

in 1994 such as death threats, stalking, chemical attacks, bombings and arson;

Whereas there has been one attempted murder in Florida and four individuals killed at reproductive health care clinics in Florida and Massachusetts in 1994;

Whereas the Congress passed and the President signed the Freedom of Access to Clinic Entrances Act of 1994, a law establishing Federal criminal penalties and civil remedies for certain violent, threatening, obstructive and destructive conduct that is intended to injure, intimidate or interfere with persons seeking to obtain or provide reproductive health services;

Whereas violence is not a mode of free speech and should not be condoned as a method of expressing an opinion; and

Whereas the President has instructed the Attorney General to order—

(1) the United States Attorneys to create tasks forces of Federal, State and local law enforcement officials and develop plans to address security for reproductive health care clinics located within their jurisdictions; and

(2) the United States Marshals Service to ensure coordination between clinics and Federal, State and local law enforcement officials regarding potential threats of violence.

Resolved, it is the sense of the Senate.—That the United States Attorney General should fully enforce the law and protect persons seeking to provide or obtain, or assist in providing or obtaining, reproductive health services from violent attack.

SEC. 2.—Nothing in this resolution shall be construed to prohibit any expressive conduct (including peaceful picketing or other peaceful demonstration) protected from legal prohibition by the first amendment to the Constitution.

SENATE RESOLUTION 68—RELATIVE TO LOCAL GOVERNMENTS

Mr. PRESSLER (for Mr. BRADLEY, for himself, Mr. CHAFEE, Mr. DORGAN, Mr. SIMPSON, Mr. ROBB, Mr. DOLE, Mr. NICKLES, Mr. LAUTENBERG, Mr. KEMPTHORNE, and Mr. WELLSTONE) submitted the following resolution; which was considered and agreed to:

S. RES. 68

IMPACT ON LOCAL GOVERNMENTS.

Whereas the Congress should be concerned about shifting costs from Federal to State and local authorities and should be equally concerned about the growing tendency of States to shift costs to local governments;

Whereas cost shifting from States to local governments has, in many instances, forced local governments to raise property taxes or curtail sometimes essential services; and

Whereas increases in local property taxes and cuts in essential services threaten the ability of many citizens to attain and maintain the American dream of owning a home in safe, secure community: Now, therefore, be it

Resolved, That it is the sense of the Senate that—

(1) the Federal Government should not shift certain costs to the State, and States should end the practice of shifting costs to local governments, which forces many local governments to increase property taxes;

(2) States should end the imposition, in the absence of full consideration by their legislatures, of State issued mandates on local governments without adequate State funding, in a manner that may displace other essential government priorities; and

(3) one primary objective of this Act and other efforts to change the relationship among Federal, State, and local governments should be to reduce taxes and spend-

ing at all levels and to end the practice of shifting costs from one level of government to another with little or no benefit to taxpayers.

ADDITIONAL STATEMENTS

HEALTH CARE FRAUD PREVENTION

• Mr. COHEN. Mr. President, yesterday I introduced S. 245, the Health Care Fraud Prevention Act of 1995. It was inadvertently not printed in the RECORD at the conclusion of my remarks. I therefore ask that a copy of the bill be printed in today's RECORD.

The bill follows:

S. 245

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 Prevention Act of 1995".

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

Sec. 1. Short title; table of contents.

TITLE I—ALL-PAYER FRAUD AND ABUSE CONTROL PROGRAM

Sec. 101. All-payer fraud and abuse control program.

Sec. 102. Application of certain Federal health anti-fraud and abuse sanctions to fraud and abuse against any health plan.

Sec. 103. Health care fraud and abuse guidance.

Sec. 104. Reporting of fraudulent actions under medicare.

TITLE II—REVISIONS TO CURRENT SANCTIONS FOR FRAUD AND ABUSE

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

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

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

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

Sec. 205. Intermediate sanctions for medicare health maintenance organizations.

Sec. 206. Effective date.

TITLE III—ADMINISTRATIVE AND MISCELLANEOUS PROVISIONS

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

TITLE IV—CIVIL MONETARY PENALTIES

Sec. 401. Civil monetary penalties.

TITLE V—AMENDMENTS TO CRIMINAL LAW

Sec. 501. Health care fraud.

Sec. 502. Forfeitures for Federal health care offenses.

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

Sec. 504. Grand jury disclosure.

Sec. 505. False Statements.

Sec. 506. Voluntary disclosure program.

Sec. 507. Obstruction of criminal investigations of Federal health care offenses.

Sec. 508. Theft or embezzlement.

Sec. 509. Laundering of monetary instruments.

TITLE VI—PAYMENTS FOR STATE HEALTH CARE FRAUD CONTROL UNITS

Sec. 601. Establishment of State fraud units.

Sec. 602. Requirements for State fraud units.

Sec. 603. Scope and purpose.

Sec. 604. Payments to States.

TITLE I—ALL-PAYER FRAUD AND ABUSE CONTROL PROGRAM

SEC. 101. ALL-PAYER 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 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 interpretative 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) REGULATIONS.—

(A) IN GENERAL.—The Secretary and the Attorney General shall by regulation establish standards to carry out the program under paragraph (1).

(B) INFORMATION STANDARDS.—

(i) IN GENERAL.—Such standards shall include standards 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 standards shall include procedures to assure that such information is provided and utilized 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 (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.

(C) DISCLOSURE OF OWNERSHIP INFORMATION.—

(i) IN GENERAL.—Such standards shall include standards relating to the disclosure of ownership information described in clause (ii) by any entity providing health care services and items.

(ii) OWNERSHIP INFORMATION DESCRIBED.—The ownership information described in this clause includes—

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

(II) the names and unique physician identification numbers of all physicians with a financial relationship (as defined in section

1877(a)(2) of the Social Security Act) with such entity;

(III) the names of all other individuals with such an ownership or investment interest in such entity; and

(IV) any other ownership and related information required to be disclosed by such entity under section 1124 or section 1124A of the Social Security Act, except that the Secretary shall establish procedures under which the information required to be submitted under this subclause will be reduced with respect to health care provider entities that the Secretary determines will be unduly burdened if such entities are required to comply fully with this subclause.

(4) AUTHORIZATION OF APPROPRIATIONS FOR 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 Defense, Labor, and Veterans Affairs and of the Office of Personnel Management, 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 Account 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 the authority described in paragraphs (4) and (5) of section 6 of the Inspector General Act of 1978 (relating to subpoenas and administration of oaths) with respect to the activities under the all-payer fraud and abuse control program established under this subsection to the same extent as such Inspector General may exercise such authorities to perform the functions assigned by such Act.

(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.

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

(b) HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—There is hereby established an account to be known as the "Health Care Fraud and Abuse Control Account" (in this section referred to as the "Anti-Fraud Account"). The Anti-Fraud Account shall consist of—

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

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

(iii) such amounts as are transferred to the Anti-Fraud Account under subparagraph (C).

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

(C) TRANSFER OF AMOUNTS.—

(i) IN GENERAL.—The Secretary of the Treasury shall transfer to the Anti-Fraud Account 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) USE OF FUNDS.—

(A) IN GENERAL.—Amounts in the Anti-Fraud Account shall be available to carry out the health care fraud and abuse control program established under subsection (a) (including the administration of the program), and may be used to cover costs incurred in operating the program, including costs (including equipment, salaries and benefits, and travel and training) 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 Anti-Fraud Account to any Federal agency be used to increase and not supplant the recipient agency's appropriated operating budget.

(3) 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 Anti-Fraud Account in each fiscal year.

(4) USE OF FUNDS BY INSPECTOR GENERAL.—

(A) REIMBURSEMENTS FOR INVESTIGATIONS.—The Inspector General is authorized 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 the Inspector General or the Inspectors General of the Departments of Defense, Labor, and Veterans Affairs and of the Office of Personnel Management, 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 their deposit.

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

(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 adding at the end the following: "OR HEALTH PLANS".

(B) In subsection (a)(1)—

(i) by striking "title XVIII or" and inserting "title XVIII," and

(ii) by adding at the end the following: "or a health plan (as defined in section 1128(i))."

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

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

(i) by inserting after "title XIX" the following: "or a health plan", and

(ii) by inserting after "the State" the following: "or the plan".

(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:

"(f) 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) HEALTH PLAN DEFINED.—Section 1128 of the Social Security Act (42 U.S.C. 1320a-7) is amended by redesignating subsection (i) as subsection (j) and by inserting after subsection (h) the following new subsection:

"(i) HEALTH PLAN DEFINED.—For purposes of sections 1128A and 1128B, the term 'health plan' means a plan that provides health benefits, whether through directly, through insurance, or otherwise, and includes a policy of health insurance, a contract of a service benefit organization, or a membership agreement with a health maintenance organization or other prepaid health plan, and also includes 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)."

(c) 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 (the (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 STATE 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 (hereafter 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 Government health care programs.

(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 Government health care programs.

(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 (hereafter 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 in response to 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 provision 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 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 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)) (hereafter 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 Inspector 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 in consultation with the Attorney General, 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.

SEC. 104. REPORTING OF FRAUDULENT ACTIONS UNDER MEDICARE.

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

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 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 FRAUD.**—Any individual or entity that has been convicted after the date of the enactment of the Health Care Fraud 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 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.**—Section 1128(b)(1) of such Act (42 U.S.C. 1320a-7(b)(1)) 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".

(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 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."

"(G) 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, director, agent, 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;

"(B) against which a civil monetary penalty has been assessed under section 1128A; or

"(C) 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 the following: “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 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 provides the organization with the 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);

“(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 Energy and 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 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 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.

(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. 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) The term "final adverse action" includes:

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

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

(C) 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.

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

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

(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 to such term by section 1128(i) of the Social Security Act.

(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 Prevention Act of 1995" after "section 422 of the Health Care Quality Improvement Act of 1986".

TITLE IV—CIVIL MONETARY PENALTIES

SEC. 401. 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 subsection (a)(1), by inserting "or of any health plan (as defined in section 1128(i)),," after "subsection (i)(1)),,".

(2) In subsection (f)—

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

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

"(3) With respect to amounts recovered arising out of a claim under a health plan, the portion of such amounts as is determined to have been paid by the plan shall be repaid to the plan, and the portion of such amounts attributable to the amounts recovered under this section by reason of the amendments made by the Health Care Fraud Prevention Act of 1995 (as estimated by the Secretary) shall be deposited into the Health Care Fraud and Abuse Control Account established under section 101(b) of such Act."

(3) In subsection (i)—

(A) in paragraph (2), by inserting "or under a health plan" before the period at the end, and

(B) in paragraph (5), by inserting "or under a health plan" after "or XX".

(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, director, agent, or managing employee (as defined in section 1126(b)) of, an entity that is participating in a program 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 the following: "claimed, including any person who repeatedly presents or causes to be presented a claim for an item or service that is based on a code that the person knows or should know will result in a greater payment to the person than the code the person knows or should 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 repeatedly knows or should 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 the following: "up to \$10,000 for each instance".

(g) PROCEDURAL PROVISIONS.—Section 1876(i)(6) of such 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) EFFECTIVE DATE.—The amendments made by this section shall take effect January 1, 1996.

(i) 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 disclosed in writing to all third party payors to whom claims are presented and as long as the differentials meet the standards as defined in regulations promulgated by the Secretary; or

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

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 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 shall 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 1128(i) of the Social Security Act.”.

(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 ACCOUNT.—The Secretary of the Treasury shall deposit into the Health Care Fraud and Abuse Control Account 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—

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

“(ii) constitutes or is derived 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, 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 ACCOUNT.—The Secretary of the Treasury shall deposit into the Health Care Fraud and Abuse Control Account 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:

“(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:

“(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:

“§ 1033. False statements relating to health care matters

“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) 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. VOLUNTARY DISCLOSURE PROGRAM.

In consultation with the Attorney General of the United States, the Secretary of Health and Human Services shall publish proposed regulations not later than 9 months after the

date of enactment of this Act, and final regulations not later than 18 months after such date of enactment, establishing a program of voluntary disclosure that would facilitate the enforcement of sections 1128A and 1128B of the Social Security Act (42 U.S.C. 1320a-7a and 1320a-7b) and other relevant provisions of Federal law relating to health care fraud and abuse. Such program should promote and provide incentives for disclosures of potential violations of such sections and provisions by providing that, under certain circumstances, the voluntary disclosure of wrongdoing would result in the imposition of penalties and punishments less substantial than those that would be assessed for the same wrongdoing if voluntary disclosure did not occur.

SEC. 507. 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 State Code, in amended by adding at the end the following:

“1518. Obstruction of Criminal Investigations of Federal Health Care Offenses.”.

SEC. 508. 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 care benefit program, shall be fined under this title or imprisoned not more than 10 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.”.

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

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

SEC. 509. 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.”

TITLE VI—PAYMENTS FOR STATE HEALTH CARE FRAUD CONTROL UNITS

SEC. 601. ESTABLISHMENT OF STATE FRAUD UNITS.

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

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

SEC. 602. REQUIREMENTS FOR STATE FRAUD UNITS.

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

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

(2) be separate and distinct from any State agency with principal responsibility for the administration of any Federally-funded or mandated health care program;

(3) meet the other requirements of this section.

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

(1) be a Unit of the office of the State Attorney General or of another department of State government which possesses statewide authority to prosecute individuals for criminal violations;

(2) if it is in a State the constitution of which does not provide for the criminal prosecution of individuals by a statewide authority and has formal procedures, (A) assure its referral of suspected criminal violations to the appropriate authority or authorities in the State for prosecution, and (B) assure its assistance of, and coordination with, such authority or authorities in such prosecutions; or

(3) have a formal working relationship with the office of the State Attorney General or the appropriate authority or authorities for prosecution and have formal procedures (including procedures for its referral of suspected criminal violations to such office) which provide effective coordination of activities between the Fraud Unit and such office with respect to the detection, investigation, and prosecution of suspected criminal violations relating to any Federally-funded or mandated health care programs.

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

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

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

(d) COOPERATIVE AGREEMENTS; MEMORANDA OF UNDERSTANDING.—The State Fraud Unit shall have cooperative agreements with—

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

(2) similar Fraud Units in other States, as exemplified through membership and participation in the National Association of Medicaid Fraud Control Units or its successor; and

(3) the Secretary.

(e) REPORTS.—The State Fraud Unit shall submit to the Secretary an application and an annual report containing such information as the Secretary determines to be necessary to determine whether the State Fraud Unit meets the requirements of this section.

(f) FUNDING SOURCE; PARTICIPATION IN ALL-PAYER PROGRAM.—In addition to those sums

expended by a State under section 604(a) for purposes of determining the amount of the Secretary's payments, a State Fraud Unit may receive funding for its activities from other sources, the identity of which shall be reported to the Secretary in its application or annual report. The State Fraud Unit shall participate in the all-payer fraud and abuse control program established under section 101.

SEC. 603. SCOPE AND PURPOSE.

The State Fraud Unit shall carry out the following activities:

(1) The State Fraud Unit shall conduct a statewide program for the investigation and prosecution (or referring for prosecution) of violations of all applicable state laws regarding any and all aspects of fraud in connection with any aspect of the administration and provision of health care services and activities of providers of such services under any Federally-funded or mandated health care programs;

(2) The State Fraud Unit shall have procedures for reviewing complaints of the abuse or neglect of patients of facilities (including patients in residential facilities and home health care programs) that receive payments under any Federally-funded or mandated health care programs, and, where appropriate, to investigate and prosecute such complaints under the criminal laws of the State or for referring the complaints to other State agencies for action.

(3) The State Fraud Unit shall provide for the collection, or referral for collection to the appropriate agency, of overpayments that are made under any Federally-funded or mandated health care program and that are discovered by the State Fraud Unit in carrying out its activities.

SEC. 604. PAYMENTS TO STATES.

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

(b) APPLICABLE PERCENTAGE DEFINED.—

(1) IN GENERAL.—In subsection (a), the “applicable percentage” with respect to a State for a fiscal year is—

(A) 90 percent, for quarters occurring during the first 3 years for which the State Fraud Unit is in operation; or

(B) 75 percent, for any other quarters.

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

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

ORDER OF BUSINESS

The PRESIDING OFFICER. The majority leader is recognized.

Mr. DOLE. I thank the Chair.

(The remarks of Mr. DOLE pertaining to the introduction of S. 256 and S. 257 are located in today's RECORD under “Statements on Introduced Bills and Joint Resolutions.”)

Mr. CRAIG addressed the Chair.

The PRESIDING OFFICER. The Chair recognizes the Senator from Idaho.

Mr. CRAIG. Mr. President, I ask unanimous consent to proceed for 5 minutes as if in morning business.

The PRESIDING OFFICER. The Senate is in morning business. The Senator from Idaho is recognized for up to 15 minutes.

Mr. CRAIG. I thank the Chair for clarifying that.

(Mr. INHOFE assumed the chair.)

REAUTHORIZE THE ENDANGERED SPECIES ACT

Mr. CRAIG. Mr. President and fellow Senators, I think the American public and even we here in the Congress recognize that the November elections was a profound statement on the part of this country to speak to change.

Since that time, all eyes have been focused on Washington, as we saw the changing of the guard in the House after 40 years of single-party rule, and certainly the change that has occurred here that has resulted with Republicans being in the majority, leading the Senate and chairing the committees. That has also resulted in a very aggressive legislative agenda that has focused most of the attention of the American people on what is going on in Washington. Whether it was the rule changes in the House or the debate on the unfunded mandates bill that still is before this Senate, directed by my colleague from Idaho, DIRK KEMPTHORNE, or whether it is the growing debate that will soon come to the floor on a balanced budget amendment, all eyes remain focused on Washington.

But while that is going on, something very tragic is still happening across America. And that is that there still remains business as usual on the part of the Federal Government and our Federal agencies and our Federal regulators—as was going on and has been going on long before the elections of last November—the trading on the private citizen, the taking away of rights, a Federal Government that is unconcerned, or demonstrating at least little concern, about the impact of their decisions and their activities on the economies of local communities.

So for just a moment this afternoon, I thought I would once again focus on something that is now occurring in my State of Idaho and try to once again impress upon the Congress, and certainly those who might be watching, the magnitude of the job we have before us and the tragedy of this administration failing to be responsive and allowing their agencies to run amok in an unwillingness to be concerned about the human being—the citizen, the taxpayer—but to be all concerned about the Federal regulations and to make sure that every letter of the law is complied with, even laws that no longer work for the American people or