

safety requirements. The purpose of the legislation I am introducing is to allow the *Focus* to engage in the coast-wise trade and the fisheries of the United States.

By Mr. ABRAHAM:

S. 1363. A bill to terminate the agricultural price support and production adjustment programs for sugar on the date the President certifies to Congress that a General Agreement on Tariffs and Trade has been entered into that prohibits all export subsidies for sugar, price support and production adjustment programs for sugar, and tariffs and other trade barriers on the importation of sugar, and for other purposes; to the Committee on Agriculture, Nutrition, and Forestry.

SUGAR LEGISLATION

• Mr. ABRAHAM. Mr. President, today I am introducing a bill to terminate U.S. agricultural price support and production adjustment programs for sugar contingent upon a GATT agreement which would eliminate export subsidies and price supports in other countries of the world. While I firmly believe that the free market should be allowed to work, it does not make sense to put our producers at a competitive disadvantage in the world subsidized market.

I can't speak for the rest of the country, but Michigan sugar beet producers are some of the most efficient producers in the world, yet without a U.S. sugar program they would most likely find it impossible to compete against less efficient foreign producers who are more highly subsidized. Other countries subsidize their sugar at a level so high that they are able to dump the excess sugar on the world market at a price well below the world's cost of production. Unilateral elimination of our sugar program would put the best producers of sugar in the world at a competitive disadvantage to less efficient producers. This simply does not make sense.

We cannot give up the hope that the world will have a free sugar market. Through the GATT, we have begun and will continue to work diligently toward that goal. I am hopeful that my legislation will prompt other Members of the House and Senate to contact the Administration in favor of further GATT talks that would move us closer to a free world market for agriculture. Until this occurs, however, we must carefully examine the consequences of the steps we take to reform or eliminate our support programs so that we do not put our producers in a position of weakness compared to other countries. Furthermore, we cannot simply assume other countries would follow our lead if we were to eliminate our sugar program. In fact, the result may be quite the opposite. Without a trade agreement, other countries would have greater access to the U.S. market, helping to perpetuate these foreign subsidies rather than encourage their elimination.

Mr. President, I assure you that during my tenure as a Member of this

body I will fight diligently on the issue of free trade. Understanding the importance of global free trade in a growing world market, I will continue to work to eliminate export subsidies and other price supports worldwide so that we may eventually achieve true free trade.●

ADDITIONAL COSPONSORS

S. 612

At the request of Mr. ROCKEFELLER, the name of the Senator from Minnesota [Mr. WELLSTONE] was added as a cosponsor of S. 612, a bill to amend title 38, United States Code, to provide for a hospice care pilot program for the Department of Veterans Affairs.

S. 1248

At the request of Mr. WELLSTONE, the name of the Senator from Nebraska [Mr. EXON] was added as a cosponsor of S. 1248, a bill to amend the Internal Revenue Code of 1986 to allow the alcohol fuels credit to be allocated to patrons of a cooperative in certain cases.

S. 1271

At the request of Mr. CRAIG, the names of the Senator from Virginia [Mr. WARNER] and the Senator from Wyoming [Mr. SIMPSON] were added as cosponsors of S. 1271 a bill to amend the Nuclear Waste Policy Act of 1982.

SENATE JOINT RESOLUTION 22

At the request of Mr. GRAMS, the name of the Senator from Tennessee [Mr. FRIST] was added as a cosponsor of Senate Joint Resolution 22, a joint resolution proposing an amendment to the Constitution of the United States to require a balanced budget.

SENATE RESOLUTION 146

At the request of Mr. JOHNSTON, the name of the Senator from California [Mrs. FEINSTEIN] was added as a cosponsor of Senate Resolution 146, a resolution designating the week beginning November 19, 1995, and the week beginning on November 24, 1996, as "National Family Week," and for other purposes.

AMENDMENTS SUBMITTED

THE BALANCED BUDGET RECONCILIATION ACT OF 1995

FORD AMENDMENT NO. 2948

(Ordered to lie on the table.)

Mr. FORD submitted an amendment intended to be proposed by him to the bill (S. 1357) to provide for reconciliation pursuant to section 105 of the concurrent resolution on the budget for fiscal year 1996; as follows:

At the end of title VI, add the following:

SEC. 6 . CONSTRUCTION OF NATCHER BRIDGE NEAR OWENSBORO, KENTUCKY.

(a) AUTHORIZATION.—The Secretary of Transportation may pay the Federal share of the cost of a project to complete construction of the William H. Natcher Bridge near Owensboro, Kentucky.

(b) FEDERAL SHARE.—The Federal share of the cost of the project shall be 80 percent.

(c) DELEGATION TO STATES.—Subject to title 23, United States Code, the Secretary of Transportation shall delegate responsibility for construction of the project to the State of Kentucky, on request of the State.

(d) ADVANCE CONSTRUCTION.—If the State of Kentucky has been delegated responsibility for construction of the project and the State—

(1) has obligated all funds made available to the State under this section for construction of the project; and

(2) proceeds to construct the project without the aid of Federal funds, in accordance with all procedures and all requirements applicable to the project, except to the extent that the procedures and requirements limit the State to the construction of projects with the aid of Federal funds previously made available to the State;

the Secretary of Transportation, on the approval of the application of the State, shall pay to the State the Federal share of the cost of the project at such time as additional funds are made available for the project under this section.

(e) APPLICABILITY OF TITLE 23.—Funds made available under this section shall be available for obligation in the manner provided for funds apportioned under chapter 1 of title 23, United States Code, except that the Federal share of the cost of an project under this section shall be determined in accordance with this section and the funds shall remain available until expended. Funds authorized by this section shall not be subject to any obligation limitation.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated from the Highway Trust Fund established by section 9503 of the Internal Revenue Code of 1986 (other than the Mass Transit Account) to carry out the project \$44,000,000, to remain available until expended.

In section 23(b)(2) of the Internal Revenue Code of 1986, as added by section 12001(a), strike "\$110,000" in subparagraph (A) and insert "\$100,000" and strike "\$55,000" in subparagraph (C) and insert "\$50,000".

Mr. FORD. Mr. President, over the next few days, we will be debating the logic of a \$245 billion tax break that adds to the deficit and cuts dangerously deep into critical programs for middle-income Americans—from Medicare to education. My Republican colleagues will justify adding to the deficit and making those cuts by striking the familiar refrain that these tax breaks will boost the economy.

But Mr. President, those tax breaks are not only jeopardizing important investments in our future economy like education and job training, they're jeopardizing critical infrastructure improvements that mean much more to local economies than a tax break for America's wealthiest few.

One of those infrastructure projects is a bridge linking my home State of Kentucky with Indiana. Without a doubt, the Natcher Bridge would mean much more to the local economies of Kentucky and Indiana than this tax break. From the increased interstate commerce to making the region more attractive to future businesses, industry, and tourism, the Natcher Bridge is a long-term investment for every Kentuckian and Hoosier. But, unfortunately, it was sold down the river for a tax break for a wealthy few.

I have filed and had planned to offer an amendment to the Budget Reconciliation bill authorizing funding for the Natcher Bridge connecting Kentucky to Indiana. It would be offset by reducing the Republicans' \$500 per child tax credit from the proposed income cap of \$110,000 to \$100,000.

However, it's my understanding that the same Republicans who killed this bridge project, will also raise a point of order against my amendment. That means I would have to get a super majority for approval of my amendment. Without that huge road block, I think I could have persuaded my colleagues on the merits of finishing this project.

That's right. Not starting this project—but finishing this project.

It's a little bit like the young officer who pointed to the place on the map he planned to have the troops cross the river. "Excellent," remarked this superior, "but your finger is not a bridge." Well neither are two piers sticking out of the Ohio River.

Nearly \$56 million in State and Federal funds have been spent on this bridge so far. Along with that financial commitment you'll find the initial stages of a new 7.4 mile, four-lane section of U.S. 60 that should—and I stress should—connect with a 4.7 mile highway leading to the bridge.

We began this bridge project back in 1988, because the current bridge was deemed incapable of dealing with future capacity, fated to become functionally obsolete. Because of the serious capacity concerns, we had to find the quickest and most efficient way to allocate funds—a demonstration project. Kentucky was very lucky to have Congressman William Natcher working diligently to get yearly funding for the bridge.

In hindsight, it probably would have been better to get total funding for the bridge in just 1 year. But at the time, that would have been over \$80 million in Federal funds and Mr. Natcher just wasn't that way. He didn't want to take any money away from other States, and leave them in a pinch. He just took what was essential to the bridge's progress each year.

With his passing, the job of securing funds became much harder, but certainly not less worthy. Despite the fact that it was not included in the House Transportation Appropriations bill last year, I was able to secure the next installment. That's because my colleagues recognized at the time that the Natcher Bridge was a critical link in our national infrastructure.

That hasn't changed. And, ending this project now—with nearly \$56 million already invested—would be a considerable waste of Federal and State funding, not to mention all but shutting the door to the economically important I-64 corridor for these communities.

While I will not be offering this amendment today, I will be offering it in the future. Because the communities on either side of the river, and those businesses counting on that corridor for moving their goods safely and effi-

ciently, know that building this bridge should come before providing a tax break to those making \$110,000.

BROWN AMENDMENT NO. 2949

Mr. BROWN proposed an amendment to the motion to commit proposed by Mr. ROCKEFELLER to the bill S. 1357, supra; as follows:

Strike all after "Finance" and insert the following: "With instructions to report the bill back to the Senate forthwith to include the findings of the Trustees of the Federal Insurance Trust Fund that, in order to save Medicare and to keep the Hospital Insurance Trust Fund solvent for future generations, Congress must address both the long-term and short-term shortfalls in the Medicare program."

ABRAHAM AMENDMENT NO. 2950

Mr. ABRAHAM proposed an amendment to the bill S. 1357, supra; as follows:

At the end of chapter 6 of title VII, insert the following:

SEC. . BENEFICIARY INCENTIVE PROGRAMS.

(a) PROGRAM TO COLLECT INFORMATION ON FRAUD AND ABUSE.—

(1) ESTABLISHMENT OF PROGRAM.—Not later than 3 months after the date of the enactment of this Act, the Secretary of Health and Human Services (hereinafter in this section referred to as the "Secretary") shall establish a program under which the Secretary shall encourage individuals to report to the Secretary information on individuals and entities who are engaging or who have engaged in acts or omissions which constitute grounds for the imposition of a sanction under section 1128, section 1128A, or section 1128B of the Social Security Act, or who have otherwise engaged in fraud and abuse against the medicare program for which there is a sanction provided under law. The program shall discourage provision of, and not consider, information which is frivolous or otherwise not relevant or material to the imposition of such a sanction.

(2) PAYMENT OF PORTION OF AMOUNTS COLLECTED.—If an individual reports information to the Secretary under the program established under paragraph (1) which serves as the basis for the collection by the Secretary or the Attorney General of any amount of at least \$100 (other than any amount paid as a penalty under section 1128B of the Social Security Act), the Secretary may pay a portion of the amount collected to the individual (under procedures similar to those applicable under section 7623 of the Internal Revenue Code of 1986 to payments to individuals providing information on violations of such Code).

(b) PROGRAM TO COLLECT INFORMATION ON PROGRAM EFFICIENCY.—

(1) ESTABLISHMENT OF PROGRAM.—Not later than 3 months after the date of the enactment of this Act, the Secretary shall establish a program under which the Secretary shall encourage individuals to submit to the Secretary suggestions on methods to improve the efficiency of the medicare program.

(2) PAYMENT OF PORTION OF PROGRAM SAVINGS.—If an individual submits a suggestion to the Secretary under the program established under paragraph (1) which is adopted by the Secretary and which results in savings to the program, the Secretary may make a payment to the individual of such amount as the Secretary considers appropriate.

LEAHY AMENDMENTS NOS. 2951-2954

(Ordered to lie on the table.)

Mr. LEAHY submitted four amendments intended to be proposed by him to the bill S. 1357, supra; as follows—

AMENDMENT NO. 2951

Amend section 1109(I)(D) to read as follows—

"(D) by amending subsection (h) to read as follows—

(h) FLOOD CONTROL.—

(1) IN GENERAL.—The Secretary may enter into contracts in accordance with paragraph (2) with producers with crop acreage base on farms with land that is frequently flooded.

(2) TERMS OF CONTRACT.—The contract described in paragraph (1) shall include the following terms—

(A) With respect to the acres which are the subject to the contract, the producer shall agree to—

(i) the removal of crop acreage base;

(ii) not build crop acreage base in future years;

(iii) not apply for crop insurance issued by the Secretary or reinsured by the Secretary;

(iv) comply with applicable wetlands and highly erodible land conservation compliance requirements described in Title XII of the Food Security Act of 1985;

(v) not apply for any conservation program payments from the Secretary;

(vi) not apply for any disaster program benefits issued by the Secretary; and

(vii) refund the payments with interest issued under the contract to the Secretary, if the producer violates the terms of this contract or if the producer transfers the property to another party who violates the terms specified in this contract.

(B) The Secretary shall agree to pay producers an amount not more than 95 percent of the projected benefits and subsidies payable to crops planted on the acres from the Commodity Credit Corporation and the Federal Crop Insurance Corporation for the fiscal years covered by the agreement during the period 1997 through 2002.

(3) COMMODITY CREDIT CORPORATION.—The Secretary shall carry out the program authorized by this subsection through the Commodity Credit Corporation."

AMENDMENT NO. 2952

(a) In section 1201(c)(2) by striking (A) and inserting the following:

"(A) IN GENERAL.—Section 1237 of the Food Security Act of 1985 (16 U.S.C. 3837) is amended—

"(i) in subsection (b)—

"(I) in paragraph (1) by striking 'and';

"(II) in paragraph (2) by—

"(aa) by striking 'not less' and inserting 'not more';

"(bb) by striking '2000' and inserting '2002'; and

"(cc) by striking the period and inserting 'and'; and

"(III) adding the following to the end:

'(3) to the maximum extent possible during the 1996 through 2002 calendar years, one-third of the acres in permanent easements, one-third of the acres in 30 year easements, and one-third of the acres in restoration cost-share agreements.'"

(b) In section 1201(c)(2) strike subparagraph (B) and insert the following:

"(B) COST SHARE AGREEMENTS.—Section 1237A of the Food Security Act of 1985 (16 U.S.C. 3837A) is amended by—

"(i) amending the section heading to read as follows:

"SEC. 1237A EASEMENTS AND AGREEMENTS";

(ii) in subsection (f) striking, except in the case of 'through' and the Secretary'; and

(iii) adding the following the end:

“(h) COST SHARE AGREEMENTS.—The Secretary may enroll land into wetland reserve through agreements which require the landowner to restore wetlands on the land, provided the agreement does not provide the Secretary with an easement.

“(C) COST SHARE AND TECHNICAL ASSISTANCE.—Section 1237C(b) of the Food Security Act of 1985 (16 U.S.C. 3837c(b)) is amended to read as follows:

“(b) COST SHARE AND TECHNICAL ASSISTANCE.—

“(1) For easements entered into from the 1991 through 1995 calendar years in making cost share payments under subsection (a)(1), the Secretary shall pay the owner an amount that is not less than 50 percent but not more than 75 percent of eligible costs with respect to an easement which is not permanent, and not less than 75 percent but not more than 100 percent of eligible costs with respect to a permanent easement.

“(2) For easements and agreements entered into from the 1996 through 2002 calendar years, in making cost share payments the Secretary shall—

(A) pay the owner an amount that is not less than 75 percent but not more than 100 percent of the eligible costs with respect to preeminent easements and cost share agreements;

(B) pay the owner an amount that is not less than 50 percent, but not more than 75 percent of the eligible costs with respect to 30 year easements; and

(C) provide owners technical assistance to assist land owners in complying with the terms of easements and agreements.”

“(C) AGREEMENTS—

“(g) EASEMENTS AND AGREEMENTS.—The Secretary shall enroll lands in the wetland reserve through easements and agreements in accordance with this subsection.

“(1) EASEMENTS.—The Secretary may enroll land into wetland reserve through the purchase of easements as provided for in section 1237A.

“(2) AGREEMENTS.—The Secretary may enroll land into the wetland reserve through agreements which require the landowner to restore wetlands on the land, provided the agreement does not provide the Secretary with an easement. Through such agreements the Secretary shall provide landowners cost share and technical assistance in accordance with section 1237C(b).”

(c) In section 1201(c)(2) strike subparagraph (B) and insert the following:

“(B) COMPENSATION.—Section 1237A(f) of the Food Security Act of 1985 (16 U.S.C. 3837a(f)) is amended by striking ‘, except in the case of through and the Secretary.’”

AMENDMENT NO. 2953

Amend section 1201(b) by adding the following after “To receive cost sharing or inventive payments, or technical assistance, participating operators shall comply with all terms and conditions of the contract and a plan, as established by the Secretary”.

“(3) CONTRACT EFFECTIVE DATE.—A contract between an operator and the Secretary under this chapter shall become effective on October 1st following the date the contract is fully entered into.”

AMENDMENT NO. 2954

Amend section 1106 by striking “for calendar year 1996, subject to subsection (d).” through “beginning January 1, 1996, and ending December 31, 2002”.

GRASSLEY AMENDMENTS NOS. 2955–2956

(Ordered to lie on the table.)

Mr. GRASSLEY submitted two amendments intended to be proposed

by him to the bill S. 1357, supra; as follows:

AMENDMENT NO. 2955

Subsection (e) of Section 2123 is amended by adding “, other than a program operated or financed by the Indian Health Service,” after “other federally operated or financed health care program”.

As amended, the subsection would read:

(e) MEDICAID AS SECONDARY PAYER.—Except as otherwise provided by law, no payment shall be made to a State under this part for expenditures for medical assistance provided for an individual under its medicaid plan to the extent that payment has been made or can reasonably be expected to be made promptly (as determined in accordance with regulations) under any other federally operated or financed health care program, other than a program operated or financed by the Indian Health Service, as identified by the Secretary. For purposes of this subsection, rules similar to the rules for overpayments under section 2122(b) shall apply.

AMENDMENT NO. 2956

On Pages 764 and 765, section 2106, Medicaid Task Force—under subsection (c) Advisory Group for the Task Force, add new number (14) to read: “(14) AMERICAN OSTEOPATHIC ASSOCIATION”.

Redesignate old No. 14 to be No. 15

Redesignate old No. 15 to be No. 16

Redesignate old No. 16 to be No. 17

Redesignate old No. 17 to be No. 18.

HARKIN AMENDMENT NO. 2957

Mr. HARKIN proposed an amendment to the bill S. 1357, supra; as follows:

Strike all after the word “SEC.” on page 1 line 3 and insert the following:

SEC. . The following provisions shall constitute all of the provisions regarding Medicare Fraud and Abuse in Title VII of this bill:

CHAPTER 6—HEALTH CARE FRAUD AND ABUSE PREVENTION

SEC. 7100. SHORT TITLE.

This chapter may be cited as the “Health Care Fraud and Abuse Prevention Act of 1995”.

Subchapter A—Fraud and Abuse Control Program

SEC. 7101. FRAUD AND ABUSE CONTROL PROGRAM.

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

“FRAUD AND ABUSE CONTROL PROGRAM

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

“(1) IN GENERAL.—Not later than January 1, 1996, 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 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 1128D.

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

“(3) GUIDELINES.—

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

“(B) INFORMATION GUIDELINES.—

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

“(ii) CONFIDENTIALITY.—Such guidelines shall include procedures to assure that such information is provided and 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) (relating to limitation on liability) shall apply to a person providing information to the Secretary or the Attorney General in conjunction with their performance of duties under this section.

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

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

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

“(1) REIMBURSEMENTS FOR INVESTIGATIONS.—The Inspector General of the Department of Health and Human Services is authorized to receive and retain for current use reimbursement for the costs of conducting investigations and audits and for monitoring compliance plans when such costs are ordered by a court, voluntarily agreed to by the payer, or otherwise.

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

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

“(1) a policy of health insurance;

“(2) a contract of a service benefit organization; and

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

(b) ESTABLISHMENT OF HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT IN FEDERAL HOSPITAL INSURANCE TRUST FUND.—Section 1817 (42 U.S.C. 1395i) is amended by adding at the end the following new subsection:

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

“(1) ESTABLISHMENT.—There is hereby established in the Trust Fund an expenditure account to be known as the ‘Health Care Fraud and Abuse Control Account’ (in this subsection referred to as the ‘Account’).

“(2) APPROPRIATED AMOUNTS TO TRUST FUND.—

“(A) IN GENERAL.—There are hereby appropriated to the Trust Fund—

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

“(ii) such amounts as may be deposited in the Trust Fund as provided in sections 7141(b) and 7142(c) of the Balanced Budget Reconciliation Act of 1995, and title XI; and

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

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

“(C) TRANSFER OF AMOUNTS.—The Managing Trustee shall transfer to the Trust Fund, under rules similar to the rules in section 9601 of the Internal Revenue Code of 1986, an amount equal to the sum of the following:

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

“(ii) Civil monetary penalties and assessments imposed in health care cases, including amounts recovered under titles XI, XVIII, and XXI, and chapter 38 of title 31, United States Code (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 obtained and otherwise creditable to miscellaneous receipts of the general fund of the Treasury obtained under sections 3729 through 3733 of title 31, United States Code (known as the False Claims Act), in cases involving claims related to the provision of health care items and services (other than funds awarded to a relator, for restitution or otherwise authorized by law).

“(3) APPROPRIATED AMOUNTS TO ACCOUNT.—

“(A) IN GENERAL.—There are hereby appropriated to the Account from the Trust Fund such sums as the Secretary and the Attorney General certify are necessary to carry out the purposes described in subparagraph (B), to be available without further appropriation, in an amount—

“(i) with respect to activities of the Office of the Inspector General of the Department of Health and Human Services and the Federal Bureau of Investigations in carrying out such purposes, not less than—

“(I) for fiscal year 1996, \$110,000,000,

“(II) for fiscal year 1997, \$140,000,000,

“(III) for fiscal year 1998, \$160,000,000,

“(IV) for fiscal year 1999, \$185,000,000,

“(V) for fiscal year 2000, \$215,000,000,

“(VI) for fiscal year 2001, \$240,000,000, and

“(VII) for fiscal year 2002, \$270,000,000; and

“(i) with respect to all activities (including the activities described in clause (i)) in carrying out such purposes, not more than—

“(I) for fiscal year 1996, \$200,000,000, and

“(II) for each of the fiscal years 1997 through 2002, the limit for the preceding fiscal year, increased by 15 percent; and

“(iii) for each fiscal year after fiscal year 2002, within the limits for fiscal year 2002 as determined under clauses (i) and (ii).

“(B) USE OF FUNDS.—The purposes described in this subparagraph are as follows:

“(i) GENERAL USE.—To cover the costs (including equipment, salaries and benefits, and

travel and training) of the administration and operation of the health care fraud and abuse control program established under section 1128C(a), including the costs of—

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

“(II) investigations;

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

“(IV) inspections and other evaluations; and

“(V) provider and consumer education regarding compliance with the provisions of title XI.

“(ii) USE BY STATE MEDICAID FRAUD CONTROL UNITS FOR INVESTIGATION REIMBURSEMENTS.—To reimburse the various State Medicaid fraud control units upon request to the Secretary for the costs of the activities authorized under section 2134(b).

“(4) 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, and the justification for such disbursements, by the Account in each fiscal year.”.

SEC. 7102. APPLICATION OF CERTAIN HEALTH ANTI-FRAUD AND ABUSE SANCTIONS TO FRAUD AND ABUSE AGAINST FEDERAL HEALTH PROGRAMS.

(a) CRIMES.—

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

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

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

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

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

(i) by striking “a State plan approved under title XIX” and inserting “a Federal health care program”; and

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

(E) In subsection (b)—

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

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

(iii) by striking “title XVIII or a State health care program” each place it appears and inserting “Federal health care program”;

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

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

(vi) in paragraph (1)(B), by striking “in return for purchasing, leasing, ordering, or arranging for or recommending” and inserting “to purchase, lease, order, or arrange for or recommend”;

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

(viii) by adding at the end of paragraphs (1) and (2) the following sentence: “A violation exists under this paragraph if one or more purposes of the remuneration is unlawful under this paragraph.”;

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

(x) in paragraph (4) (as redesignated), by striking “Paragraphs (1) and (2)” and inserting “Paragraphs (1), (2), and (3)”;

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

“(3)(A) The Attorney General may bring an action in the district courts to impose upon any person who carries out any activity in violation of this subsection a civil penalty of not less than \$25,000 and not more than \$50,000 for each such violation, plus three times the total remuneration offered, paid, solicited, or received.

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

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

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

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

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

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

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

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

“(g) (1) The Secretary and Administrator of the departments and agencies with a Federal health care program may conduct an investigation or audit relating to violations of this section and claims within the jurisdiction of other Federal departments or agencies if the following conditions are satisfied:

“(A) The investigation or audit involves primarily claims submitted to the Federal health care programs of the department or agency conducting the investigation or audit.

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

“(2) If the conditions specified in paragraph (1) are fulfilled, the Inspector General of the department or agency conducting the investigation or audit may exercise all powers granted under the Inspector General Act of 1978 with respect to the claims submitted to the other departments or agencies to the same manner and extent as provided in that Act with respect to claims submitted to such departments or agencies.”.

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

“(h) The Secretary may—

“(1) in consultation with State and local health care officials, identify opportunities for the satisfaction of community service obligations that a court may impose upon the conviction of an offense under this section, and

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

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

SEC. 7103. HEALTH CARE FRAUD AND ABUSE PROVIDER GUIDANCE.

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

(1) IN GENERAL.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) INTERPRETIVE RULINGS.—

(1) IN GENERAL.—

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

(B) ISSUANCE AND EFFECT OF INTERPRETIVE RULING.—

(i) IN GENERAL.—If appropriate, the Inspector General shall in consultation with the Attorney General, issue an interpretive ruling not later than 120 days after receiving a request described in subparagraph (A). Interpretive rulings shall not have the force of law and shall be treated as an interpretive rule within the meaning of section 553(b) of title 5, United States Code. All interpretive rulings issued pursuant to this clause shall be published in the Federal Register or otherwise made available for public inspection.

(ii) REASONS FOR DENIAL.—If the Inspector General does not issue an interpretive ruling in response to a request described in subparagraph (A), the Inspector General shall notify the requesting party of such decision not later than 120 days after receiving such a request and shall identify the reasons for such decision.

(2) CRITERIA FOR INTERPRETIVE RULINGS.—

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

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

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

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

(c) SPECIAL FRAUD ALERTS.—

(1) IN GENERAL.—

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

(B) ISSUANCE AND PUBLICATION OF SPECIAL FRAUD ALERTS.—Upon receipt of a request described in subparagraph (A), the 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 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. 7104. MEDICARE/MEDICAID BENEFICIARY PROTECTION PROGRAM.

(a) ESTABLISHMENT OF PROGRAM.—Not later than January 1, 1996, the Secretary (through the Administrator of the Health Care Financing Administration and the Inspector General of the Department of Health and Human Services) shall establish the Medicare/Medicaid Beneficiary Protection Program. Under such program the Secretary shall—

(1) educate medicare and medicaid beneficiaries regarding—

(A) medicare and medicaid program coverage;

(B) fraudulent and abusive practices;

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

(D) substandard health care items and services;

(2) identify and publicize fraudulent and abusive practices with respect to the delivery of health care items and services; and

(3) establish a procedure for the reporting of fraudulent and abusive health care providers, practitioners, claims, items, and services to appropriate law enforcement and payer agencies.

(b) RECOGNITION AND PUBLICATION OF CONTRIBUTIONS.—The program established by the Secretary under this section shall recognize and publicize significant contributions made by individual health care patients toward the combating of health care fraud and abuse.

(c) DISSEMINATION OF INFORMATION.—The Secretary shall provide for the broad dissemination of information regarding the Medicare/Medicaid Beneficiary Protection Program.

SEC. 7105. MEDICARE BENEFIT QUALITY ASSURANCE.

(a) IN GENERAL.—Part D of title XVIII (42 U.S.C. 1395 et seq.), as redesignated in section 7003, is amended by inserting after section 1888 the following new section:

"MEDICARE BENEFIT INTEGRITY SYSTEM

"SEC. 1889. (a) APPROPRIATION.—There are appropriated from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund for each fiscal year such amounts as are necessary to carry out the benefit quality assurance program activities described in subsection (b), subject to subsections (c) and (d).

"(b) ACTIVITIES DESCRIBED.—The benefit quality assurance program activities described in this subsection are as follows:

"(1) Review of activities of providers of services or other persons in connection with this title, including medical and utilization review and fraud review.

"(2) Audit of cost reports.

"(3) Determinations as to whether payment should not be, or should not have been, made under this title by reason of section 1862(b), and recovery of payments that should not have been made.

"(4) Education of providers of services, beneficiaries, and other persons with respect to payment integrity and benefit quality assurance issues.

"(c) AMOUNTS SPECIFIED.—The amount appropriated under subsection (a) for a fiscal year is as follows:

"(1) For fiscal year 1996, such amount shall be \$25,000,000.

“(2) For fiscal year 1997, such amount shall be \$550,000,000.

“(3) For fiscal year 1998, such amount shall be \$575,000,000.

“(4) For fiscal year 1999, such amount shall be \$600,000,000.

“(5) For fiscal year 2000, such amount shall be \$619,000,000.

“(6) For fiscal year 2001 and each succeeding fiscal year, the greater of—

“(A) \$619,000,000 increased by a percentage equal to the percentage increase in expenditures under this title (other than expenditures pursuant to this section) for the preceding fiscal year over fiscal year 1999; or

“(B) an amount equal to the aggregate amount expended for activities described in subsection (b) in fiscal year 2000, increased, as determined by the Secretary, to reflect—

“(i) inflation; and

“(ii) any costs attributable to oversight responsibilities added with respect to periods after fiscal year 2000.

“(d) ALLOCATION OF PAYMENTS AMONG TRUST FUNDS.—The appropriations made under subsection (a) shall be allocated to reasonably reflect the proportion of expenditures associated with part A and part B.”

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to obligations incurred after fiscal year 1995.

SEC. 7106. MEDICARE BENEFIT INTEGRITY SYSTEM.

(a) IN GENERAL.—Part D of title XVIII (42 U.S.C. 1395 et seq.), as redesignated in section 7003 and amended by section 7045, is amended by inserting after section 1888 the following new section:

“MEDICARE BENEFIT INTEGRITY CONTRACTS

“SEC. 1890. (a) AUTHORITY TO CONTRACT.—

“(1) IN GENERAL.—In order to improve the effectiveness of benefit quality assurance activities relating to programs under this title, and to enhance the Secretary’s capability to carry out program safeguard functions and related education activities to avoid the improper expenditure of assets of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, the Secretary shall enter into contracts with organizations or other entities having demonstrated capability to carry out one or more of the activities described in section 1889(b). The provisions of sections 1816 and 1842 shall be inapplicable to contracts under this section.

“(2) NUMBER OF CONTRACTS.—The Secretary shall determine the number of separate contracts which are necessary to achieve, with the maximum degree of efficiency and cost effectiveness, the objectives of this section. The Secretary may enter into contracts under this section at such time or times as are appropriate so long as not later than the fiscal year beginning October 1, 1998, and for each fiscal year thereafter, there are in effect contracts that, considered collectively, provide for benefit quality assurance activities with respect to all payments under this title.

“(b) CONTRACT REQUIREMENTS.—A benefit quality assurance contract entered into under subsection (a) must provide for one or more benefit quality assurance program activities described in section 1889(b). Each such contract shall include an agreement by the contractor to cooperate with the Inspector General of the Department of Health and Human Services, and the Attorney General, and other law enforcement agencies, as appropriate, in the investigation and deterrence of fraud and abuse in relation to this title and in other cases arising out of the activities described in such section, and shall contain such other provisions as the Secretary finds necessary or appropriate to achieve the purposes of this part. The provi-

sions of section 1153(e)(1) shall apply to contracts and contracting authority under this section, except that competitive procedures must be used when entering into new contracts under this section, or at any other time when it is in the best interests of the United States. A contract under this section may be renewed from term to term without regard to any provision of law requiring competition if the contractor has met or exceeded the performance requirements established in the current contract.

“(c) LIMITATIONS.—

“(1) IN GENERAL.—In carrying out this section, the Secretary may not enter into a contract with an organization or other entity if the Secretary determines that such organization’s or entity’s financial holdings, interests, or relationships would interfere with its ability to perform the functions to be required by the contract in an effective and impartial manner.

“(2) LIMITATION OF LIABILITY.—The Secretary shall by regulation provide for the limitation of a contractor’s liability for actions taken to carry out a contract under this section, and such regulations shall, to the extent the Secretary finds appropriate, employ the same or comparable standards and other substantive and procedural provisions as are contained in section 1157.”

PART II—REVISIONS TO CURRENT SANCTIONS FOR FRAUD AND ABUSE

SEC. 7110. MANDATORY EXCLUSION FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS.

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

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

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

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

“(1) CONVICTION RELATING TO FRAUD.—Any individual or entity that has been convicted after the date of the enactment of the Medicare Improvement and Solvency Protection Act of 1995, under Federal or State law—

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

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

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

“(B) of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct with respect to any act or omission in a program (other than a health care program) operated by or financed in whole or in part by any Federal, State, or local government agency.”

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

(1) IN GENERAL.—Section 1128(a) (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 Medicare Improvement and Solvency Protection 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) (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. 7111. 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) (42 U.S.C. 1320a-7(c)(3)) is amended by adding at the end the following new subparagraphs:

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

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

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

SEC. 7112. PERMISSIVE EXCLUSION OF INDIVIDUALS WITH OWNERSHIP OR CONTROL INTEREST IN SANCTIONED ENTITIES.

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

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

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

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

SEC. 7113. 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) (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) (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) (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. 7114. SANCTIONS AGAINST PROVIDERS FOR EXCESSIVE FEES OR PRICES.

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

(1) by inserting "(as specified by the Secretary in regulations)" after "substantially in excess of such individual's or entity's usual charges"; and

(2) striking "(or, in applicable cases, substantially in excess of such individual's or entity's costs)" and inserting ", costs or fees".

SEC. 7115. APPLICABILITY OF THE BANKRUPTCY CODE TO PROGRAM SANCTIONS.

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

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

(b) CIVIL MONETARY PENALTIES.—Section 1128(a) (42 U.S.C. 1320a-7a(a)) is amended by adding at the end the following sentence: "An exclusion imposed under this subsection is not subject to the automatic stay imposed under section 362 of title 11, United States Code, and any penalties and assessments imposed under this section shall be nondischargeable under the provisions of such title."

(c) OFFSET OF PAYMENTS TO INDIVIDUALS.—Section 1892(a)(4) (42 U.S.C. 1395ccc(a)(4)) is amended by adding at the end the following sentence: "An exclusion imposed under paragraph (2)(C)(ii) or paragraph (3)(B) is not subject to the automatic stay imposed under section 362 of title 11, United States Code."

SEC. 7116. AGREEMENTS WITH PEER REVIEW ORGANIZATIONS FOR MEDICARE COORDINATED CARE ORGANIZATIONS.

(a) 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 part C of title XVIII 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 1856(d)(7)(A) of such Act, as added by section 7003(a).

(b) REPORT BY GAO.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study of the costs incurred by eligible organizations with risk-sharing contracts under part C of title XVIII of the Social Security 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.

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

SEC. 7117. EFFECTIVE DATE.

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

PART III—ADMINISTRATIVE AND MISCELLANEOUS PROVISIONS

SEC. 7120. 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 and TIN (as defined in section 7701(a)(41) of the Internal Revenue Code of 1986) of any health care provider, supplier, or practitioner who is the subject of a final adverse action.

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

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

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

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

(4) TIMING AND FORM OF REPORTING.—The information required to be reported under this subsection shall be reported regularly (but not less often than monthly) and in such form and manner as the Secretary prescribes. Such information shall first be required to be reported on a date specified by the Secretary.

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

(c) DISCLOSURE AND CORRECTION OF INFORMATION.—

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

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

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

(2) CORRECTIONS.—Each Government agency and health plan shall report corrections of information already reported about any final adverse action taken against a health care provider, supplier, or practitioner, in such form and manner that the Secretary prescribes by regulation.

(d) ACCESS TO REPORTED INFORMATION.—

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

(2) FEES FOR DISCLOSURE.—The Secretary may establish or approve reasonable fees for the disclosure of information in this database (other than with respect to requests by Federal agencies). The amount of such a fee may be sufficient to recover the full costs of carrying out the provisions of this section, including reporting, disclosure, and administration. 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 shall be held liable in any civil action with respect to any report made as required by this section, without knowledge of the falsity of the information contained in the report.

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

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

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

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

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

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

(II) any other loss of license, or the right to apply for or renew a license of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, nonrenewability, or otherwise, or

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

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

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

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

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

(3) The term "health care provider" means a provider of services as defined in section 1861(u) of the Social Security Act (42 U.S.C. 1395x(u)), and any person or 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 (42 U.S.C. 1395i-3(a) and (b), and 1395x).

(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" means a plan or program that provides health benefits, whether directly, through insurance, or otherwise, and includes—

(A) a policy of health insurance;

(B) a contract of a service benefit organization;

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

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

(7) For purposes of paragraph (1), the existence of a conviction shall be determined under section 1128(i) of the Social Security Act.

(g) CONFORMING AMENDMENT.—Section 1921(d) (42 U.S.C. 1396r-2(d)) is amended by inserting "and section 7061 of the Medicare Improvement and Solvency Protection Act of 1995" after "section 422 of the Health Care Quality Improvement Act of 1986".

SEC. 7121. INSPECTOR GENERAL ACCESS TO ADDITIONAL PRACTITIONER DATA BANK.

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

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

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

"(4) FEES.—The Secretary may impose fees for the disclosure of information under this part sufficient to recover the full costs of carrying out the provisions of this part, including reporting, disclosure, and administration, except that a fee may not be imposed for requests made by the Inspector General of the Department of Health and Human Services. Such fees shall remain available to the Secretary (or, in the Secretary's discretion, to the agency designated in section 424(b)) until expended."

SEC. 7112. CORPORATE WHISTLEBLOWER PROGRAM.

Title XI (42 U.S.C. 1301 et seq.) is amended by inserting after section 1128B the following new section:

CORPORATE WHISTLEBLOWER PROGRAM

"SEC. 1128C (a) ESTABLISHMENT OF PROGRAM.—The Secretary, through the Inspector General of the Department of Health and Human Services, shall establish a procedure whereby corporations, partnerships, and other legal entities specified by the Secretary, may voluntarily disclose instances of unlawful conduct and seek to resolve liability for such conduct through means specified by the Secretary.

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

"(1) the matter set forth in the complaint has been voluntarily disclosed to the United States by the proposed defendant and the defendant has been accepted into the voluntary disclosure program established pursuant to subsection (a); and

"(2) any new information provided in the complaint under such section does not add substantial grounds for additional recovery beyond those encompassed within the scope of the voluntary disclosure."

PART IV—CIVIL MONETARY PENALTIES

SEC. 7121. SOCIAL SECURITY ACT CIVIL MONETARY PENALTIES.

(a) GENERAL CIVIL MONETARY PENALTIES.—Section 1128A (42 U.S.C. 1320a-7a) is amended as follows:

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

(2) In subsection (f)—

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

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

"(3) With respect to amounts recovered arising out of a claim under a Federal health care program (as defined in section 1128B(f)), the portion of such amounts as is determined to have been paid by the program shall be repaid to the program, and the portion of such amounts attributable to the amounts recovered under this section by reason of the amendments made by the Medicare Improvement and Solvency Protection Act of 1995 (as estimated by the Secretary) shall be deposited into the Hospital Insurance Trust Fund."

(3) In subsection (i)—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) EMPLOYER BILLING FOR SERVICES FURNISHED, DIRECTED, OR PRESCRIBED BY AN EXCLUDED EMPLOYEE.—Section 1128A(a)(1) (42 U.S.C. 1320a-7a(a)(1)) is amended—

(1) by striking "or" at the end of subparagraph (C);

(2) by striking "; or" at the end of subparagraph (D) and inserting ", or"; and

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

"(E) is for a medical or other item or service furnished, directed, or prescribed by an individual who is an employee or agent of the person during a period in which such employee or agent was excluded from the program under which the claim was made on any of the grounds for exclusion described in subparagraph (D)";

(d) CIVIL MONEY PENALTIES FOR ITEMS OR SERVICES FURNISHED, DIRECTED, OR PRESCRIBED BY AN EXCLUDED INDIVIDUAL.—Section 1128A(a)(1)(D) (42 U.S.C. 1320a-7a(a)(1)(D)) is amended by inserting ", directed, or prescribed" after "furnished".

(e) MODIFICATIONS OF AMOUNTS OF PENALTIES AND ASSESSMENTS.—Section 1128A(a) (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".

(f) CLAIM FOR ITEM OR SERVICE BASED ON INCORRECT CODING OR MEDICALLY UNNECESSARY SERVICES.—Section 1128A(a)(1) (42 U.S.C. 1320a-7a(a)(1)) is amended—

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

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

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

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

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

(g) PERMITTING SECRETARY TO IMPOSE CIVIL MONETARY PENALTY.—Section 1128A(b) (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)."

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

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

(1) OFFER OF REMUNERATION.—Section 1128A(a) (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) (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 beneficiaries, third party payors, and providers, to whom claims are presented and as long as the differentials meet the standards as defined in regulations promulgated by the Secretary not later than 180 days after the date of the enactment of the Medicare Improvement and Solvency Protection Act of 1995; or

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

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

PART V—CHAPTER 5—AMENDMENTS TO CRIMINAL LAW

SEC. 7131. HEALTH CARE FRAUD.

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

"§ 1347. Health care fraud

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

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

"(2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under he custody or control of, any health plan, or person in connection with the delivery of or payment for health care benefits, items, or services; shall be fined under this title or imprisoned not more than 10 years, or both. If the violation results in serious bodily injury (as defined in section 1365(g)(3) of this title), such person may be imprisoned for any term of years.

"(b) For purposes of this section, the term 'health plan' has the same meaning given such term in section 7061(f)(6) of the Medicare Improvement and Solvency Protection Act of 1995."

(b) 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."

SEC. 7132. FORFEITURES FOR FEDERAL HEALTH CARE OFFENSES.

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

"(6)(A) The court, in imposing sentence on a person convicted of a Federal health care offense, shall order the person to forfeit property, real or personal, that constitutes or is derived, directly or indirectly, from gross 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; and

"(iii) sections 287, 371, 664, 666, 669, 1001, 1027, 1341, 1343, 1920, or 1954 of this title if the violation or conspiracy relates to health care fraud."

(b) CONFORMING AMENDMENT.—Section 982(b)(1)(A) of title 18, United States Code, is amended by inserting "or (a)(6)" after "(a)(1)".

(c) PROPERTY FORFEITED DEPOSITED IN FEDERAL HOSPITAL INSURANCE TRUST FUND.—

(1) IN GENERAL.—After the payment of the costs of asset forfeiture has been made, and notwithstanding any other provision of law, the Secretary of the Treasury shall deposit into the Federal Hospital Insurance Trust Fund pursuant to section 1817(k)(2)(C) of the Social Security Act, as added by section 7101(b), an amount equal to the net amount realized from the forfeiture of property by reason of a Federal health care offense pursuant to section 982(a)(6) of title 18, United States Code.

(2) COSTS OF ASSET FORFEITURE.—For purposes of paragraph (1), the term "payment of the costs of asset forfeiture" means—

(A) the payment, at the discretion of the Attorney General, of any expenses necessary to seize, detain, inventory, safeguard, maintain, advertise, sell, or dispose of property

under seizure, detention, or forfeiture, or of any other necessary expenses incident to the seizure, detention, forfeiture, or disposal of such property, including payment for—

(i) contract services,

(ii) the employment of outside contractors to operate and manage properties or provide other specialized services necessary to dispose of such properties in an effort to maximize the return from such properties; and

(iii) reimbursement of any Federal, State, or local agency for any expenditures made to perform the functions described in this subparagraph;

(B) at the discretion of the Attorney General, the payment of awards for information or assistance leading to a civil or criminal forfeiture involving any Federal agency participating in the Health Care Fraud and Abuse Control Account;

(C) the compromise and payment of valid liens and mortgages against property that has been forfeited, subject to the discretion of the Attorney General to determine the validity of any such lien or mortgage and the amount of payment to be made, and the employment of attorneys and other personnel skilled in State real estate law as necessary;

(D) payment authorized in connection with remission or mitigation procedures relating to property forfeited; and

(E) the payment of State and local property taxes on forfeited real property that accrued between the date of the violation giving rise to the forfeiture and the date of the forfeiture order.

SEC. 7133. INJUNCTIVE RELIEF RELATING TO FEDERAL HEALTH CARE OFFENSES.

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

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

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

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

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

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

SEC. 7134. GRAND JURY DISCLOSURE.

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

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

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

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

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

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

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

SEC. 7135. FALSE STATEMENTS.

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

"§ 1035. False statements relating to health care matters

"(a) Whoever, in any matter involving a health plan, knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious, or fraudulent statements or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious, or

fraudulent statement or entry, shall be fined under this title or imprisoned not more than 5 years, or both.

“(b) For purposes of this section, the term ‘health plan’ has the same meaning given such term in section 7061(f)(6) of the Medicare Improvement and Solvency Protection Act of 1995.”.

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

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

SEC. 7136. OBSTRUCTION OF CRIMINAL INVESTIGATIONS, AUDITS, OR INSPECTIONS 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, audits, or inspections 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 Federal agent or employee involved in an investigation, audit, inspection, or other activity related to such an offense, shall be fined under this title or imprisoned not more than 5 years, or both.

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

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

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

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

SEC. 7137. THEFT OR EMBEZZLEMENT.

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

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

“(a) IN GENERAL.—Whoever willfully embezzles, steals, or otherwise without authority willfully and unlawfully converts to the use of any person other than the rightful owner, or intentionally misapplies any of the moneys, funds, securities, premiums, credits, property, or other assets of a health plan, shall be fined under this title or imprisoned not more than 10 years, or both.

“(b) HEALTH PLAN.—As used in this section the term ‘health plan’ has the same meaning given such term in section 7061(f)(6) of the Medicare Improvement and Solvency Protection Act of 1995.”.

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

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

SEC. 7138. LAUNDERING OF MONETARY INSTRUMENTS.

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

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

SEC. 7139. AUTHORIZED INVESTIGATIVE DEMAND PROCEDURES.

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

“§3486. Authorized investigative demand procedures

“(a) AUTHORIZATION.—

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

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

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

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

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

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

“(d) IMMUNITY FROM CIVIL LIABILITY.—Notwithstanding any Federal, State, or local

law, any person, including officers, agents, and employees, receiving a subpoena under this section, who complies in good faith with the subpoena and thus produces the materials sought, shall not be liable in any court of any State or the United States to any customer or other person for such production or for nondisclosure of that production to the customer.

“(e) USE IN ACTION AGAINST INDIVIDUALS.—

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

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

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

“(f) HEALTH PLAN.—As used in this section the term ‘health plan’ has the same meaning given such term in section 7061(f)(6) of the Medicare Improvement and Solvency Protection Act of 1995.”.

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

“3486. Authorized investigative demand procedures.”.

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

PART VI—STATE HEALTH CARE FRAUD CONTROL UNITS

SEC. 7141. STATE HEALTH CARE FRAUD CONTROL UNITS.

(a) EXTENSION OF CONCURRENT AUTHORITY TO INVESTIGATE AND PROSECUTE FRAUD IN OTHER FEDERAL PROGRAMS.—Section 1903(q)(3) (42 U.S.C. 1396b(q)(3)) is amended—

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

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

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

“(4)(A) The entity has—

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

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

“(iii) procedures for acting upon such complaints under the criminal laws of the State

or for referring such complaints to other State agencies for action.

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

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

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

PART VII—MEDICARE/MEDICAID BILLING ABUSE PREVENTION

SEC. 7151. UNIFORM MEDICARE/MEDICAID APPLICATION PROCESS.

Not later than 1 year after the date of the enactment of this Act, the Secretary shall establish procedures and a uniform application form for use by any individual or entity that seeks to participate in the programs under titles XVIII and XIX of the Social Security Act (42 U.S.C. 1395 et seq.; 42 U.S.C. 1396 et seq.). The procedures established shall include the following:

(1) Execution of a standard authorization form by all individuals and entities prior to submission of claims for payment which shall include the social security number of the beneficiary and the TIN (as defined in section 7701(a)(41) of the Internal Revenue Code of 1986) of any health care provider, supplier, or practitioner providing items or services under the claim.

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

(3) A right of access by the Secretary to provider records relating to items and services rendered to beneficiaries of such programs.

(4) Retention of source documentation.

(5) Provision of complete and accurate documentation to support all claims for payment.

(6) A statement of the legal consequences for the submission of false or fraudulent claims for payment.

SEC. 7152. STANDARDS FOR UNIFORM CLAIMS.

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

(b) ENSURING PROVIDER RESPONSIBILITY.—In establishing standards under subsection (a), the Secretary, in consultation with appropriate agencies including the Department of Justice, shall include such methods of ensuring provider responsibility and accountability for claims submitted as necessary to control fraud and abuse.

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

SEC. 7153. UNIQUE PROVIDER IDENTIFICATION CODE.

(a) ESTABLISHMENT OF SYSTEM.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall establish a system which provides for the issuance of a unique identifier code for each individual or entity furnishing items or services for which payment may be made under title XVIII or XIX of the Social Security (42 U.S.C. 1395 et seq.; 1396 et seq.), and the notation of such

unique identifier codes on all claims for payment.

(b) APPLICATION FEE.—The Secretary shall require an individual applying for a unique identifier code under subsection (a) to submit a fee in an amount determined by the Secretary to be sufficient to cover the cost of investigating the information on the application and the individual's suitability for receiving such a code.

SEC. 7154. USE OF NEW PROCEDURES.

No payment may be made under either title XVIII or XIX of the Social Security Act (42 U.S.C. 1395 et seq.; 42 U.S.C. 1396 et seq.) for any item or service furnished by an individual or entity unless the requirements of sections 7102 and 7103 are satisfied.

SEC. 7155. REQUIRED BILLING, PAYMENT, AND COST LIMIT CALCULATION TO BE BASED ON SITE WHERE SERVICE IS FURNISHED.

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

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

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

Subchapter B—Additional Provisions to Combat Waste, Fraud, and Abuse

PART I—WASTE AND ABUSE REDUCTION

SEC. 7161. PROHIBITING UNNECESSARY AND WASTEFUL MEDICARE PAYMENTS FOR CERTAIN ITEMS.

Notwithstanding any other provision of law, including any regulation or payment policy, the following categories of charges shall not be reimbursable under title XVIII of the Social Security Act:

(1) Tickets to sporting or other entertainment events.

(2) Gifts or donations.

(3) Costs related to team sports.

(4) Personal use of motor vehicles.

(5) Costs for fines and penalties resulting from violations of Federal, State, or local laws.

(6) Tuition or other education fees for spouses or dependents of providers of services, their employees, or contractors.

SEC. 7162. APPLICATION OF COMPETITIVE ACQUISITION PROCESS FOR PART B ITEMS AND SERVICES.

(a) GENERAL RULE.—Part B of title XVIII is amended by inserting after section 1846 the following new section:

“COMPETITION ACQUISITION FOR ITEMS AND SERVICES

“SEC. 1847. (a) ESTABLISHMENT OF BIDDING AREAS.—

“(1) IN GENERAL.—The Secretary shall establish competitive acquisition areas for the purpose of awarding a contract or contracts for the furnishing under this part of the items and services described in subsection (c) on or after January 1, 1996. The Secretary may establish different competitive acquisition areas under this subsection for different classes of items and services under this part.

“(2) CRITERIA FOR ESTABLISHMENT.—The competitive acquisition areas established under paragraph (1) shall—

“(A) initially be within, or be centered around metropolitan statistical areas;

“(B) be chosen based on the availability and accessibility of suppliers and the probable savings to be realized by the use of competitive bidding in the furnishing of items and services in the area; and

“(C) be chosen so as to not reduce access to such items and services to individuals residing in rural and other underserved areas.

“(b) AWARDING OF CONTRACTS IN AREAS.—

“(1) IN GENERAL.—The Secretary shall conduct a competition among individuals and entities supplying items and services under this part for each competitive acquisition area established under subsection (a) for each class of items and services.

“(2) CONDITIONS FOR AWARDING CONTRACT.—The Secretary may not award a contract to any individual or entity under the competition conducted pursuant to paragraph (1) to furnish an item or service under this part unless the Secretary finds that the individual or entity—

“(A) meets quality standards specified by the Secretary for the furnishing of such item or service; and

“(B) offers to furnish a total quantity of such item or service that is sufficient to meet the expected need within the competitive acquisition area and to assure that access to such items (including appropriate customized items) and services to individuals residing in rural and other underserved areas is not reduced.

“(3) CONTENTS OF CONTRACT.—A contract entered into with an individual or entity under the competition conducted pursuant to paragraph (1) shall specify (for all of the items and services within a class)—

“(A) the quantity of items and services the entity shall provide; and

“(B) such other terms and conditions as the Secretary may require.

“(c) SERVICES DESCRIBED.—The items and services to which the provisions of this section shall apply are as follows:

“(1) Durable medical equipment and medical supplies.

“(2) Oxygen and oxygen equipment.

“(3) Such other items and services with respect to which the Secretary determines the use of competitive acquisition under this section to be appropriate and cost-effective.”.

(b) ITEMS AND SERVICES TO BE FURNISHED ONLY THROUGH COMPETITIVE ACQUISITION.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

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

(2) by striking the period at the end of paragraph (15) and inserting “; or”; and

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

“(16) where such expenses are for an item or service furnished in a competitive acquisition area (as established by the Secretary under section 1847(a)) by an individual or entity other than the supplier with whom the Secretary has entered into a contract under section 1847(b) for the furnishing of such item or service in that area, unless the Secretary finds that such expenses were incurred in a case of urgent need.”.

(c) REDUCTION IN PAYMENT AMOUNTS IF COMPETITIVE ACQUISITION FAILS TO ACHIEVE MINIMUM REDUCTION IN PAYMENTS.—Notwithstanding any other provision of title XVIII of the Social Security Act, if the establishment of competitive acquisition areas under section 1847 of such Act (as added by subsection (a)) and the limitation of coverage for items and services under part B of such title to items and services furnished by providers with competitive acquisition contracts under such section does not result in a reduction, beginning on January 1, 1997, of at least 20 percent (40 percent in the case of oxygen and oxygen equipment) in the projected payment amount that would have applied to an item or service under part B if the item or service had not been furnished through competitive acquisition under such section, the Secretary shall reduce such payment amount by such percentage as the Secretary determines necessary to result in such a reduction. Notwithstanding this section, in no

case can the Secretary make a payment for items and services described in Section 1847(c) that are greater than that required by other provisions of the Balanced Budget Reconciliation Act of 1995.

SEC. 7163. REDUCING EXCESSIVE BILLINGS AND UTILIZATION FOR CERTAIN ITEMS.

Section 1834(a)(15) (42 U.S.C. 1395m(a)(15)) is amended by striking "Secretary may" both places it appears and inserting "Secretary shall".

SEC. 7164. IMPROVED CARRIER AUTHORITY TO REDUCE EXCESSIVE MEDICARE PAYMENTS.

(a) GENERAL RULE.—Section 1834(a)(10)(B) (42 U.S.C. 1395m(a)(10)(B)) is amended by striking "paragraphs (8) and (9)" and all that follows through the end of the sentence and inserting "section 1842(b)(8) to covered items and suppliers of such items and payments under this subsection as such provisions (relating to determinations of grossly excessive payment amounts) apply to items and services and entities and a reasonable charge under section 1842(b)".

(b) REPEAL OF OBSOLETE PROVISIONS.—

(1) Section 1842(b)(8) (42 U.S.C. 1395u(b)(8)) is amended—

(A) by striking subparagraphs (B) and (C),

(B) by striking "(8)(A)" and inserting "(8)", and

(C) by redesignating clauses (i) and (ii) as subparagraphs (A) and (B), respectively.

(2) Section 1842(b)(9) (42 U.S.C. 1395u(b)(9)) is repealed.

(c) PAYMENT FOR SURGICAL DRESSINGS.—Section 1834(i) (42 U.S.C. 1395m(i)) is amended by adding at the end the following new paragraph:

"(3) GROSSLY EXCESSIVE PAYMENT AMOUNTS.—Notwithstanding paragraph (1), the Secretary may apply the provisions of section 1842(b)(8) to payments under this subsection."

SEC. 7165. EFFECTIVE DATE.

The amendments made by this chapter shall apply to items and services furnished under title XVIII of the Social Security Act on or after January 1, 1996.

PART II—MEDICARE BILLING ABUSE PREVENTION

SEC. 7171. IMPLEMENTATION OF GENERAL ACCOUNTING OFFICE RECOMMENDATIONS REGARDING MEDICARE CLAIMS PROCESSING.

(a) IN GENERAL.—Not later than 90 days after the date of the enactment of this Act, the Secretary shall, by regulation, contract, change order, or otherwise, require medicare carriers to acquire commercial automatic data processing equipment (in this subchapter referred to as "ADPE") meeting the requirements of section 7122 to process medicare part B claims for the purpose of identifying billing code abuse.

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

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

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

SEC. 7172. MINIMUM SOFTWARE REQUIREMENTS.

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

(1) The ADPE shall be a commercial item.

(2) The ADPE shall surpass the capability of ADPE used in the processing of medicare part B claims for identification of code ma-

nipulation on the day before the date of the enactment of this Act.

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

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

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

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

SEC. 7173. DISCLOSURE.

(a) IN GENERAL.—Notwithstanding any other provision of law, and except as provided in subsection (b), any ADPE or data related thereto acquired by medicare carriers in accordance with section 7171(a) shall not be subject to public disclosure.

(b) EXCEPTION.—The Secretary may authorize the public disclosure of any ADPE or data related thereto acquired by medicare carriers in accordance with section 7121(a) if the Secretary determines that—

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

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

SEC. 7174. REVIEW AND MODIFICATION OF REGULATIONS.

Not later than 30 days after the date of the enactment of this Act, the Secretary shall order a review of existing regulations, guidelines, and other guidance governing medicare payment policies and billing code abuse to determine if revision of or addition to those regulations, guidelines, or guidance is necessary to maximize the benefits to the Federal Government of the use of ADPE acquired pursuant to section 7171.

SEC. 7175. DEFINITIONS.

For purposes of this chapter—

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

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

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

(4) The term "medicare part B" means the supplementary medical insurance program authorized under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j-1395w-4).

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

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

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

PART III—REFORMING PAYMENTS FOR AMBULANCE SERVICES

SEC. 7181. REFORMING PAYMENTS FOR AMBULANCE SERVICES.

(a) IN GENERAL.—Section 1834 (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

"(k) PAYMENT FOR AMBULANCE SERVICES.—

"(1) IN GENERAL.—Notwithstanding any other provision of this part, (except Section 1861(v)(1)(V)) with respect to ambulance serv-

ices described in section 1861(s)(7), payment shall be made based on the lesser of—

"(A) the actual charges for the services; or
 "(B) the amount determined by a fee schedule developed by the Secretary.

"(2) FEE SCHEDULE.—The fee schedule established under paragraph (1) shall be established on a regional, statewide, or carrier service area basis (as the Secretary may determine to be appropriate) for services performed on or after January 1, 1996.

"(3) SEPARATE PAYMENT LEVELS.—

"(A) IN GENERAL.—In establishing the fee schedule under paragraph (2), the Secretary shall establish separate payment rates for advanced life support and basic life support services. Payment levels shall be restricted to the basic life support level unless the patient's medical condition or other circumstance necessitates (as determined by the Secretary in regulations) the provisions of advanced life support services.

"(B) NONROUTINE BASIS.—The Secretary shall also establish appropriate payment levels for the provision of ambulance services that are provided on a routine or scheduled basis. Such payment levels shall not exceed 80 percent of the applicable rate for unscheduled transports.

"(4) ANNUAL ADJUSTMENT.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the fee schedules shall be adjusted annually (to become effective on January 1 of each year) by a percentage increase or decrease equal to the percentage increase or decrease in the consumer price index for all urban consumers (United States city average).

"(B) SPECIAL RULE.—Notwithstanding subparagraph (B), the annual adjustment in the fee schedules determined under such subparagraph for each of the years 1996 through 2002 shall be such consumer price index for the year minus 1 percentage point.

"(5) FURTHER ADJUSTMENTS.—The Secretary shall adjust the fee schedule to the extent necessary to ensure that the fee schedule takes into consideration the costs incurred in providing the transportation and associated services as well as technological changes.

"(6) SPECIAL RULE FOR END STAGE RENAL DISEASE BENEFICIARIES.—The Secretary shall direct the carriers to identify end stage renal disease beneficiaries who receive ambulance transports and—

"(A) make no payment for scheduled ambulance transports unless authorized in advance by the carrier; or

"(B) make no additional payment for scheduled ambulance transports for beneficiaries that have utilized ambulance services twice within 4 continuous days, or 7 times within a continuous 15-day period, unless authorized in advance by the carrier; or

"(C) institute other such safeguards as the Secretary may determine are necessary to ensure appropriate utilization of ambulance transports by such beneficiaries."

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished under title XVIII of the Social Security Act on and after January 1, 1997.

PART IV—REWARDS FOR INFORMATION

SEC. 7191. REWARDS FOR INFORMATION LEADING TO HEALTH CARE FRAUD PROSECUTION AND CONVICTION.

(a) IN GENERAL.—In special circumstances, the Secretary of Health and Human Services and the Attorney General of the United States may jointly make a payment of up to \$10,000 to a person who furnishes information unknown to the Government relating to a possible prosecution for health care fraud.

(b) INELIGIBLE PERSONS.—A person is not eligible for a payment under subsection (a) if—

(1) the person is a current or former officer or employee of a Federal or State government agency or instrumentality who furnishes information discovered or gathered in the course of government employment;

(2) the person knowingly participated in the offense;

(3) the information furnished by the person consists of allegations or transactions that have been disclosed to the public—

(A) in a criminal, civil, or administrative proceeding;

(B) in a congressional, administrative, or General Accounting Office report, hearing, audit, or investigation; or

(C) by the news media, unless the person is the original source of the information; or

(4) in the judgment of the Attorney General, it appears that a person whose illegal activities are being prosecuted or investigated could benefit from the award.

(c) DEFINITIONS.—

(1) HEALTH CARE FRAUD.—For purposes of this section, the term "health care fraud" means health care fraud within the meaning of section 1347 of title 18, United States Code.

(2) ORIGINAL SOURCE.—For the purposes of subsection (b)(3)(C), the term "original source" means a person who has direct and independent knowledge of the information that is furnished and has voluntarily provided the information to the Government prior to disclosure by the news media.

(d) NO JUDICIAL REVIEW.—Neither the failure of the Secretary of Health and Human Services and the Attorney General to authorize a payment under subsection (a) nor the amount authorized shall be subject to judicial review.

SEC. ____ BENEFICIARY INCENTIVE PROGRAMS.

(a) PROGRAM TO COLLECT INFORMATION ON FRAUD AND ABUSE.—

(1) ESTABLISHMENT OF PROGRAM.—Not later than 3 months after the date of the enactment of this Act, the Secretary of Health and Human Services (hereinafter in this section referred to as the "Secretary") shall establish a program under which the Secretary shall encourage individuals to report to the Secretary information on individuals and entities who are engaging or who have engaged in acts or omissions which constitute grounds for the imposition of a sanction under section 1128, section 1128A, or section 1128B of the Social Security Act, or who have otherwise engaged in fraud and abuse against the medicare program for which there is a sanction provided under law. The program shall discourage provision of, and not consider, information which is frivolous or otherwise not relevant or material to the imposition of such a sanction.

(2) PAYMENT OF PORTION OF AMOUNTS COLLECTED.—If an individual reports information to the Secretary under the program established under paragraph (1) which serves as the basis for the collection by the Secretary or the Attorney General of any amount of at least \$100 (other than any amount paid as a penalty under section 1128B of the Social Security Act), the Secretary may pay a portion of the amount collected to the individual (under procedures similar to those applicable under section 7623 of the Internal Revenue Code of 1986 to payments to individuals providing information on violations of such Code).

(b) PROGRAM TO COLLECT INFORMATION ON PROGRAM EFFICIENCY.—

(1) ESTABLISHMENT OF PROGRAM.—Not later than 3 months after the date of the enactment of this Act, the Secretary shall establish a program under which the Secretary shall encourage individuals to submit to the Secretary suggestions on methods to improve the efficiency of the medicare program.

(2) PAYMENT OF PORTION OF PROGRAM SAVINGS.—If an individual submits a suggestion

to the Secretary under the program established under paragraph (1) which is adopted by the Secretary and which results in savings to the program, the Secretary may make a payment to the individual of such amount as the Secretary considers appropriate.

**NICKLES (AND BROWN)
AMENDMENT NO. 2958**

Mr. NICKLES (for himself and Mr. BROWN) proposed an amendment to the motion to commit proposed by Mr. BRADLEY to the bill S. 1357, supra; as follows:

Strike all after "Finance" and insert: "with instructions to report the bill back to the Senate forthwith including a provision stating:

"The maximum earned income credit for a family with one child will increase from \$2,094 in 1995 to \$2,156 in 1996 and the maximum earned income credit for a family with two or more children will increase from \$3,110 in 1995 to \$3,208 in 1996.;

"and the effective date for section 7461, 'earned income credit denied to individuals not authorized to be employed in the U.S.', shall be moved to taxable years beginning after December 31, 1994."

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON ARMED SERVICES

Mr. NICKLES. Mr. President, I ask unanimous consent that the Committee on Armed Services be authorized to meet on Wednesday, October 25, 1995, at 10 a.m. in executive session, to consider certain pending military nominations.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON THE JUDICIARY

Mr. NICKLES. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet during the session of the Senate on Wednesday, October 25, 1995, at 10 a.m. to hold a hearing on religious liberty.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON VETERANS' AFFAIRS

Mr. NICKLES. The Committee on Veterans' Affairs would like to request unanimous consent to hold a hearing on pending veterans' health care legislation at 10 a.m., on Wednesday, October 25, 1995. The hearing will be held in room 418 of the Russell Senate Office Building.

The agenda includes: An original bill to expand VA authority to contract for health care services; S. 293, a bill to authorize payments to the States of per diem for veterans receiving adult day health care; S. 403, the Readjustment Counseling Service Amendments of 1995; S. 425, a bill to require the establishment of mental illness research, education, and clinical centers; S. 548, the Women Veterans' Mammography Quality Standards Act; S. 612, the Veterans Hospice Care Services Act; and S. 644, a bill to reauthorize the establishment of research corporations in the Veterans Health Administration.

The PRESIDING OFFICER. Without objection, it is so ordered.

SELECT COMMITTEE ON INTELLIGENCE

Mr. NICKLES. Mr. President, I ask unanimous consent that the Select Committee on Intelligence be authorized to meet during the session of the Senate on Wednesday, October 25, 1995, at 2 p.m. to hold an open hearing on Intelligence Support to Law Enforcement.

The PRESIDING OFFICER. Without objection, it is so ordered.

SELECT COMMITTEE ON INTELLIGENCE

Mr. NICKLES. Mr. President, I ask unanimous consent that the Select Committee on Intelligence be authorized to meet during the session of the Senate on Wednesday, October 25, 1995 at 9:30 a.m. to hold an open hearing on Intelligence Support to Law Enforcement.

The PRESIDING OFFICER. Without objection, it is so ordered.

SELECT COMMITTEE ON INTELLIGENCE

Mr. NICKLES. Mr. President, I ask unanimous consent that the Select Committee on Intelligence be authorized to meet during the session of the Senate on Wednesday, October 25, 1995 at 4 p.m. to hold a closed briefing on intelligence matters.

The PRESIDING OFFICER. Without objection, it is so ordered.

**SPECIAL COMMITTEE TO INVESTIGATE
WHITewater DEVELOPMENT AND RELATED
MATTERS**

Mr. NICKLES. Mr. President, I ask unanimous consent that the Special Committee to Investigate Whitewater Development and Related Matters be authorized to meet during the session of the Senate on Wednesday, October 25, 1995, to review the status of the special committee investigation.

The PRESIDING OFFICER. Without objection, it is so ordered.

ADDITIONAL STATEMENTS

BUDGET SCOREKEEPING REPORT

• Mr. DOMENICI. Mr. President, I hereby submit to the Senate the budget scorekeeping report prepared by the Congressional Budget Office under section 308(b) and in aid of section 311 of the Congressional Budget Act of 1974, as amended. This report meets the requirements for Senate scorekeeping of section 5 of Senate Concurrent Resolution 32, the first concurrent resolution on the budget for 1986.

This report shows the effects of congressional action on the budget through October 24, 1995. The estimates of budget authority, outlays, and revenues, which are consistent with the technical and economic assumptions of the 1996 concurrent resolution on the budget (H. Con. Res. 67), show that current level spending is below the budget resolution by \$3.6 billion on budget authority and above the budget resolution by \$3.4 billion in outlays. Current level is \$2.2 billion above the revenue