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MEDICARE-MEDICAID ANTI-FRAUD
AND ABUSE AMENDMENTS
OF 1977

REPORT
OF THE
COMMITTEE ON FINANCE
U.S. SENATE

ON

S. 143



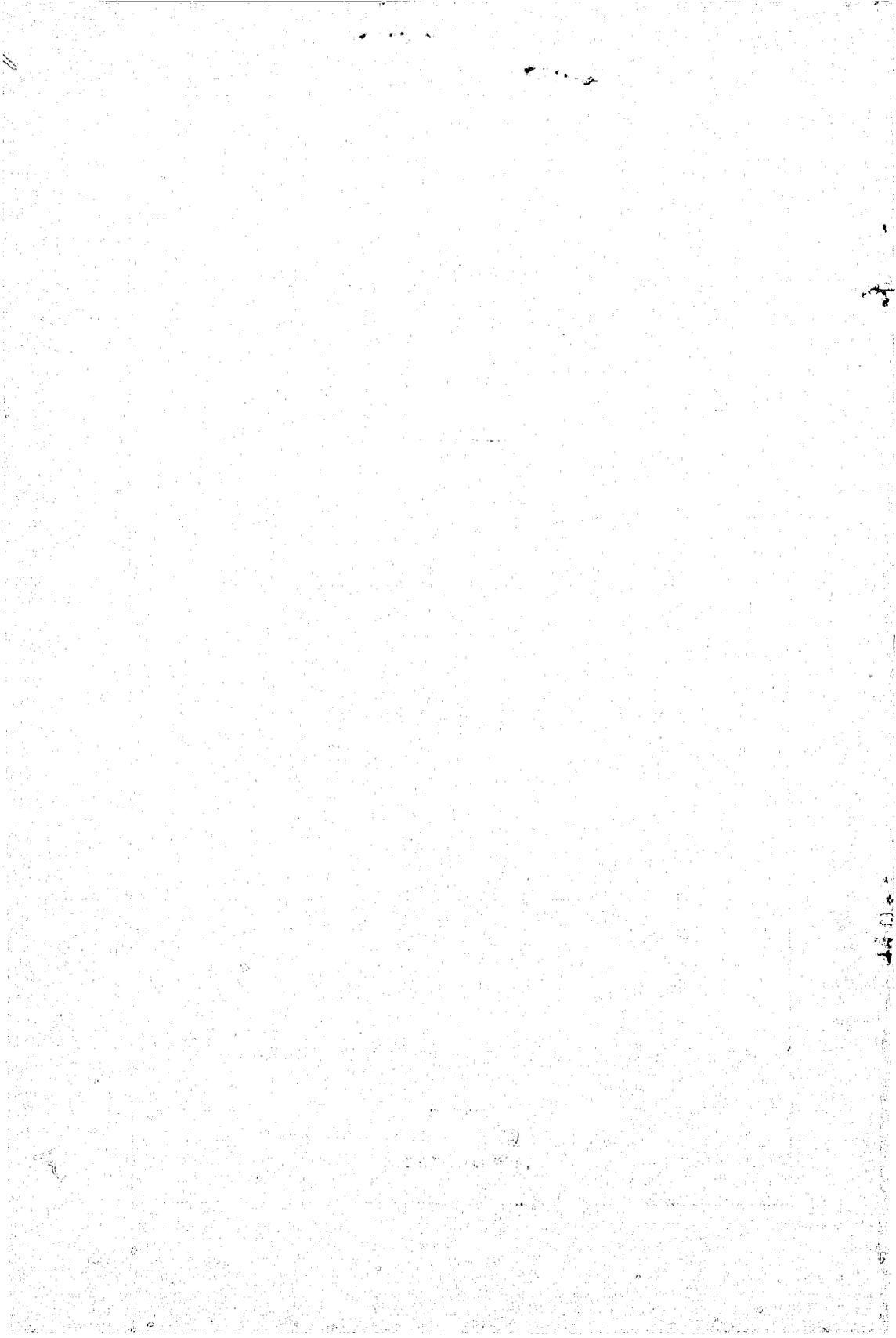
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CONTENTS ACQUISITIONS

	Page
I. Summary of the bill.....	1
Program penalty sanctions.....	1
Disclosure of information.....	2
Professional standards review.....	3
Administrative reform.....	4
Other medicaid and medicare amendments.....	5
Technical revision.....	6
II. General explanation of the bill.....	6
Prohibition against assignment by physicians and others of claims for services; claims payment procedures for medicaid program (sec. 2).....	6
Disclosure of provider ownership and financial information (sec. 3).....	8
Penalties for defrauding medicare and medicaid (sec. 4).....	10
Amendments related to professional standards review organiza- tions (sec. 5).....	14
Waiver of other review requirements (sec. 5(a)).....	14
Modification of requirements for conditionally designated PSRO's (sec. 5(b)).....	14
Review requirements (sec. 5(c)).....	15
Conclusive determinations for payment (sec. 5(d)).....	17
Clarification of sanctions provision (sec. 5(e)).....	21
National council (sec. 5(f)).....	21
National council report (sec. 5(g)).....	21
Exchange of data and information with other agencies (sec. 5(h)).....	22
Legal expenses (sec. 5(i)).....	23
Payment of PSRO expenses (sec. 5(j)).....	23
Annual reports (sec. 5(k)).....	23
Medical officer (sec. 5(l)).....	24
Payment for review of pt. B services provided by hospitals (sec. 5(m)).....	24
Statewide councils (sec. 5(n)).....	24
Technical corrections (sec. 5(o)).....	25
Physician review (sec. 5(p)).....	25
Issuance of subpoenas by the Comptroller General (sec. 6).....	25
Suspension of practitioners convicted of medicare- or medicaid- related crimes (sec. 7).....	26
Disclosure by providers of owners and certain other individuals convicted of certain offenses (sec. 8).....	27
Federal access to records (sec. 9).....	29
Claims processing and information retrieval systems for medicaid programs (sec. 10).....	29
Restriction on Federal medicaid payments. Assignment of rights of payment; incentive payments (sec. 11).....	30
Study and review of medicare claims processing (sec. 12).....	31
Abolition of program review teams under medicare (sec. 13).....	32
Nomination of intermediaries by providers (sec. 14).....	32
Disclosure by providers of the hiring of certain former employees of fiscal intermediaries (sec. 15).....	33
Payment of durable medical equipment (sec. 16).....	33
Funding of State medicaid fraud control units (sec. 17).....	34
Report on home health and other in-home services (sec. 18).....	37
Uniform reporting systems for health services facilities and organi- zations (sec. 19).....	38

II. General explanation of the bill—continued-----	Page
Modification of requirements for State medicaid utilization control programs (sec. 20)-----	39
Protection of patient funds (sec. 21)-----	42
Provision for flexible grace period (sec. 22)-----	42
Prosecution of civil fraud by Inspector General (sec. 23)-----	43
Utilization review demonstration projects (sec. 24)-----	43
Payment for certain hospital services provided in Veterans' Administration hospitals (sec. 25)-----	45
Hospital insurance for individuals, age 60 through 64, who are entitled to benefits under sec. 202 or who are spouses of individuals entitled to health insurance (sec. 26)-----	45
Treatment of Professional Standards Review Organizations for purposes of Internal Revenue Code (sec. 27)-----	46
III. Costs of carrying out the bill-----	47
IV. Regulatory impact of the bill-----	48
V. Vote of the committee in reporting the bill-----	49
VI. Changes in existing law-----	49

MEDICARE-MEDICAID ANTI-FRAUD AND
ABUSE AMENDMENTS OF 1977

SEPTEMBER 26 (legislative day, SEPTEMBER 22), 1977.—Ordered to be printed

Mr. LONG, from the Committee on Finance,
submitted the following

REPORT

[To accompany S. 143]

The Committee on Finance, to which was referred the bill (S. 143) to strengthen the capability of the Government to detect, prosecute, and punish fraudulent activities under the medicare and medicaid programs, and for other purposes, having considered the same, reports favorably thereon with amendment and recommends that the bill as amended do pass.

I. SUMMARY OF THE BILL

As reported, the provisions of S. 143, the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977, are focused on six major areas: Strengthened program penalty sanctions, increased disclosure of information, needed improvements in the professional standards review program, administrative reform, and other medicaid and medicare amendments. The summary presented below briefly outlines the principal features of the bill as reported.

Program Penalty Sanctions

1. The bill modifies the penalty provisions in existing law which relate to those persons providing services under medicare and medicaid. Most fraudulent acts now classified as misdemeanors are to become felonies. Penalties are to be increased to a maximum \$25,000 fine, up to five years imprisonment, or both. The types of financial arrangements and conduct to be classified as illegal have been clarified. In addition, States will now be permitted to suspend the eligibility of medicaid recipients convicted of defrauding the program. However,

the misdemeanor penalty presently provided under existing law for conviction of such individuals is retained, as is the misdemeanor penalty for the conviction of a beneficiary under the medicare program. The bill also requires the Health, Education, and Welfare Inspector General to include in his annual report an evaluation of the effort of the Department of Justice in the investigation and prosecution of fraud in the medicare and medicaid programs and his recommendations for improvement of that effort. (Section 4)

2. The bill requires the Secretary of Health, Education, and Welfare to suspend, for such period as he deems appropriate, from participation under medicare and medicaid, an individual practitioner who has been convicted of a criminal offense related to such individual's involvement in medicare or medicaid. When the Secretary suspends an individual, he must also notify the appropriate State licensing authorities, requesting that investigation be made and sanctions invoked in accordance with the State's law and public policy. (Section 7)

Disclosure of Information

1. (a) The bill requires, as a condition of participation or certification in either medicare, medicaid or the maternal and child health program, or health-related entities providing services under title XX, the annual disclosure to the Secretary or the appropriate State agency by the participating entity of the identity of any person who has a five percent or more ownership interest in the entity. These disclosure of ownership provisions will apply to medicare and medicaid providers of services (including independent clinical laboratories; health maintenance organizations and renal disease facilities), entities furnishing services for which payment may be claimed under medicaid or the maternal and child health program (but not including any individual or group of practitioners), and medicare carriers or intermediaries and medicaid fiscal agents. Providers of services would also have to disclose similar ownership information about any subcontractor, five percent or more of which is owned by the provider. (Section 3)

(b) Furthermore, the bill modifies existing medicare and medicaid provisions relating to termination of medicare provider agreements or suspension of medicaid payments to health care entities by adding a requirement that a provider must comply with a request specifically addressed to it by the Secretary or the medicaid State agency for full and complete information as to any significant business transactions between it and any subcontractors or between it and wholly-owned suppliers. Finally, in the case of subcontractors having more than \$25,000 in annual business transactions with a provider, compliance would be required with similar requests related to ownership information pertaining to the subcontractor. (Section 3)

2. The bill requires all institutional providers of services, or other agencies, institutions, or organizations, as a condition of participation or certification in medicare, medicaid or the social services programs under Title XX of the Social Security Act to disclose, in the application for participation or certification, the names of owners, officers, directors, agents, or managing employees who have been convicted of fraud against the medicare, medicaid, or State social service grant programs. Where an application contains the name of any such pre-

viously convicted individual, the Secretary or the State agency can refuse to enter into an agreement or refuse to contract with the applicant. The Inspector General of the Department of Health, Education, and Welfare must be informed of the receipt of any such applications and of any action taken on them. (Section 8)

3. The bill authorizes the Comptroller General of the United States to sign and issue subpoenas in order to obtain necessary information and facilitate review of Social Security Act health programs. The Comptroller General will also be authorized, upon resistance or refusal by an individual to obey a subpoena, to request a court order requiring compliance with the subpoena. (Section 6)

4. The bill requires any provider of services participating in medicare to promptly notify the Secretary of its employment of an individual who, at any time during the preceding year, was employed in a managerial, accounting, auditing, or similar capacity by a medicare fiscal intermediary or carrier that services the provider. (Section 15)

5. The bill allows Federal access to the records of persons or institutions providing services under medicaid in the same manner that such access is presently provided to State agencies. (Section 9)

6. The bill authorizes prosecution of civil fraud cases under the Social Security Act health care programs by the Inspector-General of HEW where U.S. attorneys have not initiated proceedings within six months of formal referral of a case. (Section 23)

Professional Standards Review

The bill includes several provisions designed to clarify the nature and scope of PSRO review responsibilities, to enhance the capacity of PSRO's to perform reviews of the necessity and appropriateness of services more effectively, and to improve the administration and coordination of review activities so as to assure that program funds are properly expended. Thus, the bill provides:

(1) for the termination of other duplicative review activities when the Secretary determines that a PSRO is competent to perform its review responsibilities; that the determinations of PSRO's so recognized by the Secretary with respect to the necessity and appropriateness of care are conclusive for purposes of program payment; and that the role of the State in the process of establishing and evaluating PSRO review of services provided through the medicaid program will be increased and made more specific (Section 5(a) and 5(d));

(2) for the establishment of demonstration projects for the purpose of evaluating the effectiveness of PSRO reviews compared to alternative State review methods. The bill authorizes the establishment of such projects in States which had operating onsite State evaluation systems in place on August 5, 1977, and which make application to the Secretary prior to April 1, 1978. The purpose of the projects will be to evaluate the effectiveness, both in terms of the quality and appropriateness of medical care as well as the impact on State budgets, of PSRO hospital review compared to alternative State hospital review systems. Demonstration projects would be conducted in PSRO areas which are

representative of a State's medicaid population and comprise a significant proportion of medicaid patient days (Section 24);

(3) that a PSRO may be conditionally designated for a period not to exceed 48 months (with authority for the Secretary to extend the period for an additional 24 months where warranted by unusual circumstances); and that PSRO's must assume review responsibilities for institutional services during this period (Section 5(b));

(4) that the Secretary shall require a PSRO, where he finds it is capable of undertaking ambulatory care review, to undertake such review no later than 2 years after it becomes fully operational (but not during such organization's conditional phase), and to give priority to requests by PSRO's to review services in "shared health facilities" (Section 5(c));

(5) that the Federal Government may assume the defense costs incurred by a PSRO in a liability suit related to the performance of its functions (Section 5(i));

(6) for the disclosure of information with respect to evidence of fraud to designated Federal and State law enforcement agencies (with a prohibition against access to PSRO records in the case of subpoena or discovery proceedings in a civil action), and for the disclosure of aggregate statistical data to Federal and State health planning agencies (Section 5(h));

(7) for the annual submission to the Congress by the Secretary of a comprehensive report on the administration, cost, and impact of the PSRO program (Section 5(k));

(8) for the modification of current law provisions pertaining to payment for institutional services after a PSRO has determined that such services are no longer required. The current three day grace period would be reduced to one, with the PSRO permitted to authorize up to 2 additional days on a case-by-case exception basis where the facts in the case indicate that the additional time is needed to arrange for the necessary postdischarge care (Section 22);

(9) to amend the Internal Revenue Code to specifically include PSRO's as organizations eligible for section 501(c)(3) tax status (Section 27); and

(10) for several clarifying administrative and technical changes designed to enhance a PSRO's operational capacity (Section 5).

Administrative Reform

1. The bill requires the Secretary to establish for each of the different types of health services institutions a uniform system for the reporting of such items as cost of operation, volume of services, rates, capital assets and bill data. This reporting system would be mandated for use by medicare and medicaid providers and such use would be phased in by type of provider. (Section 19)

2. The bill repeals the program review team provisions of present law. The functions formerly performed by such teams with respect to the quality and utilization of services will be performed by Professional Standards Review Organizations. (Section 13)

3. The bill would encourage each State to establish an office separate from the medicaid program agency to prepare and prosecute cases of

suspected fraud and abuse in the program by providing for 100 percent Federal matching funds in fiscal year 1978, 90 percent in fiscal year 1979 and 75 percent in fiscal year 1980 for expenditures to establish and operate State medicaid fraud control units. The bill also authorizes the Secretary to arrange for demonstration projects designed to develop improved programs for detection, investigation, and prosecution of fraud and abuse. (Section 17)

4. The bill requires States to make provision in their State medicaid plan for claims payment procedures which ensure that 95 percent of the bills submitted by eligible noninstitutionally-based providers will be reimbursed within 30 days, and 99 percent within 90 days. The State would not be cited for noncompliance if the Secretary found the State was acting in good faith to achieve this goal. (Section 2)

5. The bill directs the Comptroller General to conduct a comprehensive review of the administrative structure for the processing of medicare claims. (Section 12)

6. The bill would prohibit the Secretary from refusing to enter into an agreement with a nominated intermediary under medicare solely because of the fact that such intermediary does not operate regionally or nationally. (Section 14)

7. The bill establishes a medical support program under which medicaid applicants and recipients may be required by a State to assign their rights to medical support or indemnification to the State. Incentives would be provided for localities to make collections for States and for States to secure collections in behalf of other States. (Section 11)

8. The bill requires that as a condition for participation in the medicaid and medicare programs, a skilled nursing or intermediate care facility must establish and maintain a system to assure the proper accounting of personal patient funds. The system must provide for separate and discrete accounting for each patient with a complete accounting of income and expenditures so as to preclude the intermingling of other funds with patient funds. (Section 21)

Other Medicaid and Medicare Amendments

1. The bill modifies the requirements of current medicaid law concerning review of care delivered in institutional facilities. The section waives application of the penalties for noncompliance for calendar quarters ending prior to January 1, 1978. For subsequent calendar quarters, the required reductions in Federal matching would be imposed only in proportion to the number of patients whose care was not reviewed compared to the total patient population subject to review.

The bill further specifies procedural requirements for the Secretary to carry out the required validation requirements in a more timely fashion. (Section 20)

2. The bill modifies the requirements pertaining to the composition of medical review teams in skilled nursing facilities so as to conform them with those requirements applicable to intermediate care facility review. (Section 20)

3. The bill would permit spouses of medicare beneficiaries aged 60-64 as well as certain other persons in that age group to buy into medicare at a premium rate equal to the cost of their protection. In order for such persons to be eligible to enroll for hospital insurance they must be enrolled for supplementary medical insurance. (Section 26)

4. The bill would authorize, under certain circumstances, reimburse-

ment to a Veterans' Administration hospital for care provided to a nonveteran medicare beneficiary. (Section 25)

5. The bill requires the Secretary of Health, Education, and Welfare to report to the Congress within 12 months after enactment of this legislation with an analysis and recommendations relating to all aspects (including the availability, administration, provision, reimbursement procedures and cost) of the delivery of home health services under medicare, medicaid and the title XX social services program. (Section 18)

Technician Revision

1. Your committee's bill clarifies existing law to insure that a power of attorney cannot be used to circumvent the prohibition in existing law against the use of "factoring" arrangements in connection with the payment of provider claims by the medicare and medicaid programs. (Section 2)

2. The bill modifies the provisions of existing law related to the rental or purchase of durable medical equipment to mandate that the Secretary requires the purchase of such equipment where purchase will be less costly than extended rental payments. (Section 16)

3. The bill increases individual State's incentives to adopt a computerized medicaid claims processing and information retrieval system by modifying one current requirement for higher Federal matching funds for the development and operation of this system. The bill would require such systems to provide explanation of benefits information to only a sample group of medicaid recipients rather than to each recipient as is currently required. (Section 10)

4. The bill would preclude Federal matching of State medicaid expenditures that result from State laws or contracts which exclude or limit insurance benefits because an individual is eligible for medicaid. (Section 11)

II. GENERAL EXPLANATION OF THE BILL

Prohibition Against Assignment by Physicians and Others of Claims for Services; Claims Payment Procedures for Medicaid Program (Section 2)

The committee's bill would modify existing law to preclude the use of a power of attorney as a device to circumvent the existing ban on the use of "factoring" arrangements in connection with the payment of claims by the medicare and medicaid programs. The bill also requires State medicaid programs to provide for timely claims payment procedures.

In 1972, the Congress took action to stop a practice under which some physicians and other persons providing services under medicare and medicaid reassigned their medicare and medicaid receivables to other organizations or groups. Under the conditions of these reassignments, the organizations or groups purchased the receivables for a percentage of their face value, submitted claims and received payments in their name. By 1972, it had become apparent that such reassignments were a significant source of incorrect and inflated claims for services paid by medicare and medicaid. In addition, cases of fraudulent billings by collection agencies and substantial overpayments to these so-called "factoring" agencies were also found.

Congress concluded that such arrangements were not in the best interest of the government or the beneficiaries served by the medicare and medicaid programs. The Social Security Amendments of 1972, Public Law 92-603, therefore, included a prohibition against the payment for covered services to any one other than the patient, his physician, or other person who provided the service, unless the physician or other person is required as a condition of his employment to turn his fees over to his employer, or unless the physician or other person has an arrangement with a facility under which the facility bills for such services.

Despite these efforts to stop factoring of medicare and medicaid bills, some practitioners and other persons have circumvented the intent of the law by use of a power of attorney. The use of a power of attorney allows the factoring company to receive the medicare or medicaid payment in the name of the physician, thus allowing the continuation of program abuses which factoring activities were shown to produce in the past.

The committee bill would modify existing law to preclude the use of a power of attorney as a device for reassignments of benefits under medicare and medicaid, other than an assignment to a governmental entity or establishment, or an assignment established by or pursuant to the order of a court of competent jurisdiction. The bill also provides for similar prohibitions with respect to billings for care provided by institutions under medicare and medicaid. However, it would not preclude the agent of a physician or other person furnishing services from collecting any medicare or medicaid payment on behalf of a physician, provided the agency does so pursuant to an agreement under which the compensation paid the agency for his services or for the billings or collections of payments is unrelated (directly or indirectly) to the dollar amount of the billings or payments, and is not dependent upon the actual collection of any such payments. Thus, the use of billing agents by doctors and others, when the agents are paid on a basis related to the cost of doing business and not dollar amounts billed or collected, would not be precluded. The bill would not impose any limitations on the use of billing or collection agencies for payments owed by anyone other than the medicare or medicaid programs. Nor is it the committee's intention that this provision preclude the legitimate transfer of accounts receivable from these programs by an individual or an institution upon the "sale" of the individual's practice (for example upon retirement) or as part of the sale of all the assets of an institution.

The committee has received testimony indicating that undue delay in medicaid claims payments contributes to the rise of factoring arrangements as well as discourages physicians from participating in the program. The committee wishes to assure that the ban on factoring arrangements will not impose an undue hardship on medicaid practitioners. The bill therefore requires State medicaid plans to provide for claims payment procedures which ensure that 95 percent of clean claims (i.e. those not requiring further substantiation) of claims for services furnished by health care practitioners through individual or group practices or through shared health facilities are paid within 30 days of receipt; 99 percent of such claims must be paid within 90 days of receipt. State plans must further provide for procedures for prepayment and postpayment claims review. The bill per-

mits the Secretary of Health, Education, and Welfare to waive this State plan requirement if he finds that a State has exercised good faith in trying to ensure timeliness and accuracy in its claims payment operation. Among other things the Secretary should take into account in making a waiver determination is whether the State has received an unusually high volume of claims which are not clean claims (i.e., claims for which no further written information or substantiation is required from the provider).

The amendments made by this section clarifying the ban on factoring arrangements shall apply with respect to care and services furnished on or after the day of enactment. The amendment pertaining to medicaid claims processing shall apply to calendar quarters beginning after June 30, 1978.

*Disclosure of Provider Ownership and Financial Information
(Section 3)*

The committee's bill would require entities including health maintenance organizations (other than individual practitioners or groups of practitioners) providing services under medicare, medicaid, or the maternal and child health program and entities providing health-related services under title XX, such as homemaker, and home health agencies to disclose certain ownership interests, as a condition of program participation. These disclosure requirements would also be applied to medicare intermediaries and carriers and medicaid fiscal agents. Disclosure of additional ownership and financial information would be required, but only when specifically requested.

Current law and program policies already require the provision of certain ownership and financial information pertaining to entities providing services under medicare and medicaid. For example, an agreement with a provider of services under medicare may be terminated if the provider fails to furnish information necessary to validate the amount of payment claimed. In a different context, present law requires, as a medicare and medicaid condition of participation, a skilled nursing facility to disclose to the Secretary or appropriate State agency, and keep current, the name of anyone having significant ownership interest in the facility. Intermediate care facilities under medicaid are also required to disclose information on significant ownership interests.

The committee believes, however, that the information required under current law is often insufficient to facilitate the detection of fraudulent practices. Information now required does not provide adequate documentation on persons with significant ownership interests in more than one facility or other entity participating in medicare, medicaid, or the maternal and child health program or providing health-related services under title XX. Information is not specifically required to identify persons with significant ownership interests in related companies that supply goods and services to providers or other participating entities. Authority to obtain information on financial transactions with related suppliers or with subcontractors is not clearly defined in law.

To remedy these problems, the bill would require disclosure of specified ownership information to the Secretary or the appropriate State agency, as a condition of an entity's participation, certification, or

recertification under medicare, medicaid, the maternal and child health program, or title XX. Entities required to disclose would be defined as: Medicare providers of services (as defined in section 1861(u), which includes hospitals, skilled nursing facilities, and home health agencies), independent clinical laboratories, renal disease facilities, health maintenance organizations meeting the requirements for participation in titles XVIII or XIX, and all entities (other than individual practitioners or groups of practitioners) that claim reimbursement for services provided under medicaid, the maternal and child health program, and, in the case of health-related entities, the social services program under title XX. In addition, the bill would require medicare intermediaries and carriers and medicaid fiscal agents to disclose specified ownership information as a condition of contract or agreement approval or renewal under titles XVIII and XIX.

The bill specifies that disclosing entities must supply full and complete information as to the identity of each person who:

- (1) has a direct or indirect ownership interest of 5 percent or more in the entity,
- (2) owns (in whole or part) a 5-percent interest in any mortgage secured by the entity,
- (3) is an officer or director of the entity, if it is organized as a corporation, and
- (4) is a partner in the entity, if it is organized as a partnership.

Where disclosing entities providing services under medicare or medicaid own 5 percent or more of a subcontractor, similar ownership information would be required to be disclosed about the subcontractor.

In addition, the bill would require, to the extent feasible, that information about a person's ownership disclosed by an entity must also include information with respect to ownership interest of that person in any other entity which is required to comply with disclosure requirements under the bill.

The bill would also modify the existing provisions of title XVIII and XIX which relate to termination of medicare-provider agreements or suspension of medicaid payments to health care entities (other than individual practitioners and groups of individual practitioners) by adding two additional requirements. The bill would require a provider entity to comply with specific requests addressed to it by the Secretary or the State medicaid agency for full and complete information on: (1) the ownership of any subcontractor (as defined in regulations) with whom the provider has annual business transactions of more than \$25,000, and (2) any significant business transactions (as defined in regulations) between it and any subcontractor or between it and any wholly owned supplier.

In developing regulations to define subcontractors and suppliers, the committee intends that a distinction be made between agencies and organizations from which a provider only purchases goods and services to assist in meeting its obligations to patients and those agencies and organizations to which a provider has actually delegated some of the duties and obligations it has directly to its patients. Although the facts and circumstances of individual situations may differ, it is contemplated under such a delineation that the relationship between a hospital and a commercial laundry would be considered to be that of

a provider and its supplier, but that the relationship between a hospital and a management company with which it has contracted to administer either all or part of the day-to-day operations of the institution or the relationship between a hospital and an independent radiological service would be that of a provider and a subcontractor.

The bill specifies that the Secretary is to determine by regulation the meaning of the phrase "directly or indirectly" with respect to persons having ownership interests in disclosing entities. In directing him to do this, the committee is acutely aware of the difficulties involved in developing this definition, particularly when the phrase "persons with ownership interests" is interpreted to mean a corporation. Institutional providers of health care often are owned by corporate entities which in turn are owned by other corporations. In order to compile accurate information on persons with ownership interests in disclosing entities, the committee believes it is also necessary to obtain information on persons with ownership interests in these other corporations. The information to be disclosed under the bill must go beyond the listing of corporate identities unless that corporation is already subject to ownership disclosure under the statutes administered by the Securities and Exchange Commission or other Federal regulatory agencies. It is intended, at the minimum, to identify those persons with ownership interests of 5 percent or more in a nonpublicly held corporation that owns a disclosing entity. In addition, the Secretary may determine that it is necessary to require disclosure of persons with ownership interests in nonpublicly held corporations beyond the first level of corporate ownership where the concept of "pyramiding" of corporate structures appears to be present.

The committee views the disclosure requirements imposed by the bill to be of critical importance in the process of detecting and deterring fraudulent and abusive practices within the medicare, medicaid, the maternal and child health and the social services programs. The committee does not intend, however, for these requirements to be unduly burdensome on providers and other entities to which they apply. The provisions were designed to be incorporated into the ongoing certification or contractual process. It is, therefore, expected that their implementation and administration will be accomplished in such a way as to preclude unnecessary additional administrative burdens on those complying with them.

The amendments pertaining to ownership disclosure would apply with respect to certifications and recertifications made (and participation in the programs pursuant to certifications and recertifications made) and fiscal intermediary agreements or contracts entered into or renewed on and after the date of enactment. The remaining amendments would take effect on the date of enactment except for the provision requiring disclosure of information on subcontractors and significant business transactions under medicaid which would become effective January 1, 1978.

Penalties for Defrauding Medicare and Medicaid (Section 4)

The committee bill would strengthen and clarify the penalty provisions in existing law which relate to persons providing services under medicare and medicaid. The bill would also add a penalty for medicare providers, physicians, and other suppliers of services who have agreed

to accept an "assignment of benefits" under part B of the medicare program but repeatedly charge patients in excess of the "reasonable charge". The bill further requires the Inspector General to include an evaluation of the performance of the Attorney General in the investigations of criminal violations relating to medicare and medicaid in his annual report.

Existing law provides specific penalties under the medicare and medicaid programs for certain practices that have long been regarded by professional organizations as unethical, which are unlawful in some jurisdictions, and which contribute significantly to the cost of the programs. Such practices as the submission of false claims, or the soliciting, offering, or acceptance of kickbacks or bribes, including rebates or a portion of fees or charges for patient referrals, are misdemeanors under present law and punishable by a maximum \$10,000 fine, up to 1 year imprisonment, or both. In addition, the making of false statements with respect to material facts concerning the conditions of health care facilities in order to qualify for certification under medicare and medicaid is considered a misdemeanor and punishable by a maximum \$2,000 fine, up to 6 months in prison, or both.

Recent hearings and reports, however, indicate that such penalties have not proved adequate deterrents against illegal practices by some individuals who provide services under medicare and medicaid. In addition, these misdemeanor penalties appear inconsistent with existing Federal criminal code sanctions which make similar actions punishable as felonies. Also, it has been brought to the attention of the committee by U.S. attorneys' offices which have utilized these Social Security Act sanctions in the prosecution of medicare and medicaid fraud cases that the existing language of these penalty statutes is unclear and needs clarification.

The bill would strengthen the penalty provisions in existing law which relate to persons providing services under medicare and medicaid. Most fraudulent acts now classified as misdemeanors would become felonies. Penalties for these acts would be increased to a maximum \$25,000 fine, up to 5 years imprisonment or both.

In addition, the bill would clarify and restructure those provisions in existing law which define the types of financial arrangements and conduct to be classified as illegal under medicare and medicaid.

It would make subject to the penalty provisions any person who solicits or receives any remuneration (1) in return for referring an individual to a person for the furnishing, or arranging for the furnishing of items or services; or (2) in return for purchasing, leasing, or ordering, or arranging for, or recommending the purchasing, leasing, or ordering of goods, facilities, or services. Also, any person who offers or pays any remuneration to any person to induce such person to do similar activities would be subject to the penalty provisions.

The bill would define the term "any remuneration" broadly to encompass kickbacks, bribes, or rebates which may be made directly or indirectly, overtly or covertly, in cash or in kind. The term would exclude any amount paid by an employer to an employee for employment in the provision of covered items and services if such employee has a bona fide employment relationship with the employer. The committee has specified that the employment relationship must be bona fide to insure that other arrangements involving the payment of a salary or related benefits will not be excluded from the definition of "any remuneration".

The bill would specifically exclude the practice of discounting or other reductions in price from the range of financial transactions to be considered illegal under medicare and medicaid, but only if such discounts are properly disclosed and reflected in the cost for which reimbursement could be claimed. The committee included this provision to ensure that the practice of discounting in the normal course of business transactions would not be deemed illegal. In fact, the committee would encourage providers to seek discounts as a good business practice which results in savings to medicare and medicaid program costs.

In addition, the committee bill would allow States to suspend, for a period not to exceed 1 year, the eligibility of medicaid recipients convicted of defrauding the program. However, the misdemeanor penalty provision presently provided under existing law for conviction of such individuals would be retained (maximum fine of \$10,000, up to 1 year imprisonment, or both) as would be the penalty for conviction of a beneficiary under the medicare program.

Under present law, a physician who wishes to be paid directly by the medicare program must accept an assignment, i.e., he must agree to accept the program's reasonable charge as payment in full. Thus, he is agreeing to bill the beneficiary for no more than any unmet deductible amount and for the 20 percent of the reasonable charges that is not paid by the program. Breaches of assignment by physicians who charge beneficiaries more than the agreed-upon amount are treated under the law as a form of program "abuse." Unlike fraudulent acts, abuses are not subject to civil or criminal penalty even when the physician has acted willfully and knowingly. Breach of assignment is the most frequent form of abuse in medicare. Of the 23,000 complaints to date about program abuses by the program's beneficiaries, about half concerned physicians' failure to live up to the assignment agreement. The option to use the assignment procedure has been withdrawn from some 250 physicians who have been persistent offenders.

The committee believes that stronger measures are needed to deter physicians from violating their assignment agreements and that more severe sanctions should be available for dealing with persistent offenders. Therefore, the committee bill would make willful and repeated assignment violations a misdemeanor, subject to a fine of not more than \$2,000 and/or a prison term of not more than 6 months.

In its consideration of this and related legislation bill, the committee has focused considerable attention on the activities of the Department of Justice to investigate and prosecute fraud in the medicare and medicaid programs. The committee believes that the Department must develop the resources to combat this complex type of criminal activity. The Attorney General has made a commitment to strengthen depart-

mental efforts in this area and intends to monitor those efforts quite closely. The letter of the Attorney General to the Chairman of the Health Subcommittee of the House Ways and Means Committee outlining departmental initiatives in this area follows:

OFFICE OF THE ATTORNEY GENERAL,
Washington, D.C., May 12, 1977.

HON. DAN ROSTENKOWSKI,
Chairman, Subcommittee on Health, Committee on Ways and Means,
House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: I am writing you again with reference to the proposal to include in H.R. 3 a mandate for the establishment of a separate and identifiable organizational unit within the Department's Criminal Division to carry out specified functions relating to investigation and prosecution of criminal violations in the programs of health insurance and medical assistance provided under the Social Security Act. As I indicated in my appearance before your subcommittee, I fully concur in the need for vigorous investigation and prosecutions of fraudulent activities in the medicare-medicaid program. I strongly feel, however, that the aforementioned provision is unnecessary and would set an undesirable precedent by dictating in law a particular subordinate organization within the Criminal Division.

In recognition of the importance of taking effective action against medicare-medicaid abuses, we are currently taking the following steps.

1. We have within the Fraud Section of the Criminal Division a program fraud unit which coordinates Department efforts directed against program abuse and maintains regular liaison with program agencies including HEW.

2. We are currently working on preparation of a Medicaid Enforcement Manual for distribution to Assistant United States Attorneys to assist them in prosecuting medicaid-medicare cases.

3. We are meeting on a regular basis with the Inspector General and his staff of HEW in an attempt to develop strategies and enforcement priorities within medicaid-medicare areas.

4. There is a separate program fraud unit within the Public Integrity Section which focuses on situations involving corruption of government officials in the administration of programs.

5. We are attempting to identify significant cases in order to insure that ample resources are devoted to their development and prosecution.

6. Many of the larger of the U.S. attorneys offices, including the southern district of New York and Chicago, have established separate program fraud units within the district to focus on these types of offenses.

I have every intention of continuing emphasis in this area. I do respectfully recommend, however, against placing in the law the requirement of a specific organization entity for this purpose. I am afraid that other congressional committees will feel that they must support similar organizational requirements in law for their programs to insure that such programs receive appropriate attention. A proliferation of special units would inevitably lead to confusion, lack of flexibility and be self-defeating of the purposes intended.

Sincerely,

GRIFFIN B. BELL, *Attorney General.*

The committee bill modifies section 204(a) of Public Law 94-505, relating to the annual reports of the Health, Education, and Welfare Inspector General, to require the Inspector General's report to include an evaluation of the performance of the Attorney General in the investigation and prosecuting of criminal violations relating to fraud in the medicare and medicaid programs and include any recommendations with respect to improving the performance of such activities.

The penalty provisions of this section would apply with respect to acts occurring or statements or representations made on or after the date of enactment.

Amendments Related to Professional Standards Review Organizations (Section 5)

Waiver of Other Review Requirements (Section 5(a))

The committee's bill provides that where the Secretary finds a given Professional Standards Review Organization (PSRO) competent to perform required review functions, similar activities otherwise required by law would not apply, except to the extent specified by the Secretary.

Under present law, the Secretary is authorized to waive any or all of the review, certification, or similar activities otherwise required under the law where he finds, on the basis of substantial evidence of the effective performance of review and control activities by PSRO's, that the activity or activities are no longer needed for the provision of adequate review and control. The purpose of this provision was to avoid duplication of review functions. Current law does not specifically state that the waiver authority is applicable to conditionally designated organizations, although the language has been interpreted to permit such actions.

The bill would both clarify present law and simplify its application by providing that where the Secretary makes a formal determination that a given PSRO is competent to perform required review functions, the review, certification and similar activities otherwise required by law would not be applicable with respect to those providers, suppliers, and practitioners being reviewed by such PSRO, except to the extent specified by the Secretary. A finding by the Secretary under this subsection could be made both with respect to conditionally designated and qualified PSRO's. The provision would not affect other provisions of existing law relating to determinations with respect to conditions for eligibility to or payment of benefits (as distinct from reviews or certifications of medical necessity).

The amendments made by this subsection would be effective upon enactment.

Modification of Requirements for Conditionally Designated PSRO's (Section 5(b))

The committee's bill extends the time period for conditional designation of PSRO's and clarifies the language of present law pertaining to the duties and functions a PSRO must assume during this trial period.

Current law provides that each PSRO shall initially be designated on a trial basis for a period not to exceed 2 years. By the end of the

period, the organization shall be considered a qualified organization only if the Secretary finds that it is substantially carrying out in a satisfactory manner the functions required of a PSRO with respect to institutional services in its area. When the legislation was enacted, it was anticipated that conditionally designated organizations would be able to assume review responsibilities with respect to all institutional services within a 2-year period. Implementation of the program has been slower than anticipated with the major focus to date on review of inpatient hospital services. A number of conditionally designated organizations have or are approaching the end of their 2-year trial period. While many are effectively performing reviews of services, they are technically not eligible for continuation of their conditional status or designation as qualified organizations.

The bill modifies the conditional designation provision of present law to provide for a conditional period not to exceed 48 months. The Secretary would be authorized to extend this period for an additional 24 months if an organization has, for reasons beyond its control, been unable to satisfactorily perform all of its required functions. The committee expects that this extension of the conditional period would be authorized only in unusual circumstances.

The bill also clarifies the requirement of present law that PSRO's must assume responsibility for review of all institutional services (including ancillary services) during the conditional period. Additionally, the bill clarifies the requirement that PSRO's must be reviewing long-term institutional care services (subject to the provisions of section 5(d) which leave the responsibility for review of services in an intermediate care facility where such a facility is not also a skilled nursing facility with the State medicaid agency unless the Secretary finds the State is not performing effective review).

The amendments made by this subsection would be effective upon enactment.

Review Requirements (Section 5(c))

The committee's bill requires the Secretary to give priority to PSRO requests to review services provided in "shared health facilities"; requires a PSRO to undertake ambulatory care review not later than 2 years after it has achieved operational status (but the Secretary may not require a conditional PSRO to undertake such ambulatory care review); and modifies the language in current law pertaining to physicians excluded from participation in review activities.

Under current law, a PSRO is required to review only care provided by or in institutions. It may request authority to review other kinds of health services, and the Secretary may approve the request at his option. To date, little emphasis has been given to the assumption of review responsibility by PSRO's for other kinds of health care services.

The bill would require the Secretary to give priority to requests by PSRO's to review services in "shared health facilities" with the highest priority being assigned to requests from PSRO's located in areas with substantial numbers of such facilities. A "shared health facility" is defined as an arrangement meeting all of the following criteria:

- (1) Two or more practitioners practice their professions at a common physical location;

(2) The practitioners share common space, services of supporting staff or equipment;

(3) The practitioners have a person (who may himself be a practitioner), paid on a percentage or other basis clearly unrelated to the value of the services provided, who either is in charge of or supervises substantial aspects of the operation or who makes available services of supporting staff who are not employees of such practitioners; and

(4) At least one of the practitioners receives from medicare, medicaid, and maternal and child health fee-for-service payments in excess of \$5,000 for one month or \$40,000 for 12 months.

The term "shared health facility" specifically excludes hospitals, skilled nursing facilities, home health agencies, federally approved health maintenance organizations, hospital cooperative shared services organizations meeting the requirements of section 501(e) of the Internal Revenue Code, or any public entities.

The definition of a "shared health facility" is designed to distinguish those types of ambulatory facilities (sometimes referred to as "Medicaid Mills") which are characterized by a high volume of services to medicaid patients (often of an excessive or unnecessary nature), and the payment of a percentage of the medicare and medicaid billings to the owner or manager of the facility, from legitimate group practice arrangements under which several practitioners render services at a common location. Since a shared health facility could evade the test of percentage arrangements, the Secretary has leeway to determine whether the payments to the owner or manager, while technically not a percentage of billings, are clearly unrelated to the value of the services provided by such person to the facility. By requiring a facility to meet all four criteria specified in the bill, it is expected that such legitimate arrangements among practitioners would be excluded from the definition. The committee expects, therefore, that the Department will exercise judgment in applying this definition so as to assure that legitimate group practice arrangements are not inappropriately classified.

Recent congressional hearings and reports have documented widespread instances of fraud and abuse in certain types of ambulatory facilities which have come to be known as Medicaid Mills. The definition of shared health facilities is designed to identify these specific types of arrangements in order to facilitate PSRO review of the services furnished by such facilities. Committee wishes to emphasize that a PSRO is not a fraud detection organization; its role is to render professional determinations as to the medical necessity and appropriateness of services. Thus, a PSRO will be expected, where it chooses to undertake review of services furnished by "shared health facilities," to review those services for the same purposes—to judge appropriateness and quality—that it would review services provided in other health care settings.

Under current law, PSRO's may request authority to review ambulatory care services, i.e., those provided in clinics or doctors' offices, however, to date, little emphasis has been given to this type of review. The committee bill would require the Secretary to approve a request by a PSRO (whether under conditional or operational status) to undertake ambulatory review if the Secretary finds it capable of performing this function. The bill further directs the Secretary, where he

finds an operational PSRO (not a conditional PSRO) capable, to require such organization to undertake ambulatory review not later than 2 years after it has achieved operational status. The committee expects that in implementing this requirement, the Secretary will exercise judgment with respect to the varying capacities of PSRO's and, where appropriate, will establish a reasonable classification of ambulatory care review activities for an organization to undertake. Such classification might include specific categories of services or specific aspects of various service categories. The committee further notes that "ambulatory care services" are those services not rendered by or in an institution. Institutional review, including review of services provided in hospital outpatient departments or emergency rooms, is a requirement of current law and must be conducted before an organization can achieve operational status.

Under current PSRO review provisions, a physician is precluded from reviewing health services provided to a patient if he was directly or indirectly involved in providing the services. Present law further precludes review by a physician of services furnished in any institution, organization, or agency if he or any member of his family has, directly or indirectly, any financial interest in such entity.

The bill would modify these restrictions to permit greater opportunity for physicians participation in PSRO review activities. Under the bill, a physician would not be permitted to review services for which he was directly responsible (rather than directly or indirectly responsible as in present law) or services in an institution in which he or a member of his family has a "significant" financial interest (rather than "any" financial interest, as in present law). The committee expects that in implementing this provision, HEW will employ the same definition of "significant" financial interest as is currently used in administering medicare.

The bill further clarifies that the contractual relationship between the Government and a PSRO is one of assistance rather than procurement. The major thrust of an agreement with a PSRO is not the procurement of services but rather a determination by the Secretary that the PSRO is authorized to carry out the functions prescribed by law. The fiscal aspects of the agreement are intended as assistance to the PSRO in the performance of its functions. The term "assistance agreement" is intended to permit the flexibility which an assistance arrangement allows rather than to require the procurement contract approach in reimbursing PSRO's for carrying out the functions vested in them by statute pursuant to a designation by the Secretary.

The amendments made by this subsection would be effective upon enactment.

Conclusive Determinations for Payment (Section 5(d))

The committee's bill provides that where a PSRO has been found competent by the Secretary and is performing specific review functions, medical determinations made in connection with such review shall be considered conclusive on those issues for purposes of payment. The bill provides a formal role for the States in the process of establishing and evaluating PSRO review of services provided through the medicaid program;

The bill generally precludes delegated review in skilled nursing facilities and provides that review of services provided in intermediate care facilities (which are not also skilled nursing facilities) will be undertaken by a PSRO only if the Secretary finds that the State is not performing effective review in these facilities.

Under present law, medicare payments and the Federal share of medicaid payments may not generally be made for health care services which a PSRO, in the proper exercise of its duties, has determined to be medically unnecessary or inappropriate. However, the committee believes that it is necessary, in order to avoid the performance of disruptive duplicative reviews by medicare and medicaid agencies, to clarify the scope of the PSRO's authority and the role of the medicaid State agencies.

Accordingly, the bill provides that where a conditionally designed or a qualified PSRO has been found competent by the Secretary to assume specific review responsibilities and is performing such reviews, a determination as to quality or necessity made in connection with such review would constitute the conclusive determination on those issues for purposes of payment. (Such determinations would be subject to the hearings and appeals provisions of present law.) Medicare fiscal intermediaries and State medicaid agencies would continue to be responsible for other types of reviews and determinations relating to program eligibility, coverage of services, audit, claims payment, fraud and abuse detection, and related activities.

The committee has received comments from a number of States expressing concern over the potential impact of PSRO determinations on State medicaid budgets. The committee has concluded that since substantial State monies are involved it is appropriate that they be given an opportunity to evaluate a PSRO's capability to efficiently and effectively perform review of medicaid services. The bill, therefore, makes provision for the participation of States in the PSRO designation process and in the ongoing monitoring of PSRO review activities.

The bill requires a PSRO to consult with the medicaid State agency in the development of its formal review plan (required as a condition for designation) and in any modification of the plan involving assumption of review responsibility for additional categories of services. The bill provides the States with an opportunity to review and comment on the proposed conditional designation of a PSRO, the change in designation status from conditional to operational, and the assumption by the PSRO of responsibility for long-term care and ambulatory care review. Before the Secretary designates a PSRO or substantially adds to its functions, he is required to take the State's views into account. If his decision differs from the course recommended by the State, he must notify the State of the reason for his decision and allow it additional time to provide further support for its views.

The bill provides that a PSRO's determination shall constitute a conclusive determination for purposes of payment under medicaid only if the PSRO has entered into a memorandum of understanding (approved by the Secretary) with the appropriate State medicaid agency. The purpose of this memorandum is to delineate the relationship between the PSRO and the State agency. The requirement for a memorandum of understanding may be waived only if the State

indicates that it does not wish to enter into such an understanding or if the Secretary finds that the State agency has refused to negotiate in good faith or in a timely manner with the PSRO involved.

A State medicaid agency may request a PSRO to include in its memorandum of understanding a specification of review goals and methods (in addition to those required in the PSRO's formal review plan) for the performance of its required functions. If the State medicaid agency and the PSRO are unable to agree on the inclusion of such items, the Secretary would review the requested specification and require that it be included in the memorandum if he determines that the review goals and methods are consistent with titles XI and XIX of the act and do not impair the effectiveness and uniformity of aid. For example, a State might request that a PSRO emphasize the the PSRO's review of health care services under medicare and medic-prevention of unnecessary Friday admissions of medicaid patients for elective procedures not scheduled to be performed until Monday. Your committee notes that the PSRO's application of norms, criteria, and standards would not be affected by this provision; standards for quality, appropriateness and necessity of services would continue to be the same for both programs. If the PSRO found review of weekend admissions was appropriate, it would generally be applied to all patients whose care was reviewed by the PSRO.

The committee intends that the Secretary shall not deny a State agency request solely because the PSRO has not been utilizing such a requested method or goal for the medicare program or because the PSRO cannot apply the method or goal to the medicare program due to differences in the patient populations. Rather, the committee intends that where differences in the patient populations do not preclude uniform review by the PSRO, the Secretary's decision shall be based on his determination as to whether the PSRO can effectively apply such review methods or goals to the review of services provided under both the medicare and medicaid programs in order to ensure that the uniformity of PSRO review under the Social Security Act can be maintained.

The committee intends that any review specified by the State agency which the PSRO performs in accordance with its memorandum of understanding with the agency and pursuant to its review authority under title XI would be fully federally funded. In addition, the bill provides regular Federal matching if a medicaid State agency contracts with a PSRO to undertake additional review responsibilities, provided the State agency formally requests it and the performance of such responsibilities is provided for in an approved medicaid plan amendment. For example, the State agency may request the PSRO to approve so-called administrative days, such as an additional day of hospital stay which may be required because there is no immediately available skilled nursing facility bed.

The bill also provides Federal financial participation to State medicaid agencies for the costs of monitoring the performance of review activities by PSRO's under State monitoring plans which have been approved by the Secretary. It is expected that the Secretary will develop criteria for approval of such plans and that they will not be approved where the proposed monitoring activities duplicate the purposes of PSRO review. The State medicaid agency may include in its

plans for monitoring a specification of the performance criteria for judging PSRO effectiveness. Inclusion of such specifications in the State's monitoring plan is not mandated because it is believed that most States during the development and initial implementation of State monitoring of PSRO review will not have such performance criteria developed. However, at such time as the State agency intends to utilize performance criteria for judging PSRO review effectiveness, the committee expects the agency to discuss the criteria with the PSRO and to amend the State's monitoring plan to include the agreed-upon criteria.

The bill authorizes the State agency to request suspension of the PSRO's authority to make conclusive determinations if in the course of its monitoring activities it develops reasonable documentation that the PSRO review determinations are not consistent with quality and appropriateness of medical care and services and have caused an unreasonable and detrimental impact on total State medicaid expenditures. The Secretary is required to determine the reasonableness of the State's complaint within 30 days of receipt of the documentation. Upon a finding of reasonableness, the Secretary may suspend all or part of the PSRO's conclusive determination authority under medicaid. (For example, he may suspend its review of long-term care services, but not hospital services. He may also take similar action with respect to PSRO determinations under medicare if he determines such action is appropriate.) The committee expects that where the substance of a State's complaint can be and is promptly corrected a suspension action would not be taken. The committee bill further provides that the Secretary may suspend immediately all or part of a PSRO's conclusive determination authority if he makes his own finding that such entity is not performing its functions in a reasonable and appropriate manner. Any suspension actions taken by the Secretary (either in response to a State's complaint or as a result of his own evaluation) or any determination by the Secretary that a suspension is not in order shall not be subject to judicial review. During any suspension period the Secretary is required to conduct a reevaluation of the PSRO's capability to perform review activities and to inform the appropriate agencies, organizations, and congressional committees of any documentation submitted and actions taken.

The bill requires the Secretary to establish procedures and mechanisms governing his relationship to State agencies in connection with their respective responsibilities concerning memoranda of understanding, monitoring, and reevaluations. The Secretary is required to periodically consult with representatives of State agencies and PSRO's. Further, the appropriate State medicaid agency is permitted to be represented on any project assessments conducted by the Secretary. The committee intends that the procedures and mechanisms developed by the Secretary shall promote smooth working relationships between all parties involved and shall involve a minimum of disruption in the orderly implementation of the PSRO program. The committee further intends that State monitoring activities will become less intensive over time (particularly with respect to PSRO's which are no longer in conditional status) and will focus on problem areas which have been detected in the performance of PSRO review.

The committee is aware of the fact that as PSRO's begin to review services provided in institutional settings other than hospitals, different requirements may be appropriate. Accordingly, the bill generally prohibits delegated review in skilled nursing facilities since these facilities have generally had far less experience in conducting in-house review activities than hospitals. This prohibition would not be applicable in cases where a skilled nursing facility is a distinct part of a hospital. The committee bill specifies that PSRO-delegated review to a hospital also encompasses an attached skilled nursing or intermediate care facility.

The committee bill further provides that PSRO's shall have responsibility for the review of services provided in an intermediate care facility where such facility is also a skilled nursing facility. PSRO review of care in other intermediate care facilities and public institutions for the mentally retarded (services which are paid for only under the medicaid program) would only be undertaken where the Secretary determines that the State is not performing effective review of the quality and necessity of services provided in such facilities. If the Secretary does make such a finding, and the PSRO is required to carry out the review, the committee expects that the PSRO would not delegate review to the intermediate care facility, just as they are prohibited from such delegation to skilled nursing facilities.

The amendments made by this subsection would be effective upon enactment.

Clarification of Sanctions Provision (Section 5(e))

Current law specifies those conditions under which the Secretary may, at the recommendation of a PSRO, withdraw a medical care provider's eligibility to participate in Social Security Act medical care programs where it is determined that it is not willing, or cannot, carry out its obligations to order and provide only necessary care of acceptable quality.

The committee bill makes clear that the provision in question applies to any health care practitioner, or any hospital or other health care facility, agency, or organization which is subject to PSRO review.

The amendment made by this subsection would be effective upon enactment.

National Council (Section 5(f))

The bill provides for staggered terms for members of the National Professional Standards Review Council.

Present law provides that the 11 members of the Council shall be appointed for 3-year terms and may be eligible for reappointment. The bill would amend this provision. The general term for Council members would continue to be 3 years, except that for members appointed in 1977, four shall be appointed for a 2-year term and three for a 1-year term. All members would continue to be eligible for reappointment.

The amendment made by this subsection would be effective upon enactment.

National Council Report (Section 5(g))

The committee bill would delete the requirement in present law for an annual report on its activities by the National Professional Stand-

ards Review Council and would require instead the submission by the Secretary of a detailed annual report on the PSRO program.

Under the new reporting requirement included in the bill, the Secretary would be required to submit substantially more information concerning the cost and operation of the PSRO program than has previously been required of the National Council. Accordingly, the bill would delete the requirement for the National Council report as duplicative and unnecessary.

The amendment made by this subsection would be effective upon enactment.

Exchange of Data and Information With Other Agencies (Section 5(h))

The committee's bill would expand and clarify the circumstances under which the provision of data or information by PSRO's would not violate the confidentiality requirement of law.

Under present law, any data or information acquired by a PSRO in the exercise of its duties must be held in confidence and may not be disclosed to any person except (1) to the extent that may be necessary to carry out the purpose of the PSRO provisions, or (2) in such cases and under such circumstances as the Secretary shall by regulations provide to assure adequate protection of the rights and interests of patients, health care practitioners, or providers of health care. Interim regulations issued by the Department on December 3, 1976, provide for the disclosure of two types of information acquired by the PSRO:

1. Data and information acquired by the PSRO: (a) which has been published; (b) which has not been identified by the source as confidential; and (c) whose disclosures are not otherwise prohibited by law.

2. Summary statistics aggregated from the Uniform Hospital Discharge Data Set (UHDDS) to the extent that it is not identifiable to an individual patient or health care practitioner.

The bill would expand and clarify those circumstances under which the provision of data or information would not violate the confidentiality provisions to include: (1) provision of data or information by the PSRO, on the basis of its finding as to evidence of fraud or abuse, to Federal or State agencies recognized by the Secretary as having responsibility for the identification or detection of fraud and abuse activities; such data and information may be provided at the request of the recognized agencies at the discretion of the PSRO; and (2) provision of aggregate statistical data to agencies having responsibility for health planning and related activities under Federal or State law. The data and information furnished to the planning agencies would be provided in the format and manner prescribed by the Secretary or agreed upon by the agencies and the PSRO. Such data and information would be in the form of aggregate statistical data on a geographic, institutional, or other basis reflecting the volume and frequency of services furnished and the demographic characteristics of the population whose services are subject to review by the PSRO. However, the data would not identify any individual.

Data and information made available to Federal or State agencies recognized by the Secretary as having responsibility for identifying

and investigating fraud and abuse may not be further disclosed except when the disclosure is made in the course of a legal, judicial, or administrative proceeding. Violation of this prohibition would result in application of the penalty specified in existing law.

The committee has included this provision to facilitate the exchange of data and information with other agencies while at the same time assuring that the confidentiality of patient records will not be violated. The committee has received information that PSRO's which have identified suspected cases or widespread patterns of fraud and abuse have been unable to make the information available to enforcement agencies. The committee also notes that the provision of aggregate statistical data to Federal and State planning agencies will enable those bodies to develop a more accurate picture of medical care patterns in their areas, facilitate planning for future resource needs, and prevent unnecessary duplicative data gathering activities.

The bill also includes a provision to protect patient records from subpoena or discovery proceedings in a civil suit. This provision, however, would not preclude the subpoena or discovery of originals or copies of the same documents in the possession of others.

The amendment made by this subsection would be effective upon enactment.

Legal Expenses (Section 5(i))

The committee's bill provides for payment of legal fees in connection with the defense of suits brought against a PSRO related to the performance of its functions. The bill would authorize the Secretary to assume responsibility for legal fees incurred in connection with the defense of any suit, action, or proceeding brought against the PSRO or any of its members or employees related to the performance of its functions. While all PSRO's currently have liability insurance which covers such attorneys' fees, this provision would serve as an additional guarantee in the event such insurance is subsequently withdrawn.

The amendment made by this subsection shall be effective upon enactment.

Payment of PSRO Expenses (Section 5(j))

The committee's bill would clarify the intent of present law that payment for PSRO expenses is to be made from Federal funds.

Under present law, expenses incurred by PSRO's are payable from medicare trust funds and from funds appropriated to carry out the other health care provisions of the Social Security Act. The bill would clarify that it is not intended that States or local governmental entities contribute toward these expenses, as they normally must do to receive Federal matching funds under title XIX.

The amendment made by this subsection would be effective upon enactment.

Annual Reports (Section 5(k))

Current law does not require the preparation of a detailed report on the activities, cost, and impact of the PSRO program. The committee believes that this information is necessary to determine the status of program operations, to evaluate the progress of program implementation, and to assess the program's effectiveness.

The bill committee therefore requires the Secretary to submit annual reports to the Congress by April 1 of each year beginning in 1978 on the administration, impact, and cost of the PSRO program during the preceding fiscal year. The reports must include program data on each PSRO; institutions and practitioners whose services are subject to review; penalties and sanctions; total costs under titles V, XI, XVIII, and XIX in the implementation of all required review procedures; changes attributable to PSRO activities; results of program evaluation activities; extent to which PSRO's are performing reviews for other private or governmental programs; and legislative recommendations.

The amendment made by this subsection would be effective upon enactment.

Medical Officer (Section 5(l))

The bill would include medical officers in American Samoa, the Northern Mariana Islands and the Trust Territory of the Pacific Islands in the PSRO program. In these areas medical officers rather than doctors of medicine provide medical care. The bill would therefore permit medical officers licensed to practice medicine in these localities to participate in the PSRO program. These individuals may not, however, serve on the National Council or make any final determinations with respect to medical necessity or appropriateness of care provided by a duly licensed doctor of medicine or osteopathy.

The amendment made by this subsection would be effective upon enactment.

Payment for Review of Part B Services Provided by Hospitals (Section 5(m))

Public Law 94-182, enacted on December 31, 1975, included an amendment to the medicare program which was designed to equalize reimbursement for PSRO hospital review activities whether such review was carried out by a hospital under delegation from a PSRO or by the PSRO itself. Previously, only delegated review activities could be funded out of the medicare trust funds. Under the new law, PSRO expenses in carrying out nondelegated review for hospital services covered under medicare part A or medicaid or the maternal and child health program would also be reimbursed through this mechanism. The law did not, however, provide for similar funding for PSRO review of hospital services covered under medicare part B.

Accordingly, the bill corrects this oversight by providing that funding for delegated review activities for services provided by a hospital which are covered under medicare part B shall be made from the medicare trust funds.

The amendment made by this subsection would be effective upon enactment.

Statewide Councils (Section 5(n))

The bill extends the protection currently provided to members and employees of a PSRO from criminal prosecution or civil liability when carrying out PSRO functions to members and employees of Statewide Professional Standards Review Councils.

The amendment made by this subsection would be effective upon enactment.

Technical Corrections (Section 5(o))

The committee bill makes technical corrections in sections 1152(b)(1)(A), 1155(a)(1), and 1160(b)(1) of the act.

Physician Review (Section 5(p))

The committee bill deletes the current law distinction, based on whether a hospital has or has not been delegated PSRO review, in determining those physicians who may be responsible for review activities.

Under current PSRO review provisions, a physician is ordinarily prevented from being responsible for the review of hospital care and services provided in any hospital in which he has active staff privileges when the review of such services has not been delegated to the hospital by a PSRO. However, where review has been delegated to the hospital, a physician with active staff privileges in that facility may be responsible for the review.

The committee notes that there is no evidence that such a distinction in the qualification of the physician responsible for the review is necessary. The decision whether or not to delegate review is not necessarily related to the ability of an individual physician with active staff privileges in a particular hospital to do the required review, but is more likely to be related to other factors. The committee has concluded that the existing prohibition places an undue burden on nondelegated hospital review.

The committee bill therefore deletes the restriction contained in current law which ordinarily prevents physicians with active staff privileges in a hospital from being responsible for review in a facility if review responsibilities have not been delegated.

Issuance of Subpenas by the Comptroller General (Section 6)

The bill would give the Comptroller General of the United States the power to sign and issue subpenas to gain information regarding programs authorized under the Social Security Act.

Currently, the Comptroller General of GAO does not have the statutory authority, under the Social Security Act, to issue subpenas in connection with GAO investigations into programs authorized by that act. In a December 29, 1976, letter to the House Ways and Means Committee, which was in response to an inquiry concerning Social Security Act subpoena power for the General Accounting Office, the Acting Comptroller General stated that:

From the overall perspective, we believe that the subpoena power in question would be a useful tool. In all probability, the mere existence of such a power would be sufficient to preclude problems in most cases and, in our opinion, resort to its use would be relatively infrequent. We would thus favor the inclusion of subpoena authority in the anticipated new legislation.

The bill would give the Comptroller General of GAO the power to sign and issue subpenas in order to gain information and facilitate review of programs authorized under the Social Security Act particularly with respect to investigations of fraudulent and abusive practices. In connection with GAO's statutory functions including investigations, examinations, and auditing, subpenas could be issued to gain access to pertinent books, records, documents, or other information.

Under resistance or refusal by an individual to obey a subpoena, the bill would authorize the Comptroller General to request a court order requiring compliance.

The amendments made by this section would be effective upon enactment.

Suspension of Practitioners Convicted of Medicare- or Medicaid-Related Crimes (Section 7)

The committee's bill requires the suspension of physicians or other individual practitioners from participation in medicare or medicaid if such practitioner has been convicted of a program-related criminal offense.

The committee has included this provision in response to the concern that some program violators have been permitted continued participation, often without interruption, in Federal health care programs. The committee feels that misuse of Federal and State funds is a very serious offense and that those convicted of crimes against the programs should not be permitted continued and uninterrupted receipt of Federal and State funds. The committee believes that this threat of suspension, together with the upgraded penalties authorized under the bill, will serve as a significant deterrent to fraudulent practices under medicare and medicaid.

Under current law, physicians or other individual practitioners who have been convicted of an offense related to their participation in medicare or medicaid are not automatically suspended from these programs and can continue to receive payment therefrom. The Secretary may suspend Federal payment to a person who has falsified information related to a request for payment. The Secretary may also suspend a person who bills the program for charges substantially in excess of the person's customary charges or who has furnished services found to be substantially in excess of an individual's need, to be harmful, or to be of grossly inferior quality.

The bill requires the Secretary to suspend from participation under medicare, a physician or individual practitioner who he determines has been convicted of a criminal offense related to such individual's involvement in medicare or medicaid. To permit case-by-case determinations, the suspension would be for such period as the Secretary deems appropriate and no medicare payment could be made for any item or service furnished by such individual during this period. Individuals subject to suspension are those who are convicted on or after the date of enactment of the law or within such period prior to enactment as the Secretary may specify in regulation. Provision is made for appropriate notice to the individual and the public and hearing and judicial review of the Secretary's determination. In any case where the Secretary suspends a practitioner from participation in medicare he is required to promptly notify every State medicaid agency and the appropriate State or local licensing authority.

Whenever a State medicaid agency is notified by the Secretary that a practitioner has been suspended under medicare, it shall suspend such individual from participation in medicaid. This is intended to prevent practitioners from moving from one State to another in

order to avoid the effect of the suspension. To conform the timing of suspensions, the medicaid suspension period shall not be less than the suspension period applicable to the individual under medicare. No medicaid program payments may be made for services provided by such individual during the suspension period.

In his notification to the licensing authority the Secretary shall request that investigations be made and sanctions be invoked, as deemed appropriate in accordance with the State's law and policy. The Secretary and Inspector General would be notified of whatever action, if any, is taken by these authorities.

The committee was concerned that imposition of this suspension, under certain unusual circumstances, could deny adequate access to medical care to persons eligible for services under medicare or medicaid. To ensure that this would not occur, the bill provides two remedies. First, the bill would authorize the Secretary to designate a community as a health manpower shortage area (as defined under title III of the Public Health Service Act) for purposes of placement of National Health Service Corps personnel, if he determines that imposition of a suspension would leave those residents of the area eligible under medicare or medicaid without adequate access to health services. Second, the bill permits the Secretary, on the request of a State, to waive a practitioner's suspension under the State's medicaid program. The committee intends that such waivers be granted sparingly. It is expected that waivers will only be approved where imposition of the suspension would deny a community of needed medical service because of the shortage of practitioners in that area and no National Health Service Corps personnel have been assigned.

The amendments made by this section would be effective upon enactment except for the provision relating to medicaid suspensions which would be effective for calendar quarters beginning on or after January 1, 1978.

Disclosure by Providers of Owners and Certain Other Individuals Convicted of Certain Offenses (Section 8)

The committee's bill requires all institutional providers of services participating in medicare, medicaid, or title XX State social service grant programs to disclose the names of owners and certain other individuals who have been previously convicted of fraud against any one of these programs. The bill also permits the Secretary or appropriate State agency to decline to enter into an agreement or contract with an institution whose application contains the names of any such individuals and further permits the Secretary or any State agency to terminate existing provider agreements if the names of such individuals have not been disclosed as required.

Current disclosure of ownership provisions do not require institutional providers of services and other agencies and organizations certified to provide services under titles XVIII and XIX of the Social Security Act to disclose information about criminal records any of their owners and managerial employees may have. Similar information is also not required from institutional providers participating in title XX of the Social Security Act, a number of whom are also certified to provide services under medicare and medicaid. Existing

procedures for determining this information are inadequate, time-consuming, and have permitted individuals previously convicted of such offenses to continue ownership or management in participating facilities or become owners or managers in other participating facilities without program administrators being aware of an individual's past activities which might have a bearing on a facility's future performance.

Lack of adequate disclosure of these individuals is an additional restraint on HEW's attempts to investigate and control program abuse. It has hampered and restricted Department efforts to limit the participation of those facilities and other organizations providing services under titles XVIII, XIX, or XX that are partially owned or controlled by persons convicted of criminal offenses against the programs.

Even when such individuals can be identified by the Department of HEW or State administering agencies, it is difficult under existing procedures to limit participation of facilities owned by these persons. Currently, no provisions exist to enable the Secretary of HEW or a State agency to refuse to enter into or to terminate provider agreements or contracts with institutional providers or other organizations owned by such individuals as long as existing conditions for participation under titles XVIII, XIX, or XX are met.

The result of the failure of the current law to provide procedures whereby facilities owned by persons who have previously been convicted of fraud against medicare or medicaid has been that these persons continue to receive payments from the programs. Even criminal conviction is not sufficient to exclude an individual from the nursing home industry or the Medicaid system. Lengthy state administrative procedures must also be carried out, vulnerable to delaying litigation. The problem would be compounded under present law whenever a provider convicted in one State continues to operate in another. Then the speedy removal of the provider from the medicaid program would be almost impossible. Conferring the proposed powers on the Secretary would ensure that providers who have flagrantly abused the system will not be able to exploit the delays in State administration processes to continue their profiteering.

In order to deal with this problem, as a condition of participation, certification, or recertification under titles XVII, XIX, or XX of the Social Security Act, the bill would require all institutional providers of services, or other agencies, institutions, or organizations to disclose to the Department of Health, Education, and Welfare or to the appropriate State agency the names of its owners, officers, directors, agents, or managing employees who have been convicted of a criminal offense against medicare, medicaid, or State social service grant programs. The bill specifies that when an application requesting such participation or certification contains the names of any such previously convicted individual, the Secretary of HEW or the State agency may refuse to enter into an agreement or contract with the institution to provide services under titles XVIII, XIX, or XX. In addition, the bill specifies that the HEW Inspector General must be informed of any such applications received and of any actions taken

on them. The bill would also permit the Secretary or appropriate State agency to terminate existing provider agreements or contracts under title XVIII, XIX, or XX, if the names of such individuals have not been disclosed, as required.

In applying the disclosure requirements to convicted persons who are officers, directors, agents, or managing employees of the institution, as well as to convicted persons with ownership interests, the committee feels that this parallel requirement is necessary in order to ensure that program administrators are aware of the renewed involvement of these persons in participating institutions.

The bill would specifically define the term "managerial employee" to mean a person who exercises operation or managerial control over the institution or one who directly or indirectly conducts the day-to-day operations of the institution including, but not limited to, an institution's general manager, business manager, administrator, and director. The bill would define the owner of an institution as any person who has a direct or indirect ownership or control interest of at least 5 percent in the institution.

The amendments made by this section should apply with respect to contracts, agreements, and arrangements entered into and approvals given pursuant to applications or requests made on and after the first day of the fourth month following enactment.

Federal Access to Records (Section 9)

Under present law, State plans under medicaid are required to provide for agreements with every person or institution providing services whereby such persons or entities will keep complete records of services provided under the program and furnish the State agency, upon request, which information regarding any payments claimed under the program. Similar access to records by the Secretary is not required. The committee feels this could hamper Federal efforts to obtain information necessary to examine potential instances of fraudulent and abusive activities. The bill therefore specifically permits the Secretary to have access to records of persons or institutions providing services under medicaid in the same manner presently provided to State medicaid agencies.

The amendment made by this section would be effective upon enactment.

Claims Processing and Information Retrieval Systems for Medicaid Programs (Section 10)

The bill permits States to send explanation of benefits forms to a sample of medicaid recipients and still be entitled to increased Federal matching for operation of approval management information systems. The bill specifies that there would be no explanation of benefit forms in the case of services which are confidential in nature.

Present law authorizes an increase in Federal matching to 75 percent toward the costs of operating an approved medicaid claims processing and information retrieval system if the system provides explanation of benefits information to all recipients. The committee has been informed that this strict requirement for explanation of benefit forms in every case has limited the growth of approved sys-

tems. In addition, questions have been raised about the cost effectiveness of this requirement because of the high volume of claims for services provided under medicaid.

The bill therefore modifies the current requirement by permitting the increased matching if the system provides explanation of benefits information to a sample group of recipients. The committee expects that the samples will be of sufficient size and sufficiently representative of the population served and the services rendered to enable the identification of any questionable or unusual patterns. It is the intention of the committee that all confidential services, and services integrally related to a confidential service such as family planning services and venereal disease treatment be deleted from the explanation of benefit forms in order to assure privacy for the medicaid patient. States will be expected to institute appropriate safeguards to accomplish this.

The committee notes that this change in the medicaid statute does not constitute a new entitlement to higher Federal matching, but merely increases the workability of the existing provision.

The amendment made by this section would apply with respect to calendar quarters beginning after the date of enactment.

Restriction on Federal Medicaid Payments. Assignment of Rights of Payment; Incentive Payments (Section 11)

The bill precludes Federal matching payments for expenditures under medicaid for services which a private insurer would have an obligation to pay except for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or receiving medicaid.

The section also establishes a medical support program under which medicaid applicants and recipients may be required by a State to assign their rights to medical support or indemnification to the State. Incentives would be provided for localities to make collections for States and for States to secure collections in behalf of other States.

Under current law, States or local agencies administering medical assistance plans are required to take all reasonable measures to ensure that third parties legally liable to pay for any medical care rendered to medicaid recipients meet their legal obligations. However, some private insurance policies contain a provision that limits the insurance companies' liability to the amount not covered by medicaid. In some cases, State insurance commissioners have not taken action to stop this practice. When it occurs, the medicaid program is forced to assume the costs despite the existing subrogation requirement.

The bill would provide an incentive to States to stop this practice by stopping all Federal matching payments for expenditures made under the plan for care or services provided to the extent the private insurer (as defined by the Secretary) would have been obligated to pay for or a provision of its contract which has the effect of limiting or excluding such obligation because the individual is receiving assistance under medicaid.

States have advised the committee that there are cases where absent parents who have been ordered by a court to provide for the medical support of their families have failed to do so. Frequently these families

must turn to the medicaid program for their medical needs. The medical support program established by the bill would authorize States to require that medicaid recipients and applicants, as a condition of eligibility, assign their medical support or indemnification rights to the State. The State would enter into cooperative arrangements to secure the medical support. Localities securing collections on behalf of the State and States securing collections on behalf of other States would receive incentive payments of 15 percent of the amounts collected.

The amendments made by this section would apply with respect to medical assistance provided and assignments made for calendar quarters beginning on or after January 1, 1978.

Study and Review of Medicare Claims Processing (Section 12)

The committee bill directs the Comptroller General to conduct a comprehensive study of the claims processing system under medicare for the purpose of determining what modifications should be made to achieve more efficient claims administration.

Under medicare part A, groups or associations of providers can nominate an organization to serve as a fiscal intermediary between the providers and the government. An individual member of an association or group of providers that has nominated one organization as intermediary may select some other organization if this is satisfactory to the organization and HEW, or alternatively it may elect to deal directly with the government. HEW may not enter into an agreement with an organization unless it finds that such agreement is consistent with efficient and effective administration. The Social Security Administration selected 10 hospital-nominated organizations to serve as intermediaries. These include the Blue Cross Association which carries out its claims administration activities through 73 statewide and local Blue Cross plans. Under medicare part B, the Secretary contracts with carriers to perform claims processing activities. Carriers are selected to serve specified geographic areas. There are 47 carriers, including 32 Blue Shield plans. Both intermediaries and carriers are reimbursed on a cost basis for carrying out their activities.

A reexamination of the administrative framework of the medicare program in order to assess the need for possible modifications is desirable.

The committee bill therefore directs the Comptroller General to conduct a comprehensive study and review of the administrative structure established for processing claims under medicare. The study is to determine whether and to what extent more efficient claims administration could be achieved by reducing the number of carriers and intermediaries, making a single organization responsible for processing claims under parts A and B in a particular geographic area, paying for claims processing on the basis of a prospective fixed price, providing other types of incentive payments for efficiency, or by other modifications in existing structure and procedures. The Comptroller General would be required to submit a report containing his findings and recommendations to the Congress by July 1, 1979.

The amendment made by this section would be effective upon enactment.

Abolition of Program Review Teams Under Medicare (Section 13)

The committee bill repeals the provisions in current law relating to program review teams.

The Social Security Amendments of 1972 included a provision authorizing the Secretary to suspend or terminate medicare payments to a supplier of services found to have abused the program. In the case of such a suspension or termination, Federal participation was also to be withheld for medicaid payments made in behalf of such supplier. This provision was included to permit HEW to bar future payments to suppliers who have made a practice of furnishing inferior or harmful supplies or services, engaging in fraudulent activities, or consistently overcharging for their services.

To assist him in making determinations under this section, the Secretary was required to establish program review teams in each State. These professionally based bodies were to advise the Secretary concerning such matters as whether excessive, harmful, or grossly inferior care is being rendered to patients. The functions of program review teams relating to the review of the quality and appropriateness of services are essentially duplicative of the functions required to be performed by PSRO's.

The committee bill therefore deletes the requirements in current law pertaining to the establishment and responsibilities of program review teams with the expectation that the appropriate PSRO will instead be available to advise the Secretary in cases that require the application of professional medical judgment.

The amendment made by this section would be effective upon enactment.

Nomination of Intermediaries by Providers (Section 14)

The bill would prohibit the Secretary from refusing to enter into an agreement with a nominated intermediary solely because of the fact that such intermediary does not operate regionally or nationally.

Under present law, the Secretary of HEW is authorized to use public agencies or private organizations to facilitate medicare payment to providers of services. Such agencies or organizations (intermediaries) are ordinarily nominated by the individual provider. For example, most hospitals have nominated Blue Cross Association as their intermediary and the Secretary has contracted with that organization. The Blue Cross Association, in turn, utilizes local Blue Cross plans for the day-to-day administrative and operating activities.

The Secretary is prohibited from entering into an agreement with any agency or organization unless he finds that to do so is consistent with effective and efficient administration; that the intermediary is willing and able to assist providers in safeguarding against unnecessary utilization of services; and that the intermediary agrees to provide the Secretary with such information as it may acquire in performing its duties and which he finds necessary in performing his functions.

The committee is concerned that the Secretary may refuse to enter into an agreement with a prospective intermediary nominated by a provider or group of providers, or may terminate an agreement with an existing intermediary, solely on account of the fact that the inter-

mediary transacts business only within the State in which the provider(s) is located and that current law indirectly may give him the authority to require the designation instead, of a regional or national intermediary.

The committee has, therefore, included an amendment prohibiting the Secretary from refusing to enter into an agreement with a nominated intermediary, terminating an existing agreement, or making a determination with respect to whether an agreement or proposed agreement is effective or efficient, solely because of the fact that such intermediary operates only within a single State or on the basis that regional or national intermediaries serve or could serve providers within the State. It is the intention of the committee that the Secretary not go outside the State to a region or beyond when providers within a given State wish to be served (and other applicable requirements of the statute are met) by intermediaries who operate wholly within the State.

Disclosure by Providers of the Hiring of Certain Former Employees of Fiscal Intermediaries (Section 15)

The committee bill would require a provider of services under the medicare program to notify the Secretary promptly of its employment of an individual who at any time during the preceding year was employed in a managerial, accounting, auditing or similar capacity by a fiscal intermediary or carrier who had served that provider.

In certain cases in the past, providers have specifically recruited and employed personnel of the fiscal intermediary serving it, apparently in order to assist the provider in justifying questionable accounting and cost reporting procedures. This type of hiring practice potentially subverts the integrity of the intermediary provider relationship, including the integrity of the auditing process. The Department of HEW is expected to utilize the information gained under the notification required under the bill to discourage such practices, especially when such information suggests possible conflict of interest situations.

Providers who hire employees of fiscal intermediaries, particularly accountants and auditors who have been involved in auditing that provider, should be on notice that such practices will be followed closely.

The amendment made by this section would apply with respect to agreements entered into or renewed on and after the date of enactment.

Payment for Durable Medical Equipment (Section 16)

The committee bill would modify the present methods for reimbursing medicare beneficiaries for expenses incurred in obtaining durable medical equipment. The intent of this modification is to reduce program expenditures and assure greater protection for beneficiaries against the need to pay excessive rental fees.

Present law provides for reimbursement under part B of medicare for expenses incurred in the rental or purchase of durable medical equipment used in the patients' home. The beneficiary has the option to rent or purchase such equipment. In the case of purchase, reimbursement is generally made in monthly installments equivalent to amounts that would have been paid had the equipment been rented.

Reimbursement may be made on a lump-sum basis for purchased

equipment that is relatively inexpensive, i.e., items for which the reasonable charge is \$50 or less.

Where a beneficiary elects to rent equipment, medicare will continue to reimburse him for 80 percent of his rental expenses as long as his medical need for the equipment continues. A study conducted by GAO showed that rental payments under the program for durable medical equipment require over an extended period of time frequently exceeded, by a substantial amount, the reasonable purchase price of the equipment. Moreover, beneficiaries were also overpaying for equipment since they are liable for the 20-percent coinsurance amount.

The Social Security Amendments of 1972 added provisions to the law to help avoid unreasonable expenses to the program and to beneficiaries resulting from prolonged rentals of equipment. These provisions authorized the Secretary to experiment with alternative reimbursement mechanisms, including the use of lease-purchase arrangements and lump-sum payments for purchased equipment where it could be determined in advance that the use of the equipment would be medically necessary for an extended period of time. Although the Department has not conducted the extensive experimentation contemplated by the legislation, sufficient evidence is available to indicate that changes in the reimbursement methods are needed to deal with the long-standing problems arising under the durable medical equipment provision of law.

To remedy these problems, the committee bill makes several changes in the methods used in reimbursing beneficiaries and suppliers for durable medical equipment. First, the bill requires the Secretary to determine, on the basis of medical evidence, whether the expected duration of medical need for the equipment warrants the presumption that purchase would be less costly or more practical than rental, and would not impose financial hardship on the beneficiary. Where such a presumption can be made, the Secretary would require purchase of the equipment and would provide reimbursement on the basis of a lump-sum payment or on the basis of a lease-purchase arrangement. Since lease-purchase would generally be the preferred mode of payment, and would ordinarily provide the greatest degree of cost-effectiveness for the program and the beneficiary alike, the bill specifically directs the Secretary to take steps to encourage suppliers, through whatever administrative arrangements he finds feasible and economical, to make equipment available to beneficiaries on a lease-purchase basis.

Second, the bill retains the provision in existing law which authorizes the Secretary to waive the 20-percent coinsurance requirement with respect to the purchase of used durable medical equipment whenever the purchase price is at least 25 percent less than the reasonable charge for comparable new equipment.

The amendment made by this section would apply to durable medical equipment purchase for rented on or after October 1, 1977.

Funding of State Medicaid Fraud Control Units (Section 17)

The committee bill authorizes 100 percent Federal matching in fiscal year 1978, 90 percent matching in fiscal year 1979, and 75 percent matching in fiscal year 1980 for the establishment and operation of State Medicaid fraud control units. The bill also authorizes the

Secretary to conduct demonstration projects for the purpose of developing improved methods for the investigation and prosecution of fraud in the provision of health services under the Social Security Act.

The committee is concerned that sufficient efforts have not been made to date to identify and prosecute cases of medicaid fraud in a number of States. In the absence of effective investigative units, individuals engaging in fraudulent practices are able to continue their activities virtually unchecked. Sections of the bill provide for criminal sanctions and suspension actions for those convicted of medicaid fraud. However, strengthened penalties must be coupled with strengthened investigatory powers in order to assure that those engaging in criminal activities are identified and prosecuted. Further, the combination of rigorous enforcement and criminal sanctions should serve as a deterrent to similar practices by other providers and practitioners.

Testimony has been presented to the Congress showing that where a separate statewide investigative entity has been established, the rate of prosecutions and convictions has been substantially increased. For example, there was testimony that in the period from 1970 to January 1975, there was not a single prosecution in New York State for medicaid fraud arising out of the operation of a nursing home. In January 1975, a special office was established to examine the rapidly growing scandal in the nursing home industry. As a result of its investigations, grand juries have indicted more than 90 individuals mostly for medicaid fraud. To date, there have been 27 convictions and the office has forced payment of more than \$4 million in criminal restitution—an amount several hundred thousand dollars in excess of the offices first year budget. The committee is particularly impressed with the organization and operation of the New York Special Prosecutor's Office and its demonstrated effectiveness, and believes it constitutes a model for antifraud efforts in other States.

The committee has learned that a number of States are interested in establishing or strengthening existing medicaid fraud and abuse control units. It wished to encourage efforts similar to the New York unit. However, in view of the fiscal constraints being experienced by many of them, the current 50-percent administrative matching rate has not served as a sufficient incentive to the establishment or expansion of such units. The committee believes that a short-term increase in the Federal matching rate will enable States to establish effective investigative entities and expand existing efforts. After these units have been operational for a few years, their recoveries from prosecutions should begin to equal or exceed the cost of operation. Therefore, under the bill, the increased matching rate would only be in effect for 3 years.

The committee bill therefore provides for 100 percent Federal matching in fiscal year 1978, 90 percent in fiscal year 1979, and 75 percent in fiscal year 1980 for the costs incurred in the establishment and operation (including the training of personnel) of State fraud control units meeting specified requirements, subject to a quarterly limitation of the higher of \$125,000 or one-quarter of 1 percent of total medicaid expenditures in such State in the previous quarter.

To be eligible for the increased matching rate, the State medicaid fraud control unit must be a single identifiable entity of State government which the Secretary certifies (and annually recertifies) as meeting specific requirements. Such entity must be a unit of the office of the State Attorney General or of another department of State government which has statewide prosecutorial authority (unless it is located in a State where the State constitution prohibits prosecution by a statewide authority, or an entity which is independent of the single State agency or medicaid agency—if different—and has a close working relationship with the State attorney general's office; then, to receive the higher matching, the unit must have procedures acceptable to the Secretary of HEW to refer suspected criminal violations to the appropriate prosecuting authorities, and to assist with the prosecutions. Any entity would be required to be separate and distinct from the State medicaid agency (or single State agency). If the unit is not part of the State attorney general's office, it must have a close working relationship with that office or other appropriate prosecuting authorities in the State. Such relationship should include procedures for referral of suspected criminal violations and assistance with prosecutions.

The State fraud control unit must conduct a statewide program for the investigation and prosecution of violations of all applicable State laws relating to fraud in connection with the provision of medical assistance and the activities of medicaid providers. Such unit is not, however, required to examine potential instances of recipient fraud; this function may continue to be the responsibility of the State medicaid agency. The fraud and abuse control unit must have procedures for reviewing complaints of the abuse and neglect of patients by health care facilities, and, where appropriate for acting on such complaints or for referring them to other State agencies for action. The entity is required to provide for the collection, or referral for collection, of overpayments made to health care facilities. In order to promote effective and efficient conduct of the entity's activities, it must be organized in a manner to achieve these objectives and it must employ auditors, attorneys, and investigators and other necessary personnel. The entity is further required to submit an application and annual report containing information deemed necessary by the Secretary to determine whether the entity meets these requirements. To facilitate implementation of this section, the Secretary is required to issue regulations within 90 days of enactment.

The committee wishes to emphasize the need for the employment of highly skilled auditors, attorneys, and investigators specially trained in the area of medicaid fraud. The committee has received substantial evidence of the complex schemes employed by those engaging in fraudulent activities and notes that the only way such practices can be effectively addressed is by utilizing persons specially skilled in uncovering these activities.

The committee intends that the increased matching rate authorized under this section be made available to existing State fraud control units providing they meet (or appropriately modify their operation so as to meet) the specified requirements.

The bill specifically authorizes the Secretary (in addition to his general authority to carry out demonstrations designed to improve

administration and effectiveness of Social Security Act programs) to arrange for demonstration projects designed to develop improved programs for the detection, investigation, and prosecution of fraud and abuse.

The committee has been impressed by the innovative methods employed by several States in the detection, investigation and prosecution of certain types of fraudulent and abusive activities under the medicare and medicaid programs. The committee believes that States, such as New York, which have demonstrated their ability to conduct vigorous and innovative antifraud activities with respect to one class of providers should be encouraged to develop and implement such programs with respect to other classes of providers.

The amendment authorizing increased Federal matching payments would apply with respect to calendar quarters beginning after September 30, 1977. The amendment authorizing demonstration projects would be effective on enactment.

Report on Home Health and Other In-Home Services (Section 18)

The committee's bill would require the Secretary of Health, Education, and Welfare to report to Congress on home health and other in-home services authorized under titles XVIII, XIX, and XX of the Social Security Act.

The committee is concerned that, with respect to home health and in-home services authorized to be provided under medicare, medicaid, and title XX social service programs, more effective methods need to be developed to assure the quality of services provided and efficiency in administration of the programs, and more effective efforts to curb fraud and abuse. While it is understood that there are, by necessity, differences among these programs in entitlement to the services and the types of services covered, it is the feeling of the committee that any efforts to develop methods of quality assurance and administrative efficiency should, where possible and practical, provide for coordination between the programs, particularly with respect to requirements for providers of services and reimbursement methods.

The Secretary is, therefore, directed to submit within 1 year a report to the appropriate committees in Congress analyzing all aspects of the delivery of home health and in-home services authorized under these titles. Further, since the intent of this legislation is to facilitate establishment of a set of specific, enforceable standards in the programs to assure high quality home health services and the protection of the health and safety of recipients of such services, the Secretary is required to report on regulatory changes needed and to recommend appropriate statutory changes with respect to quality assurance and administrative efficiency.

The committee has not addressed the question of inclusion of proprietary home health agencies beyond the provisions of current law. However, the committee would note that the standards for quality review to be developed should be suitable for application to all home health providers, regardless of sponsorship.

The Secretary of Health, Education, and Welfare has been designated to conduct this study in view of the extensive information

gathered by the Department during recent regional hearings on home health care and the subsequent activity of the Department in analyzing this information. The Secretary is to include in this report an analysis of the impact of his recommendations on the demand for and cost of services authorized under the programs and the method of financing any recommended increase in the provision of such services.

The amendment made by this section would require the submission of the report within 1 year of enactment.

Uniform Reporting Systems for Health Services Facilities and Organizations (Section 19)

The bill would require the Secretary to establish for each of the different types of health services facilities and organizations a uniform system for the reporting of such items as cost of operation, volume of services, rates, capital assets and bill data. This reporting system would be mandated for use by medicare and medicaid providers and such use would be phased in by type of provider.

A persistent problem under the medicare and medicaid programs as currently structured is the presence of variations in the information contained in medicare and medicaid cost reports. Since it is generally agreed that the existence of comparable cost and related data is essential for effective cost and policy analysis, the assessment of alternative reimbursement mechanisms and, in certain situations, the identification and control of fraud and abuse, the committee believes it is necessary to correct the deficiencies in the present reporting system under these programs.

Accordingly, the bill requires the Secretary to establish for each type of health service facility or organization a uniform system for the reporting of the following types of information:

- (1) The aggregate cost of operation and the aggregate volume of services;
- (2) The costs and volume of services for various functional accounts and subaccounts;
- (3) Rates, by category of patient and class of purchaser;
- (4) Capital assets, as defined by the Secretary, including (as appropriate) capital funds, debt service, lease agreements used in lieu of capital funds, and the value of land, facilities, and equipment; and
- (5) Discharge and bill data.

It is the committee's intent that the uniform reporting system for each type of health service facility or organization provide for appropriate variation in the application of the system to different classes of facilities or organizations within that type. The Secretary would be required to develop and establish uniform reporting systems, after consultation with interested parties, for hospitals, skilled nursing facilities and intermediate care facilities within a year following enactment of this legislation, and for other types of health service facilities and organizations (such as home health agencies) within 2 years of enactment.

The committee intends that in the development and implementation of uniform reporting requirements the Secretary shall take into ac-

count the administrative costs both for the institutions and the Department as well as the relationship of those costs to enhanced program administration.

Within each class of facility, cost allocation formats and definitions should be uniform. Each institution of a particular type performing a function to which a standard applies should be required to report on such functions in the same way. For example, all hospitals should be required to report X-ray costs on the basis of costs per patient exposure to diagnostic X-ray. Another type of institution, such as a long-term care facility, may be required to employ another method, if one more suited to such type of institution's operations can be formulated. This combination of variation by institutional type and uniformity within each such type of institution provides necessary flexibility while assuring that the information obtained is useful.

It is also the committee's intent that the Secretary should take into account the unique organizational arrangement of health maintenance organizations, and should make those adjustments he finds necessary and appropriate to tailor the uniform reporting system to their particular situation, while maintaining the necessary comparability of data.

Under the bill, the Secretary would require all medicare and medic-aid providers of services to submit reports to the Secretary of the aforementioned cost-related information in accordance with the uniform reporting system. For hospitals, skilled nursing facilities, and intermediate care facilities, these uniform reports would be required beginning with their first fiscal year that begins more than 6 months after the reporting system has been promulgated by the Secretary. For all types of health service facilities or organizations, the reporting requirement will only be implemented at such time (after such systems are promulgated for these institutions) as the Secretary deems to be most productive. After establishing the uniform systems of reporting, the bill requires the Secretary to monitor their operation, assist with support demonstrations and evaluations of the effectiveness and cost of the operation of such systems, encourage State adoption of such systems and periodically revise the systems to improve their effectiveness and diminish their cost.

Under the bill, the Secretary would be required to provide such information obtained through use of the uniform reporting system as may be deemed necessary by him to assist health systems agencies and State health planning and development agencies in carrying out such agencies' functions.

The Secretary would prescribe a chart of accounts to be used by hospitals to help to achieve the needed uniformity of reporting. The chart of accounts would be designed for this limited purpose so that its application should not prove unduly onerous.

Modification of Requirements for State Medicaid Utilization Control Programs (Section 20)

The committee bill modifies the requirements of current Medicaid law concerning review of care delivered in institutional facilities. The section waives application of the penalties for noncompliance for calendar quarters ending prior to January 1, 1978. For subsequent

calendar quarters, the required reductions in Federal matching would be imposed only in proportion to the number of patients whose care was not reviewed compared to the total patient population subject to review.

The section further specifies procedural requirements for the Secretary to carry out the validation requirements under Section 1903(g) (2) in more timely fashion.

The bill also modifies the requirements pertaining to the composition of medical review teams in skilled nursing facilities so as to conform them with those requirements applicable to intermediate care facility review.

The "Social Security Amendments of 1972" (Public Law 92-603) added section 1903(g) to the Social Security Act. This section requires a one-third reduction in Federal matching payments under medicaid for long-term stays in institutional settings, unless a State demonstrates that it has an adequate program of control over the utilization of institutional services. The program must include a showing that:

(1) The physician certifies at the time of admission and recertifies every 60 days that the patient requires inpatient institutional services.

(2) The services are furnished under a plan established and periodically reviewed by a physician.

(3) The State has a continuous program of utilization review whereby the necessity for admission and continued stay of patients is reviewed by personnel not directly responsible for care of the patient, not financially interested in a similar institution, or, except in the case of a hospital, employed in the institution.

(4) The State has a program of independent medical review for SNF's, ICF's, and mental hospitals whereby the professional management of each case is subject to independent annual review. The section further requires the Secretary to conduct sample onsite surveys of institutions as part of his validation procedures.

The committee notes that this section was to go into effect on July 1, 1973, as an incentive payment for States showing a satisfactory program of utilization control. States which did not make the requisite showings were automatically to be subject to the reduced Federal matching rate. Despite the clear intent of the law and extensive evidence developed by the Congress and the Comptroller General of the United States, that a large number of States failed to meet the requirements, HEW indicated that it was reluctant to impose the reductions. The first reduction actually to be imposed under this authority was announced to take effect July 1977. During the intervening 4-year period the committee has on a number of occasions indicated its concern that HEW had failed to fulfill its responsibilities.

On June 8, 1977, HEW announced that it would reduce July 1977 medicaid payments to 20 States by a total of \$142 million (actual application of these announced reductions was delayed by Public Law 95-59 until October 1977). These reductions were to take effect because the States failed, during the first quarter of 1977, to conduct annual medical reviews of patients in long-term care facilities. The Department further announced that it had under review the potential disallowance of \$378 million of fiscal year 1975 funds for failure to have

adequate utilization controls in place, based upon validation requirements. The committee is encouraged that the Department has begun to aggressively implement the congressional mandate. However, in view of past inaction on the part of HEW, it feels that the sudden reduction in Federal funds for past years activities could have a severe and unanticipated impact on affected State medicaid programs. Further, Congress intended this program to be an incentives program to be validated on a current basis by HEW. This section is intended to bring this validation process into timely synchronization with State showings.

The committee bill waives application of reductions in matching for noncompliance for calendar quarters ending prior to January 1, 1978. For subsequent calendar quarters, the required reductions in Federal matching would be imposed only in proportion to the number of patients whose care was not reviewed compared to the total patient population subject to review. This provision is included because, among other reasons, HEW had in June 1977 announced penalties on States which failed to review only two or three homes out of hundreds of homes subject to review within the annual time limit.

The committee believes that imposition of the full reduction in such cases would be unduly severe. The bill therefore modifies the existing language to assure that the reduction will be assessed in proportion to the population whose care was not subject to the required review.

The committee bill also authorizes the Secretary to waive a reduction otherwise required by law to be imposed if the State's noncompliance is technical or due to circumstances beyond its control. The committee intends, however, that this waiver authority is to be invoked only when reasonably appropriate and not as a generalized routine exception. Circumstances considered outside of a State's control are those which could not reasonably be anticipated and provided for in advance. Technical noncompliance for example, would include instances where a State had reviewed patients in most facilities on time with the remaining facilities also reviewed but not until several weeks after the deadline for completion of all reviews by a State.

The committee bill provides that a State should provide its required showing of compliance with review requirements with respect to a calendar quarter to HEW within 30 days of the end of the quarter, so that HEW can make the appropriate determinations and give States sufficient notice of any action (although HEW can extend the period if the Secretary finds good cause for doing so). The committee intends that the required showing will demonstrate good faith efforts on the part of a State to conduct on-site reviews of those patients subject to review in hospitals, skilled nursing facilities, and intermediate care facilities. The bill also modifies the requirements for the composition of medical review teams in skilled nursing facilities to permit them to be headed by either a physician or registered nurse.

While existing law requires the Secretary to undertake onsite validation surveys in timely fashion, HEW has not done so in the past. When they have performed validations, the validations have lagged months and even years behind the year in question. The committee believes HEW has an obligation to the States, to the Congress, and to institutional care recipients to undertake validations in a timely

fashion, and to impose any reductions resulting from them at that point. States should not be subjected to the uncertainty of a possible reduction years later. Accordingly, the bill requires that the Secretary must complete his validations and give notice of his determinations within 9 months of the end of the period in question if he is imposing reductions on the States as a result.

The section also requires the Secretary to submit to the Congress within 60 days of the close of each calendar quarter a report on: (1) his determination as to whether showings made by States are satisfactory; (2) his review of the validity of previously submitted showings; and (3) any reductions made for the quarter.

The amendment would be effective with respect to calendar quarters beginning on and after October 1, 1977.

Protection of Patient Funds (Section 21)

The committee bill requires that as a condition for participation in the medicaid and medicare programs, a skilled nursing or intermediate care facility must establish and maintain a system to assure the proper accounting of personal patient funds.

Nursing home patients normally turn their personal funds over to the facility to hold and manage until they need them for their personal use. The General Accounting Office, the Senate Committee on Aging, and State investigators have found that misuse of these personal funds exists in some nursing homes. The types of abuse cited include: Charging patients' personal funds for items which should have been provided as part of routine medical care, improper maintenance of records of receipts and disbursements of patients' funds, use of funds to meet operating costs, commingling of patients' funds with operating funds, use of patients' funds as collateral for a loan for operating expenses, and retaining for the home interest earned on patients' funds.

The bill would therefore require that, as a condition for participation in the medicare and medicaid programs, a skilled nursing or intermediate care facility must establish and maintain a system to assure the proper accounting of personal patient funds. Such system must provide for separate and discrete accounting for each patient with a complete accounting of income and expenditures so as to preclude the intermingling of other funds with patient funds. The Secretary would be required to issue regulations within 90 days of enactment defining what types of items are to be paid from patients' personal funds.

The amendment would be effective on the first day of the first calendar quarter which begins more than 6 months after the date of enactment.

Provision for Flexible Grace Period (Section 22)

The committee bill modifies present law provisions pertaining to payment for institutional services after a PSRO has determined that such services are no longer required.

Under present law hospital and skilled nursing facility patients who are determined to need no further care in the institution are allowed an additional 3 days of benefits to give them time to arrange for their postdischarge care. It has come to the committee's attention

that the mandated 3-day grace period has sometimes undermined the effectiveness of the PSRO review effort by unnecessarily delaying discharges. Therefore, the committee's bill would reduce the 3-day period to 1-day where a PSRO is undertaking the review, and permit the PSRO to authorize up to 2 additional days on a case-by-case exception basis where the facts in the case indicate that the additional time is needed to arrange for the necessary postdischarge care.

The amendment would be effective upon enactment.

Prosecution of Civil Fraud by Inspector General (Section 23)

The committee bill authorizes prosecution of civil fraud cases under the Social Security Act health care programs by the Inspector General of HEW where U.S. attorneys have not initiated proceedings within 6 months of formal referral of a case.

The committee believes that strengthened program penalties provided for under the bill coupled with more intensive anti-fraud efforts by both HEW and the Department of Justice should facilitate timely prosecution of criminal violations. The committee is concerned, however, that similar intensive efforts must be made to prosecute cases of civil fraud. Testimony received by the committee indicates that there is some hesitation in pursuing prosecution of these cases as expeditiously as criminal cases. In 1976, Congress created the Office of the Inspector General in the Department of Health, Education, and Welfare. The Inspector General was required to establish within his office a unit with specific responsibility for antifraud and antiabuse activities relating to health care financing programs. The Inspector General was not, however, empowered to prosecute. The committee bill would authorize the Inspector General to prosecute, under certain circumstances, civil fraud cases relating to health programs authorized under the Social Security Act in order to facilitate the timely disposition of these cases. Specifically, the Inspector General would be permitted to prosecute such cases if the Justice Department has not initiated formal legal action within 6 months of a formal referral to it by HEW of an alleged fraud case.

This authority to prosecute is residual. It is intended, primarily, to deal with those situations where appropriate fraud prosecutions are not undertaken because of workload considerations or lack of expertise.

The amendment would be effective upon enactment.

Utilization Review Demonstration Projects (Section 24)

The bill authorizes the establishment of demonstration projects in States which currently have a medicaid hospital onsite evaluation system for the purpose of evaluating the effectiveness of PSRO reviews compared to alternative State review methods.

During consideration of the bill, questions were raised concerning the comparative impact of PSRO review versus that of existing State onsite hospital review systems. Accordingly, the committee bill authorizes the Secretary to provide for the establishment of demonstration projects in States which had operating onsite State evaluation systems in place on August 5, 1977, and which make application to the Secretary prior to May 1, 1978. The purpose of the projects will be to evaluate the effectiveness, both in terms of the quality and appropriate-

ness of medical care as well as the impact on State budgets, of PSRO hospital review compared to alternative State hospital review systems. Demonstration projects shall be conducted in PSRO areas which are representative of a State's medicaid population and comprise a significant proportion of medicaid patient days. Services provided to medicare patients in project areas will be subject to PSRO review.

The committee bill requires the Secretary to select an independent organization to establish the study design of the demonstration project as well as to monitor, evaluate, and report on the study's findings. The study design shall provide that each hospital in a project area shall be designated as subject to either PSRO review or alternative State review. To the extent feasible, the selection of facilities shall insure a comparability of institutions and patients in each category. Approximately half of the medicaid patient load in each demonstration area (but in different hospitals) shall be subject to PSRO review while half shall be subject to the alternative State review system. The independent organization is required to maintain an ongoing monitoring role and to evaluate the effectiveness of each review system. Criteria used for evaluation shall include but not be limited to quality, appropriateness and availability of patient care, as well as changes in total patient days, numbers and types of services provided, and operating costs. The study design shall further insure that any changes in the number of providers, availability of beds, or other factors that could affect the statistical validity of the project shall be taken into account.

The committee bill provides that an approved demonstration project shall ordinarily run for 2 years following acceptance of the study design by the Secretary. The committee expects that any demonstration projects conducted under this authority shall run concurrently. The bill requires the Secretary to submit to the Senate Committee on Finance and the House Committees on Ways and Means and Interstate and Foreign Commerce an interim report at the end of the first full year of operation. The Secretary is required to submit a final report to these committees within 3 months of the completion of the demonstration projects. The reports shall contain the findings of the independent organization selected to monitor the project together with the Secretary's comments and recommendations. The committee bill provides that review costs in demonstration areas shall be funded as provided for under current law. Approved PSRO review costs will be fully federally funded while review costs of State review programs will be matched at the rate applicable for administrative costs under State medicaid programs. Both State review and PSRO decisions shall be considered conclusive for purposes of payment for the group of hospitals they are responsible for reviewing as part of the demonstration project. The Secretary may, however, suspend for good cause either the State's or PSRO's conclusive determination authority. The committee bill further requires that PSRO areas in a State participating in a demonstration project but which themselves are not part of the project shall proceed to implement PSRO review requirements in a timely fashion. The committee expects that in such areas, good-faith efforts will be made to encourage the development and operation of PSRO review systems.

Payment for Certain Hospital Services Provided in Veterans' Administration Hospitals (Section 25)

The bill would authorize, under certain circumstances, reimbursement to a Veterans' Administration hospital for care provided to a nonveteran medicare beneficiary.

Under current law, medicare payments cannot be made to a Federal provider of services. The committee has learned of a limited number of cases where care was provided in a VA hospital on the assumption that the medicare beneficiary was also an eligible veteran. However, such individual was subsequently determined not to be entitled to care in the VA hospital and was forced to assume the costs of the care provided.

The committee bill amends current law to permit reimbursement to a Veterans' Administration hospital for care provided to a medicare beneficiary under certain limited circumstances. Specifically, the individual must not have been entitled to have services furnished free of charge by a VA hospital but upon admission there must have been the reasonable belief on the part of the admitting authorities that he was entitled to have such services furnished to him. Further both the admitting authorities and the individual must have acted in good faith. The VA hospital must have discontinued furnishing such services on the day the authorities first become aware that the individual was not entitled to have services furnished free of charge, or, if later, on the first day it was medically feasible to discharge him or transfer him to a hospital participating under medicare.

The bill provides that payment for hospital services furnished to a nonveteran medicare beneficiary shall be equal to the charge imposed by the VA for such services or, if less, the reasonable cost of such services. Payment shall be made to the entity to which the payment would have been payable if the payment had been made by the individual receiving the services or by another acting on his behalf.

The amendment made by this section would be applicable in the case of inpatient hospital services furnished on and after July 1, 1974.

Hospital Insurance for Individuals, Age 60 Through 64, Who Are Entitled to Benefits Under Section 202 or Who are Spouses of Individuals Entitled to Health Insurance (Section 26)

The bill would permit certain persons aged 60-64 to buy into medicare at a premium rate equal to the cost of their protection.

The committee is concerned that many social security and railroad retirement cash beneficiaries aged 60-64 and spouses aged 60-64 of medicare beneficiaries find it difficult to obtain adequate private health insurance at a rate which they can afford. Frequently these older persons—retired workers, wives, husbands, widows, widowers, mothers, parents, brothers and sisters, for example—have been dependent for health insurance protection on their own group coverage or that of a related worker who is now retired or deceased. It is a difficult task for such older persons to secure comparable protection at affordable cost when they are not connected with the labor force.

The bill therefore includes a provision which would make medicare protection (both part A and part B) available on an optional basis at

cost to spouses aged 60-64 of medicare beneficiaries; others aged 60-64 who are entitled to retirement, wife's, husband's, widow's, widower's, mother's, or parent's, under social security and the railroad retirement programs; and disability beneficiaries aged 60-64 not otherwise eligible for medicare because they have not been entitled to cash disability benefits for 24 months, the availability of medicare protection would be limited to persons aged 60-64 because the committee believes that people under age 60 who are not disabled generally have relatively little difficulty in obtaining private health insurance.

Persons who elect to avail themselves of medicare protection under this provision would pay the full cost of such protection. Enrollees would pay a monthly part A premium based upon the estimated cost of hospital insurance protection for persons eligible to enroll plus amounts sufficient to cover administrative expenses and underwriting losses or gains, if any; such premium would be equal to the premium charged to others eligible to enroll under part A until July 1, 1979, and would be adjusted for each 12-month period thereafter to reflect both the experience of the group and any changes in costs.

The monthly premium for persons in the group who enroll for part B would be three times the premium paid by an individual who has attained age 65 until July 1979 and would be adjusted for each 12-month period thereafter to reflect the estimated cost of supplementary medical insurance protection for persons eligible to enroll under the provisions plus amounts sufficient to cover administrative expenses and underwriting losses or gains, if any. Aliens who have been in the United States less than 5 years and persons who have been convicted of certain subversive crimes would be excluded from participation under this provision, just as they are excluded from enrolling for supplementary medical insurance.

The bill would require, as the law now requires for making medicare protection available to uninsured persons aged 65 and over, that in order for persons to be eligible to enroll for hospital insurance they must be enrolled for supplementary medical insurance. If a person terminates his supplementary medical insurance, his hospital insurance coverage under this provision would be automatically terminated effective the same date as his supplementary medical insurance termination. The committee believes that such a restriction is necessary to reduce the possibility of excessive utilization of the more expensive hospital insurance coverage as might occur if an individual were enrolled for hospital insurance (covering primarily institutional care) but not for supplementary medical insurance (covering primarily outpatient care).

Coverage would be initially available as of April 1, 1978, to enrolled eligible persons.

Treatment of Professional Standards Review Organizations for Purposes of Internal Revenue Code (Section 27)

The committee bill amends the Internal Revenue Code to specifically include PSRO's as organizations eligible for section 501(c)(3) tax status.

Current law does not specify the tax status for PSRO's. Since the inception of the program, PSRO's have been engaged in a discussion with the Internal Revenue Service concerning whether they should be placed in a 501(c)(3) or a 501(c)(6) status. Both designations

apply to tax-exempt nonprofit organizations. The 501(c)(3) status is conferred on organizations engaged in a totally public purpose, such as a charitable, educational, religious, scientific or literary endeavor. The 501(c)(6) status is assigned to a corporation whose primary purpose is to promote the common business/professional interests of its members. For practical purposes only 501(c)(3) organizations are permitted to receive grants from private foundations. Individuals making donations to these organizations may also be entitled to a tax deduction. Further, a 501(c)(3) designation may also confer additional local benefits such as lower rents or lower local taxes.

In a recent IRS ruling, several Virginia PSRO's were informed that they were to remain designated as 501(c)(6) corporations. The IRS took the position that one substantial purpose of a PSRO is to serve the common business interest of members of the medical profession. Such an entity could not, therefore, be considered as organized and operated exclusively for charitable purposes as required for section 501(c)(3) designation. A final IRS ruling on the issue reaffirmed the earlier refusal to grant PSRO's this 501(c)(3) status. Further, it stated that PSRO's promote the common business interests of the medical profession because they minimize public criticism by assuring that physicians and other health care practitioners do not improperly utilize health resources and facilities.

The committee shares the concern of PSRO's over the language of the IRS ruling. It notes that PSRO's were mandated by the Social Security Amendments of 1972 to serve a public purpose. Those activities which have been construed as promoting physician self-interest are, in fact, carried out to comply with legislative and contractual obligations. The committee believes that the language of the IRS ruling could impede the development of good relationships between the review groups and the medical community and erode current physician support.

The committee bill therefore amends the Internal Revenue Code to specifically include PSRO's as eligible for section 501(c)(3) tax status under the Code.

The amendment would be effective with respect to taxable years beginning on or after January 1, 1977.

III. COSTS OF CARRYING OUT THE BILL

In compliance with section 252(a) of the Legislative Reorganization Act of 1970, as amended, the following statement is made relative to the costs to be incurred in carrying out this bill.

Properly carried out, effective efforts to detect and punish fraud and abuse should result in significant moderation in Medicare and Medicaid program expenditures. This would result from deterrence of fraudulent or abusive activities as well as denial of payment or recoveries of payments inappropriately made.

For obvious reasons, it is difficult to supply specific or even approximate dollar amounts of savings. It is certainly fair to say, again assuming reasonable implementation, that cost-savings would far outweigh any administrative expenses involved. Other nonfraud and abuse provisions are negligible in terms of added program costs and, in addition, are generally offset by cost savings provisions such as improved payment procedures for durable medical equipment.

In compliance with section 403 of the Congressional Budget Act of 1974, the Director of the Congressional Budget Office has submitted the following statement to the committee:

CONGRESSIONAL BUDGET OFFICE,
U.S. CONGRESS,
Washington, D.C., September 26, 1977.

HON. RUSSELL LONG,
Chairman, Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: Pursuant to section 403 of the Congressional Budget Act of 1974, the Congressional Budget Office has reviewed S. 143 (as reported by the Senate Committee on Finance), the Medicare-Medicaid Anti-Fraud and Abuse Amendments, with regard to its potential cost impact.

The provisions in S. 143 are intended to clarify and extend current statute in order to facilitate both State and Federal efforts to monitor and control possible fraud and abuse in the Medicare and Medicaid programs. This is accomplished in the bill through the expansion both of legislative powers and sanctions and of the collection and coordination of relevant information, as well as through the provision of increased funding to the states to support such activities. Last, as a means of further reducing costs, the bill permits the Secretary of HEW to require that necessary durable medical equipment be purchased rather than rented under Medicare if it is determined that purchase would be a less costly alternative.

Thus, many of the provisions in this bill include possible added costs or savings (or both) to the programs. Some sections, for example, although requiring additional expenditures, are intended to actually reduce costs, thus representing no net outlay effect. However, limitations of available and relevant data, uncertainties of the actual extent and effectiveness of the future implementation of the provisions, and the unknown magnitude of the fraud and abuse presently extant in the programs make it impracticable for CBO to project the actual cost impact of this measure at this time.

Our review of the bill and the limited information available leads us to conclude that costs and savings would essentially offset each other during the first couple of years of implementation with some savings accrued subsequently. This assessment is based upon the fact that the early years would involve both the necessary startup costs and the time to bring the various activities up to a level where their full cost savings impact would be seen.

If we can be of further assistance to you in this matter, please feel free to contact me.

Sincerely,

ALICE M. RIVLIN, *Director.*

IV. REGULATORY IMPACT OF THE BILL

In compliance with paragraph 5 of rule XXIX of the Standing Rules of the Senate, the following is a statement of the regulatory impact of the bill.

The primary thrust of the bill is to strengthen the capability of the Government to detect, prosecute and punish fraudulent activities under the Medicare and Medicaid programs.

The bill focuses on six major areas: Increased disclosure of information, strengthened penalty sanctions, improvements in the professional standards review program, administrative reform, and other medicare and medicaid amendments.

While most provisions will require implementing regulations to inform providers, suppliers, fiscal intermediaries and others of actions they will have to take, the most significant impact in terms of new regulatory and reporting requirements relate to those provisions requiring increased disclosure of information.

Expanded disclosure requirements would apply to medicare providers and suppliers, of services, which include hospitals, skilled nursing facilities, home health agencies, independent clinical laboratories, renal disease facilities, health maintenance organizations meeting the requirements for participation in titles XVIII or XIX, and all entities (other than individual practitioners or groups of practitioners) that claim reimbursement for services provided under medicaid, the maternal and child health program, and in the case of health-related entities, the social services program under title XX. In addition, the bill would require medicare intermediaries and carriers and medicaid fiscal agents to disclose specified ownership information as a condition of contract or agreement approval or renewal under titles XVIII and XIX.

V. VOTE OF COMMITTEE IN REPORTING THE BILL

In compliance with section 133 of the Legislative Reorganization Act, as amended, the following statement is made relative to the vote of the Committee on reporting the bill. This bill was ordered favorably reported by the Committee by a voice vote and without objection.

VI. CHANGES IN EXISTING LAW

In compliance with subsection (4) of the XXIX of the Standing Rules of the Senate, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT, AS AMENDED

* * * * *

TITLE XI—GENERAL PROVISIONS AND PROFESSIONAL STANDARDS REVIEW

* * * * *

PART A—GENERAL PROVISIONS

DEFINITIONS

SEC. 1101. (a) When used in this Act—

(1) The term "State", except where otherwise provided, includes the District of Columbia and the Commonwealth of Puerto Rico, and when used in titles IV, V, VII, XI, and XIX includes the Virgin Islands and Guam. Such term when used in title V *and in part B of this title* also includes American Samoa and the Trust Territory of the

Pacific Islands. Such term when used in titles III, IX, and XII also includes the Virgin Islands. In the case of Puerto Rico, the Virgin Islands, and Guam, titles I, X, and XIV, and title XVI, (as in effect without regard to the amendment made by section 301 of the Social Security Amendments of 1972) shall continue to apply, and the term "States" when used in such titles (but not in title XVI as in effect pursuant to such amendment after December 31, 1973) includes Puerto Rico, the Virgin Islands, and Guam.

* * * * *

(9) The term "shared health facility" means any arrangement whereby—

(A) two or more health care practitioners practice their professions at a common physical location;

(B) such practitioners share (i) common waiting areas, examining rooms, treatment rooms, or other space, (ii) the services of supporting staff, or (iii) equipment;

(C) such practitioners have a person (who may himself be a practitioner)—

(i) who is in charge of, controls, manages, or supervises substantial aspects of the arrangement or operation for the delivery of health or medical services at such common physical location, other than the direct furnishing of professional health care services by the practitioners to their patients; or

(ii) who makes available to such practitioners the services of supporting staff who are not employees of such practitioners; and

who is compensated in whole or in part, for the use of such common physical location or support services pertaining thereto, on a basis related to amounts charged or collected for the services rendered or ordered at such location or on any basis clearly unrelated to the value of the services provided by the person; and

(D) at least one of such practitioners received payments on a fee-for-service basis under titles V, XVIII, and XIX in an amount exceeding \$5,000 for any one month during the preceding 12 months, or in an aggregate amount exceeding \$40,000 during the preceding 12 months;

except that such term does not include a provider of services (as defined in section 1861(u) of this Act), a health maintenance organization (as defined in section 1301 of the Public Health Services Act), a hospital cooperative shared services organization meeting the requirements of section 501(e) of the Internal Revenue Code of 1954, or any public entity.

* * * * *

UNIFORM REPORTING SYSTEMS FOR HEALTH SERVICES FACILITIES
AND ORGANIZATIONS

Sec. 1121. (a) For the purposes of reporting the cost of services provided by, of planning, and of measuring and comparing the efficiency of and effective use of services in, hospitals, skilled nursing facilities, intermediate care facilities, home health agencies, health

maintenance organizations, and other types of health services facilities and organizations to which payment may be made under this Act, the Secretary shall establish by regulation, for each such type of health services facility or organization, a uniform system for the reporting by a facility or organization of that type of the following information:

- (1) *The aggregate cost of operation and the aggregate volume of services.*
- (2) *The costs and volume of services for various functional accounts and subaccounts.*
- (3) *Rates, by category of patient and class of purchaser.*
- (4) *Capital assets, as defined by the Secretary, including (as appropriate) capital funds, debt service, lease agreements used in lieu of capital funds, and the value of land, facilities, and equipment.*
- (5) *Discharge and bill data.*

The uniform reporting system for a type of health services facility or organization shall provide for appropriate variation in the application of the system to different classes of facilities or organizations within that type and shall be established, to the extent practicable, consistent with the cooperative system for producing comparable and uniform health information and statistics described in section 306(e)(1) of the Public Health Service Act. However, hospitals shall employ the chart of accounts, definitions, principles, and statistics, prescribed by the Secretary, in order to reach a uniform reconciliation of financial and statistical data for specified uniform reports to be provided to the Secretary.

(b) The Secretary shall—

- (1) *monitor the operation of the systems established under subsection (a);*
- (2) *assist with and support demonstration and evaluations of the effectiveness and cost of the operation of such systems and encourage State adoption of such systems; and*
- (3) *periodically revise such systems to improve their effectiveness and diminish their cost.*

(c) The Secretary shall provide information obtained through use of the uniform reporting system described in subsection (a) in a useful manner and format to appropriate agencies and organizations, including health systems agencies (designated under section 1515 of the Public Health Service Act) and State health planning and development agencies (designated under section 1521 of such Act), as may be necessary to carry out such agencies' and organizations' functions.

DISCLOSURE OF OWNERSHIP AND RELATED INFORMATION

SEC. 1124. (a) (1) The Secretary shall by regulation or by contract provision provide that each disclosing entity (as defined in paragraph (2)) shall—

- (A) *as a condition of the disclosing entity's participation in, or certification or recertification under, any of the programs established by titles V, XVIII, XIX, and XX, or*
- (B) *as a condition for the approval or renewal of a contract or agreement between the disclosing entity and the Secretary or*

the appropriate State agency under any of the programs established under titles V, XVIII, XIX, and XX,

supply the Secretary or the appropriate State agency with full and complete information as to the identity of each person with an ownership or control interest (as defined in paragraph (3)) in the entity.

(2) As used in this section, the term "disclosing entity" means an entity which is—

(A) a provider of services (as defined in section 1861(u), other than a fund), an independent clinical laboratory, or a renal disease facility;

(B) an entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, items or services with respect to which payment may be claimed by the entity under any plan or program established pursuant to title V or under a State plan approved under title XIX;

(C) a carrier or other agency or organization that is acting as a fiscal intermediary or agent with respect to one or more providers of services (for purposes of part A or part B of title XVIII, or both, or for purposes of a State plan approved under title XIX) pursuant to (i) an agreement under section 1816, (ii) a contract under section 1842, or (iii) an agreement with a single State agency administering or supervising the administration of a State plan approved under title XIX;

(D) a health maintenance organization as defined in section 1301 of the Public Health Service Act; or

(E) an entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health related services with respect to which payment may be claimed by the entity under a State plan or program approved under title XX.

(3) As used in this section, the term "person with an ownership or control interest" means, with respect to an entity, a person who—

(A) (i) has directly or indirectly (as determined by the Secretary in regulations) as ownership interest of 5 per centum or more in the entity; or

(ii) is the owner (in whole or in part) of an interest of 5 per centum or more in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the property or assets thereof; or

(B) is an officer or director of the entity, if the entity is organized as a corporation; or

(C) is a partner in the entity, if the entity is organized as a partnership.

(b) To the extent determined to be feasible under regulations of the Secretary, a disclosing entity shall also include in the information supplied under subsection (a) (1), with respect to each person with an ownership or control interest in the entity, the name of any other disclosing entity with respect to which the person is a person with an ownership or control interest.

(c) A provider disclosing entity shall also include in the information supplied under subsection (a) (1) full and complete information as to the identity of each person with an ownership or control interest in

any subcontractor (as defined by the Secretary in regulations) in which the provider directly or indirectly has a 5 per centum or more ownership interest.

ISSUANCE OF SUBPENAS BY COMPTROLLER GENERAL

SEC. 1125. (a) For the purpose of any audit, investigation, examination, analysis, review, evaluation, or other function authorized by law with respect to any program authorized under this Act, the Comptroller General of the United States shall have power to sign and issue subpoenas to any person requiring the production of any pertinent books, records, documents, or other information. Subpoenas so issued by the Comptroller General shall be served by anyone authorized by him (1) by delivering a copy thereof to the person named therein, or (2) by registered mail or by certified mail addressed to such person at his last dwelling place or principal place of business. A verified return by the person so serving the subpoena setting forth the manner of service, or, in the case of service by registered mail or by certified mail, the return post office receipt therefor signed by the person so served, shall be proof of service.

(b) In case of contumacy by, or refusal to obey a subpoena issued pursuant to subsection (a) of this section and duly served upon, any person, any district court of the United States for the judicial district in which such person charged with contumacy or refusal to obey is found or resides or transacts business, upon application by the Comptroller General, shall have jurisdiction to issue an order requiring such person to produce the books, records, documents, or other information sought by the subpoena; and any failure to obey such order of the court may be punished by the court as a contempt thereof. In proceedings brought under this subsection, the Comptroller General shall be represented by attorneys employed in the General Accounting Office or by counsel whom he may employ without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and the provisions of chapter 51 and subchapters III and VI of chapter 53 of such title relating to classification and General Schedule pay rates.

DISCLOSURE BY INSTITUTIONS, ORGANIZATIONS, AND AGENCIES OF OWNERS AND CERTAIN OTHER INDIVIDUALS WHO HAVE BEEN CONVICTED OF CERTAIN OFFENSES

SEC. 1126. (a) As a condition of participation in or certification or recertification under the programs established by titles XVIII, XIX, and XX, any hospital, nursing facility, or other institution, organization, or agency shall be required to disclose to the Secretary or to the appropriate State agency the name of any person who—

(1) has a direct or indirect ownership or control interest of 5 percent or more in such institution, organization, or agency or is an officer, director, agent, or managing employee (as defined in subsection (b)) of such institution, organization, or agency, and

(2) has been convicted (on or after the date of the enactment of this section, or within such period prior to that date as the Secretary shall specify in regulations) of a criminal offense related to the involvement of such person in any of such programs.

The Secretary or the appropriate State agency shall promptly notify the Inspector General in the Department of Health, Education, and Welfare of the receipt from any institution, organization, or agency of any application or request for such participation, certification, or recertification which discloses the name of any such person, and shall notify the Inspector General of the action taken with respect to such application or request.

(b) For the purposes of this section, the term "managing employee" means, with respect to an institution, organization, or agency, an individual, including a general manager, business manager, administrator, and director, who exercises operational or managerial control over the institution, organization, or agency, or who directly or indirectly conducts the day-to-day operations of the institution, organization, or agency.

PART B—PROFESSIONAL STANDARDS REVIEW

* * * * *

DESIGNATION OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

SEC. 1152. (a) * * *

(b) For purposes of subsection (a), the term "qualified organization" means—

(1) when used in connection with any area—

(A) an organization (i) which is a nonprofit professional association (or a component organization thereof), (ii) which is composed of licensed doctors of medicine or osteopathy engaged in the practice of medicine or surgery in such area, (iii) the membership of which includes a substantial proportion of all such physicians in such area, (iv) which is organized in a manner which makes available professional competence to review health care services of the types and kinds with respect to which Professional Standards Review Organizations have review responsibilities under this part, (v) the membership of which is voluntary and open to all doctors of medicine or osteopathy licensed to engage in the practice of medicine or surgery in such area without requirement of membership in or payment of dues to any organized medical society or association, and (vi) which does not restrict the eligibility of any member for service as an officer of the Professional Standards Review Organization or eligibility for and assignment to duties of such Professional Standards Review Organization, or, subject to subsection (c) [(i)](1),

* * * * *

(2) an organization which the Secretary, on the basis of his examination and evaluation of a formal plan *which shall be developed and submitted [to him]* by the association, agency, or organization *in accordance with subsection (h)* (as well as on the basis of other relevant data and information), finds to be willing to perform and capable of performing, in an effective, timely, and objective manner and at reasonable cost, the duties, functions, and activities of a Professional Standards Review Organization required by or pursuant to this part.

* * * * *

[(e) In order to avoid duplication of functions and unnecessary review and control activities, the Secretary is authorized to waive any or all of the review, certification, or similar activities otherwise required under or pursuant to any provision of this Act (other than this part) where he finds, on the basis of substantial evidence of the effective performance of review and control activities by Professional Standards Review Organizations, that the review, certification, and similar activities otherwise so required are not needed for the provision of adequate review and control.]

(e) *Where the Secretary finds a Professional Standards Review Organization (whether designated on a conditional basis or otherwise) to be competent to perform review responsibilities, the review, certification, and similar activities otherwise required pursuant to provisions of this Act (other than this part) shall not be applicable with respect to those providers, suppliers, and practitioners being reviewed by such Professional Standards Review Organization, except to the extent specified by the Secretary. Nothing in the preceding sentence shall be construed as rendering inapplicable any provision of this Act wherein requirements with respect to conditions for eligibility to or payment of benefits (as distinct from reviews and certifications made with respect to determinations of the kind made pursuant to paragraphs (1) and (2) of section 1155(a)) must be satisfied.*

* * * * *

(h)(1) *During the development and preparation by an organization of its formal plan under subsection (b)(2) or of any modification of such plan to include review of services in skilled nursing facilities (as defined in section 1861(j)) or intermediate care facilities (as defined in section 1905(c)) or review of ambulatory care services, the organization shall consult with the single State agency responsible for administering or supervising the administration of the State plan approved under title XIX for the State in which the organization is located.*

(2) *Such plan and any such modification shall be submitted to the Governor of such State, at the time of its submission to the Secretary, for his comments.*

(3) *The Secretary, before making the findings described in subsection (b)(2) or a finding regarding the organization's capability to perform review of such services (as the case may be), shall consider any such comments submitted to him by such Governor before the end of the thirty-day period beginning on the date of submission of the plan or of any such modification (as the case may be).*

(4) *If, after considering such comments, the Secretary intends to make findings which are adverse to such comments, the Secretary shall provide the Governor making such comments with the opportunity to submit additional evidence and comments on such intended findings during a period of not less than thirty days ending before the findings become effective.*

* * * * *

TRIAL PERIOD FOR PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

SEC. 1154. (a) * * *

(b) During any such trial period (which may not exceed [24] 48

months *except as provided in subsection (c)*, the Secretary may require a Professional Standards Review Organization to perform, *in addition to review of health care services provided by or in institutions*, only such of the duties and functions required under this part of Professional Standards Review Organization as he determines such organization to be capable of performing. The number and type of such duties shall, during the trial period, be progressively increased as the organization becomes capable of added responsibility so that, by the end of such period, such organization shall be considered a qualified organization only if the Secretary finds that it is substantially carrying out in a satisfactory manner, the activities and functions required of Professional Standards Review Organizations under this part with respect to the review of health care services provided or ordered by physicians and other practitioners and institutional and other health care facilities, agencies, and organizations. Any of such duties and functions not performed by such organization during such period shall be performed in the manner and to the extent otherwise provided for under law.

(c) If the Secretary finds that an organization designated under subsection (a) has been unable to perform satisfactorily all of the duties and functions required under this part for reasons beyond the organization's control, he may extend such organization's trial period for an additional period not exceeding twenty-four months.

[(c)] *(d) Any agreement under which any organization is conditionally designated as the Professional Standards Review Organization for any area may be terminated by such organization upon 90 days notice to the Secretary or by the Secretary upon 90 days notice to such organization.*

(e) In determining whether an organization designated on a conditional basis as the Professional Standards Review Organization for any area is substantially carrying out its duties in a satisfactory manner and should be considered a qualified organization, the Secretary shall follow the procedures specified in section 1152(h) (concerning the Secretary's consideration of comments of the Governor of the State in which the organization is located).

DUTIES AND FUNCTIONS OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

SEC. 1155. (a) (1) Notwithstanding any other provision of law, but consistent with the provisions of this part, it shall [(subject to the provisions of subsection (g))] be the duty and function of each Professional Standards Review Organization for any area to assume, at the earliest date practicable, responsibility for the review of the professional activities in such area of physicians and other health care practitioners and institutional and noninstitutional providers of health care services (*except as provided in paragraph (7)*) in the provision of health care services and items for which payment may be made (in whole or in part) under this Act for the purpose of determining whether—

- (A) such services and items are or were medically necessary;
- (B) the quality of such services meets professionally recognized standards of health care; and

(C) in case such services and items are proposed to be provided in a hospital or other health care facility on an inpatient basis, such services and items could, consistent with the provision of appropriate medical care, be effectively provided on an outpatient basis or more economically in an inpatient health care facility of a different type.

* * * * *

(5) Physicians assigned responsibility for the review of hospital care may be only those having active hospital staff privileges in at least one of the participating hospitals in the area served by the Professional Standards Review Organization. [and (except as may be otherwise provided under subsection (e) (1) of this section) such physicians ordinarily should not be responsible for, but may participate in the review of care and services provided in any hospital in which such physicians have active staff privileges.]

(6) No physician shall be permitted to review—

(A) health care services provided to a patient if he was directly [or indirectly involved in] *responsible for* providing such services, or

(B) health care services provided in or by an institution, organization, or agency, if he or any member of his family has, directly or indirectly, [any] *a significant* financial interest in such institution, organization, or agency.

For purposes of this paragraph, a physician's family includes only his spouse (other than a spouse who is legally separated from him under a decree of divorce or separate maintenance), children (including legally adopted children), grandchildren, parents, and grandparents.

(7) *A Professional Standards Review Organization located in a State has the function and duty to assume responsibility for the review under paragraph (1) of professional activities in intermediate care facilities (as defined in section 1905(e)) and in public institutions for the mentally retarded (described in section 1905(d)(1)) only if the Secretary finds, on the basis of such documentation as he may require from the State, that the single State agency which administers or supervises the administration of the State plan approved under title XIX for that State is not performing effective review of the quality and necessity of health care services provided in such facilities and institutions, except that the provisions of this paragraph shall not apply with respect to an intermediate care facility which is also a skilled nursing facility (as defined in section 1861(j)).*

* * * * *

(e)(1) Each Professional Standards Review Organization shall utilize the services of, and accept the findings of, the review committees of a hospital (*including any skilled nursing facility, as defined in section 1861(j), or intermediate care facility, as defined in section 1905(e), which is also a part of such hospital*) or other operating health care facility or organization (*other than a skilled nursing facility which is not a part of a hospital*) located in the area served by such organization, but only when and only to the extent and only for such time that such committees in such hospital or other operating health care facility or organization have demonstrated to the sat-

isfaction of such organization their capacity effectively and in timely fashion to review activities in such hospital or other operating health care facility or organization (including the medical necessity of admissions, types and extent of services ordered, and lengths of stay) so as to aid in accomplishing the purposes and responsibilities described in subsection (a) (1), except where the Secretary disapproves, for good cause, such acceptance.

* * * * *

(f) (1) * * *

(2) Any such agreement with an organization under this part shall provide that the Secretary make payments to such organization, in a manner similar to that provided for under section 1816(c), equal to the amount of expenses reasonably and necessarily incurred, as determined by the Secretary, by such organization in carrying out or preparing to carry out the duties and functions required by such agreement.

(3) Any such agreement with an organization under this part may be in the form of a grant or an assistance agreement.

[(g) Notwithstanding any other provision of this part, the responsibility for review of health care services of any Professional Standards Review Organization shall be the review of health care services provided by or in institutions, unless such Organization shall have made a request to the Secretary that it be charged with the duty and function of reviewing other health care services and the Secretary shall have approved such request.]

(g) (1) Where a Professional Standards Review Organization (whether designated on a conditional basis or otherwise) requests review responsibility with respect to services furnished in shared health facilities, the Secretary must give priority to such request, with the highest priority being assigned to requests from organizations located in areas with substantial numbers of shared health facilities.

(2) The Secretary shall require any Professional Standards Review Organization which is capable of exercising review responsibility with respect to ambulatory care services to perform review responsibility with respect to such services on and after a date not later than two years after the date the organization has been designated as a Professional Standards Review Organization (other than under section 1154), but any such designated Professional Standards Review Organization may be approved to perform such review responsibility at any earlier time if such organization applies for, and is found capable of exercising, such responsibility. However, the Secretary may not require such an organization to perform such review responsibility prior to the date the organization is designated as a Professional Standards Review Organization (other than under section 1154).

SUBMISSION OF REPORTS BY PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

SEC. 1157. If, in discharging its duties and functions under this part, any Professional Standards Review Organization determines that any health care practitioner or any hospital, or other health care facility, agency, or organization has violated any of the obligations imposed by

section 1160, such organization shall report the matter to the Statewide Professional Standards Review Council for the State in which such Organization is located together with the recommendations of such Organization as to the action which should be taken with respect to the matter. Any Statewide Professional Standards Review Council receiving any such report and recommendation shall review the same and promptly transmit such report and recommendation to the Secretary together with any additional comments or recommendations thereon as it deems appropriate. [The Secretary may utilize a Professional Standards Review Organization, in lieu of a program review team as specified in sections 1862 and 1866, for purposes of subparagraph (C) of section 1862(d) (1) and subparagraph (F) of section 1866(b) (2).]

REQUIREMENT OF REVIEW APPROVAL AS CONDITION OF PAYMENT OF CLAIMS

Sec. 1158. (a) Except as provided for in section 1159 and subsection (d), no Federal funds appropriated under any title of this Act (other than title V) for the provision of health care services or items shall be used (directly or indirectly) for the payment, under such title or any program established pursuant thereto, of any claim for the provision of such services or items, unless the Secretary, pursuant to regulation determines that the claimant is without fault if—

(1) the provision of such services or items is subject to review under this part by any Professional Standards Review Organization, or other agency; and

(2) such organization or other agency has, in the proper exercise of its duties and functions under or consistent with the purposes of this part, disapproved of the services or items giving rise to such claim, and has notified the practitioner or provider who provided or proposed to provide such services or items and the individual who would receive or was proposed to receive such services or items of its disapproval of the provision of such services or items.

* * * * *

(c) Where a Professional Standards Review Organization (whether designated on a conditional basis or otherwise) has been found competent by the Secretary to assume review responsibility with respect to specific types of health care services or specified providers or practitioners of such services and is performing such reviews, determinations made pursuant to paragraphs (1) and (2) of section 1155(a) in connection with such reviews shall constitute the conclusive determination on those issues (subject to sections 1159, 1171(a)(1) and 1171(d)(3)) for purposes of payment under this Act, and no reviews with respect to those determinations shall be conducted, for purposes of payment, by agencies and organizations which are parties to agreements entered into by the Secretary pursuant to section 1816, carriers which are parties to contracts entered into by the Secretary pursuant to section 1842, or single State agencies administering or supervising the administration of State plans approved under title XIX.

(d) In any case in which a Professional Standards Review Organization disapproves (under subsection (a)) of inpatient hospital services or post-hospital extended care services, payment may be made for

such services furnished before the second day after the day on which the provider received notice of such disapproval, or, if such organization determines that more time is required in order to arrange post-discharge care, payment may be made for such services furnished before the fourth day after the day on which the provider received notice of such disapproval.

OBLIGATIONS OF HEALTH CARE PRACTITIONERS AND PROVIDERS OF HEALTH CARE SERVICES; SANCTIONS AND PENALTIES; HEARINGS AND REVIEW

SEC. 1160. (a) (1) * * *

* * * * *

(b) (1) If after reasonable notice and opportunity for discussion with the [practitioner or provider] *health care practitioner or hospital, or other health care facility, agency, or organization* concerned, any Professional Standards Review Organization submits a report and recommendations to the Secretary pursuant to section 1157 (which report and recommendations shall be submitted through the State-wide Professional Standards Review Council, if such Council has been established, which shall promptly transmit such report and recommendations together with any additional comments and recommendations thereon as it deems appropriate) and if the Secretary determines that such [practitioner or provider] *health care practitioner or hospital, or other health care facility, agency, or organization*, in providing health care services over which such organization has review responsibility and for which payment (in whole or in part) may be made under this Act has—

(A) by failing, in a substantial number of cases, substantially to comply with any obligation imposed on him under subsection (a), or

(B) by grossly and flagrantly violating any such obligation in one or more instances, demonstrated an unwillingness or a lack of ability substantially to comply with such obligations, he (in addition to any other sanction provided under law) may exclude (permanently or for such period as the Secretary may prescribe) such [practitioner or provider] *health care practitioner or hospital, or other health care facility, agency, or organization* from eligibility to provide such services on a reimbursable basis.

* * * * *

NATIONAL PROFESSIONAL STANDARDS REVIEW COUNCIL

SEC. 1163. (a) (1) There shall be established a National Professional Standards Review Council (hereinafter in this section referred to as the "Council") which shall consist of eleven physicians, not otherwise in the employ of the United States, appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive service.

(2) Members of the Council shall be appointed for a term of three years [and shall be eligible for reappointment], *except that of the members appointed in 1977, four shall be appointed for a term of only*

two years, and three for a term of only one year. Members of the Council shall be eligible for reappointment.

* * * * *

[(f) The National Professional Standards Review Council shall from time to time, but not less often than annually, submit to the Secretary and to the Congress a report on its activities and shall include in such report the findings of its studies and investigations together with any recommendations it may have with respect to the more effective accomplishment of the purposes and objectives of this part. Such report shall also contain comparative data indicating the results of review activities, conducted pursuant to this part, in each State and in each of the various areas thereof.]

* * * * *

PROHIBITION AGAINST DISCLOSURE OF INFORMATION

SEC. 1166. (a) Any data or information acquired by any Professional Standards Review Organization, in the exercise of its duties and functions, shall be held in confidence and shall not be disclosed to any person except (1) to the extent that may be necessary to carry out the purposes of this part [(or (2))], (2) in such cases and under such circumstances as the Secretary shall by regulations provide to assure adequate protection of the rights and interests of patients, health care practitioners, or providers of health care, or (3) in accordance with subsection (b).

(b) *A Professional Standards Review Organization shall provide, in accordance with procedures established by the Secretary, data and information—*

(1) to assist Federal and State agencies recognized by the Secretary as having responsibility for identifying and investigating cases or patterns of fraud or abuse, which data and information shall be provided by such Organization to such agencies at the request of such agencies at the discretion of such Organization on the basis of its findings with respect to evidence of fraud or abuse;

(2) to assist the Secretary, and such Federal and State agencies recognized by the Secretary as having health planning or related responsibilities under Federal or State law (including health systems agencies and State health planning and development agencies), in carrying out appropriate health care planning and related activities, which data and information shall be provided in such format and manner as may be prescribed by the Secretary or agreed upon by the responsible Federal and State agencies and such Organization, and shall be in the form of aggregate statistical data (without identifying any individual) on a geographic, institutional, or other basis reflecting the volume and frequency of services furnished, as well as the demographic characteristics of the population subject to review by such Organization.

The penalty provided in subsection (c) shall not apply to the disclosure of any data and information received under this subsection, except that such penalty shall apply to the disclosure (by the agency receiving such data and information) of any such data and information

described in paragraph (1) unless such disclosure is made in a judicial, administrative, or other formal legal proceeding resulting from an investigation conducted by the agency receiving the data and information; and

(5) by inserting after subsection (c) (as so redesignated) the following new subsection:

(d) No patient record in the possession of a Professional Standards Review Organization, a Statewide Professional Standards Review Council, or the National Professional Standards Review Council shall be subject to subpoena or discovery proceedings in a civil action.

LIMITATION ON LIABILITY FOR PERSONS PROVIDING INFORMATION, AND FOR MEMBERS AND EMPLOYEES OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS AND STATEWIDE PROFESSIONAL STANDARDS REVIEW COUNCILS, AND FOR HEALTH CARE PRACTITIONERS AND PROVIDERS

SEC. 1167. (a) Notwithstanding any other provision of law, no person providing information to any Professional Standards Review Organization or to any Statewide Professional Standards Review Council, shall be held, by reason of having provided such information, to have violated any criminal law, or to be civilly liable under any law, of the United States or of any State (or political subdivision thereof) unless—

(1) such information is unrelated to the performance of the duties and functions of such Organization or such Council, or

(2) such information is false and the person providing such information knew, or had reason to believe, that such information was false.

(b) (1) No individual who, as a member or employee of any Professional Standards Review Organization or of any Statewide Professional Standards Review Council or who furnishes professional counsel or services to such organization or council, shall be held by reason of the performance by him of any duty, function, or activity authorized or required of Professional Standards Review Organizations or of Statewide Professional Standards Review Councils under this part, to have violated any criminal law, (or to be civilly liable under any law, of the United States or of any State (or political subdivision thereof) provided he has exercised due care.

(2) The provisions of paragraph (1) shall not apply with respect to any action taken by any individual if such individual, in taking such action, was motivated by malice toward any person affected by such action.

* * * * *

(d) The Secretary shall make payment to a Professional Standards Review Organization, whether conditionally designated or qualified, or to any member or employee thereof, or to any person who furnishes legal counsel or services to such organization, in an amount equal to the reasonable amount of the expenses incurred, as determined by the Secretary, in connection with the defense of any suit, action, or proceeding brought against such organization, member, or employee related to the performance of any duty or function of such organization, member, or employee (as described in section 1155).

AUTHORIZATION FOR USE OF CERTAIN FUNDS TO ADMINISTER THE
PROVISIONS OF THIS PART

SEC. 1168. Expenses incurred in the administration of this part shall be payable from—

- (a) funds in the Federal Hospital Insurance Trust Fund;
- (b) funds in the Federal Supplementary Medical Insurance Trust Fund; and
- (c) funds appropriated to carry out the health care provisions of the several titles of this Act:

in such amounts from each of the sources of funds (referred to in subsections (a), (b), and (c)) as the Secretary shall deem to be fair and equitable after taking into consideration the costs attributable to the administration of this part with respect to each of such plans and programs. The Secretary shall make such transfers of moneys between the funds, referred to in clauses (a), (b) and (c) of the preceding sentence, as may be appropriate to settle accounts between them in cases where expenses properly payable from the funds described in one such clause have been paid from funds described in another of such clauses. *The Secretary shall make payments to Professional Standards Review Organizations (whether designated on a conditional basis or otherwise) from funds described in the first sentence of this section (without any requirement for the contribution of funds by any State or political subdivision thereof) for expenses incurred in the performance of duties by such Organizations.*

* * * * *

MEMORANDUMS OF UNDERSTANDING; FEDERAL-STATE RELATIONS
GENERALLY

SEC. 1171. (a) (1) *Except as provided in paragraph (2), no determination made by a Professional Standards Review Organization pursuant to paragraphs (1) and (2) of section 1155(a) in connection with reviews shall constitute conclusive determinations under section 1158(a) for purposes of payment under title XIX, unless such organization has entered into a memorandum of understanding, approved by the Secretary, with the single State agency responsible for administering or supervising the administration of the State plan approved under title XIX for the State in which the organization is located (hereinafter in this section referred to as the "State agency") for the purpose of delineating the relationship between the organization and the State agency and of providing for the exchange of data or information, administrative procedures, coordination mechanisms, and modification of the memorandum at any time that additional responsibility for review by the organization is authorized by the Secretary.*

(2) *The requirement of paragraph (1) may be waived by the Secretary if (A) the State agency indicates to the Secretary that it does not wish to enter into a memorandum of understanding with the organization involved, or (B) the Secretary finds that the State agency has refused to negotiate in good faith or in a timely manner with the organization involved.*

(b) (1) *The State agency may request a Professional Standards Review Organization which is entering into such a memorandum of understanding with the agency to include in the memorandum a specification of review goals or methods (additional to any such goals or methods contained in the organization's formal plan) for the performance of the organization's duties and functions under this part.*

(2) *If the agency and the organization cannot reach agreement regarding the inclusion of any such requested specification, the Secretary shall review such specification and shall require that the specification be included in the memorandum if the Secretary determines that such specification of goals or methods (A) is consistent with the functions of the organization under this part and with the provisions of title XIX and the State's plan approved under such title, and (B) does not seriously impact on the effectiveness and uniformity of the organization's review of health care services paid for under title XVIII and title XIX of this Act.*

(c) *Notwithstanding any other provision of this Act, the State agency may contract with any Professional Standards Review Organization located in the State for the performance of review responsibilities in addition to those performed pursuant to this part (and the cost of performance of such additional responsibilities is reimbursable as an expense of the State agency under section 1903(a)) if—*

(1) *the State agency formally requests the performance of such additional responsibilities, and*

(2) *the performance of such additional responsibilities is not inconsistent with this part and is provided for in an amendment to the State's plan which is approved by the Secretary under title XIX.*

(d) (1) *Each State agency may monitor the performance of review responsibilities by Professional Standards Review Organizations located within the State, in accordance with a State monitoring plan which is developed after review and comment by such organizations and is approved by the Secretary. The costs of activities of the State agency under and in accordance with such plan are reimbursable as an expense of the State agency under section 1903(a).*

(2) *A monitoring plan developed and approved under paragraph (1) may include a specification of performance criteria for judging the effectiveness of the review performance of the Professional Standards Review Organizations. If the State agency and the Professional Standards Review Organizations cannot reach agreement regarding such criteria, the Secretary shall assist the agency and organizations in resolving the matters in dispute.*

(3) (A) *Whenever a State agency monitoring the performance of review responsibilities by a Professional Standards Review Organization under a plan developed and approved under paragraph (1) submits to the Secretary reasonable documentation that the review determinations of such organization have caused an unreasonable and detrimental impact on total State expenditures under title XIX and on the quality of care received by individuals under the State's plan approved under such title, and requests the Secretary to act, the Secretary shall, within thirty days from the date of receipt of the documentation, make a determination as to the reasonableness of the allegation by the State agency. If the Secretary determines that the review*

determinations of such organization have caused an unreasonable and detrimental impact on total State expenditures under title XIX and on the quality of care received by individuals under the State's plan approved under such title, he may immediately suspend such organization's authority in whole or in part under section 1153(c) to make conclusive determinations for purposes of payment under title XIX (and he may suspend such authority for purposes of payment under title XVIII) pending a reevaluation of such organization's performance of the responsibilities involved and any appropriate action the Secretary may take as a result of such reevaluation. Any such action taken by the Secretary shall be final and shall not be subject to judicial review.

(B) The Secretary shall notify the State agency submitting such documentation, and the organization involved, in writing, of his determination, any subsequent actions taken, and the basis thereof, and shall notify the appropriate committees of the United States House of Representatives and the Senate of any such documentation submitted and the actions taken.

(e) (1) The Secretary shall in a timely manner establish procedures and mechanisms to govern his relationships with State agencies under this part (specifically including his relationships with such agencies in connection with their respective functions under the preceding provisions of this section). Such mechanisms shall include periodic consultation by the Secretary with State agency representatives and representatives of Professional Standards Review Organizations regarding relationships between such agencies and such organizations (including the appropriate exchange of data and information between such agencies and such organizations) and other problems of mutual concern, and such procedures shall permit the State agency to be represented on any project assessments conducted by the Secretary with respect to a Professional Standards Review Organization located within its State.

(2) Each Professional Standards Review Organization shall provide to the State agency for the State in which it is located, upon request, data or information which the Secretary requires such organizations to report to him routinely on a periodic basis, and such other data or information as the Secretary authorizes to be disclosed.

ANNUAL REPORTS

SEC. 1172. The Secretary shall submit to the Congress not later than April 1, 1978, and not later than April 1 of each year thereafter, a full and complete report on the administration, impact, and cost of the program under this part during the preceding fiscal year, including data and information on—

(1) the number, status (conditional or otherwise), and service areas of, and review methodologies employed by, all Professional Standards Review Organizations participating in the program;

(2) the number of health care institutions and practitioners whose services are subject to review by Professional Standards Review Organizations, and the number of beneficiaries and recipients who received services subject to such review during such year;

(3) the imposition of penalties and sanctions under this title for violations of law and for failure to comply with the obligations imposed by this part;

(4) the total costs incurred under titles V, XI, XVIII, and XIX of this Act in the implementation and operation of all procedures required by such titles for the review of services to determine their medical necessity, appropriateness of use, and quality;

(5) changes in utilization rates and patterns, and changes in medical procedures and practices, attributable to the activities of Professional Standards Review Organizations;

(6) the results of program evaluation activities, including the operation of data collection systems and the status of Professional Standards Review Organization data policy and implementation;

(7) the extent to which Professional Standards Review Organizations are performing reviews of services for other governmental or private health insurance programs; and

(8) recommendations for legislative changes.

MEDICAL OFFICERS IN AMERICAN SAMOA, THE NORTHERN MARIANA ISLANDS, AND THE TRUST TERRITORY OF THE PACIFIC ISLANDS TO BE INCLUDED IN THE PROFESSIONAL STANDARDS REVIEW PROGRAM

SEC. 1173. For purposes of applying this part (except sections 1155(c) and 1163) to American Samoa, the Northern Mariana Islands, and the Trust Territory of the Pacific Islands, individuals licensed to practice medicine in those places shall be considered to be physicians and doctors of medicine.

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * *

PART A—HOSPITAL INSURANCE BENEFITS FOR THE AGED AND DISABLED DESCRIPTION OF PROGRAM

SEC. 1814. (a) * * *

NO PAYMENTS TO FEDERAL PROVIDERS OF SERVICES

(c) Subject to section 1880, no payment may be made under this part (except under subsection (d) or subsection (j)) to any Federal provider of services, except a provider of services which the Secretary determines is providing services to the public generally as a community institution or agency; and no such payment may be made to any provider of services for any item or service which such provider is obligated by a law of, or a contract with, the United States to render at public expense.

* * * * *

Payments for Certain Hospital Services Provided in Veterans' Administration Hospitals

(j) (1) Payments shall also be made to any hospital operated by the Veterans' Administration for inpatient hospital services furnished

in a calendar year by the hospital or under arrangements (as defined in section 1861(w)) with it, to an individual entitled to hospital benefits under section 226 even though such hospital is a Federal provider of services if (A) such individual was not entitled to have such services furnished to him free of charge by such hospital, (B) such individual was admitted to such hospital in the reasonable belief on the part of the admitting authorities that such individual was a person who was entitled to have such services furnished to him free of charge, (C) the authorities of such hospital, in admitting such individual, and the individual, acted in good faith, and (D) such services were furnished during a period ending with the close of the day on which the authorities operating such hospital first became aware of the fact that such individual was not entitled to have such services furnished to him by such hospital free of charge, or (if later) ending with the first day on which it was medically feasible to remove such individual from such hospital by discharging him therefrom or transferring him to a hospital which has in effect an agreement under this title.

(2) Payment for services described in paragraph (1) shall be in an amount equal to the charge imposed by the Veterans' Administration for such services, or (if less) the reasonable costs for such services (as estimated by the Secretary). Any such payment shall be made to the entity to which payment for the services involved would have been payable, if payment for such services had been made by the individual receiving the services involved (or by another private person acting on behalf of such individual).

PAYMENT TO PROVIDERS OF SERVICES

SEC. 1815. (a) * * *

* * * * *

(c) No payment which may be made to a provider of services under this title for any service furnished to an individual shall be made to any other person under an assignment or power of attorney; but nothing in this subsection shall be construed (1) to prevent the making of such a payment in accordance with an assignment from the provider if such assignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (2) to preclude an agent of the provider of services from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such provider under this title is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment.

* * * * *

USE OF PUBLIC AGENCIES OR PRIVATE ORGANIZATIONS TO FACILITATE PAYMENT TO PROVIDERS OF SERVICES

SEC. 1816. * * *

* * * * *

(h) The Secretary may not disapprove a proposed agreement under this section, terminate an agreement under this section, or make a determination with respect to whether an agreement or proposed agreement is consistent with the effective and efficient administration of this part under subsection (b)(1)(A) or (e)(2)(B), solely on the grounds that the agency or organization requesting such agreement, or having such agreement, serves providers located only in a single State, or on the grounds that any provider in such single State is served, or could be served, by another agency or organization which serves providers located in more than one State.

* * * * *

HOSPITAL INSURANCE FOR INDIVIDUALS, AGE 60 THROUGH 64, WHO ARE ENTITLED TO BENEFITS UNDER SECTION 202 OR WHO ARE SPOUSES OF INDIVIDUALS ENTITLED TO HEALTH INSURANCE

SEC. 1819. (a) Every individual who—

(1) has attained the age of 60, but has not attained the age of 65; and

(2) is either—

(A) an individual entitled to monthly insurance benefits under section 202 or benefits under the Railroad Retirement Act of 1937, or

(B) the wife or husband of a person entitled to benefits under this part, or

(C) an individual entitled to benefits under—

(i) section 223(a), or

(ii) subsection (e), (f), (g), or (h), of section 202 based on disability,

but who has not met the conditions of section 226(b)(2); and

(3) is enrolled under part B of this title shall be eligible to enroll in the insurance program established by this part.

(b)(1) An individual may enroll only one under this section and only in such manner and form as may be prescribed in regulations, and only during an enrollment period prescribed in or under this section.

(2) In the case of an individual who satisfies paragraph (1) of subsection (a) of this section and either subparagraph (A) or (C) of paragraph (2) of such subsection, his enrollment period shall begin with whichever of the following is the latest:

(A) April 1, 1978, or

(B) the date such individual first meets the conditions in such paragraph (2), or

(C) the date the Secretary sends notice to such individual that he is entitled to any monthly insurance benefits as specified in subparagraph (A) or (C) of such paragraph (2), and shall end at the close of—

(D) 90th day thereafter, if such enrollment period begins on the date specified in subparagraph (B) or (C) of this paragraph, or

(E) 180th day thereafter, if such enrollment period begins on April, 1978.

(3) In the case of an individual satisfying paragraph (1) and paragraph (2)(B) of subsection (a) of this section, his enrollment period

shall begin on whichever of the following is the later: (A) April 1, 1978, or (B) the date such individual first meets the conditions specified in such paragraphs, and shall end at the close of the (C) 90th day thereafter, if such enrollment period begins on the date specified in clause (B) of this paragraph, or (D) 180th day thereafter, if such enrollment period begins on April 1, 1978.

(c) (1) In the case of an individual who enrolls pursuant to the provisions of this section, the coverage period during which he is entitled to benefits under this part shall begin on the first day of the second month after the month in which he enrolls, or July 1, 1978, whichever is later.

(2) An individual's coverage period shall terminate at the earlier of the following—

(A) for failure to make timely premium payments, at such time as may be prescribed in regulations which may include a grace period in which overdue premiums may be paid and coverage continued, but such grace period shall not exceed 30 days; except that it may be extended to not to exceed 60 days in any case where the Secretary determines that there was good cause for failure to pay overdue premiums within such 30-day period; or

(B) at the close of the month following the month in which an individual files a notice with the Secretary that he no longer desires to be enrolled under this section; or

(C) with the month before the month he no longer meets the conditions specified in subsection (a).

Notwithstanding the preceding provisions of this paragraph, an individual's coverage period shall terminate at such time as such individual becomes eligible for hospital insurance benefits under section 226 of this Act or section 103 of the Social Security Amendments of 1965; and upon such termination such individual shall be deemed, solely for purposes of hospital insurance entitlement, to have filed in such month the application required to establish such entitlement.

(d) (1) The monthly premium of each individual under this section for each month in his coverage period before July 1, 1979, shall be the amount of the premium charged to individuals enrolling under section 1818.

(2) The Secretary shall, during the last calendar quarter of each year beginning in 1978 determine and promulgate the dollar amount (whether or not such dollar amount was applicable for premiums for any prior month) which shall be applicable for premiums chargeable to individuals for months occurring in the 12-month period commencing July 1 of the next succeeding year. Such amount shall be actuarially adequate on a per capita basis to meet the estimated amounts of incurred claims and administrative expenses for individuals enrolled under this section during such period; and such amount shall take into consideration underwriting losses or gains incurred during prior years. Any amount determined under the preceding sentence which is not a multiple of \$1 shall be rounded to the nearest \$1, or if midway between multiples of \$1, to the next higher multiple of \$1.

(e) Payment of the monthly premiums on behalf of any individual who meets the conditions of subsection (a) may be made by any public or private agency or organization under a contract or other arrange-

ment entered into between it and the Secretary if the Secretary determines that payment of such premiums under such contract or other arrangement is administratively feasible.

(f) (1) The provisions of section 1840 shall apply to individuals enrolled under this section if such individuals are entitled to monthly insurance benefits under section 202 or 223. The provisions of subsections (e), (f), (g), and (h) of such section 1840 shall apply to any other individual so enrolled.

(2) Where an individual enrolled under this section meets the provisions of paragraph (2) (B) of subsection (a) (but does not meet the provisions of paragraph (2) (A) or (2) (C) of such subsection) and the person referred to in such paragraph (2) (B) is entitled to monthly insurance benefits under section 202 or section 223, the provisions of section 1840(a) (1) shall apply to such benefits as though such husband or wife were entitled to such benefits, unless such person files a notice with the Secretary that the deductions provisions of such section 1840 (a) (1) shall not apply.

(g) The term "wife", or "husband" as used in this section shall have the meaning assigned to those terms by subsection (b) and subsection (f) of section 216, as the case may be, except that the provisions of clause (2) of such subsection (b) and clause (2) of such subsection (f) shall not apply.

PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

* * * * *

PAYMENT OF BENEFITS

SEC. 1833. (a) * * *

* * * * *

[(f) (1) In the case of the purchase of durable medical equipment included under section 1861(s) (6), by or on behalf of an individual, payment shall be made in such amounts as the Secretary determines to be equivalent to payments that would have been made under this part had such equipment been rented and over such period of time as the Secretary finds such equipment would be used for such individual's medical treatment, except that (A) payment may be made in a lump sum if the Secretary finds that such method of payment is less costly or more practical than periodic payments, and (B) with respect to purchases of used equipment the Secretary is authorized to waive the 20 percent coinsurance amount applicable under subsection (a) whenever the purchase price of such equipment is at least 25 percent less than the reasonable charge for comparable new equipment.

[(2) In the case of rental of durable medical equipment the Secretary may, pursuant to agreements made with suppliers of such equipment, establish any reimbursement procedures (including payment on a lump sum basis in lieu of prolonged rental payments) which he finds to be equitable, economical, and feasible.]

"(f) (1) In the case of durable medical equipment to be furnished an individual as described in section 1861(s) (6), the Secretary shall determine, on the basis of such medical and other evidence as he finds

appropriate (including certification by the attending physician with respect to expected duration of need), whether the expected duration of the medical need for the equipment warrants a presumption that purchase of the equipment would be less costly or more practical than rental. If the Secretary determines that such a presumption does exist, he shall require that the equipment be purchased, on a lease-purchase basis or otherwise, and shall make payment in accordance with the lease-purchase agreement (or in a lump sum amount if the equipment is purchased other than on a lease-purchase basis); except that the Secretary may authorize the rental of the equipment notwithstanding such determination if he determines that the purchase of the equipment would be inconsistent with the purposes of this title or would create an undue financial hardship on the individual who will use it.

(2) With respect to purchases of used durable medical equipment, the Secretary may waive the 20 percent coinsurance amount applicable under subsection (a) whenever the purchase price of the used equipment is at least 25 percent less than the reasonable charge for comparable new equipment.

(3) For purposes of paragraph (1), the Secretary may, pursuant to agreements made with suppliers of durable medical equipment, establish reimbursement procedures which he finds to be equitable, economical, and feasible.

(4) The Secretary shall encourage suppliers of durable medical equipment to make their equipment available to individuals entitled to benefits under this title on a lease-purchase basis whenever possible."

USE OF CARRIERS FOR ADMINISTRATION OF BENEFITS

SEC. 1842. (a) * * *

(b) (1) * * *

* * * * *

(5) No payment under this part for a service provided to any individual shall (except as provided in section 1870) be made to anyone other than such individual or (pursuant to an assignment described in subparagraph (B) (ii) of paragraph (3)) the physician or other person who provided the service, except that payment may be made (A) to the employer of such physician or other person if such physician or other person is required as a condition of his employment to turn over his fee for such service to his employer, or (B) (where the service was provided in a hospital, clinic, or other facility) to the facility in which the service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such service. No payment which under the preceding sentence may be made directly to the physician or other person providing the service involved (pursuant to an assignment described in subparagraph (B) (ii) of paragraph (3)) shall be made to anyone else under a reassignment or power of attorney (except to an employer or facility as described in clause (A) or (B) of such sentence); but nothing in this subsection shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the individual to whom the service was provided or a reassignment from the physician or other person providing such

service if such assignment or reassignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of the physician or other person providing the service from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such physician or other person under this title is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment.

* * * * *

ELIGIBILITY OF INDIVIDUALS AGE 60 THROUGH 64, WHO ARE ENTITLED TO BENEFIT UNDER SECTION 202 OR WHO ARE SPOUSES OF INDIVIDUALS ENTITLED TO HOSPITAL INSURANCE

SEC. 1845. (a) Any individual who meets the conditions of paragraph (1) and paragraph (2) of section 1819(a) shall be eligible to enroll in the insurance program established by this part. The provisions of subsections (b), (c), (e), (f), and (g) of section 1819 shall apply to individuals authorized to enroll under this section.

(b) An individual's coverage period shall also terminate when (A) he no longer meets the conditions specified in paragraphs (1) and (2) of section 1819(a), or (B) his enrollment under section 1819 is terminated. Where termination occurs pursuant to this subsection, the coverage period shall terminate with the close of whichever of the following months is the earliest: (C) the month before the month the individual attains the age of 65, or (D) the month following the month in which such individual no longer meets the conditions of paragraph (2) of section 1819(a), or (E) the month in which his enrollment under section 1819 terminates.

(c) (1) The monthly premium of each individual under this section for each month in his coverage period before July 1979 shall be 300 per centum of the premium payable by an individual who has attained age 65 for such month.

(2) The Secretary shall, during December of each year beginning in 1978 determine and promulgate the dollar amount (whether or not such dollar amount was applicable for premiums for any prior month) which shall be applicable for premiums for months occurring in the 12-month period commencing July 1 of the next year. Such amount shall be actuarially adequate on a per capita basis to meet the estimated amounts of incurred claims and administrative expenses for individuals enrolled under this section during such period, and such amount shall take into consideration underwriting losses or gains incurred during prior years. Any amount determined under the preceding sentence which is not a multiple of \$1 shall be rounded to the nearest \$1 or if midway between multiples of \$1, to the next higher multiple of \$1.

(d) All premiums collected from individuals enrolled pursuant to this section shall be deposited in the Federal Supplementary Medical Insurance Trust Fund.

PART C—MISCELLANEOUS PROVISIONS

DEFINITION OF SERVICES, INSTITUTIONS, ETC.

SEC. 1861. For purposes of this title.

Spell of Illness

(a) * * *

* * * * *

Skilled Nursing Facility

(j) The term "skilled nursing facility" means (except for purposes of subsection (a)(2)) an institution (or a distinct part of an institution) which has in effect a transfer agreement (meeting the requirements of subsection (1)) with one or more hospitals having agreements in effect under section 1866 and which—

(1) * * *

* * * * *

[(11) supplies full and complete information to the Secretary or his delegate as to the identity (A) of each person who has any direct or indirect ownership interest of 10 per centum or more in such skilled nursing facility or who is the owner (in whole or in part) of any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by such skilled nursing facility or any of the property or assets of such skilled nursing facility, (B) in case a skilled nursing facility is organized as a corporation, of each officer and director of the corporation, and (C) in case a skilled nursing facility is organized as a partnership, of each partner; and promptly reports any changes which would affect the current accuracy of the information so required to be supplied;]

(11) *complies with the requirements of section 1124;*

* * * * *

(13) meets such provisions of the Life Safety Code of the National Fire Protection Association (23d edition, 1973)¹ as are applicable to nursing homes; except that the Secretary may waive, for such periods as he deems appropriate, specific provisions of such Code which if rigidly applied would result in unreasonable hardship upon a nursing home, but only if such waiver will not adversely affect the health and safety of the patients; except that the provisions of such Code shall not apply in any State if the Secretary finds that in such State there is in effect a fire and safety code, imposed by State law, which adequately protects patients in nursing facilities; [and]

(14) *establishes and maintains a system which shall assure a full and complete accounting of patients' personal funds, including the use of a separate account for patient funds which shall preclude any commingling of such funds with facility funds or with the funds of any person other than another such patient; and*

Reasonable Cost

(v) (1) (A) * * *

* * * * *

(F) Such regulations shall require each provider of services (other than a fund) to make reports to the Secretary of information described in section 1121 (a) in accordance with the uniform reporting system (established under such section) for that type of provider.

Arrangements for Certain Services

(w) (1) The term "arrangements" is limited to arrangements under which receipt of payment by the hospital, a skilled nursing facility, or home health agency (whether in its own right or as agent), with respect to services for which an individual is entitled to have payment made under this title, discharges the liability of such individual or any other person to pay for the services.

(2) Utilization review activities conducted, in accordance with the requirements of the program established under part B of title XI of the Social Security Act with respect to services furnished by a hospital to patients insured under part A of this title or entitled to have payment made for such services under *part B of this title or under a State plan approved under title V or XIX*, by a Professional Standards Review Organization designated for the area in which such hospital is located shall be deemed to have been conducted pursuant to arrangements between such hospital and such organization under which such hospital is obligated to pay to such organization, as a condition of receiving payment for hospital services so furnished under this part or under such a State plan, such amount as is reasonably incurred and requested (as determined under regulations of the Secretary) by such organization in conducting such review activities with respect to services furnished by such hospital to such patients.

* * * * *

EXCLUSIONS FROM COVERAGE

SEC. 1862.(a) * * *

* * * * *

(d) (1) No payment may be made under this title with respect to any item or services furnished to an individual by a person where the Secretary determines under this subsection that such person—

(A) has knowingly and willfully made, or caused to be made, any false statement or representation of a material fact for use in an application for payment under this title or for use in determining the right to a payment under this title;

(B) has submitted or caused to be submitted (except in the case of a provider of services), bills or requests for payment under this title containing charges (or in applicable cases requests for payment of costs to such person) for services rendered which the Secretary finds, with the concurrence of the appropriate program review team appointed pursuant to paragraph (4), to be substantially in excess of such person's customary charges (or in

applicable cases substantially in excess of such person's costs) for such services, unless the Secretary finds there is good cause for such bills or requests containing such charges (or in applicable cases, such costs); or

(C) has furnished services or supplies which are determined by the Secretary, [with the concurrence of the members of the appropriate program review team appointed pursuant to paragraph (4) who are physicians or other professional personnel in the health care field, to be substantially in excess of the needs of individuals or to be harmful to individuals or to be of a grossly inferior quality] *on the basis of reports transmitted to him in accordance with section 1157 of this Act (or, in the absence of any such report, on the basis of such data as he acquires in the administration of the program under this title), to be substantially in excess of the needs of individuals or to be of a quality which fails to meet professionally recognized standards of health care.*

* * * * *

[(4) For the purposes of paragraph (1) (B) and (C) of this subsection, and clause (F) of section 1866(b) (2), the Secretary shall, after consultation with appropriate State and local professional societies, the appropriate carriers and intermediaries utilized in the administration of this title, and consumer representatives familiar with the health needs of residents of the State, appoint one or more program review teams (composed of physicians, other professional personnel in the health care field, and the consumer representatives) in each State which shall, among other things—

[(A) undertake to review such statistical data on program utilization as may be submitted by the Secretary,

[(B) submit to the Secretary periodically, as may be prescribed in regulations, a report on the results of such review, together with recommendations with respect thereto,

[(C) undertake to review particular cases where there is a likelihood that the person or persons furnishing services and supplies to individuals may come within the provisions of paragraph (1) (B) and (C) of this subsection or clause (F) of section 1866 (b) (2), and

[(D) submit to the Secretary periodically, as may be prescribed in regulations, a report of cases reviewed pursuant to subparagraph (C) along with an analysis of, and recommendations with respect to, such cases.]

(e) (1) Whenever the Secretary determines that a physician or other individual practitioner has been convicted (on or after the date of the enactment of this subsection, or within such period prior to that date as the Secretary shall specify in regulations) of a criminal offense related to such physician's or practitioner's involvement in the program under this title or the program under title XIX, the Secretary shall suspend such physician or practitioner from participation in the program under this title for such period as he may deem appropriate; and no payment may be made under this title with respect to any item or service furnished by such physician or practitioner during the period of such suspension. The provisions of paragraphs (2) and (3) of

subsection (d) shall apply with respect to determinations made by the Secretary under this subsection.

(2) In any case where the Secretary under paragraph (1) suspends any physician or other individual practitioner from participation in the program under this title, he shall—

(A) promptly notify each single State agency which administers or supervises the administration of a State plan approved under title XIX of the fact, circumstances, and period of such suspension; and

(B) promptly notify the appropriate State or local agency or authority having responsibility for the licensing or certification of such physician or practitioner of the fact and circumstances of such suspension, request that appropriate investigations be made and sanctions invoked in accordance with applicable State law and policy, and request that such State or local agency or authority keep the Secretary and the Inspector General of the Department of Health, Education, and Welfare fully and currently informed with respect to any actions taken in response to such request.

AGREEMENTS WITH PROVIDERS OF SERVICES

SEC. 1866. (a) (1) Any provider of services (except a fund designated for purposes of section 1814(g) and section 1835(e)) shall be qualified to participate under this title and shall be eligible for payments under this title if it files with the Secretary an agreement—

(A) not to charge, except as provided in paragraph (2), any individual or any other person for items or services for which such individual is entitled to have payment made under this title (or for which he would be so entitled if such provider of services had complied with the procedural and other requirements under or pursuant to this title or for which such provider is paid pursuant to the provisions of section 1814(e)), and

(B) not to charge any individual or any other person for items or services for which such individual is not entitled to have payment made under this title because payment for expenses incurred for such items or services may not be made by reason of the provisions of paragraph (1) or (9), but only if (i) such individual was without fault in incurring such expense and (ii) the Secretary's determination that such payment may not be made for such items and services was made after the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this title, and

(C) to make adequate provision for return (or other disposition, in accordance with regulations) of any moneys incorrectly collected from such individual or other person [.] and

(D) to promptly notify the Secretary of its employment of an individual who, at any time during the year preceding such employment, was employed in a managerial, accounting, auditing, or similar capacity (as determined by the Secretary by regulation) by an agency or organization which serves as a fiscal intermedi-

ary or carrier (for purposes of part A or part B, or both, of this title) with respect to the provider.

An agreement under this paragraph with a skilled nursing facility shall be for a term of not exceeding 12 months, except that the Secretary may extend such term for a period not exceeding 2 months, where the health and safety of patients will not be jeopardized thereby, if he finds that such extension is necessary to prevent irreparable harm to such facility or hardship to the individuals being furnished items or services by such facility or if he finds it impracticable within such 12-month period to determine whether such facility is complying with the provisions of this title and regulations thereunder.

* * * * *

(3) *The Secretary may refuse to enter into or renew an agreement under this section with a provider of services if any person who has a direct or indirect ownership or control interest of 5 percent or more in such provider, or who is an officer, director, agent, or managing employee (as defined in section 1127 1126 (b)) of such provider, is a person described in section 1127 1126 (a).*

(b) An agreement with the Secretary under this section may be terminated (and in the case of a skilled nursing facility, prior to the end of the term specified in subsection (a) (1))—

(1) by the provider of services at such time and upon such notice to the Secretary and the public as may be provided in regulations, except that notice of more than 6 months shall not be required, or

(2) by the Secretary at such time and upon such reasonable notice to the provider of services and the public as may be specified in regulations, but only after the Secretary has determined (A) that such provider of services is not complying substantially with the provisions of such agreement, or with the provisions of this title and regulations thereunder, or (B) that such provider of services no longer substantially meets the applicable provisions of section 1861, or (C) that such provider of services has failed (i) to provide such information as the Secretary finds necessary to determine whether payments are or were due under this title and the amounts thereof, or has refused to permit such examination of its fiscal and other records by or on behalf of the Secretary as may be necessary to verify such information, or (ii) to supply (within such period as may be specified by the Secretary in regulations) upon request specifically addressed to such provider by the Secretary (I) full and complete information as to the ownership of a subcontractor (as defined by the Secretary in regulations) with whom such provider has had, during the previous twelve months, business transactions in an aggregate amount in excess of \$25,000, and (II) full and complete information as to any significant business transactions (as defined by the Secretary in regulations), occurring during the five-year period ending on the date of such request, between such provider and any wholly owned supplier or between such provider and any subcontractor, or (D) that such provider has made, or caused to be made, any false statement or representation of a material fact for use in an application for payment under this title or for use in determining

the right to a payment under this title, or (E) that such provider has submitted, or caused to be submitted, requests for payment under this title of amounts for rendering services substantially in excess of the costs incurred by such provider for rendering such services, or (F) that such provider has furnished services or supplies which are determined by the Secretary [, with the concurrence of the members of the appropriate program review team appointed pursuant to section 1862(d) (4) who are physicians or other professional personnel in the health care field, to be substantially in excess of the needs of individuals or to be harmful to individuals or to be of a grossly inferior quality] *to be substantially in excess of the needs of individuals or to be of a quality which fails to meet professionally recognized standards of health care, or (G) that such provider (at the time the agreement was entered into) did not fully and accurately make any disclosure required of it by section 1126 (a).*

* * * * *

PENALTIES

SEC. 1877. (a) Whoever—

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under this title,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to any such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

[shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than \$10,000 or imprisoned for not more than one year, or both.]

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than \$25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than \$10,000 or imprisoned for not more than one year or both.

[(b) Whoever furnishes items or services to an individual for which

payment is or may be made under this title and who solicits, offers, or receives any—

[(1) kickback or bribe in connection with the furnishing of such items or services or the making or receipt of such payment, or

[(2) rebate of any fee or charge for referring any such individual to another person for the furnishing of such items or services,

shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than \$10,000 or imprisoned for not more than one year, or both.]

(b) (1) *Whoever solicits or receives any remuneration (including kickbacks, bribes, or rebates directly or indirectly, overtly or covertly, in cash or in kind—*

(A) *in return for referring an individual to a person for the furnishing or arranging for the furnishing of items or services for which payment may be made in whole or in part under this title, or*

(B) *in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing or ordering goods, facilities, services, or any item for which payment may be made in whole or in part under this title.*

shall be guilty of a felony and upon conviction thereof, shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.

(2) *Whoever offers or pays any remuneration (including kickbacks, bribes, or rebates directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—*

(A) *to refer an individual to a person for the furnishing or arranging for the furnishing of items or services for which payment may be made in whole or in part under this title, or*

(B) *to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering goods, facilities, services, or any item for which payment may be made in whole or in part under this title,*

shall be guilty of a felony and upon conviction thereof, shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.

(3) *Paragraphs (1) and (2) shall not apply to—*

(A) *a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; and*

(B) *any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.*

(c) *Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon re-*

certification) as a hospital, skilled nursing facility, or home health agency (as those terms are defined in section 1861), shall be guilty of a [misdemeanor] *felony* and upon conviction thereof shall be fined not more than [\\$2,000] *\\$25,000* or imprisoned for not more than [6 months] *five years*, or both.

* * * * *

(d) *Whoever knowingly and willfully, after having accepted any assignment described in section 1842(b)(3)(B)(ii), charges an amount in excess of the reasonable charge with respect to services furnished to individuals on whose behalf payment is made under any such assignment, shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than \$2,000 or imprisoned for not more than six months, or both.*

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

* * * * *

STATE PLANS FOR MEDICAL ASSISTANCE

SEC. 1902. (a) A State plan for medical assistance must—

(1) * * *

* * * * *

(26) effective July 1, 1969, provide (A) for a regular program of medical review (including medical evaluation) of each patient's need for skilled nursing facility care or (in the case of individuals who are eligible therefor under the State plan) need for care in a mental hospital, a written plan of care, and, where applicable, a plan of rehabilitation prior to admission to a skilled nursing facility; (B) for periodic inspections to be made in all skilled nursing facilities and mental institutions (if the State plan includes care in such institutions) within the State by one or more medical review teams (composed of physicians and other appropriate health and social service personnel, *or, in the case of skilled nursing facilities composed of physicians or registered nurses and other appropriate health and social service personnel*) of (i) the care being provided in such nursing facilities (and mental institutions, if care therein is provided under the State plan) to persons receiving assistance under the State plan, (ii) with respect to each of the patients receiving such care, the adequacy of the services available in particular nursing facilities (or institutions) to meet the current health needs and promote the maximum physical well-being of patients receiving care in such facilities (or institutions), (iii) the necessity and desirability of the continued placement of such patients in such nursing facilities (or institutions), and (iv) the feasibility of meeting their health care needs through alternative institutional or noninstitutional services; and (C) for the making by such team or teams of full and complete reports of the findings resulting from such inspections together with any recommendations to the State agency administering or supervising the administration of the State plan;

(27) provide for agreements with every person or institution providing services under the State plan under which such person or institution agrees (A) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan, and (B) to furnish the State agency or the Secretary with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency or the Secretary may from time to time request;

* * * * *

(32) provide that no payment under the plan for any care or service provided to an individual [by a physician, dentist, or other individual practitioner shall be made to anyone other than such individual or such physician, dentist, or practitioner, except that payment may be made (A) to the employer of such physician, dentist, or practitioner if such physician, dentist, or practitioner is required as a condition of his employment to turn over his fee for such care or service to his employer, or (B) (where the care or service was provided in a hospital, clinic, or other facility) to the facility in which the care or service was provided if there is a contractual arrangement between such physician, dentist, or practitioner and such facility under which such facility submits the bill for such care or service;] shall be made to anyone other than such individual or the person or institution providing such care or service, under an assignment or power of attorney or otherwise; except that—

(A) in the case of any care or service provided by a physician, dentist, or other individual practitioner, such payment may be made (i) to the employer of such physician, dentist, or other practitioner if such physician, dentist, or practitioner is required as a condition of his employment to turn over his fee for such care or service to his employer, or (ii) (where the care or service was provided in a hospital, clinic, or other facility) to the facility in which the care or service was provided if there is a contractual arrangement between such physician, dentist, or practitioner and such facility under which such facility submits the bill for such care or service; and

(B) nothing in this paragraph shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the person or institution providing the care or service involved if such assignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of such person or institution from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such person or institution under the plan is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and

is not dependent upon the actual collection of any such payment;

* * * * *

[(35) effective January 1, 1973, provide that any intermediate care facility receiving payments under such plan must supply to the licensing agency of the State full and complete information as to the identity (A) of each person having (directly or indirectly) and ownership interest of 10 per centum or more in such intermediate care facility or who is the owner (in whole or in part) of any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by such intermediate care facility or any of the property or assets of such intermediate care facility, (B) in case an intermediate care facility is organized as a corporation, of each officer and director of the corporation, and (C) in case an intermediate care facility is organized as a partnership, of each partner; and promptly report any changes which would affect the current accuracy of the information so required to be supplied; and]

(35) provide that any intermediate care facility receiving payments under such plan, complies with the requirements of section 1124;

(36) provide that within 90 days following the completion of each survey of any health care facility, laboratory, agency, clinic, or organization, by the appropriate State agency described in paragraph (9), such agency shall (in accordance with regulations of the Secretary) make public in readily available form and place the pertinent findings of each such survey relating to the compliance of each such health care facility, laboratory, clinic, agency, or organization with (A) the statutory conditions of participation imposed under this title, and (B) the major additional conditions which the Secretary finds necessary in the interest of health and safety of individuals who are furnished care or services by any such facility, laboratory, clinic, agency, or organization[.];

(37) provide for claims payment procedures which (A) ensure that 95 per centum of claims for payment made for services covered under the plan and furnished by health care practitioners through individual or group practices or through shared health facilities are paid within 30 days of the date of receipt of such claims and that 99 per centum of such claims are paid within 90 days of the date of receipt of such claims, and (B) provide for procedures of prepayment and postpayment claims review, including review of appropriate data with respect to the recipient and provider of a service and the nature of the service for which payment is claimed, to ensure the proper and efficient payment of claims and management of the program;

(38) require that an entity (other than an individual practitioner or a group of practitioners) that furnishes, or arranges for the furnishing of, items or services under the plan, shall supply (within such period as may be specified in regulations by the Secretary or by the single State agency which administers or supervises the administration of the plan) upon request specifically addressed to such entity by the Secretary or such State

agency, respectively, (A) full and complete information as to the ownership of a subcontractor (as defined by the Secretary in regulations) with whom such entity has had, during the previous twelve months, business transactions in an aggregate amount in excess of \$25,000, and (B) full and complete information as to any significant business transactions (as defined by the Secretary in regulations), occurring during the five-year period ending on the date of such request, between such entity and any wholly owned supplier or between such entity and any subcontractor; and

(39) provide that, subject to subsection (g), whenever the single State agency which administers or supervises the administration of a State plan approved under title XIX is notified by the Secretary under section 1862(e) (2) (A) that a physician or other individual practitioner has been suspended from participation in the program under title XVIII, the agency shall promptly suspend such physician or practitioner from participation in its plan under this title for not less than the period specified in such notice, and no payment may be made under its plan with respect to any items or service furnished by such physician or practitioner during the period of the suspension under this title.

(40) require each health services facility or organization which receives payments under the plan and of a type for which a uniform reporting system has been established under section 1121 (a) to make reports to the Secretary of information described in such section in accordance with the uniform reporting system (established under such section) for that type of facility or organization.

* * * * *

The requirement of clause (A) of paragraph (37) with respect to a State plan may be waived by the Secretary if he finds that the State has exercised good faith in trying to meet such requirement.

* * * * *

(g) The Secretary may waive suspension under subsection (a) (39) of a physician's or practitioner's participation in a State plan approved under this title and of the prohibition under such subsection of payment for items or services furnished by him during the period of such suspension, if the single State agency which administers or supervises the administration of a State plan approved under title XIX such plan submits a request to the Secretary for such waiver and if the Secretary approves such request.

* * * * *

PAYMENT TO STATES

SEC. 1903. (a) From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing January 1, 1966

(1) * * *

* * * * *

(3) an amount equal to—

(A) (i) * * *

* * * * *

(B) 75 per centum of so much of the sums expended during such quarter as are attributable to the operation of systems (whether such systems are operated directly by the State or by another person under a contract with the State) of the type described in subparagraph (A) (i) (whether or not designed, developed, or installed with assistance under such subparagraph) which are approved by the Secretary and which include provision for prompt written notice to each individual who is furnished services covered by the plan, or to each individual in a sample group of individuals who are furnished such services, of the specific services (other than confidential services) so covered, the name of the person or persons furnishing the services, the date or dates on which the services were furnished, and the amount of the payment or payments made under the plan on account of the services; plus

* * * * *

(6) subject to subsection (b) (3), an amount equal to 100 per centum of the sums expended during each quarter of the fiscal year beginning October 1, 1977, 90 per centum of the sums expended during each quarter of the fiscal year beginning October 1, 1978, and 75 per centum of the sums expended during each quarter of the fiscal year beginning October 1, 1979, with respect to costs incurred during such quarter (as found necessary by the Secretary for the elimination of fraud in the provision and administration of medical assistance provided under the State plan) which are attributable to establishment and operation of (including the training of personnel employed by) a State Medicaid fraud control unit (described in subsection (p)); plus

[(6)] (7) an amount equal to 50 per centum of the remainder of the amounts expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.

(b) (1) Notwithstanding the preceding provisions of this section, the amount determined under subsection (a) (1) for any State for any quarter beginning after December 31, 1969, shall not take into account any amounts expended as medical assistance with respect to individuals aged 65 or over and disabled individuals entitled to hospital insurance benefits under title XVIII which would not have been so expended if the individuals involved had been enrolled in the insurance program established by part B of title XVIII, other than amounts expended under provisions of the plan of such State required by section 1902(a) (34).

(2) For limitation on Federal participation for capital expenditures which are out of conformity with a comprehensive plan of a State or arewide planning agency, see section 1122.

(3) The amount of funds which the Secretary is otherwise obligated to pay a State during a quarter under subsection (a) (7) may not exceed the higher of—

(A) \$125,000, or

(B) one quarter of 1 per centum of the sums expended by the Federal, State, and local governments during the previous quarter in carrying out the State's plan under this title.

* * * * *

(g)(1) *Subject to paragraphs (5) and (6), with respect to amounts paid for the following services furnished under the State plan after June 30, 1973 (other than services furnished pursuant to a contract with a health maintenance organization as defined in section 1876), the Federal medical assistance percentage shall be decreased as follows: After an individual has received care as an inpatient in a hospital (including an institution for tuberculosis), skilled nursing facility or intermediate care facility on 60 days, or in a hospital for mental diseases on 90 days (whether or not such days are consecutive), during any fiscal year, which for purposes of this section means the four calendar quarters ending with June 30, the Federal medical assistance percentage with respect to amounts paid for any such care furnished thereafter to such individual in the same fiscal year shall be decreased as determined under the provisions of paragraph (3) unless the State agency responsible for the administration of the plan makes a showing satisfactory to the Secretary that, with respect to each calendar quarter for which the State submits a request for payment at the full Federal medical assistance percentage for amounts paid for inpatient hospital services (including tuberculosis hospitals), skilled nursing facility services, or intermediate care facility services furnished beyond 60 days (or inpatient mental hospital services furnished beyond 90 days), there is in operation in the State an effective program of control over utilization of such services; such a showing must include evidence that—*

(A) in each case for which payment is made under the State plan, a physician certifies at the time of admission, or, if later, the time the individual applies for medical assistance under the State plan (and recertifies, where such services are furnished over a period of time, in such cases, at least every 60 days, and accompanied by such supporting material, appropriate to the case involved, as may be provided in regulations of the Secretary), that such services are or were required to be given on an inpatient basis because the individual needs or needed such services; and

(B) in each such case, such services were furnished under a plan established and periodically reviewed and evaluated by a physician;

(C) such State has in effect a continuous program of review of utilization pursuant to section 1902(a) (30) whereby each admission is reviewed or screened in accordance with criteria established by medical and other professional personnel who are not themselves directly responsible for the care of the patient involved, and who do not have a significant financial interest in any such institution and are not, except in the case of a hospital, employed by the institution providing the care involved; and the information developed from such review or screening, along with the data obtained from prior reviews of the necessity for admission and continued stay of patients by such professional personnel, shall be used as the basis for establishing the size and composition of the same of admissions to be subject to review and evaluation by such personnel, and any such sample may be of any size up to 100 per centum of all admissions and must be of sufficient size to serve the purpose of (i) identifying the patterns of care being

provided and the changes occurring over time in such patterns so that the need for modification may be ascertained, and (ii) subjecting admissions to early or more extensive review where information indicates that such consideration is warranted; and

(D) such State has an effective program of medical review of the care of patients in mental hospitals, skilled nursing facilities, and intermediate care facilities pursuant to section 1902(a) (26) and (31) whereby the professional management of each case is reviewed and evaluated at least annually by independent professional review teams.

In determining the number of days on which an individual has received services described in this subsection, there shall not be counted any days with respect to which such individual is entitled to have payments made (in whole or in part) on his behalf under section 1812.

(2) The Secretary shall, as part of his validation procedures under this subsection, conduct timely sample onsite surveys of private and public institutions in which recipients of medical assistance may receive care and services under a State plan approved under this title, and his findings with respect to such surveys (as well as the showings of the State agency required under this subsection) shall be made available for public inspection.

(3) *In the case of a State with respect to which a reduction in the Federal medical assistance percentage is required under the provisions of paragraph (1), such Federal medical assistance percentage shall be reduced by a percentage equal to $33\frac{1}{3}$ per centum multiplied by a fraction, the denominator of which is equal to the total number of patients with respect to whom the provisions (as contained in paragraph (1)) relating to the making of a satisfactory showing are applicable, and the numerator of which is equal to the number of such patients with respect to whom such a showing was not made in accordance with such paragraph (after application of paragraphs (4) and (5)).*

(4) *The Secretary may not find the showing of a State, with respect to a calendar quarter under paragraph (1), to be satisfactory if the showing is submitted to the Secretary later than the 30th day after the last day of the calendar quarter, unless the State demonstrates to the satisfaction of the Secretary good cause for not meeting such deadline.*

(5) *No reduction in the Federal medical assistance percentage of a State otherwise required to be imposed under this subsection shall take effect—*

(A) *if such reduction is due to the State's unsatisfactory or invalid showing made with respect to a calendar quarter beginning prior to January 1, 1978;*

(B) *unless a notice of such decrease has been provided to the State at least 30 days before the date such decrease takes effect; or*

(C) *if such reduction is due to the State's unsatisfactory or invalid showing made with respect to a calendar quarter beginning after December 31, 1977, unless notice of such reduction has been provided to the State no later than the first day of the fourth calendar quarter following the calendar quarter with respect to which such showing was made.*

(6) *The Secretary is authorized to waive the application of all or part (as is appropriate) of any reduction in the Federal medical as-*

assistance percentage of a State otherwise required to be imposed under paragraph (1) in any case in which the Secretary determines that the unsatisfactory or invalid showing made by the State is of a technical nature only, or is due to circumstances beyond the control of the State.

(7) The Secretary shall submit to Congress, not later than 60 days after the end of each calendar quarter, a report on—

(A) his determination as to whether or not each showing, made under paragraph (1) by a State with respect to the calendar quarter, has been found to be satisfactory under such paragraph;

(B) his review (through onsite surveys and otherwise) under paragraph (2) of the validity of showings previously submitted by a State; and

(C) any reduction in the Federal medical assistance percentage he has imposed on a State because of its submittal under paragraph (1) of an unsatisfactory or invalid showing.

* * * * *

(i) Payment under the preceding provisions of this section shall not be made—

(1) with respect to any amount paid for items or services furnished under the plan after December 31, 1972, to the extent that such amount exceeds the charge which would be determined to be reasonable for such items or services under the fourth and fifth sentences of section 1842(b) (3); or

(2) with respect to any amount paid for services furnished under the plan after December 31, 1972, by a provider or other person during any period of time, if payment may not be made under title XVIII with respect to services furnished by such provider or person during such period of time solely by reason of a determination by the Secretary under section 1862(d) (1) or under clause (D), (E), or (F) of section 1866(b) (2), or by reason of noncompliance with a request made by the Secretary under clause (C) (ii) of such section 1866(b) (2) or under section 1902(a) (38); or

* * * * *

(n) The State agency may refuse to enter into any contract or agreement with a hospital, nursing home, or other institution, organization, or agency for purposes of participation under the State plan, or otherwise to approve an institution, organization, or agency for such purposes, if any person who has a direct or indirect ownership or control interest of 5 percent or more in such institution, organization, or agency, or who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of such institution, organization, or agency, is a person described in section 1126(a) (whether or not such institution, organization, or agency has in effect an agreement entered into with the Secretary pursuant to section 1866 or is subject to a suspension of payment order issued under subsection (j) of this section); and, notwithstanding any other provision of this section, the State agency may terminate any such contract, agreement, or approval if it determines that the institution, organization, or agency did not fully and accurately make any disclosure required of it by section 1126(a) at the time such contract or agreement was entered into or such approval was given.

(o) Notwithstanding the preceding provisions of this section, no payment shall be made to a State under the preceding provisions of this section for expenditures for medical assistance provided for an individual under its State plan approved under this title to the extent that a private insurer (as defined by the Secretary by regulation) would have been obligated to provide such assistance but for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or is provided medical assistance under the plan.

(p) (1) When a political subdivision of a State makes, for the State of which it is a political subdivision, or one State makes, for another State, the enforcement and collection of rights of support or payment assigned under section 1912, pursuant to a cooperative arrangement under such section (either within or outside such State), there shall be paid to such political subdivision or such other State from amounts which would otherwise represent the Federal share of payments for medical assistance provided to the eligible individuals on whose behalf such enforcement and collection was made, an amount equal to 15 percent of any amount collected which is attributable to such rights of support or payment.

(2) Where more than one jurisdiction is involved in such enforcement or collection, the amount of the incentive payment determined under paragraph (1) shall be allocated among the jurisdictions in a manner to be prescribed by the Secretary.

(q) For the purposes of this section, the term "State medicare fraud control unit" means a single identifiable entity of the State government which the Secretary certifies (and annually recertifies) as meeting the following requirements:

(1) The entity (A) is a unit of the office of the State Attorney General or of another department of State government which possesses statewide authority to prosecute individuals for criminal violations, (B) is in a State the constitution of which does not provide for the criminal prosecution of individuals by a statewide authority and has formal procedures, approved by the Secretary, which (i) assure its referral of suspected criminal violations relating to the program under this title to the appropriate authority or authorities in the State for prosecution and (ii) assure its assistance of, and coordination with, such authority or authorities in such prosecutions, or (C) is an entity which has formal procedures and a formal working relationship, approved by the Secretary, which provide effective coordination with the Office of the State Attorney General with respect to activities directed toward detection, investigation, and prosecution of suspected criminal violations relating to the program under this title, including referral of such suspected violations to the Office of the State Attorney General.

(2) The entity is separate and distinct from the title XIX operating agency or (if different) single State agency that administers or supervises the administration of the State plan under this title.

(3) The entity's function is conducting a statewide program for the investigation and prosecution of violations of all applicable

State laws regarding any and all aspects of fraud in connection with any aspect of the provision of medical assistance and the activities of providers of such assistance under the State plan under this title.

(4) The entity has procedures for reviewing complaints of the abuse and neglect of patients of health care facilities which receive payments under the State plan under this title, and, where appropriate, for acting upon such complaints under the criminal laws of the State or for referring them to other State agencies for action.

(5) The entity provides for the collection, or referral for collection to a single State agency, of overpayments made under the State plan to health care facilities and discovered by the entity in carrying out its activities.

(6) The entity employs such auditors, attorneys, investigators, and other necessary personnel and is organized in such a manner as is necessary to promote the effective and efficient conduct of the entity's activities.

(7) The entity submits to the Secretary an application and annual reports containing such information as the Secretary determines, by regulation, to be necessary to determine whether the entity meets the other requirements of this subsection.

PENALTIES

SEC. 1909. (a) Whoever—

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a State plan approved under this title,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

[shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than \$10,000 or imprisoned for not more than one year, or both.]

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may

be made under this title, be guilty of a felony and upon conviction thereof fined not more than \$25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than \$10,000 or imprisoned for not more than one year or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under this title is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of this title or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

[(b) Whoever furnishes items or services to an individual for which payment is or may be made in whole or in part out of Federal funds under a State plan approved under this title and who solicits, offers, or receives any—

[(1) kickback or bribe in connection with the furnishing of such items or services or the making or receipt of such payment, or

[(2) rebate of any fee or charge for referring any such individual to another person for the furnishing of such items or services shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than \$10,000 or imprisoned for not more than one year, or both.]

(b) (1) Whoever solicits or receives any remuneration (including kickbacks, bribes, or rebates, directly or indirectly, overtly or covertly, in cash or in kind—

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of items or services for which payment may be made in whole or in part under this title, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering goods, facilities, services, or any item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than \$25,000 or imprisoned for not more than 5 years, or both.

(2) Whoever offers or pays any remuneration (including kickbacks, bribes, or rebates directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of items or services for which payment may be made in whole or in part under this title, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering goods, facilities, services, or any item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and, upon conviction thereof, shall be fined

not more than \$25,000 or imprisoned for not more than 5 years, or both.

(3) Paragraphs (1) and (2) shall not apply to—

(a) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; and

(b) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facility, or home health agency (as those terms are employed in this title) shall be guilty of a [misdemeanor] felony and upon conviction thereof shall be fined not more than [\$2,000] \$25,000 or imprisoned for not more than [6 months] five years, or both.

ASSIGNMENT OF RIGHTS OF PAYMENT

SEC. 1912. (a) For the purpose of assisting in the collection of medical support payments and other payments for medical care owed to recipients of medical assistance under the State plan approved under this title, a State plan for medical assistance may—

(1) provide that, as a condition of eligibility for medical assistance, each applicant or recipient who has legal capacity to execute an assignment for himself, or on behalf of another individual who is eligible to receive medical assistance by reason of the requirements of this title and lacks such legal capacity to make an assignment for himself, will be required—

(A) to assign the State any rights to support which is specified as support for the purpose of medical care by a court or administrative order, and any rights to payment for medical care from any third party; which such applicant or recipient may have (i) on his own behalf or in behalf of such eligible individual lacking such legal capacity, and (ii) which have accrued at the time such assignment is executed; and

(B) to cooperate with the State (i) in establishing the paternity of the eligible individual lacking such legal capacity if such eligible individual is a child born out of wedlock, and (ii) in obtaining such support and such payments for himself and for the eligible individual lacking such legal capacity, unless (in either case) such applicant or recipient is found to have good cause for refusing to cooperate as determined by the State agency in accordance with standards prescribed by the Secretary, which standards shall take into consideration the best interests of the individuals involved; and

(2) provide for entering into cooperative arrangements with any appropriate agency or appropriate organizational unit of any



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agency of the State, or of another State, and with appropriate courts and law enforcement officials (i) to assist the State or local agency, including the entering into of financial arrangements with such agency, organizational unit, courts, and officials in order to conduct or assist in the conducting of the enforcement and collection of rights to support or payment assigned under this section, and (ii) with respect to any other matters of common concern to such agency, organizational unit, courts, or officials and the State or local agency.

(b) Such part of any amount collected by the State under an assignment made under the provisions of this section shall be retained by the State as is necessary to reimburse it for medical assistance payments made to such individual on whose behalf such assignment was executed (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing of such medical assistance), and the remainder of such amount collected shall be paid to such individual.

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TITLE XX—GRANTS TO STATES FOR SERVICES

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SEC. 2002. (a)

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(15) No payment may be made under this section with respect to any expenditure for the provision of any health related service if such service is provided by an entity which has failed to comply with a request made by the Secretary or State agency under section 2003 (d) (1), for so long as such entity remains in noncompliance with such request.

(16) Any State may refuse to enter into a contract or other arrangement with a provider of services for purposes of participation under the program established by this title, or otherwise to approve a provider for such purposes, if any person who has a direct or indirect ownership or control interest of 5 percent or more in such provider, or who is an officer, director, agent, or managing employee (as defined in section 1126 (b)) of such provider, is a person described in section 1126 (a), and may terminate any such contract, arrangement, or approval if it determines that the provider did not fully and accurately make any disclosure required of it by section 1126 (a) at the time the contract or arrangement was entered into or the approval was given.

PROGRAM REPORTING

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SEC. 2003. (d) (1) * * *

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(H) provides that the State's program for the provision of the services described in section 2002(a) (1) will be in effect in all political subdivisions of the State; [and]

(I) provides for financial participation by the State in the provision of the services described in section 2002(a) (1) [I]; and

(J) provides that any entity (other than an individual practitioner or a group of practitioners) receiving payments for the provision of health-related services complies with the requirements of section 1124, and supplies (within such period as may be specified in regulations by the Secretary or by the single State agency which administers or supervises the administration of the plan) upon request specifically addressed to such entity by the Secretary or such State agency, respectively, (i) full and complete information as to the ownership of a subcontractor (as defined by the Secretary in regulations) with whom such entity has had, during the previous twelve months, business transactions in an aggregate amount in excess of \$25,000, and (ii) full and complete information as to any significant business transactions (as defined by the Secretary in regulations), occurring during the five-year period ending on the date of such request, between such entity and any wholly owned supplier or between such entity and any subcontractor.

SECTION 332 OF THE PUBLIC HEALTH SERVICE ACT

DESIGNATION OF HEALTH MANPOWER SHORTAGE AREAS

SEC. 332. (a) (1) * * *

* * * * *

(c) In determining whether to make a designation, the Secretary shall take into consideration the following:

(1) (A) The recommendations of each health systems agency (designated under section 1515) for a health service area which includes all or any part of the area, population group, medical facility, or other public facility under consideration for designation.

(B) The recommendations of the State health planning and development agency (designated under section 1521) if such area, population group, medical facility, or other public facility is within a health service area for which no health systems agency has been designated.

(2) The recommendations of the Governor of each State in which the area, population group, medical facility, or other public facility under consideration for designation is in whole or part located.

(3) The extent to which individuals who are (A) residents of the area, members of the population group, or patients in the medical facility or other public facility under consideration for designation, and (B) entitled to have payment made for medical services under title XVIII or XIX of the Social Security Act, cannot obtain such services because of suspension of physicians from the programs under such titles.

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(Public Law 94-505)

AN ACT To authorize conveyance of the interests of the United States in certain lands in Salt Lake County, Utah, to Shriners' Hospitals for Crippled Children, a Colorado corporation.

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TITLE II—OFFICE OF INSPECTOR GENERAL

DUTIES AND RESPONSIBILITIES

SEC. 203. (a) It shall be the duty and responsibility of the Inspector General—

(1) to supervise, coordinate, and provide policy direction for auditing and investigative activities relating to programs and operations of the Department;

(2) to recommend policies for, and to conduct, supervise, or coordinate other activities carried out or financed by the Department for the purpose of promoting economy and efficiency in the administration of, or preventing and detecting fraud and abuse in, its programs and operations;

(3) to recommend policies for, and to conduct, supervise, or coordinate relationships between the Department and other Federal agencies, State and local governmental agencies, and non-governmental entities with respect to (A) all matters relating to the promotion of economy and efficiency in the administration of, or the prevention and detection of fraud and abuse in, programs and operations administered or financed by the Department, or (B) the identification and prosecution of participants in such fraud or abuse; [and]

(4) to keep the Secretary and the Congress fully and currently informed, by means of the reports required by section 4 and otherwise, concerning fraud and other serious problems, abuses, and deficiencies relating to the administration of programs and operations administered or financed by the Department, to recommend corrective action concerning such problems, abuses, and deficiencies, and to report on the progress made in implementing such corrective action []; and

(5) to bring civil actions on behalf of the United States in cases of alleged civil fraud relating to any health related program established or totally or partially funded under any provision of the Social Security Act, if no such civil action has been initiated by the Department of Justice within a period of six months following a formal referral of such case of alleged fraud by the Department to the Department of Justice and when such action is appropriate in the opinion of the Inspector General.

(b) In carrying out the responsibilities specified in subsection (a) (1), the Inspector General shall have authority to approve or disapprove the use of outside auditors or to take other appropriate steps to insure the competence and independence of such auditors.

(c) In carrying out the duties and responsibilities provided by this Act, the Inspector General shall give particular regard to the activities of the Comptroller General of the United States with a view to avoiding duplication and insuring effective coordination and cooperation.

REPORTS

SEC. 204. (a) The Inspector General shall, not later than March 31 of each year, submit a report to the Secretary and to the Congress summarizing the activities of the Office during the preceding calendar year. Such report shall include, but need not be limited to—

- (1) an identification and description of significant problems, abuses, and deficiencies relating to the administration of programs and operations of the Department disclosed by such activities;
- (2) a description of recommendations for corrective action made by the Office with respect to significant problems, abuses, or deficiencies identified and described under paragraph (1);
- (3) an evaluation of progress made in implementing recommendations described in the report or, where appropriate, in previous reports; and
- (4) a summary of matters referred to prosecutive authorities and the extent to which prosecutions and convictions have resulted.

Such report shall also include an evaluation of the performance of the Attorney General in the investigation and prosecution of criminal violations relating to fraud in the programs of health insurance and medical assistance provided under titles XVIII and XIX of the Social Security Act, and shall include any recommendations with respect to improving the performance of such activities.

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SOCIAL SECURITY AMENDMENTS OF 1967

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INCENTIVES FOR ECONOMY WHILE MAINTAINING OR IMPROVING QUALITY IN THE PROVISION OF HEALTH SERVICES

SEC. 402. (a) (1) ***

* * * * *

“(H) to establish an experimental program to provide day-care services, which consist of such personal care, supervision, and services as the Secretary shall by regulation prescribe, for individuals eligible to enroll in the supplemental medical insurance program established under part B of title XVIII and title XIX of the Social Security Act, in day-care centers which meet such standards as the Secretary shall by regulation establish; [and]

“(I) to determine whether the services of clinical psychologists may be made more generally available to persons eligible for services under titles XVIII and XIX of this Act in a manner con-

sistent with quality of care and equitable and efficient administration [1]; and

“(J) to develop or demonstrate improved methods for the investigation and prosecution of fraud in the provision of care or services under the health programs established by the Social Security Act.”

SELECTED PROVISIONS OF THE INTERNAL REVENUE CODE OF 1954

26 U.S.C. 1—

Subtitle A—Income Taxes

CHAPTER 1—NORMAL TAXES AND SURTAXES

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Subchapter F—Exempt Organizations

PART I—GENERAL RULE

SEC. 501. Exemption From Tax On Corporations, Certain Trusts, Etc.

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(i) PROHIBITION OF DISCRIMINATION BY CERTAIN SOCIAL CLUBS.—Notwithstanding subsection (a), an organization which is described in subsection (c) (7) shall not be exempt from taxation under subsection (a) for any taxable year if, at any time during such taxable year, the charter, bylaws, or other governing instrument, or such organization contains a provision which provides for discrimination against any person on the basis of race, color, or religion.

“(j) PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS.—For purposes of this title, a Professional Standards Review Organization designated as such by the Secretary of Health, Education, and Welfare under the provisions of part B of title XI of the Social Security Act (including an organization designated under section 1154 of such Act) shall be treated as an organization organized and operated exclusively for charitable purposes.”

[(j)] (k) CROSS REFERENCE.—

For nonexemption of Communist-controlled organizations, see section 11(b) of the Internal Security Act of 1950 (64 Stat. 997; 50 U.S.C. 790(b)).



END