordinate Federal, State, and local  
21 law enforcement programs to control fraud and  
22 abuse with respect to the delivery of and pay-  
23 ment for health care in the United States;

24 (B) to conduct investigations, audits, eval-  
25 uations, and inspections, including undercover

1 operations, relating to “fraud and abuse in” the  
2 delivery of and payment for health care in the  
3 United States;

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

9 (D) to provide for the modification and es-  
10 tablishment of safe harbors, and to issue advi-  
11 sory opinions and special fraud alerts pursuant  
12 to section 105.

13 (2) COORDINATION WITH HEALTH PLANS.—In  
14 carrying out the program established under para-  
15 graph (1), the Secretary and the Attorney General  
16 shall consult with, and arrange for the sharing of  
17 data, with representatives of health plans.

18 (3) REGULATIONS.—

19 (A) IN GENERAL.—The Secretary and the  
20 Attorney General shall by regulation establish  
21 standards to carry out the program under para-  
22 graph (1).

23 (B) INFORMATION STANDARDS.—

24 (i) IN GENERAL.—Such regulations  
25 shall include standards relating to the fur-

1 nishing of information by health plans,  
2 providers, and others to enable the Sec-  
3 retary and the Attorney General to carry  
4 out the program (including coordination  
5 with health plans under paragraph (2)).

6 (ii) CONFIDENTIALITY.—Such regula-  
7 tions shall include procedures to assure  
8 that such information is provided and uti-  
9 lized in a manner that appropriately pro-  
10 tects the confidentiality of the information  
11 and the privacy of individuals receiving  
12 health care services and items.

13 (iii) QUALIFIED IMMUNITY FOR PRO-  
14 VIDING INFORMATION.—The provisions of  
15 section 1157(a) of the Social Security Act  
16 (relating to limitation on liability) shall  
17 apply—

18 (I) to a person providing infor-  
19 mation or communications to the  
20 Commission, the Secretary or the At-  
21 torney General in conjunction with  
22 their performance of duties under this  
23 Act; or

24 (II) to health plans sharing infor-  
25 mation in good faith and without mal-

1                   ice with any other health plan with re-  
2                   spect to matters relating to health  
3                   care fraud detection, investigation and  
4                   prosecution.

5                   (4) ENSURING ACCESS TO DOCUMENTATION.—

6                   The Inspector General of the Department of Health  
7                   and Human services is authorized to exercise such  
8                   authority described in paragraphs (4) and (5) of sec-  
9                   tion 6 of the Inspector General Act of 1978 (5  
10                  U.S.C. App.) (relating to subpoenas and administra-  
11                  tion of oaths) with respect to the activities under the  
12                  fraud and abuse control program established under  
13                  this subsection to the same extent as the Inspector  
14                  General may exercise such authorities to perform the  
15                  functions assigned by such Act.

16                  (5) AUTHORITY OF INSPECTOR GENERAL.—

17                  Nothing in this Act shall be construed to diminish  
18                  the authority of any Inspector General, including  
19                  such authority as provided in the Inspector General  
20                  Act of 1978 (5 U.S.C. App.).

21                  (b) HEALTH PLAN DEFINED.—For purposes of this  
22                  section, the term “health plan” means a plan or program  
23                  that provides health benefits, whether directly, through in-  
24                  surance, or otherwise, and includes—

25                         (1) a policy of health insurance;

1 (2) a contract of a service benefit organization;

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

5 (4) an employee welfare benefit plan or a mul-  
6 tiple employer welfare plan (as such terms are de-  
7 fined in section 3 of the Employee Retirement In-  
8 come Security Act of 1974 (29 U.S.C. 1002).

9 **SEC. 104. COURT-IMPOSED OBLIGATIONS UPON HEALTH**  
10 **CARE FRAUD AND ABUSE CONVICTIONS.**

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

15 “(g) 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 offi-  
24 cials.”.

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

3 **SEC. 105. HEALTH CARE FRAUD AND ABUSE GUIDANCE.**

4 (a) SOLICITATION AND PUBLICATION OF MODIFICA-  
5 TIONS TO EXISTING SAFE HARBORS AND NEW SAFE  
6 HARBORS.—

7 (1) IN GENERAL.—

8 (A) SOLICITATION OF PROPOSALS FOR  
9 SAFE HARBORS.—Not later than January 1,  
10 1996, and not less than annually thereafter, the  
11 Secretary shall publish a notice in the Federal  
12 Register soliciting proposals, which will be ac-  
13 cepted during a 60-day period, for—

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

19 (ii) additional safe harbors specifying  
20 payment practices that shall not be treated  
21 as a criminal offense under section  
22 1128B(b) of the Social Security Act (42  
23 U.S.C. 1320a–7b(b)) and shall not serve  
24 as the basis for an exclusion under section

1 1128(b)(7) of such Act (42 U.S.C. 1320a-  
2 7(b)(7));

3 (iii) advisory opinions to be issued  
4 pursuant to subsection (b); and

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

7 (B) PUBLICATION OF PROPOSED MODI-  
8 FICATIONS AND PROPOSED ADDITIONAL SAFE  
9 HARBORS.—After considering the proposals de-  
10 scribed in clauses (i) and (ii) of subparagraph  
11 (A), the Secretary, in consultation with the At-  
12 torney General, shall by May of each year pub-  
13 lish in the Federal Register proposed modifica-  
14 tions to existing safe harbors and proposed ad-  
15 ditional safe harbors, if appropriate, with a 60-  
16 day comment period. After considering any pub-  
17 lic comments received during this period, the  
18 Secretary shall within 60 days after the close of  
19 the comment period issue final rules modifying  
20 the existing safe harbors and establishing new  
21 safe harbors, as appropriate.

22 (C) REPORT.—The Inspector General of  
23 the Department of Health and Human Services  
24 (in this section referred to as the “Inspector  
25 General”) shall, in an annual report to Con-

1           gress or as part of the year-end semiannual re-  
2           port required by section 5 of the Inspector Gen-  
3           eral Act of 1978 (5 U.S.C. App.), describe the  
4           proposals received under clauses (i) and (ii) of  
5           subparagraph (A) and explain which proposals  
6           were included in the publication described in  
7           subparagraph (B), which proposals were not in-  
8           cluded in that publication, and the reasons for  
9           the rejection of the proposals that were not in-  
10          cluded.

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

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

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

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

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

1 (E) An increase or decrease in the cost to  
2 health care programs under the Social Security  
3 Act.

4 (F) An increase or decrease in the poten-  
5 tial overutilization of health care services.

6 (G) Any other factors the Secretary deems  
7 appropriate in the interest of preventing fraud  
8 and abuse in health care programs under the  
9 Social Security Act.

10 (b) ADVISORY OPINIONS.—

11 (1) ADVISORY OPINIONS UNDER TITLE XI.—  
12 Title XI of the Social Security Act (42 U.S.C. 1301  
13 et seq.) is amended by inserting after section 1128B  
14 the following new section:

15 “ADVISORY OPINIONS

16 “SEC. 1129. (a) ISSUANCE OF ADVISORY OPIN-  
17 IONS.—The Secretary shall issue advisory opinions as pro-  
18 vided in this section.

19 “(b) MATTERS SUBJECT TO ADVISORY OPINIONS.—  
20 The Secretary shall issue advisory opinions as to the fol-  
21 lowing matters:

22 “(1) What constitutes prohibited remuneration  
23 within the meaning of section 1128B(b) of the So-  
24 cial Security Act.

25 “(2) Whether an arrangement or proposed ar-  
26 rangement satisfies the criteria set forth in section

1 1128B(b)(3) of the Social Security Act for activities  
2 which do not result in prohibited remuneration.

3 “(3) Whether an arrangement or proposed ar-  
4 rangement satisfies the criteria which the Secretary  
5 has established, or shall establish by regulation for  
6 activities which do not result in prohibited remu-  
7 neration.

8 “(4) What constitutes an inducement to reduce  
9 or limit services to individuals entitled to benefits  
10 under title XVIII or title XIX within the meaning  
11 of section 1128B(b).

12 “(5) Whether an arrangement or proposed ar-  
13 rangement will result in a prohibited referral within  
14 the meaning of section 1877 of the Social Security  
15 Act.

16 “(6) Whether an arrangement, activity or pro-  
17 posed arrangement or proposed activity violates any  
18 other provision of this Act.

19 “(c) MATTERS NOT SUBJECT TO ADVISORY OPIN-  
20 IONS.—Such advisory opinions shall not address the fol-  
21 lowing matters:

22 “(1) Whether the fair market value shall be, or  
23 was paid or received for any goods, services or prop-  
24 erty.

1           “(2) Whether an individual is a bona fide em-  
2           ployee within the requirements of section 3121(d)(2)  
3           of the Internal Revenue Code of 1986.

4           “(d) EFFECT OF ADVISORY OPINIONS.—

5           “(1) IN GENERAL.—Each advisory opinion is-  
6           sued by the Secretary shall be binding as to the Sec-  
7           retary and the party or parties requesting the opin-  
8           ion, so long as the party’s actions or omissions do  
9           not deviate from the actions or omissions presented  
10          in the request for the advisory opinion.

11          “(2) The failure of a party to seek an advisory  
12          opinion may not be introduced into evidence to prove  
13          that the party intended to violate the provisions of  
14          sections 1128, 1128A, 1128B, 1877, of this Act.

15          “(e) FEE.—

16          “(1) IN GENERAL.—The Secretary shall require  
17          an individual or entity requesting an advisory opin-  
18          ion under this section to submit a fee.

19          “(2) AMOUNT.—The amount of the fee required  
20          under paragraph (1) shall be equal to the costs in-  
21          curred by the Secretary in responding to the re-  
22          quest.

23          “(f) REGULATIONS.—The Secretary within 90 days  
24          of the date of the enactment shall issue regulations estab-

1 lishing a system for the issuance of advisory opinions.

2 Such regulations shall provide for—

3 “(1) the procedure to be followed by a party ap-  
4 plying for an advisory opinion;

5 “(2) the procedure to be followed by the Sec-  
6 retary in responding to a request for an advisory  
7 opinion;

8 “(3) the interval in which the Secretary shall  
9 respond; and

10 “(4) the manner in which advisory opinions will  
11 be made available to the public.

12 “(g) INTERVAL FOR ISSUANCE OF ADVISORY OPIN-  
13 IONS.—Under no circumstances shall the interval in which  
14 the Secretary shall respond to a party requesting an advi-  
15 sory opinion exceed 30 days.”.

16 (2) ADVISORY OPINIONS RELATING TO PHYSI-  
17 CIAN OWNERSHIP AND REFERRAL.—Section 1877 of  
18 the Social Security Act (42 U.S.C. 1395nn) is  
19 amended by the addition of the following new sub-  
20 section:

21 “(i) ADVISORY OPINIONS.—

22 “(1) IN GENERAL.—The Secretary shall issue  
23 advisory opinions on whether an arrangement or  
24 proposed arrangement will result in a prohibited re-  
25 ferral within the meaning of this section.

1           “(2) EFFECT OF ADVISORY OPINIONS.—

2                   “(A) Each advisory opinion issued by the  
3           Secretary shall be binding as to the Secretary  
4           and the party or parties requesting the opinion,  
5           so long as the party’s actions or omissions do  
6           not deviate from the actions or omissions pre-  
7           sented in the request for the advisory opinion.

8                   “(B) The failure of a party to seek an ad-  
9           visory opinion may not be introduced into evi-  
10          dence to prove that the party intended to vio-  
11          late the provisions of this section.

12          “(3) FEE.—

13                   “(A) IN GENERAL.—The Secretary shall  
14          require an individual or entity requesting an ad-  
15          visory opinion under this section to submit a  
16          fee.

17                   “(B) AMOUNT.—The amount of the fee re-  
18          quired under paragraph (1) shall be equal to  
19          the costs incurred by the Secretary in respond-  
20          ing to the request.

21          “(3) REGULATIONS.—The Secretary within one  
22          hundred and twenty days of the date of enactment,  
23          shall issue regulations establishing a system for the  
24          issuance of advisory opinions. Such regulations shall  
25          provide for—

1           “(A) the procedure to be followed by a  
2 party applying for an advisory opinion;

3           “(B) the procedure to be followed by the  
4 Secretary in responding to a request for an ad-  
5 visory opinion;

6           “(C) the interval in which the Secretary  
7 shall respond; and

8           “(D) the manner in which advisory opin-  
9 ions will be made available to the public.

10           “(4) INTERVAL FOR ISSUANCE OF ADVISORY  
11 OPINIONS.—Under no circumstances shall the inter-  
12 val in which the Secretary shall respond to a party  
13 requesting an advisory opinion exceed thirty days.”.

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) or section 1877 of the Social Security  
23 Act (42 U.S.C. 1320a-7b(b) or 42 U.S.C.  
24 1395nn) (in this subsection referred to as a  
25 “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 issue a spe-  
8           cial fraud alert in response to the request. All  
9           special fraud alerts issued pursuant to this sub-  
10          paragraph shall be published in the Federal  
11          Register.

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

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

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

1           **TITLE II—REVISIONS TO CURRENT**  
2           **SANCTIONS FOR FRAUD AND ABUSE**

3   **SEC. 201. MANDATORY EXCLUSION FROM PARTICIPATION**  
4                   **IN MEDICARE AND STATE HEALTH CARE PRO-**  
5                   **GRAMS.**

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

8                   (1) IN GENERAL.—Section 1128(a) of the So-  
9 cial Security Act (42 U.S.C. 1320a-7(a)) is amend-  
10 ed by adding at the end the following new para-  
11 graph:

12                   “(3) FELONY CONVICTION RELATING TO  
13 HEALTH CARE FRAUD.—Any individual that has  
14 been convicted after the date of the enactment of the  
15 Health Care Anti-Fraud Act of 1995, under Federal  
16 or State law, in connection with the delivery of a  
17 health care item or service or with respect to any act  
18 or omission in a health care program (other than  
19 those specifically described in paragraph (1)) oper-  
20 ated by or financed in whole or in part by any Fed-  
21 eral, State, or local government agency, of a criminal  
22 offense consisting of a felony relating to fraud, theft,  
23 embezzlement, breach of fiduciary responsibility, or  
24 other financial misconduct.”.

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

4           “(1) CONVICTION RELATING TO FRAUD.—

5           “(A) CONVICTION RELATING TO HEALTH  
6 CARE FRAUD.—Any individual or entity with re-  
7 spect to a misdemeanor, or entity with respect  
8 to a felony, that has been convicted after the  
9 date of the enactment of the Health Care Anti-  
10 Fraud Act of 1995, under Federal or State law,  
11 of a criminal offense relating to fraud, theft,  
12 embezzlement, breach of fiduciary responsibil-  
13 ity, or other financial misconduct—

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

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

22           “(B) CONVICTION RELATING TO FRAUD  
23 GENERALLY.—Any individual or entity that has  
24 been convicted after the date of enactment of  
25 the Health Care Anti-Fraud Act of 1995, under

1 Federal or State law, of a criminal offense re-  
2 lating to fraud, theft, embezzlement, breach of  
3 fiduciary responsibility, or other financial mis-  
4 conduct with respect to any act or omission in  
5 a program (other than a health care program)  
6 operated by or financed in whole or in part by  
7 any Federal, State, or local government agen-  
8 cy.”.

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

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

15 “(4) FELONY CONVICTION RELATING TO CON-  
16 TROLLED SUBSTANCE.—Any individual or entity  
17 that has been convicted after the date of the enact-  
18 ment of the Health Care Anti-Fraud Act of 1995,  
19 under Federal or State law, of a criminal offense  
20 consisting of a felony relating to the unlawful manu-  
21 facture, distribution, prescription, or dispensing of a  
22 controlled substance.”.

23 (2) CONFORMING AMENDMENT.—Section  
24 1128(b)(3) of such Act (42 U.S.C. 1320a-7(b)(3))  
25 is amended—

1 (A) in the heading, by striking “CONVIC-  
2 TION” and inserting “MISDEMEANOR CONVIC-  
3 TION”; and

4 (B) by striking “criminal offense” and in-  
5 serting “criminal offense consisting of a mis-  
6 demeanor”.

7 **SEC. 202. ESTABLISHMENT OF MINIMUM PERIOD OF EX-**  
8 **CLUSION FOR CERTAIN INDIVIDUALS AND**  
9 **ENTITIES SUBJECT TO PERMISSIVE EXCLU-**  
10 **SION FROM MEDICARE AND STATE HEALTH**  
11 **CARE PROGRAMS.**

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

15 “(D) In the case of an exclusion of an indi-  
16 vidual or entity under paragraph (1), (2), or (3)  
17 of subsection (b), the period of the exclusion  
18 shall be 3 years, unless the Secretary deter-  
19 mines in accordance with published regulations  
20 that a shorter period is appropriate because of  
21 mitigating circumstances or that a longer pe-  
22 riod is appropriate because of aggravating cir-  
23 cumstances.

24 “(E) In the case of an exclusion of an indi-  
25 vidual or entity under subsection (b)(4) or

1 (b)(5), the period of the exclusion shall not be  
2 less than the period during which the individ-  
3 ual's or entity's license to provide health care is  
4 revoked, suspended, or surrendered, or the indi-  
5 vidual or the entity is excluded or suspended  
6 from a Federal or State health care program.

7 “(F) In the case of an exclusion of an indi-  
8 vidual or entity under subsection (b)(6)(B), the  
9 period of the exclusion shall be not less than 1  
10 year.”.

11 **SEC. 203. PERMISSIVE EXCLUSION OF INDIVIDUALS WITH**  
12 **OWNERSHIP OR CONTROL INTEREST IN**  
13 **SANCTIONED ENTITIES.**

14 Section 1128(b) of the Social Security Act (42 U.S.C.  
15 1320a-7(b)) is amended by adding at the end the follow-  
16 ing new paragraph:

17 “(15) INDIVIDUALS CONTROLLING A SANC-  
18 TIONED ENTITY.—Any individual who has a direct  
19 or indirect ownership or control interest of 5 percent  
20 or more, or an ownership or control interest (as de-  
21 fined in section 1124(a)(3)) in, or who is an officer  
22 or managing employee (as defined in section  
23 1126(b)) of, an entity—



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

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

8 (2) by striking the third sentence.

9 **SEC. 205. INTERMEDIATE SANCTIONS FOR MEDICARE**  
10 **HEALTH MAINTENANCE ORGANIZATIONS.**

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

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

23 “(A) has failed substantially to carry out  
24 the contract;

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

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

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

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

17           “(i) Civil money penalties of not more  
18           than \$25,000 for each determination under  
19           paragraph (1) if the deficiency that is the  
20           basis of the determination has directly ad-  
21           versely affected (or has the substantial  
22           likelihood of adversely affecting) an indi-  
23           vidual covered under the organization’s  
24           contract.

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

7           “(iii) Suspension of enrollment of in-  
8           dividuals under this section after the date  
9           the Secretary notifies the organization of a  
10          determination under paragraph (1) and  
11          until the Secretary is satisfied that the de-  
12          ficiency that is the basis for the determina-  
13          tion has been corrected and is not likely to  
14          recur.”.

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

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

1           “(A) the Secretary first provides the orga-  
2           nization with the reasonable opportunity to de-  
3           velop and implement a corrective action plan to  
4           correct the deficiencies that were the basis of  
5           the Secretary’s determination under paragraph  
6           (1) and the organization fails to develop or im-  
7           plement such a plan;

8           “(B) in deciding whether to impose sanc-  
9           tions, the Secretary considers aggravating fac-  
10          tors such as whether an entity has a history of  
11          deficiencies or has not taken action to correct  
12          deficiencies the Secretary has brought to their  
13          attention;

14          “(C) there are no unreasonable or unneces-  
15          sary delays between the finding of a deficiency  
16          and the imposition of sanctions; and

17          “(D) the Secretary provides the organiza-  
18          tion with reasonable notice and opportunity for  
19          hearing (including the right to appeal an initial  
20          decision) before imposing any sanction or termi-  
21          nating the contract.”.

22          (4) CONFORMING AMENDMENTS.—Section  
23          1876(i)(6)(B) of such Act (42 U.S.C. mm(i)(6)(B))  
24          is amended by striking the second sentence.

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

4 **TITLE III—ADMINISTRATIVE AND**  
5 **MISCELLANEOUS PROVISIONS**

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

8 (a) GENERAL PURPOSE.—Not later than January 1,  
9 1996, the Secretary (in this title referred to as the “Sec-  
10 retary”) shall establish a national health care fraud and  
11 abuse data collection program for the reporting of final  
12 adverse actions (not including settlements in which no  
13 findings of liability have been made) against health care  
14 providers, suppliers, or practitioners as required by sub-  
15 section (b), with access as set forth in subsection (c).

16 (b) REPORTING OF INFORMATION.—

17 (1) IN GENERAL.—Each Government agency  
18 and health plan shall report to the task force de-  
19 scribed in section 101 any final adverse action (not  
20 including settlements in which no findings of liability  
21 have been made) taken against a health care pro-  
22 vider, supplier, or practitioner.

23 (2) INFORMATION TO BE REPORTED.—The in-  
24 formation to be reported under paragraph (1) in-  
25 cludes:

1 (A) The name and TIN (as defined in sec-  
2 tion 7701(a)(41)) of any health care provider,  
3 supplier, or practitioner who is the subject of a  
4 final adverse action.

5 (B) The name (if known) of any health  
6 care entity with which a health care provider,  
7 supplier, or practitioner is affiliated or associ-  
8 ated.

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

11 (D) A description of the acts or omissions  
12 and injuries upon which the final adverse action  
13 was based, and such other information as the  
14 task force determines is required for appro-  
15 priate interpretation of information reported  
16 under this section.

17 (3) CONFIDENTIALITY.—In determining what  
18 information is required, the Secretary shall include  
19 procedures to assure that the privacy of individuals  
20 receiving health care services is appropriately pro-  
21 tected.

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

1 task force prescribes. Such information shall first be  
2 required to be reported on a date specified by the  
3 task force.

4 (5) TO WHOM REPORTED.—The information re-  
5 quired to be reported under this subsection shall be  
6 reported to the task force.

7 (c) DISCLOSURE AND CORRECTION OF INFORMA-  
8 TION.—

9 (1) DISCLOSURE.—With respect to the informa-  
10 tion about final adverse actions (not including settle-  
11 ments in which no findings of liability have been  
12 made) reported to the task force under this section  
13 respecting a health care provider, supplier, or practi-  
14 tioner, the task force shall provide for—

15 (A) disclosure of the information, upon re-  
16 quest, to the health care provider, supplier, or  
17 licensed practitioner, and

18 (B) procedures in the case of disputed ac-  
19 curacy of the information.

20 (2) CORRECTIONS.—Each Government agency  
21 and health plan shall report corrections of informa-  
22 tion already reported about any final adverse action  
23 taken against a health care provider, supplier, or  
24 practitioner, in such form and manner that the task  
25 force prescribes.

1 (d) ACCESS TO REPORTED INFORMATION.—

2 (1) AVAILABILITY.—The information in this  
3 database shall be available to Federal and State gov-  
4 ernment agencies and health plans pursuant to pro-  
5 cedures that the task force shall provide.

6 (2) FEES FOR DISCLOSURE.—The task force  
7 may establish or approve reasonable fees for the dis-  
8 closure of information in this database (other than  
9 with respect to requests by Federal agencies). The  
10 amount of such a fee may not exceed the costs of  
11 processing the requests for disclosure and of provid-  
12 ing such information. Such fees shall be available to  
13 the task force.

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

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

21 (1)(A) The term “final adverse action” in-  
22 cludes:

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

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

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

8               (I) formal or official actions, such as  
9 revocation or suspension of a license (and  
10 the length of any such suspension), rep-  
11 rimand, censure or probation;

12               (II) any other loss of license of the  
13 provider, supplier, or practitioner, by oper-  
14 ation of law; or

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

18           (iv) Exclusion from participation in Fed-  
19 eral and State health care programs.

20           (v) Any other adjudicated actions or deci-  
21 sions that the task force shall establish.

22           (B) The term does not include any action—

23               (i) with respect to a malpractice claim; or

24               (ii) which is based on something other  
25 than health care fraud and abuse.

1           (2) The terms “licensed health care practi-  
2           tioner”, “licensed practitioner”, and “practitioner”  
3           mean, with respect to a State, an individual who is  
4           licensed or otherwise authorized by the State to pro-  
5           vide health care services (or any individual who,  
6           without authority holds himself or herself out to be  
7           so licensed or authorized).

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

14          (4) The term “supplier” means a supplier of  
15          health care items and services described in section  
16          1819 (a) and (b), and section 1861 of the Social Se-  
17          curity Act.

18          (5) The term “Government agency” shall in-  
19          clude:

20                   (A) The Department of Justice.

21                   (B) The Department of Health and  
22                   Human Services.

23                   (C) Any other Federal agency that either  
24                   administers or provides payment for the deliv-  
25                   ery of health care services, including, but not

1 limited to the Department of Defense and the  
2 Veterans' Administration.

3 (D) State law enforcement agencies.

4 (E) State Medicaid fraud and abuse units.

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

8 (G) The task force.

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

11 (7) For purposes of paragraph (2), the exist-  
12 ence of a conviction shall be determined under para-  
13 graph (4) of section 1128(j) of the Social Security  
14 Act.

15 (g) CONFORMING AMENDMENT.—Section 1921(d) of  
16 the Social Security Act is amended by inserting "and sec-  
17 tion 301 of the Health Care Anti-Fraud Act of 1995"  
18 after "section 422 of the Health Care Quality Improve-  
19 ment Act of 1986".

## 20 **TITLE IV—MONETARY PENALTIES**

### 21 **SEC. 401. SOCIAL SECURITY ACT CIVIL MONETARY PEN-** 22 **ALTIES.**

23 (a) MODIFICATIONS OF AMOUNTS OF PENALTIES  
24 AND ASSESSMENTS.—Section 1128A(a) of the Social Se-

1 curity Act (42 U.S.C. 1320a-7a(a)) is amended in the  
2 matter following paragraph (3)—

3 (1) by striking “\$2,000” and inserting  
4 “\$10,000”;

5 (2) by striking \$15,000 and inserting \$75,000;  
6 and

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

9 (b) CLAIM FOR ITEM OR SERVICE BASED ON INCOR-  
10 RECT CODING OR MEDICALLY UNNECESSARY SERV-  
11 ICES.—Section 1128A(a)(1) of the Social Security Act (42  
12 U.S.C. 1320a-7a(a)(1)) is amended—

13 (1) in subparagraph (A) by striking “claimed,”  
14 and inserting “claimed, including any person who  
15 engages in a pattern or practice of presenting or  
16 causing to be presented a claim for an item or serv-  
17 ice that is based on a code that the person knows  
18 or has reason to know will result in a greater pay-  
19 ment to the person than the code the person knows  
20 or has reason to know is applicable to the item or  
21 service actually provided,”;

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

24 (3) in subparagraph (D), by striking “; or” and  
25 inserting “, or”; and

1           (4) by inserting after subparagraph (D) the fol-  
2           lowing new subparagraph:

3                   “(E) is for a medical or other item or serv-  
4                   ice that a person knows or has reason to know  
5                   is not medically necessary; or”.

6           (c) PERMITTING SECRETARY TO IMPOSE CIVIL MON-  
7           ETARY PENALTY.—Section 1128A(b) of the Social Secu-  
8           rity Act (42 U.S.C. 1320a-7a(a)) is amended by

9                   (1) adding the following new paragraph:

10                   “(3) Any person (including any organization,  
11                   agency, or other entity, but excluding a beneficiary  
12                   as defined in subsection (i)(5)) who the Secretary  
13                   determines has violated section 1128B(b) of this  
14                   title shall be subject to a civil monetary penalty of  
15                   not more than \$10,000 for each such violation. In  
16                   addition, such person shall be subject to an assess-  
17                   ment of not more than three times the total amount  
18                   of the remuneration offered, paid, solicited, or re-  
19                   ceived in violation of section 1128B(b). The total  
20                   amount of remuneration subject to an assessment  
21                   shall be calculated without regard to whether some  
22                   portion thereof also may have been intended to serve  
23                   a purpose other than one proscribed by section  
24                   1128B(b).” and

1           (2) striking \$2,000 each place it appears and  
2           inserting \$10,000.

3           (d) SANCTIONS AGAINST PRACTITIONERS AND PER-  
4           SONS FOR FAILURE TO COMPLY WITH STATUTORY OBLI-  
5           GATIONS.—Section 1156(b)(3) of the Social Security Act  
6           (42 U.S.C. 1320c-5(b)(3)) is amended by striking “the  
7           actual or estimated cost” and inserting “up to \$10,000  
8           for each instance”.

9           (e) PROCEDURAL PROVISIONS.—Section 1876(i)(6)  
10          of the Social Security Act (42 U.S.C. m(i)(6)) is amended

11           (1) by adding at the end the following new sub-  
12          paragraph:

13                   “(D) The provisions of section 1128A  
14                   (other than subsections (a) and (b)) shall apply  
15                   to a civil money penalty under subparagraph  
16                   (A) or (B) in the same manner as they apply  
17                   to a civil money penalty or proceeding under  
18                   section 1128A(a).”,

19           (2) by striking \$25,000 and inserting \$125,000;

20           (3) by striking \$100,000 and inserting  
21          \$1,000,000; and

22           (4) by striking \$15,000 and inserting \$75,000.

23          (f) PROHIBITION AGAINST OFFERING INDUCEMENTS  
24          TO INDIVIDUALS ENROLLED UNDER PROGRAMS OR  
25          PLANS.—

1           (1) OFFER OF REMUNERATION.—Section  
2 1128A(a) of the Social Security Act (42 U.S.C.  
3 1320a–7a(a)) is amended—

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

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

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

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

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

21           (2) REMUNERATION DEFINED.—Section  
22 1128A(i) of such Act (42 U.S.C. 1320a–7a(i)) is  
23 amended by adding the following new paragraph:

24           “(6) The term ‘remuneration’ includes the waiv-  
25 er of coinsurance and deductible amounts (or any

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

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

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

8 “(ii) the person does not routinely  
9 waive coinsurance or deductible amounts;

10 and

11 “(iii) the person—

12 “(I) waives the coinsurance and  
13 deductible amounts after determining  
14 in good faith that the individual is in  
15 financial need;

16 “(II) fails to collect coinsurance  
17 or deductible amounts after making  
18 reasonable collection efforts; or

19 “(III) provides for any permis-  
20 sible waiver as specified in section  
21 1128B(b)(3) or in regulations issued  
22 by the Secretary;

23 “(B) differentials in coinsurance and de-  
24 ductible amounts as part of a benefit plan de-  
25 sign as long as the differentials have been dis-

1 closed in writing to all beneficiaries, third party  
2 payors, and providers, to whom claims are pre-  
3 sented; or

4 “(C) incentives given to individuals to pro-  
5 mote the delivery of preventive care.

6 (g) CLARIFICATION OF INTENT STANDARD.—Section  
7 1128A(i) of the Social Security Act (42 U.S.C. 1320a-  
8 7a(i)) is amended, by adding at the end the following new  
9 paragraph:

10 “(6) The term ‘should know’ means that a per-  
11 son, with respect to information—

12 “(A) acts in deliberate ignorance of the  
13 truth or falsity of the information; or

14 “(B) acts in reckless disregard of the truth  
15 or falsity of the information.”

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

18 **SEC. 402. OTHER SOCIAL SECURITY ACT CIVIL PENALTIES.**

19 (a) STANDARDS FOR NURSING FACILITIES.—

20 (1) PROVIDING ADVANCE NOTICE OF SURVEY  
21 TO NURSING FACILITY.—Section 1819(g)(2)(A)(i) of  
22 such Act (42 U.S.C. 1395i-3(g)(2)(A)(i)) is amend-  
23 ed by striking “\$2,000” and inserting “\$10,000”.

24 (b) DISTRIBUTION BY SUPPLIERS OF MEDICAL  
25 EQUIPMENT OF MEDICAL NECESSITY FORMS.—

1           (1) Section 1834(j)(2)(A)(iii) of such Act (42  
2 U.S.C. 1395m(j)(2)(A)(iii)), as added by section  
3 131(a)(1) of the Social Security Act Amendments of  
4 1994, is amended by striking “\$1,000” and insert-  
5 ing “\$5,000”; and

6           (2) Section 1834(j)(2)(B) of the Social Security  
7 Act is amended by inserting “one-page” before  
8 “form”; and deleting “or other document” after  
9 “form”.

10       (c) INTERMEDIATE SANCTIONS FOR PROVIDERS OR  
11 SUPPLIERS OF CLINICAL DIAGNOSTIC LABORATORY  
12 TESTS.—Section 1846(b)(2)(A)(ii) of such Act (42 U.S.C.  
13 1395w–2(b)(2)(A)(ii)) is amended by striking “\$10,000”  
14 and inserting “\$50,000”.

15       (d) MEDICARE SECONDARY PAYER.—

16           (1) OFFERING FINANCIAL INCENTIVES FOR  
17 BENEFICIARIES NOT TO ENROLL IN PRIMARY  
18 PLANS.—The second sentence of section  
19 1862(b)(3)(C) of such Act (42 U.S.C.  
20 1395y(b)(3)(C)) is amended by striking “\$5,000”  
21 and inserting “\$25,000”.

22           (2) FAILURE OF EMPLOYER TO PROVIDE  
23 MATCHING INFORMATION ON SECONDARY PAYER  
24 SITUATIONS.—The second sentence of section  
25 1862(b)(5)(C)(ii) of such Act (42 U.S.C.

1 1395y(b)(5)(C)(ii) is amended by striking “\$1,000”  
2 and inserting “\$5,000”.

3 (3) FAILURE OF PROVIDER TO PROVIDE INFOR-  
4 MATION ON AVAILABILITY OF OTHER PAYERS.—Sec-  
5 tion 1862(b)(6)(B) of such Act (42 U.S.C.  
6 1395y(b)(6)(B)), as added by section 151(a)(2)(A)  
7 of the Social Security Act Amendments of 1994, is  
8 amended by striking “\$2,000” and inserting  
9 “\$10,000”.

10 (e) REFERRALS BY PHYSICIANS WITH OWNERSHIP  
11 OR INVESTMENT INTERESTS.—

12 (1) CIRCUMVENTION SCHEMES.—Section  
13 1877(g)(4) of such Act (42 U.S.C. 1395nn(g)(4)) is  
14 amended by striking “\$100,000” and inserting  
15 “\$500,000”.

16 (2) FAILURE TO REPORT INFORMATION.—Sec-  
17 tion 1877(g)(5) of such Act (42 U.S.C.  
18 1395nn(g)(5)) is amended by striking “\$10,000”  
19 and inserting “\$50,000”.

20 (f) MEDICARE SUPPLEMENTAL POLICIES.—

21 (1) ISSUANCE OF POLICIES WHERE NO STAND-  
22 ARDS IN EFFECT.—The second sentence of section  
23 1882(a)(2) of such Act (42 U.S.C. 1395ss(a)(2)) is  
24 amended by striking “\$25,000” and inserting  
25 “\$125,000”.

1           (2) MISREPRESENTATIONS OF POLICIES.—Sec-  
2           tion 1882(d) of such Act (42 U.S.C. 1395ss(d)) is  
3           amended—

4                   (A) in paragraphs (1), (2), and (4)(A), by  
5                   striking “\$5,000” and inserting “\$25,000”;  
6                   and

7                   (B) in paragraphs (3)(A) and (3)(B)(iv),  
8                   by striking “\$25,000 (or \$15,000” and insert-  
9                   ing “\$125,000 (or \$75,000”.

10           (3) VIOLATION OF BENEFITS STANDARDS.—  
11           Section 1882(p) of such Act (42 U.S.C. 1395ss(p))  
12           is amended by striking “\$25,000 (or \$15,000” each  
13           place it appears in paragraphs (8) and (9)(C) and  
14           inserting “\$125,000 (or \$75,000”.

15           (4) VIOLATION OF GUARANTEED RENEWABIL-  
16           ITY STANDARDS.—Section 1882(q)(5)(C) of such  
17           Act (42 U.S.C. 1395ss(q)(5)(C)) is amended by  
18           striking “\$25,000” and inserting “\$125,000”.

19           (5) VIOLATION OF LOSS RATIO STANDARDS.—  
20           Section 1882(r)(6)(A) of such Act (42 U.S.C.  
21           1395ss(r)(6)(A)) is amended by striking “\$25,000”  
22           and inserting “\$125,000”.

23           (6) VIOLATION OF PRE-EXISTING CONDITION  
24           STANDARDS.—Section 1882(s)(3) of such Act (42

1 U.S.C. 1395ss(s)(3)) is amended by striking  
2 “\$5,000” and inserting “\$25,000”.

3 (7) MEDICARE SELECT POLICIES.—Section  
4 1882(t)(2) of such Act (42 U.S.C. 1395ss(t)(2)) is  
5 amended by striking “\$25,000” and inserting  
6 “\$125,000”.

7 (g) VIOLATION OF HOME HEALTH PARTICIPATION  
8 STANDARDS.—Section 1891 of such Act (42 U.S.C.  
9 1395bbb) is amended—

10 (1) in subsection (a)(3)(D)(iii)(III), by striking  
11 “\$5,000” and inserting “\$25,000”;

12 (2) in subsection (c)(1), by striking “\$2,000”  
13 and inserting “\$10,000”; and

14 (3) in subsection (f)(2)(A)(i), by striking  
15 “\$10,000” and inserting “\$50,000”.

16 **SEC. 403. SOCIAL SECURITY ACT CRIMINAL PENALTIES.**

17 (a) Section 1128B of the Social Security Act (42  
18 U.S.C. 1320a-7b) is amended—

19 (1) in subsection (a)—

20 (A) by striking “\$25,000” and inserting  
21 “\$50,000”, and

22 (B) by striking “\$10,000” and inserting  
23 “\$20,000”;



1 **SEC. 502. CLARIFICATIONS AND ADDITIONS TO ANTI-KICK-**  
2 **BACK EXCEPTIONS.**

3 (a) EXCEPTION FOR DISCOUNTS.—Section  
4 1128B(b)(3)(A) of the Social Security Act (42 U.S.C.  
5 1320a–7b(b)(3)(A)) is amended by inserting the following:  
6 “(including reductions in price applied to combinations of  
7 items and services, and reductions made available as part  
8 of capitation, risk sharing, disease management or similar  
9 programs)” after “a discount or other reduction in price”;  
10 and by inserting at the end: “provided, however, that  
11 where an entity which does not report its costs on a cost  
12 report separately claims an item or service for payment,  
13 and payment by the Medicare program or a state health  
14 care program is not based on actual acquisition costs, then  
15 a price reduction on the item or service may be properly  
16 disclosed and appropriately reflected by providing full and  
17 accurate information concerning the price reduction at the  
18 time the value of the reduction is known, at the request  
19 of the Secretary or a State agency.”

20 (b) Section 1128B(b)(3) of the Social Security Act  
21 (42 U.S.C. § 1320a–7b(b)(3)) is amended as follows:

22 (1) In subparagraph (D), by striking “Public  
23 Health Service Act; and” and inserting “Public  
24 Health Service Act;”

25 (2) By renumbering subparagraph (E) as sub-  
26 paragraph (K).

1 (c) EXCEPTION FOR MANAGED CARE RELATION-  
2 SHIPS.—Section 1128B(b)(3) of the Social Security Act  
3 (42 U.S.C. 1320a–7b(b)(3) is amended by inserting after  
4 subparagraph (D) the following:

5 “(E) any reduction in cost sharing or in-  
6 creased benefits given to an individual, any  
7 amounts paid to a provider for an item or serv-  
8 ice furnished to an individual, or any discount  
9 or reduction in price given by the provider for  
10 such item or service if the item or service is  
11 provided by an organization which—

12 “(i) provides health care services di-  
13 rectly or through one or more subsidiary  
14 entities or arranges under agreement with  
15 contract health care providers for the pro-  
16 vision of items or services, in exchange for  
17 a premium; and

18 “(ii) assumes or, in the case of items  
19 or services provided under agreement with  
20 contract health care providers, places the  
21 contract health care providers under, sub-  
22 stantial financial risk (including through a  
23 withhold, capitation, incentive pool, per  
24 diem payment, or other similar substantial

1 risk-sharing arrangement) for the provision  
2 of health services.

3 For the purpose of this subparagraph, the term  
4 “contract health care provider” means an indi-  
5 vidual or entity under contract with a health  
6 plan to furnish items or services to enrollees  
7 who are covered by the health plan (which may  
8 include Title XVIII beneficiaries and Title XIX  
9 recipients).”.

10 (d) EXCEPTION FOR RISK-SHARING ARRANGE-  
11 MENTS.—Section 1128B(b)(3) of the Social Security Act  
12 (42 U.S.C. 1320a–7b(b)(3) is amended—

13 (1) by redesignating subparagraph (E) as sub-  
14 paragraph (F);

15 (2) by striking “and” at the end of subpara-  
16 graph (D); and

17 (3) by inserting after subparagraph (D) the fol-  
18 lowing:

19 “(E) any remuneration between an organi-  
20 zation and a provider of services pursuant to an  
21 agreement between the organization and pro-  
22 vider if the written agreement places the pro-  
23 vider of services at substantial financial risk for  
24 the cost or utilization of the services the pro-  
25 vider is obligated to provide, whether through

1           capitation, incentive pools, per diem payments,  
2           or a similar risk-sharing arrangement that  
3           places the provider at substantial financial risk;  
4           and”.

5           (e) EXCEPTION FOR DE MINIMUS REMUNERA-  
6 TION.—Section 1128B(b)(3) of the Social Security Act  
7 (42 U.S.C. 1320a–7b(b)(3)) is amended by inserting the  
8 following new subparagraph:

9                   “(F) items provided free of charge to a li-  
10           censed health care practitioner who is furnish-  
11           ing services reimbursed under title XVIII or a  
12           State health care program, provided the items  
13           primarily benefit patients receiving such serv-  
14           ices and the value of the items does not exceed  
15           limits set forth in generally accepted profes-  
16           sional or ethical guidelines applicable to the  
17           health care practitioner (or, if no such guide-  
18           lines exist, the value of the items does not ex-  
19           ceed limits established by the Secretary);”.

20           (f) EXCEPTIONS FOR DRUG SAMPLES.—Section  
21 1128B(b)(3) of the Social Security Act (42 U.S.C. 1320a–  
22 7b(b)(3)) is amended by inserting the following new sub-  
23 paragraph:

1           “(G) drug samples distributed in compli-  
2           ance with section 503(d) of the Federal Food,  
3           Drug, and Cosmetic Act (21 U.S.C. § 553(d));”.

4           (g) EXCEPTION FOR SCIENTIFIC AND EDUCATIONAL  
5 PROGRAMS FOR PRACTITIONERS.—Section 1128B(b)(3)  
6 of the Social Security Act (42 U.S.C. 1320a-7b(b)(3)) is  
7 amended by inserting the following new subparagraph:

8           “(H) any amount paid to support scientific  
9           or educational programs or materials for li-  
10          censed health care practitioners or pharmacists,  
11          provided that—

12                   “(i) such programs or materials are  
13                   designed to improve the care or treatment  
14                   of patients;

15                   “(ii) such programs are conducted in  
16                   accordance with generally accepted profes-  
17                   sional or ethical guidelines applicable to  
18                   the health care practitioner; and

19                   “(iii) the receipt of such amount, or of  
20                   such programs or materials, is not condi-  
21                   tioned on the purchase, lease, order, or  
22                   furnishing (or the recommending for pur-  
23                   chase, lease, order, or furnishing) of any  
24                   item or service reimbursed under Title  
25                   XVIII or a State health care program;”.

1 (h) EXCEPTION FOR EDUCATIONAL PROGRAMS FOR  
2 PATIENTS.—Section 1128B(b)(3) of the Social Security  
3 Act (42 U.S.C. 1320a–7b(b)(3)) is amended by inserting  
4 the following new subparagraph:

5 “(I) any amount paid to provide edu-  
6 cational programs or materials for patients,  
7 provided that—

8 “(i) the programs or materials are de-  
9 signed to improve the care, treatment (in-  
10 cluding compliance with treatment re-  
11 gimes), or health of such patients; and

12 “(ii) the receipt of such amount, or of  
13 such programs or materials, is not condi-  
14 tioned on the purchase, lease, order or fur-  
15 nishing (or the recommending of the pur-  
16 chase, lease, order, or furnishing) of any  
17 item or service reimbursed under Title  
18 XVIII or a State health care program;”.

19 (i) EXCEPTION FOR PAYMENTS MADE ON BEHALF  
20 OF HEALTH PLANS.—Section 1128B(b)(3) of the Social  
21 Security Act (42 U.S.C. 1320a–7b(b)(3)) is amended by  
22 inserting the following new subparagraph:

23 “(J) any amount paid by a contract health  
24 plan service firm to a contract health provider,  
25 provided that the amount is paid at the direc-

1           tion of or on behalf of a health plan, and that  
2           the purpose of the payment is to reduce the  
3           cost or improve the quality of items or services  
4           provided by the health plan to its enrollees. For  
5           purposes of this subparagraph, the term—

6                   “(i) ‘contract health plan service firm’  
7                   means an entity that is under a written  
8                   agreement with a health plan to assist in  
9                   carrying out the functions of the health  
10                  plan;

11                  “(ii) ‘contract health provider’ means  
12                  an individual or entity that is under writ-  
13                  ten agreement with a health plan to fur-  
14                  nish to the health plan’s enrollees items or  
15                  services that are covered by the health  
16                  plan, or reimburse under Title XVIII or a  
17                  State health care plan; and

18                  “(iii) ‘health plan’ means an entity  
19                  that furnishes or arranges under agree-  
20                  ment with contract health care providers  
21                  for the furnishing of items or services to  
22                  enrollees, or furnishes insurance coverage  
23                  for the provision of such items and serv-  
24                  ices, in exchange for a premium.”.

1 **SEC. 503. CLARIFICATION OF SAFE HARBOR AUTHORITY IN**  
2 **ANTI-KICKBACK PROVISIONS.**

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

6 “(4) The regulations authorized by section  
7 14(a) of the Medicare and Medicaid Patient and  
8 Program Protection Act of 1987 are—

9 “(A) solely for the purpose of adding addi-  
10 tional exceptions to the conduct proscribed by  
11 this subsection, not for the purpose of limiting  
12 the scope of the exceptions specified in para-  
13 graph (3) of this subsection; and

14 “(B) for the purpose of prescribing criteria  
15 for qualifying for an exception notwithstanding  
16 the intent of the parties.”.

17 **TITLE VI AMENDMENTS TO THE**  
18 **PHYSICIAN SELF-REFERRAL LAW**

19 **SEC. 601. FINANCIAL RELATIONSHIP DEFINED.**

20 (a) Section 1877(a)(2) of the Social Security Act (42  
21 U.S.C. 1395nn(a)(2)) is amended by deleting the para-  
22 graph heading “(A)”; by deleting “,or” at the end of para-  
23 graph (a) and by deleting, in its entirety, paragraph (B).

24 (b) Section 1877(b) of the Social Security Act (42  
25 U.S.C. 1395nn(b)) by deleting in its heading all language  
26 following “EXCEPTIONS”.

1 (c) Section 1877(d) of the Social Security Act (42  
2 U.S.C. 1395nn(d)) is amended in its title by deleting all  
3 language after “EXCEPTIONS”.

4 (d) Section 1877(e) of the Social Security Act (42  
5 U.S.C. 1395nn(e)) is deleted in its entirety.

6 (e) Section 1877(f) of the Social Security Act (42  
7 U.S.C. 1395nn(f)) is amended by deleting “, and com-  
8 pensation” after “investment” and paragraph (2) is  
9 amended by deleting “, or with a compensation arrange-  
10 ment (as described in subsection (a)(2)(B)) after “invest-  
11 ment interest” and by deleting “or who have such a com-  
12 pensation relationship with the entity” after “investment  
13 interest.”

14 (f) Section 1877(h) of the Social Security Act (42  
15 U.S.C. 1395nn(h)) is amended by deleting paragraphs (1),  
16 (2), and (3).

17 **SEC. 602. SELF-REFERRALS FOR PHYSICIAN SERVICES.**

18 Section 1877(b)(1) of the Social Security Act (42  
19 U.S.C. 1395nn(b)(1)) is amended by inserting “the physi-  
20 cian or” immediately before “another physician.”

21 **SEC. 603. RISK-SHARING ARRANGEMENTS.**

22 Section 1877(b)(3) of the Social Security Act (42  
23 U.S.C. 1395nn(b)(3)) is amended as follows:

1           (1) By deleting from the heading the phrase  
2           “Prepaid Plans” and inserting in its place “Risk-  
3           Sharing Arrangements”.

4           (2) By deleting from the heading the word “by”  
5           and inserting in its place “to an individual enrolled  
6           with”; and

7           (3) By adding after subparagraph (3)(D) the  
8           following new subparagraph:

9                   “(E) pursuant to written agreement be-  
10                   tween the organization and the provider of serv-  
11                   ices if the written agreement places the provider  
12                   of services at substantial financial risk (full or  
13                   partial) for the cost or utilization of the services  
14                   the provider is obligated to provide, whether  
15                   through capitation, incentive pools, per diem  
16                   payment arrangements, or other substantial fi-  
17                   nancial risk-sharing arrangements.”.

18   **SEC. 604. PHYSICIAN OWNERSHIP.**

19           Section 1877(d) of the Social Security Act (42 U.S.C.  
20   1395nn(d)) is amended by inserting at the end the follow-  
21   ing new paragraph:

22                   “(4) INTEGRATED DELIVERY SYSTEM OWNER-  
23                   SHIP.—In the case of the physician’s ownership or  
24                   investment interest in a management services orga-  
25                   nization (MSO), preferred provider organization

1 (PPO), physician-hospital organization (PHO), phy-  
2 sician-hospital arrangement (PHA), or similar orga-  
3 nization designed to facilitate the integrated delivery  
4 of health care services, if the referring physician is  
5 managed by or contracts with the MSO, PPO, PHO,  
6 PHA or similar organization (or the group practice  
7 of which the physician is a member is managed by  
8 or contracts with the MSO, PPO, PHO, PHA or  
9 similar organization and the ownership or invest-  
10 ment interest is in the MSO, PPO, PHA or similar  
11 organization itself (and not merely in a subdivision  
12 thereof).”.

13 **SEC. 605. SHARED FACILITY SERVICES.**

14 Section 1877(b) of such Act (42 U.S.C. 1395nn(b))  
15 is amended—

16 (1) by redesignating paragraph (4) as para-  
17 graph (6); and

18 (2) by inserting after paragraph (3) the follow-  
19 ing new paragraph:

20 “(4) SHARED FACILITY SERVICES.—

21 “(A) IN GENERAL.—In the case of a  
22 shared facility services of a shared facility

23 “(i) that is furnished

24 “(I) personally by the referring  
25 physician who is a shared facility phy-

1           sician by an individual directly em-  
2           ployed or directly supervised by such  
3           a physician,

4           “(II) by a shared facility in a  
5           building in which the referring physi-  
6           cian furnishes substantially all of the  
7           services of the physician that are un-  
8           related to the furnishing of shared fa-  
9           cility services, and

10          “(III) to a patient of a shared fa-  
11          cility physician; and

12          “(ii) that is billed by the referring  
13          physician.

14          “(B) SHARED FACILITY RELATED DEFINI-  
15          TIONS.—

16               (i) SHARED FACILITY SERVICE.—The  
17               term “shared facility service” means, with  
18               respect to a shared facility, a designated  
19               health service furnished by the facility to  
20               patients of shared facility physicians.

21               (ii) SHARED FACILITY.—The term  
22               “shared facility” means an entity that fur-  
23               nishes shared facility services under a  
24               shared facility arrangement.

1 (iii) SHARED FACILITY PHYSICIAN.—

2 The term “shared facility, a physician who  
3 has a financial relationship under a shared  
4 facility arrangement with the facility.

5 (iv) SHARED FACILITY ARRANGE-  
6 MENT.—The term “shared facility arrange-  
7 ment” means, with respect to the provision  
8 of shared facility services in a building, a  
9 financial arrangement.

10 (I) which is only between physi-  
11 cians who are providing services (un-  
12 related to shared facility services) in  
13 the same building;

14 (II) in which the overhead ex-  
15 penses of the facility are shared, in  
16 accordance with methods previously  
17 determined by the physicians in the  
18 arrangement; and

19 (III) which, in the case of a cor-  
20 poration, is wholly owned and con-  
21 trolled by shared facility physicians.”.

22 **SEC. 606. PAYER DIRECTED CARE.**

23 (a) Section 1877(b) of the Social Security Act (42  
24 U.S.C. 1395nn(b)) is amended by inserting the following

1 paragraph after paragraph 4, as amended by section 604  
2 of the Health Care Anti-Fraud Act of 1995:

3 “(5) PAYER DIRECTED CARE.—In the case of  
4 items or services furnished to a patient where the se-  
5 lection of provider is substantially determined by, or  
6 results from financial incentives provided by, a payer  
7 of such items or services.”.

8 **SEC. 607. SELF-REFERRALS FOR CERTAIN DESIGNATED**  
9 **HEALTH SERVICES.**

10 (a) Section 1877(h)(6) of the Social Security Act (42  
11 U.S.C. n(h)(6)) is amended by deleting paragraph (k)  
12 thereof.

13 **SEC. 608. DEFINITION OF DIRECT SUPERVISION.**

14 (a) Section 1877(h) of the Social Security Act (42  
15 U.S.C. n(h)) is amended by adding at the end thereof the  
16 following new paragraph:

17 “(7) ‘Directly supervised’ by a physician means  
18 the physician has responsibility for oversight of the  
19 provision, by a person (whether or not an employee  
20 of the physician or group practice), of in-office ancil-  
21 lary services, and such responsibility must include:

22 “(A) Specifying the tasks to be performed  
23 by the person;

1           “(B) Instructing the person with regard to  
2           the manner and method for performing the  
3           tasks;

4           “(C) Evaluating the person’s performance  
5           of the tasks;

6           “(D) Taking, or causing to be taken, per-  
7           sonnel actions which are based upon evaluation  
8           of the person’s performance of the tasks; and

9           “(E) Being available, in person or by tele-  
10          phone, to the person at all times such person is  
11          providing in-office ancillary services.”.

12 **SEC. 609. EFFECTIVE DATE.**

13          (a) Section 1877 of the Social Security Act (42  
14 U.S.C. n(h)) is amended with respect to its effective date  
15 as follows:

16          “In the case of designated health services other than  
17 clinical laboratory services, this law shall apply to referrals  
18 made after the later of:

19                 “(1) December 31, 1994; or

20                 “(2) the date that final regulations implement-  
21                 ing all sections of this law are promulgated.”.



1 **SEC. 702. MINIMUM SOFTWARE REQUIREMENTS.**

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

4 (1) The ADPE shall be a commercial item and  
5 shall be reviewed by a private standard setting orga-  
6 nization with expertise in the development of de-  
7 scriptive terms and identifying codes for reporting  
8 medical services and procedures. The Secretary shall  
9 determine the appropriate organization to perform  
10 this review.

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

15 (3) The ADPE shall be capable of being modi-  
16 fied to—

17 (A) satisfy pertinent statutory require-  
18 ments of the Medicare program; and

19 (B) conform to general policies of the  
20 Health Care Financing Administration regard-  
21 ing claims processing.

22 (b) MINIMUM STANDARDS.—Nothing in this title  
23 shall be construed as preventing the use of ADPE which  
24 exceeds the minimum requirements described in sub-  
25 section (a).

1 **SEC. 703. DISCLOSURE.**

2 (a) IN GENERAL.—Notwithstanding any other provi-  
3 sion of law, and except as provided in subsection (b), any  
4 ADPE or data related thereto acquired by Medicare car-  
5 riers in accordance with section 701(a) shall not be subject  
6 to public disclosure.

7 (b) EXCEPTION.—The Secretary may authorize the  
8 public disclosure of any ADPE or data related thereto ac-  
9 quired by Medicare carriers in accordance with section  
10 701(a) if the Secretary determines that—

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

13 (2) the information to be released is not pro-  
14 tected from disclosure under section 552(b) of title  
15 5, United States Code.

16 (c) COPYRIGHT PROTECTION.—Nothing in this part,  
17 or any other part, shall be construed to divest the holder  
18 of a copyright in any code set, of its copyright in such  
19 code set or in any derivative work made therefrom.

20 **SEC. 704. REVIEW AND MODIFICATION OF REGULATIONS.**

21 Not later than 30 days after the date of the enact-  
22 ment of this Act, the Secretary shall order a review of  
23 existing regulations, guidelines, and other guidance gov-  
24 erning Medicare payment policies and billing code abuse  
25 to determine if revision of or addition to those regulations,  
26 guidelines, or guidance is necessary to maximize the bene-

1 fits to the Federal Government of the use of ADPE ac-  
2 quired pursuant to section 701.

3 **SEC. 705. DEFINITIONS.**

4 For purposes of this title—

5 (1) The term “automatic data processing equip-  
6 ment” (ADPE) has the same meaning as in section  
7 111(a)(2) of the Federal Property and Medicare  
8 payments for Medicare part B benefits payable on a  
9 charge basis and to perform other related functions.

10 (2) The term “billing code abuse” means the  
11 intentional and willful submission to Medicare car-  
12 riers of claims for services that include procedure  
13 codes that do not appropriately describe the total  
14 services provided or otherwise violate Medicare pay-  
15 ment policies.

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

19 (4) The term “Medicare part B” means the  
20 supplementary medical insurance program author-  
21 ized under part B of title XVIII of the Social Secu-  
22 rity Act (42 U.S.C. 1395j–1395w–4).

23 (5) The term “Medicare carrier” means an en-  
24 tity that has a contract with the Health Care Fi-  
25 nancing Administration to determine and make Med-

1       icare payments for Medicare part B benefits payable  
2       on a charge basis and to perform other related func-  
3       tions.

4               (6) The term “payment policies” means regula-  
5       tions and other rules that govern billing code abuses  
6       such as unbundling, global service violations, double  
7       billing, and unnecessary use of assistants at surgery.

8               (7) The term “Secretary” means the Secretary  
9       of Health and Human Services.

10   **SEC. 706. TERMINATION OF PROPOSED MEDICARE TRANS-**  
11                                   **ACTION SYSTEM.**

12       The Secretary may not implement the Medicare  
13       transaction system proposed to detect improper billing for  
14       items and services under the Medicare program resulting  
15       from the improper unbundling of items and services.

○

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