/* Title IV of the proposed Health Security Act follows. */

Title IV MEDICARE AND MEDICAID

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Quality Management Initiatives

Section 4031 Repeal of separate medicare peer review program

Section 4000 REFERENCES IN TITLE.

(a) Amendments to Social Security Act. Except as otherwise specifically provided, whenever in this title an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(b) References to OBRA. In this title, the terms "OBRA091986", "OBRA091987", "OBRA091989", "OBRA091990", and "OBRA091993" refer to the Omnibus Budget Reconciliation Act of 1986 (Public Law 9909509), the Omnibus Budget Reconciliation Act of 1987 (Public Law 10009203), the Omnibus Budget Reconciliation Act of 1989 (Public Law 10109239), the Omnibus Budget Reconciliation Act of 1990 (Public Law 10109508), and the Omnibus Budget Reconciliation Act of 1993 (Public Law 1030966), respectively.

Subtitle A Medicare and the Alliance System

Part 1 ENROLLMENT OF MEDICARE BENEFICIARIES IN REGIONAL ALLIANCE PLANS

Section 4001 OPTIONAL STATE INTEGRATION OF MEDICARE BENEFICIARIES INTO REGIONAL ALLIANCE PLANS.

Title XVIII is amended by adding at the end the following:

"integration of medicare into state health security programs

"Sec. 1893. (a) Payment to States. The Secretary shall pay a participating State that has submitted an application, as specified by subsection (b) which the Secretary has approved under subsection (c), the amount specified by subsection (d) for the period specified by subsection (e) for covered medicare beneficiaries. This section shall apply without regard to whether or not a State is a single-payer State.

"(b) Application by State. An application submitted by a participating State shall contain the following assurances:

"(1) Coverage of all medicare-eligible individuals. The State's application assure that the provisions of the succeeding paragraphs of this subsection shall apply to all medicare-eligible individuals who are residents of the State.".

"(2) Enrollment in and selection of health plans.

"(A) Enrollment. Each medicare-eligible individual (within a class of medicare beneficiaries covered under the application) who is a resident of the State will be enrolled in a regional alliance health plan serving the area in which the individual resides (or, in the case of an individual who is a resident of a

single-payer State, in the Statewide single-payer system operated under part 2 of subtitle C of title I of the Health Security Act).

"(B) Selection. Each such individual will have the same choice among applicable health plans as other individuals in the State who are eligible individuals under the Health Security Act.

"(C) Offer of fee-for-service plan. Each such individual shall be offered enrollment in at least one health plan that is a fee-for-service plan (or, in the case of an individual who is a resident of a single-payer State, the Statewide single-payer system under part 2 of subtitle C of title I of the Health Security Act) that meets the following requirements:

"(i) The plan's premium rate, and the actuarial value of the plan's deductibles, coinsurance, and copayments, charged to the individual do not exceed the actuarial value of the coinsurance and deductibles that would be applicable on the average if this section did not apply to those individuals.

"(ii) The plan's payment rates for covered items and services are accepted as payment in full for such items and services.

"(3) Coverage of full medicare benefits. For each health plan providing coverage under this section

"(A) the plan shall cover at least the items and services for which payment would otherwise be made under this title (including payments under section 1862(b)(4)), and

"(B) coverage determinations under the plan are made under rules that are no more restrictive than otherwise applicable under this title.

"(4) Premium. During the period for which payments are made to a State under this section, the requirements of the Health Security Act relating to premiums that are otherwise applicable with respect to individuals enrolled in health plans in a State shall not apply with respect to medicare-eligible individuals in the State who are covered under the State's application under this section. Nothing in the previous sentence shall operate to permit a State or health plans in a State to charge different premiums among medicare-eligible individuals within the same premium class under the Health Security Act.

"(5) Quality assurance. For each health plan providing coverage under this section there are quality assurance mechanisms for covered medicare individuals that equal, or exceed, such mechanisms otherwise applicable under this title.

"(6) Review rights. Covered medicare individuals have review, reconsideration, and appeal rights (including appeals to courts of the State) that equal or exceed such rights otherwise applicable under this title.

"(7) Data reporting and access to documents.The State will

"(A) provide such utilization and statistical data as the Secretary determines are needed for purposes of the programs established under this title, and

"(B) the State will ensure access by the Secretary or the Comptroller General to relevant documents.

"(8) Use of payments. Payments made to the State under subsection (a) will be used only to carry out the purposes of this section.

"(c) Approval by Secretary. The Secretary shall approve an application under subsection (b) if the Secretary finds

"(1) that the individuals covered under the State's application shall receive at least the benefits provided under this title (including cost sharing);

"(2) that the amount of expenditures that will be made under this title will not exceed the amount of expenditures that will be made if the State's application is not accepted; and

"(3) that the State is able and willing to carry out the assurances provided in its application.

"(d) Amount and Source of Payment.

"(1) Amount of payment. For purposes of subsection (a), the amount of payments to a State

"(A) for the first year for which payments are made to the State under this section shall be determined by the applicable rate specified in section 1876(a)(1)(C) (but at 100 percent, rather than 95 percent, of the applicable amount) for each

medicare-eligible individual who is a resident of the State (but without regard to any reduction based on payments to be made under section 1876(a)(1)(G)), and

"(B) for each succeeding year, shall be determined by the applicable rate determined under subparagraph (A) or this subparagraph for the preceding year for each such individual, adjusted by the regional alliance inflation factor applicable to regional alliances in the State (as determined in accordance with section 6001(a) of the Health Security Act) for the year.

"(2) Source of payment. Payment shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund as provided under paragraph (5) of section 1876(a) (other than as provided under subparagraph (B) of that paragraph).

"(e) Period for Which Payment Made. The period for which payment may be made under subsection (a) to a State

"(1) begins with January 1 of the first calendar year for which the Secretary approves under subsection (c) the application of the State; and

"(2) ends

"(A) on December 31 of the year in which the State notifies the Secretary (before April of that year) that the State no longer intends to receive payments under this section, or

"(B) if the Secretary finds that the State is no longer in substantial compliance with the requirements under paragraphs (2) or (3) of subsection (c), at the time specified by the Secretary. No termination is effective under paragraph (2) unless notice has been provided to medicare covered individuals, health providers, and health plans affected by the termination.

"(f) Payments Under this Section as Sole Medicare Benefits. Payments to a State under subsection (a) shall be instead of the amounts that would otherwise be payable, pursuant to sections 1814(b) and 1833(a), for services furnished to medicare-eligible residents of the State covered under the application.

"(g) Evaluation. The Secretary shall evaluate on an ongoing basis the compliance of a State with the requirements of this section.

"(h) Definitions. In this section the terms `applicable health plan', `fee-for-service plan', `health plan', `medicare-eligible individual', `participating State', `single-payer State', and `Statewide single-payer system' have the meanings of those terms in the Health Security Act.".

Section 4002 INDIVIDUAL ELECTION TO REMAIN IN CERTAIN HEALTH PLANS.

(a) In General. Section 1876 (42 U.S.C. 1395mm) is amended by adding at the end the following new subsection:

"(k)(1) Notwithstanding any other provision of this section, each eligible organization with a risk-sharing contract (or which is eligible to enter into such a contract, as determined by the Secretary) that is the sponsor of a health plan under subtitle E of title I of the Health Security Act shall provide each individual who meets the requirements of paragraph (2) with the opportunity to elect (by submitting an application at such time and in such manner as specified by the Secretary) to continue enrollment in such plan (for the same benefits as alliance-eligible individuals) and to have payments made by the Secretary to the plan on the individual's behalf in accordance with paragraph (3). The premium imposed with respect to such an individual by the plan shall be in an amount (determined in accordance with rules of the Secretary and notwithstanding other provisions of such Act) which reflects the difference between the premium otherwise established (adjusted by a factor to reflect the actuarial difference between medicare beneficiaries and other plan enrollees) and the amount payable under paragraph (3).

"(2) An individual meets the requirements of this paragraph if the individual is

"(A) enrolled in the health plan of an eligible organization in a month in which the individual is either not entitled to benefits under part A, or is an eligible employee (as defined in the Health Security Act) or the spouse or dependent of an eligible employee,

"(B) entitled to benefits under part A and enrolled under part B in the succeeding month,

"(C) an eligible individual under the Health Security Act in that succeeding month, and

"(D) not an eligible employee (as defined in the Health Security Act) or the spouse or dependent of an eligible employee in that succeeding month.

"(3) The Secretary shall make a payment to an eligible organization on behalf of each individual enrolled with the organization for whom an election is in effect under this subsection in an amount determined by the rate specified by subsection (a)(1)(C) (notwithstanding the second sentence of paragraph (1)). Such payment shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund as provided under subsection (a)(5) (other than as provided under subparagraph (B) of that paragraph).

"(4) The period for which payment may be made under paragraph (3)

"(A) begins with the first month for which the individual meets the requirements of paragraph (2) (or a later month, in the case of a late application, as may be specified by the Secretary); and

"(B) ends with the earliest of

"(i) the month following the month

"(I) in which the individual notifies the Secretary that the individual no longer wishes to be enrolled in the health plan of the eligible organization and to have payment made on the individual's behalf under this subsection; and

"(II) which is a month specified by the Secretary as a uniform open
enrollment period under subsection (c)(3)(A)(i), or

"(ii) the month in which the individual ceases to meet the requirements of paragraph (2).

"(5) Notwithstanding any other provision of this title, payments to an eligible organization under this subsection on behalf of an individual shall be the sole payments made with respect to items and services furnished to the individual during the period for which the individual's election under this subsection is in effect.".

(b) Conforming Amendment. Section 1838(b) (42 U.S.C. 1395q(b)) is amended by inserting after "section 1843(e)" the following:

",201876(c)(3)(B), 1876(k)(4)(B), or 1890(j)(1)(B)(iv)".

Section 4003 PAYMENTS TO REGIONAL ALLIANCES ON BEHALF OF CERTAIN MEDICARE-ELIGIBLE INDIVIDUALS.

Title XVIII, as amended by section 4001, is further amended by adding at the end the following new section:

"payments to regional alliances on behalf of certain medicare-eligible individuals under health security act

"Sec. 1894. The Secretary shall provide for a transfer from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, in appropriate proportions, to each regional alliance in each year of the amount of the reductions in liability owed to the alliance in the year resulting from the application of section 6115 of the Health Security Act. In the case of an individual to whom such section applies, unless all the members of the family would be medicare-eligible individuals (but for section 1012(a) of such Act), the reductions in liability under section 6115 of such Act shall be based upon the alliance credit amount for an individual class of enrollment (as defined in section 1011(c)(1)(A) of such Act).".

Section 4004 PROHIBITING EMPLOYERS FROM TAKING INTO ACCOUNT STATUS AS MEDICARE BENEFICIARY ON ANY GROUNDS.

(a) Extension of Protections for Working Aged to Group Health Plans of All Employers. Section 1862(b)(1)(A) (42 U.S.C. 1395y(b)(1)(A)) is amended by striking clauses (ii) and (iii).

(b) Extension of Protections for Disabled Individuals to All Group Health Plans.

(1) In general. Section 1862(b)(1)(B) (42 U.S.C. 1395y(b)(1)(B)), as amended by section 13561(e) of OBRA091993, is amended

(A) in clause (i), by striking "large group health plans (as defined in clause (iv))" and inserting "group health plan (as defined in subparagraph (A)(v), taking into account the exceptions described in clauses (ii) and (iii) of subparagraph

(A))"; and

(B) by striking clause (iv).

(2) Conforming amendment. Section 1862(b)(1)(A)(v) (42 U.S.C. 1395y(b)(1)(A)(v)) is amended by striking "this subparagraph, and subparagraph (C)" and inserting "this paragraph".

(c) Repeal of Limitation on Period of Protection for Individuals With End Stage Renal Disease.

(1) In general. Section 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)), as amended by section 13561(c) of OBRA091993, is amended

(A) in clause (i), by striking "an individual is entitled" and all that follows through "such benefits" and inserting "an individual (or a member of the individual's family) who is covered under the plan by virtue of the individual's current employment status with an employer is entitled to benefits under this title under section 226A";

(B) in clause (ii), by striking the semicolon at the end and inserting a period; and

(C) by striking the matter following clause (ii).

(2) Conforming amendment.Section 1862(b)(1) is amended

(A) in subparagraph (A), by striking clause (iv); and

(B) in subparagraph (B), by striking clause (ii).

(d) No Primary Payment for Services Under a Health Plan. Section 1862(b)(2)(A) (42 U.S.C. 1395y(b)(2)(A)(i)) is amended

(1) by striking "or" at the end of clause (i);

(2) by striking the period at the end of clause (ii) and inserting ",
or";

(3) by inserting after clause (ii) the following new clause:

"(iii) payment has been made, or can reasonably be expected to

be made, with respect to the item or service under any health plan under the Health Security Act."; and

(4) in the second sentence

(A) by striking "and" after "applies", and

(B) by inserting before the period at the end the following: ", and a health plan under the Health Security Act to the extent that clause (iii) applies".

(e) Simplification of Coordination of Benefits. Section 1862(b)(4) (42 U.S.C. 1395y(b)(4)) is amended by adding after and below subparagraph the following:

"Notwithstanding the previous sentence, where payment is made for an item or service by a primary plan that is a health plan (within the meaning of section 1400 of the Health Security Act) and for which payment would be made under this title but for this subsection, payment may be made under this title (without regard to deductibles and coinsurance) in the amount of the cost sharing imposed under such primary plan (consistent with such Act).".

(f) Effective Date.The amendments made by this section shall apply with respect to medicare-eligible individuals residing in a participating State as of January 1 of the first year for which the State is a participating State.

I 73 PART 2 ENCOURAGING MANAGED CARE UNDER MEDICARE PROGRAM; COORDINATION WITH MEDIGAP PLANS

Section 4011 ENROLLMENT AND TERMINATION OF ENROLLMENT.

(a) Uniform Open Enrollment Periods.

(1) For capitated plans.The first sentence of section 1876(c)(3)(A)(i) (42 U.S.C. 1395mm(c)(3)(A)(i)) is amended by inserting "(which may be specified by the Secretary)" after "open enrollment period".

(2) For medigap plans. Section 1882(s) (42 U.S.C. 1395ss(s)) is amended

(A) in paragraph (3), by striking "paragraphs (1) and (2)" and inserting "paragraph (1), (2), or (3)",

(B) by redesignating paragraph (3) as paragraph (4), and

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

"(3) Each issuer of a medicare supplemental policy shall have an open enrollment period (which shall be the period specified by the Secretary under section 1876(c)(3)(A)(i)), of at least 30 days duration every year, during which the issuer may not deny or condition the issuance or effectiveness of a medicare supplemental policy, or discriminate in the pricing of the policy, because of age, health status, claims experience, receipt of health care, or medical condition. The policy may not provide any time period applicable to pre-existing conditions, waiting periods, elimination periods, and probationary periods (except as provided by paragraph (2)(B)). The Secretary may require enrollment through a third party designated under section 1876(c)(3)(B).".

(b) Enrollments for New Medicare Beneficiaries and Those Who Move. Section 1876(c)(3)(A) (42 U.S.C. 1395mm(c)(3)(A)) is amended

(1) in clause (i), by striking "clause (ii)" and inserting
"clauses (ii) through (iv)", and

(2) by adding at the end the following:

"(iii) Each eligible organization shall have an open enrollment period for each individual eligible to enroll under subsection (d) during any enrollment period specified by section 1837 that applies to that individual. Enrollment under this clause shall be effective as specified by section 1838.

"(iv) Each eligible organization shall have an open enrollment period for each individual eligible to enroll under subsection (d) who has previously resided outside the geographic area which the organization serves. The enrollment period shall begin with the beginning of the month that precedes the month in which the individual becomes a resident of that geographic area and shall end at the end of the following month. Enrollment under this clause shall be effective as of the first of the month following the month in which the individual enrolls.".

(c) Enrollment Through Third Party; Uniform Termination of Enrollment. The first sentence of section 1876(c)(3)(B) (42 U.S.C. 1395mm(c)(3)(B)) is amended

(1) by inserting "(including enrollment through a third party)" after "regulations", and

(2) by striking everything after "with the eligible organization" and inserting "during an annual period as prescribed by the Secretary, and as specified by the Secretary in the case of financial insolvency of the organization, if the individual moves from the geographic area served by the organization, or in other special circumstances that the Secretary may prescribe.".

(d) Effective Date. The amendments made by the previous subsections apply to enrollments and terminations of enrollments occurring after 1995 (but only after the Secretary of Health and Human Services has prescribed the relevant annual period), except that the amendments made by subsection (a)(2) apply to enrollments for a medicare supplemental policy made after 1995.

Section 4012 UNIFORM INFORMATIONAL MATERIALS.

(a) For Capitated Plans. Section 1876(c)(3)(C) (42 U.S.C. 1395mm(c)(3)(C)) is amended by adding at the end the following:

"In addition, the Secretary shall develop and distribute comparative materials about all eligible organizations. Each eligible organization shall reimburse the Secretary for its pro rata share (as determined by the Secretary) of the costs incurred by the Secretary in carrying out the requirements of the preceding sentence and other enrollment activities.".

(b) For Medigap Plans. Paragraph (1) of section 1882(f) (42 U.S.C. 1395ss(f)) is amended to read as follows:

"(f)(1) The Secretary shall develop and distribute comparative materials about all medicare supplemental policies issued in a State. Each issuer of such a policy shall reimburse the Secretary for its pro rata share (as determined by the Secretary for purposes of section 1876(c)(3)(C)) of the costs incurred by the Secretary in carrying out the requirements of the preceding sentence and other enrollment activities, or the issuer shall no longer be considered as meeting the requirements of this

section.".

(c) Effective Date. The amendments made by this section shall apply with respect to materials for enrollment in years after 1995.

Section 4013 OUTLIER PAYMENTS.

(a) General Rule. Section 1876(a)(1) (42 U.S.C. 1395mm(a)(1)) is amended by adding at the end the following:

"(G)(i) In the case of an eligible organization with a risk-sharing contract, the Secretary may make additional payments to the organization equal to not more than 50 percent of the imputed reasonable cost (or, if so requested by the organization, the reasonable cost) above the threshold amount of covered under parts A and B and provided (or paid for) in a year by the organization to any individual enrolled with the organization under this section.

"(ii) For purposes of clause (i), the `imputed reasonable cost' is an amount determined by the Secretary on a national, regional, or other basis that is related to the reasonable cost of services.

"(iii) For purposes of clause (i), the `threshold amount' is an amount determined by the Secretary from time to time, adjusted by the geographic factor utilized in determining payments to the organization under subparagraph (C) and rounded to the nearest multiple of $100, such that the total amount to be paid under this subparagraph for a year is estimated to be 5 percent or less of the total amount to be paid under risk-sharing contracts for services furnished for that year.

"(iv) An eligible organization shall submit a claim for additional payments under subsection (i) within such time as the Secretary may specify.

"(v) To the extent that total payments under clause (i) in a year

"(I) exceed the payment set aside as a result of the reduction under subparagraph (C) for the year, the Secretary shall increase the percentage reduction under such subparagraph for the following year by such percentage as will result in an increase in the reduction equal to such excess in previous payments, or

"(II) are less than the payment set aside as a result of the reduction under subparagraph (C) for the year, the amount of such difference shall remain available in the succeeding years for additional payments under this subparagraph and the Secretary may take such difference into account in establishing the percentage reduction under subparagraph (C) for the following year.".

(b) Conforming Amendment.Section 1876(a)(1)(C)(i) (42 U.S.C. 1395mm(a)(1)(C)(i)), as amended by section 4132(a), is further amended by inserting ",20and reduced by a uniform percentage (determined by the Secretary for a year, subject to adjustment under subparagraph (G)(v)) so that the total reduction is estimated to equal the amount to be paid under subparagraph (G)" before the period.

(c) Effective Date. The amendments made by the preceding subsections apply to services furnished after 1994.

Section 4014 POINT OF SERVICE OPTION.

(a) Point of Service Contracts. Part C of title XVIII is amended by inserting after section 1889 the following:

"point of service option

"Sec. 1890. (a) Establishment of Program.Not later than July 1, 1995, the Secretary shall promulgate regulations establishing a point-of-service program under which individuals entitled to benefits under this title (other than individuals enrolled with an eligible organization with a risk-sharing contract under section 1876(g)) may obtain such benefits through providers and suppliers who are members of a point-of-service network established by the Secretary in accordance with the criteria described in subsection (b).

"(b) Criteria for Networks.In establishing criteria for point-of-service networks under the program under this section, the Secretary shall

"(1) designate an appropriate geographic service area for each such network to ensure that each network has a sufficient number of participating members to provide items and services under this title to beneficiaries, except that no such service area may be served by more than one such network;

"(2) establish requirements for participating members;

"(3) establish a schedule of payments for services furnished by networks, including a schedule of bundled payment arrangements for selected medical and surgical procedures;

"(4) delineate permissible incentives to encourage physicians and other suppliers to join the network, and to encourage individuals to receive services under this title through the network;

"(5) specify the rules under which carriers under section 1842 may administer the program;

"(6) establish procedures to used for the provision of case management services and criteria for determining whether (and under which circumstances) services which would otherwise not be covered under this title would be covered by the network under such case management;

"(7) establish standards for the processing and payment of claims for payment for services furnished by the network, including standards for the apportionment of payments among the Trust Funds established under this title;

"(8) establish standards for the selection of physicians for the network based on practice patterns and a demonstration of effective quality assurance;

"(9) develop standards to ensure that the point-of-service option does not result in a net financial loss to the medicare program under this title after the implementation of the option in an area, taking into account administrative costs, the costs of services (which would otherwise not be covered under this title) provided to beneficiaries under case management, and the costs of incentives for physicians, other providers, and beneficiaries; and

"(10) apply such other criteria as the Secretary considers appropriate.

"(c) Bonus Payments Permitted.

"(1) In general. Notwithstanding any other provision of this title, the Secretary may increase the amount of payment otherwise provided under this title for items and services furnished by

individuals who are members of a point-of-service network under this section by a bonus payment (in such amount as the Secretary may determine).

"(2) Criteria for receiving payment. The Secretary may make a bonus payment under this subsection to members of a point-of-service network if the Secretary determines that the members of the network have reduced the costs to the medicare program of the items and services furnished by the network without adversely affecting the quality of care provided to beneficiaries.".

(b) Conforming Amendments.

(1) Section 1812(a) (42 U.S.C. 1395d(a)) is amended

(A) by striking "and" at the end of paragraph (3),

(B) by substituting "; and" for the period at the end of paragraph (4), and

(C) by adding at the end the following:

"(5) such additional items and services furnished by a provider of services to an individual subject to case management as may be specified under a point-of-service network arrangement under section 1890.".

(2) (A) Section 1814(b) (42 U.S.C. 1395f(b)) is amended

(i) in paragraph (1), by inserting "or (4)" after "paragraph (3)",

(ii) by striking "or" at the end of paragraph (2),

(iii) by substituting "; and" for the period at the end of paragraph (3), and

(iv) by inserting after paragraph (3) the following:

"(4) in the case of items and services furnished through a point of service network (as described in section 1890), the payment basis specified under the arrangement established for such network, plus any bonus payments as determined under subsection (c) of that section.".

(B) The matter in section 1886(d)(1)(A) (42 U.S.C.

1395ww(d)(1)(A)) preceding clause (i) is amended by inserting "(other than paragraph (4))" after "1814(b)".

(3) Section 1832(a)(2) (42 U.S.C. 1395k(a)(2)) is amended

(A) by striking "and" at the end of subparagraph (I),

(B) by substituting "; and" for the period at the end of subparagraph (J), and

(C) by adding at the end the following:

"(K) such additional items and services (other than inpatient services furnished by providers of services) as may be specified under a point-of-service network arrangement under section 1890.".

(4) Section 1833 (42 U.S.C. 1395l), as amended by section 4032, is amended by adding at the end the following new subsection:

"(u) In the case of items and services furnished through a point of service network (as described in section 1890), there shall be paid (subject to subsection (b)) amounts equal to 80 percent of the payment basis specified in an agreement entered into pursuant to that section, plus any bonus payments as determined under subsection (c) of that section.".

(5) Section 1862(a) (42 U.S.C. 1395y(a)), as amended by sections 4034(b)(4), 4118(b), and 2003(b), is further amended

(A) in paragraph (7), by striking "or under paragraph (1)(F)" and inserting ", under paragraph (1)(F), or under a contract under section 1890",

(B) by striking "or" at the end of paragraph (16),

(C) by striking the period at the end of paragraph (17) and inserting "; or", and

(D) by inserting after paragraph (17) the following new paragraph:

"(18) which are furnished to an individual and related to a health condition with respect to which the individual is subject

to case management through a point-of-service network under section 1890 but which are not included in the plan of care developed for such individual and agreed to by the individual and the case manager.".

(c) Effective Date. The amendments made by this subsection shall take effect January 1, 1996.

Part 3 MEDICARE COVERAGE EXPANSIONS

Section 4021 REFERENCE TO COVERAGE OF OUTPATIENT PRESCRIPTION DRUGS.

For provisions adding a new outpatient prescription drug benefit to the medicare program, see subtitle A of title II.

Section 4022 EXPANDED COVERAGE FOR PHYSICIAN ASSISTANTS, NURSE PRACTITIONERS, AND CLINICAL NURSE SPECIALISTS.

(a) Physician Assistants. Section 1861(s)(2)(K)(i) (42 U.S.C. 1395x(s)(2)(K)(i)) is amended by striking "(I) in a hospital" and all that follows through "shortage area".

(b) Nurse Practitioners and Clinical Nurse Specialists. Section 1861(s)(2)(K)(iii) (42 U.S.C. 1395x(s)(2)(K)(iii)) is amended

(1) by inserting "(I)" before "in a rural area", and

(2) by inserting ", (II) in any other area, in the case of services furnished by nurse practitioners other than services furnished to an inpatient of a hospital, or (III) in any other area, in the case of services furnished by clinical nurse specialists other than services furnished to an inpatient of a hospital, skilled nursing facility or nursing facility (as defined in section 1919(a)), and" after "section 1886(d)(2)(D))".

(c) Conforming Amendments. (1) Section 1832(a)(2)(B)(iv) (42 U.S.C. 1395k(a)(2)(B)(iv)) is amended by striking "provided in a rural area (as defined in section 1886(d)(2)(D))" and inserting

"described in section 1861(s)(2)(K)(iii)".

(2) Section 1833(a)(1)(O) (42 U.S.C. 1395l(a)(1)(O)) is amended by striking "provided in a rural area".

(3) Section 1833(r)(1) (42 U.S.C. 1395l(r)(1)) is amended by striking "provided in a rural area".

(d) Effective Date. The amendments made by this section shall apply to services furnished on or after January 1, 1996.

Part 4 COORDINATION WITH ADMINISTRATIVE SIMPLIFICATION AND QUALITY MANAGEMENT INITIATIVES

Section 4031 REPEAL OF SEPARATE MEDICARE PEER REVIEW PROGRAM.

Part B of title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by adding at the end the following new section:

"termination

"Sec. 1165. The provisions of this part shall terminate effective upon the adoption of the National Quality Management Program under subtitle A of title V of the Health Security Act. Any reference to this part or any section in this part shall not be effective after such date.".

Section 4032 MANDATORY ASSIGNMENT FOR ALL PART B SERVICES.

Section 1833 (42 U.S.C. 1395l) is amended

(1) by redesignating the subsection (r) added by section 4206(b)(2) of OBRA091990 as subsection (s); and

(2) by adding at the end the following new subsection:

"(t)(1) Notwithstanding any other provision of this part, payment under this part for any item or service furnished on or after January 1, 1996, may only be made on an assignment-related basis.

"(2) Except for deductible, coinsurance, or copayment amounts applicable under this part, no physician, supplier, or other person may bill or collect any amount from an individual enrolled under this part or other person for an item or service for which payment may be made under this part. No such individual or person is liable for payment of any amounts billed in violation of the previous sentence.

"(3) If a physician, supplier, or other person knowingly and willfully bills or collects an amount in violation of paragraph (2), the Secretary may apply sanctions against such physician, supplier, or other person in accordance with section 1842(j)(2). Paragraph (4) of section 1842(j) shall apply in this paragraph in the same manner as such paragraph applies to such section.".

Section 4033 ELIMINATION OF COMPLEXITIES CAUSED BY DUAL FUNDING SOURCES AND RULES FOR PAYMENT OF CLAIMS.

(a) In General. The Secretary of Health and Human Services shall take such steps as may be necessary to consolidate the administration (including processing systems) of parts A and B of the medicare program (under title XVIII of the Social Security Act).

(b) Combination of Intermediary and Carrier Functions. In taking such steps, the Secretary shall contract with a single entity that combines the fiscal intermediary and carrier functions in each area except where the Secretary finds that special regional or national contracts are appropriate.

(c) Superseding Conflicting Requirements. The provisions of sections 1816 and 1842 of the Social Security Act (including provider nominating provisions in such section 1816) are superseded to the extent required to carry out this section.

Section 4034 REPEAL OF PRO PRECERTIFICATION REQUIREMENT FOR CERTAIN SURGICAL PROCEDURES.

(a) In General. Section 1164 (42 U.S.C. 1320c0913) is repealed.

(b) Conforming Amendments.

(1) Section 1154 (42 U.S.C. 1320c093) is amended

(A) in subsection (a), by striking paragraph (12), and

(B) in subsection (d), by striking "(and except as provided in section 1164)".

(2) Section 1833 (42 U.S.C. 1395l) is amended

(A) in subsection (a)(1)(D)(i), by striking ", or for tests furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion)";

(B) in subsection (a)(1), by striking clause (G);

(C) in subsection (a)(2)(A), by striking ", to items and services (other than clinical diagnostic laboratory tests) furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion),";

(D) in subsection (a)(2)(D)(i)

(i) by striking "basis," and inserting "basis or", and

(ii) by striking ", or for tests furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion)";

(E) in subsection (a)(3), by striking "and for items and services furnished in connection with obtaining a second opinion required under section 1164(c)(2), or a third opinion, if the second opinion was in disagreement with the first opinion)"; and

(F) in the first sentence of subsection (b), by striking "(4)" and all that follows through "and (5)" and inserting and "(4)".

(3) Section 1834(g)(1)(B) (42 U.S.C. 1395m(g)(1)(B)) is amended by striking "and for items and services furnished in connection with obtaining a second opinion required under section 1164(c)(2), or a third opinion, if the second opinion was in disagreement with the first opinion)".

(4) Section 1862(a) (42 U.S.C. 1395y(a)) is amended

(A) by adding "or" at the end of paragraph (14),

(B) by striking "; or" at the end of paragraph (15) and inserting a period, and

(C) by striking paragraph (16).

(5) The third sentence of section 1866(a)(2)(A) (42 U.S.C. 1395w(a)(2)(A)) is amended by striking ", with respect to items and services furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion),".

(c) Effective Date. The amendments made by this section shall apply to services provided on or after the date of the enactment of this Act.

Section 4035 REQUIREMENTS FOR CHANGES IN BILLING PROCEDURES.

(a) Limitation on Frequency of System Changes. The Secretary of Health and Human Services may not implement any change in the system used for the billing and processing of claims for payment for items and services furnished under title XVIII of the Social Security Act within 6 months of implementing any previous change in such system.

(b) Advance Notification to Providers as Requirement for Carriers and Fiscal Intermediaries.

(1) Fiscal intermediaries. Section 1816(c) (42 U.S.C. 1395h(c)) is amended by adding at the end the following new paragraph:

"(4) Each agreement with an agency or organization under this section
shall provide that the agency or organization shall notify providers of
services of any major change in the procedures for billing for services
furnished under this part at least 120 days before such change is to take
effect.".

(2) Carriers. Section 1842(b)(3) (42 U.S.C. 1395u(b)(3)) is amended

(A) by striking "and" at the end of subparagraph (G) and the end of subparagraph (H); and

(B) by inserting after subparagraph (H) the following new subparagraph:

"(I) will notify individuals and entities furnishing items and services for which payment may be made under this part of any major change in the procedures for billing for such items and services at least 120 days before such change is to take effect; and".

(3) Effective date. The amendments made by paragraphs (1) and (2) shall apply to agreements with fiscal intermediaries under section 1816 of the Social Security Act and to contracts with carriers under section 1842 of such Act for years beginning after the expiration of the 9-month period beginning on the date of the enactment of this Act.

Part 5 AMENDMENTS TO ANTI-FRAUD AND ABUSE PROVISIONS

Section 4041 ANTI-KICKBACK PROVISIONS.

(a) Revision to Penalties.

(1) Permitting secretary to impose civil monetary penalty. Section 1128A(a) (42 U.S.C. 1320a097a(a)) is amended

(A) by striking "or" at the end of paragraphs (1) and (2);

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

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

"(4) carries out any activity in violation of paragraph (1) or (2) of section 1128B(b);".

(2) Description of civil monetary penalty applicable. Section 1128A(a) (42 U.S.C. 1320a097a(a)) is amended

(A) by striking "given)." at the end of the first sentence and inserting the following: "given or, in cases under paragraph (4), $50,000 for each such violation)."; and

(B) by striking "claim." at the end of the second sentence and inserting the following: "claim (or, in cases under

paragraph (4), damages of not more than three times the total amount of remuneration offered, paid, solicited, or received, without regard to whether a portion of such remuneration was offered, paid, solicited, or received for a lawful purpose).".

(3) Increase in criminal penalty. Paragraphs (1) and (2) of section 1128B(b) (42 U.S.C. 1320a097b(b)) are each amended

(A) by striking "$25,000" and inserting "$50,000"; and

(B) by striking the period at the end and inserting the following: ", and shall be subject to damages of not more than three times the total remuneration offered, paid, solicited, or received, without regard to whether a portion of such remuneration was offered, paid, solicited, or received for a lawful purpose.".

(b) Revisions to Exceptions.

(1) Exception for discounts. Section 1128B(b)(3)(A) (42 U.S.C. 1320a097b(b)(3)(A)) is amended by striking "program;" and inserting "program and is not

"(i) for the furnishing of one item or service without charge or at a reduced charge in exchange for any agreement to buy a different item or service;

"(ii) applicable to one payor but not to providers of services or other entities under title XVIII or a State health care program; or

"(iii) in the form of a cash payment;".

(2) Exception for payments to employees. Section 1128B(b)(3)(B) (42 U.S.C. 1320a097b(b)(3)(B)) is amended by inserting at the end

"if the amount of remuneration under the arrangement is consistent
with the fair market value of the services and is not determined in a
manner that takes into account (directly or indirectly) the volume or
value of any referrals, except that such employee can be paid remuneration in the form of a productivity bonus based on

services
personally performed by the employee.".

(3) Exception for waiver of coinsurance by certain providers. Section 1128B(b)(3)(D) (42 U.S.C. 1320a097b(b)(3)(D)) is amended to read as follows:

"(D) a waiver or reduction of any coinsurance or other copayment if the waiver or reduction is made pursuant to a public schedule of discounts which the person is obligated as a matter of law to apply to certain individuals.".

(4) New exception for certain providers. Section 1128B(b)(3) (42 U.S.C. 1320a097b(b)(3)) is amended

(A) by striking "and" at the end of subparagraph (D);

(B) by striking the period at the end of subparagraph (E) and inserting "; and"; and

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

"(F) any remuneration obtained by or given to an individual or entity who receives assistance under a grant or cooperative agreement for the provision of health care services under title V, title XX, or the Public Health Service Act, or is obligated as a matter of law to provide services according to a schedule which provides for discounts based on the ability of the individual services to pay, if

"(i) in the case of an individual or entity who receives assistance under a grant or cooperative agreement for the provision of health care services under title V, title XX, or the Public Health Service Act, the remuneration is directly and primarily related to the activity supported by the grant or cooperative agreement; and

"(ii) the remuneration is pursuant to a written arrangement for the use or procurement of space, equipment, goods, or services for the referral of patients that

"(I) does not result in private inurement to any current employee, officer, member of the Board of Directors, or agent of the recipient or any other person involved in recommending or negotiating the arrangement; and

"(II) does not preclude the referral of patients to other providers of service of the patient's own choosing and does not interfere with the ability of health professionals to refer patients to providers of services they believe are the most appropriate, except to the extent such choices or referrals are limited by the terms of a health plan in which the patient has enrolled or the terms of a grant or cooperative agreement described in clause (i).".

(5) New exception for capitated payments. Section 1128B(b)(3) (42 U.S.C. 1320a097b(b)(3)), as amended by paragraph (4), is further amended

(A) by striking "and" at the end of subparagraph (E);

(B) by striking the period at the end of subparagraph (F) and inserting "; and"; and

(C) by adding at the end the following new subparagraph

"(G) any reduction in cost sharing or increased benefits given to an individual, any amounts paid to a provider of services for items or services furnished to an individual, or any discount or reduction in price given by the provider for such items or services, if the individual is enrolled with and such items and services are covered under any of the following:

"(i) A health plan which is furnishing items or services under title XVIII or a State health care program to individuals on an at-risk, prepaid, capitated basis pursuant to a written agreement with the Secretary or a State health care program.

"(ii) An organization receiving payments on a prepaid basis, under a demonstration project under section 402(a) of the Social Security Amendments of 1967 or under section 222(a) of the Social Security Amendments of 1972.

"(iii) Any other plan or insurer under which each participating provider is paid wholly on an at-risk, prepaid, capitated basis for such items or services pursuant to a written arrangement between the plan and the provider.".

(c) Clarification of Coverage of Employers and Employees. Section 1128B(b) (42 U.S.C. 1320a097b(b)), as amended by

subsection (a)(4), is further amended by adding at the end the following new paragraph:

"(5) In this subsection, the term `referral' includes the referral by an employee to his or her employer of any item or service for which payment may be made in whole or in part under title XVIII or a State health care program."

(d) Authorization for the Secretary To Issue Regulations. Section 1128B(b) (42 U.S.C. 1320a097b(b)), as amended by subsections (a)(4) and (c), is further amended by adding at the end the following new paragraph:

"(6) The Secretary is authorized to impose by regulation such other requirements as needed to protect against program or patient abuse with respect to any of the exceptions described in paragraph (3).".

(e) Clarification of Other Elements of Offense. Section 1128B(b) (42 U.S.C. 1320a097b(b)) is amended

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

(2) in paragraph (1)(A), by striking "in return for referring" and inserting "to refer";

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

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

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

Section 4042 REVISIONS TO LIMITATIONS ON PHYSICIAN SELF-REFERRAL.

(a) Clarification of Payment Ban. Section 1877(a)(1)(B) (42

U.S.C. 1395nn(a)(1)(B)) is amended to read as follows:

"(B) no physician or entity may present or cause to be presented a claim
under this title or bill to any third party payor or other entity for
designated health services furnished pursuant to a referral prohibited under
subparagraph (A).".

(b) Clarification of Coverage of Holding Company Type Arrangements and Loans. The last sentence of section 1877(a)(2) (42 U.S.C. 1395nn(a)(2)) is amended by striking "an interest in an entity that holds an ownership or investment interest in any entity providing the designated health service" and inserting the following: "a loan from the entity, and an interest held indirectly through means such as (but not limited to) having a family member hold such investment interest or holding a legal or beneficial interest in another entity (such as a trust or holding company) that holds such investment interest".

(c) Revisions to General Exceptions to Both Ownership and Compensation Arrangement Prohibitions.

(1) Repeal of exception for physicians' services.Section 1877(b) (42 U.S.C. 1395nn(b)) is amended

(A) by striking paragraph (1); and

(B) by redesignating paragraphs (2) and (3) as paragraphs (1) and (2).

(2) Revision to in-office ancillary services exception. Section 1877(b)(1) (42 U.S.C. 1395nn(b)(1)), as redesignated by paragraph (1), is amended

(A) in the matter preceding subparagraph (A), by striking

"services (other than durable medical equipment (excluding infusion pumps) and parenteral and enteral nutrients, equipment, and supplies)" and inserting "clinical laboratory services, x-ray and ultrasound services that are provided at low-cost (as determined in accordance with regulations of the Secretary)"; and

(B) in subparagraph (A)

(i) in clause (ii)(I), by striking "(or another physician who is a member of the same group practice)",

(ii) in clause (ii)(II) by inserting "the same or" before "another building", and

(iii) in clause (ii)(II)(bb), by inserting "all of" after "centralized provision of".

(3) Revision to prepaid plan exception.Section 1877(b)(2), (42 U.S.C. 1395nn(b)(2)), as redesignated by paragraph (1), is amended to read as follows:

"(2) Prepaid plans. In the case of designated health services furnished by an organization

"(A) with a risk sharing contract under section 1876(g) to an individual enrolled with the organization,

"(B) receiving payments on a prepaid basis, under a demonstration project under section 402(a) of the Social Security Amendments of 1967 or under section 222(a) of the Social Security Amendments of 1972, to an individual enrolled with the organization, or

"(C) that is a qualified health maintenance organization (within the meaning of section 1310(d) of the Public Health Service Act) to an individual enrolled with the organization.".

(4) New exception for capitated payments.Section 1877(b) (42 U.S.C. 1395nn(b)), as amended by paragraph (1), is amended by inserting after paragraph (2) the following new paragraph:

"(3) Other capitated payments. In the case of a designated health service, if the designated health service is included in the services for which a physician or physician group is paid wholly on an at-risk, prepaid, capitated basis by a health plan or insurer pursuant to a written arrangement between the plan or insurer and the physician or physician group.".

(d) Revision to Publicly Traded Securities Exception. Section 1877(c)(1) (42 U.S.C. 1395nn(c)(1)) is amended by inserting "at the time acquired by the physician" after "which may be purchased on terms generally available to the public".

(e) Revision to Rural Provider Exception. Section 1877(d)(2) (42 U.S.C. 1395nn(d)(2)) is amended by striking "substantially all" and inserting "not less than 85 percent (as determined in accordance with regulations of the Secretary)".

(f) Revisions to Exceptions Relating to Other Compensation Arrangements.

(1) Exception for personal services arrangements. (A) Section 1877(e)(3)(B)(i)(II) (42 U.S.C. 1395nn(e)(3)(B)(i)(II)) is amended to read as follows:

"(II) If the plan places a physician or physician group at substantial financial risk (as determined by the Secretary pursuant to section 1876(i)(8)(A)(ii)), for services not provided by the physician, the entity complies with the provisions of subclauses (I) and (II) of section 1876(i)(8)(A)(ii).";

(B) Section 1877(e)(3)(B)(ii), 42 U.S.C. 1395nn(e)(3)(B)(ii) is amended by striking "may directly or indirectly have the effect of" and inserting "has the purpose of".

(2) Repeal of exception for remuneration unrelated to the provision of designated health services. Section 1877(e) (42 U.S.C. 1395nn(e)) is amended

(A) by striking paragraph (4); and

(B) by redesignating paragraphs (5), (6), (7), and (8) as paragraphs (4), (5), (6), and (7).

(3) Exception for certain physician recruitment. Section 1877(e)(4) (42 U.S.C. 1395nn(e)(4)), as redesignated by paragraph (2), is amended to read as follows:

"(4) Physician recruitment. In the case of remuneration which is provided by an entity located in a rural area (as defined in section 1886(d)(2)(D)) or a health professional shortage areas (designated under section 332 of the Public Health Service Act), or an entity for which 85 percent of the patients are members of a medically underserved population designated under section 330 of the Public Health Service Act (as determined in accordance with regulations of the Secretary), in order to induce a physician who has been practicing within the physician's current specialty for less than one year to establish staff privileges at the entity, or to induce any other physician to relocate his or

her primary place of practice to the geographic area served by the entity, if the following standards are met:

"(A) The arrangement is set forth in a written agreement that specifies the benefits provided by the entity to the physician, the terms under which the benefits are to be provided, and the obligations of each party.

"(B) If a physician is leaving an established practice, the physical location of the new primary place of practice must be not less than 100 miles from the location of the established primary place of practice and at least 85 percent of the revenues of the physician's new practice must be generated from new patients for whom the physician did not previously provide services at the former practice.

"(C) The benefits are provided by the entity for a period not in excess of 3 years, and the terms of the agreement are not renegotiated during this 3-year period in any substantial aspect, unless the physician's new primary place of practice is designated as a health professional shortage area (pursuant to section 332 of the Public Health Service Act) for the physician's specialty category during the entire duration of the relationship between the physician and the entity.

"(D) There is no requirement that the physician make referrals to, be in a position to make or influence referrals to, or otherwise generate business for the entity as a condition for receiving the benefits.

"(E) The physician is not restricted from establishing staff privileges at, referring any service to, or otherwise generating any business for any other entity of the physician's choosing.

"(F) The amount or value of the benefits provided by the entity may not vary (or be adjusted or renegotiated) in any manner based on the volume or value of any expected referrals to or business otherwise generated for the entity by the physician for which payment may be made in whole or in part under this title or a State health care program (as defined in section 1128(h)).

"(G) The physician agrees to treat patients entitled to benefits under this title or enrolled in a State plan for medical assistance under title XIX.".

(4) Exception for isolated transactions. Section 1877(e)(5) (42 U.S.C. 1395nn(e)(6)), as redesignated by paragraph (2), is amended

(A) by redesignating subparagraph (B) as subparagraph (C);

(B) by striking "and" at the end of subparagraph (A); and

(C) by inserting after subparagraph (A) the following new subparagraph:

"(B) there is no financing of the sale between the parties, and".

(5) Exception for payments by a physician. Section 1877(e)(7) (42 U.S.C. 1395nn(e)(7)), as redesignated by paragraph (2), is amended to read as follows:

"(7) Payments by a physician for items and services. Payments made by a physician to an individual or entity as compensation for items or services if the items or services are furnished at a price that is consistent with fair market value.".

(6) Additional exception for discounts or other reductions in price. Section 1877(e) (42 U.S.C. 1395nn(e)), as amended by paragraph (2), is amended by adding at the end the following new paragraph:

"(8) Discounts or other reductions in price. Discounts or other reductions in price between a physician and an entity for items or services for which payment may be made under this title so long as the discount or other reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the physician or entity under this title and is not

"(A) for the furnishing of one item or service without charge or at a reduced charge in exchange for any agreement to buy a different item or service,

"(B) applicable to one or more payers but not to all individuals and entities providing services for which payment may be made under this title, or

"(C) in the form of a cash payment.".

(g) Clarification of Sanction Authority. Section 1877(g)(4) (42 U.S.C. 1395nn(g)(4)) is amended by striking "Any physician" and all that follows through "to such entity," and inserting the following: "Any physician or other entity that enters into an arrangement or scheme (such as a cross-referral arrangement or an arrangement with multiple leases overlapping in time for the same or similar rental space or equipment) which the physician or entity knows or should know has a principal purpose of inducing referrals to another entity, which referrals, if made directly by the physician or entity to such other entity,".

(h) Clarification of Definition of Remuneration. Section 1877(h)(1)(B) (42 U.S.C. 1395nn(h)(1)(B)) is amended to read as follows:

"(B) The term `remuneration' includes any payment, discount or other reduction in price, forgiveness of debt or other benefit made directly or indirectly, overtly or covertly, in cash or in kind.".

(i) Revision to Definition of Group Practice. Section 1877(h)(4) (42 U.S.C. 1395nn(h)(4)) is amended

(1) in subparagraph (A)(vi), by striking the period at the end and inserting the following: ", including a requirement for the physical grouping of physician practices as may be reasonably required to prevent the abuse of any exceptions provided to group practices under this section."; and

(2) in subparagraph (B)(i), by striking "or services incident to such personally performed services".

(j) Expansion to Cover Additional Items and Services. Section 1877(h)(6) (42 U.S.C. 1395nn(h)(6)), as amended by section 2005(c)(3), is amended

(1) in subparagraph (D), by striking "or other"; and

(2) by adding at the end the following new subparagraphs:

"(M) Diagnostic services.

"(N) Any other item or service not rendered by the physician personally or by a person under the physician's direct

supervision.".

(k) Authorization for the Secretary to Issue Regulations. Section 1877 (42 U.S.C. 1395nn) is amended by adding the following new subsection:

"(i) Additional Requirements. The Secretary is authorized to impose by regulation such other requirements as needed to protect against program or patient abuse with respect to any of the exceptions under this section.".

(l) Incorporation of Amendments Made Under OBRA091993. In this section, any reference to section 1877 of the Social Security Act shall be considered a reference to such section as amended by section 13562(a) of OBRA091993.

Section 4043 CIVIL MONETARY PENALTIES.

(a) Prohibition Against Offering Inducements to Individuals Enrolled Under Plans.

(1) Offer of remuneration. Section 1128A(a) (42 U.S.C. 1320a097a(a)) (as amended by section 4041(a)(1)) is amended

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

(B) by striking the semicolon at the end of paragraph (4) and inserting "; or"; and

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

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

(2) Remuneration defined. Section 1128A(i) (42 U.S.C. 1320a097a(i)) is amended by adding at the end the following new paragraph:

"(6) The term `remuneration' includes the waiver of coinsurance and deductible amounts (or any part thereof), and transfers of items or services for free or for other than fair market value, except that such term does not include the waiver of coinsurance or deductible amounts by a person or entity, if

"(A) the waiver is not offered as part of any advertisement or solicitation;

"(B) the person does not routinely waive coinsurance or deductible amounts; and

"(C) the person

"(i) waives the coinsurance and deductible amounts after determining in good faith that the individual is indigent;

"(ii) fails to collect coinsurance or deductible amounts after making reasonable collection efforts; or

"(iii) provides for any permissible waiver as specified in section 1128B(b)(3) or in regulations issued by the Secretary.".

(b) Claim for Item or Service Based on Incorrect Coding or Medically Unnecessary Services. Section 1128A(a)(1) (42 U.S.C. 1320a097a(a)(1)) is amended

(1) in subparagraph (A), by striking "claimed," and inserting the following: "claimed, including any person who presents or causes to be presented a claim for an item or service which includes a procedure or diagnosis code that the person knows or should know will result in a greater payment to the person than the code applicable to the item or service actually provided or actual patient medical condition,";

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

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

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

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

(c) Excluded Individual Retaining Ownership or Control Interest in Participating Entity. Section 1128A(a) of such Act, as amended by section 4041(a)(1) and subsection (a)(1), is further amended

(1) by striking "or" at the end of paragraph (4);

(2) by striking the semicolon at the end of paragraph (5) and inserting "; or"; and

(3) by inserting after paragraph (5) the following new paragraph:

"(6) in the case of a person who is not an organization, agency, or other entity, who is excluded from participating in a program under title XVIII or a State health care program in accordance with this section, section 1128, or section 1156 and who, during the period of exclusion, retains either a direct or indirect ownership or control interest of 5 percent or more in, or an ownership or control interest (as defined in section 1124(a)(3)) in, or who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of, an entity that is participating in a program under title XVIII or a State health care program;".

(d) Additional Offenses Relating to Alliance System. Section 1128A(a) of such Act, as amended by section 4041(a)(1) and subsections (a)(1) and (c), is further amended

(1) by striking "or" at the end of paragraph (5);

(2) by striking the semicolon at the end of paragraph (6) and inserting "; or"; and

(3) by inserting after paragraph (6) the following new paragraphs:

"(7) engages in a practice that circumvents a payment methodology intended to reimburse for two or more discreet medical items or services at a single or fixed amount, including but not limited to, multiple admissions or readmission to hospitals and other institutions reimbursed on a diagnosis reimbursement grouping basis;

"(8) engages in a practice which has the effect of limiting or

discouraging (as compared to other plan enrollees) the utilization of health care services covered by law or under the service contract by title XIX or other publicly subsidized patients, including but not limited to differential standards for the location and hours of service offered by providers participating in the plan;

"(9) substantially fails to cooperate with a quality assurance program or a utilization review activity;

"(10) fails substantially to provide or authorize medically necessary items and services that are required to be provided to an individual covered under a health plan under the Health Security Act or public program for the delivery of or payment for health care items or services, if the failure has adversely affected (or had a substantial likelihood of adversely affecting) the individual;

"(11) employs or contracts with any individual or entity who is excluded from participating in a program under title XVIII or a State health care program in accordance with this section, section 1128, or section 1156, for the provision of any services (including but not limited to health care, utilization review, medical social work, or administrative), or employs or contracts with any entity for the direct or indirect provision of such services, through such an excluded individual or entity; or

"(12) submits false or fraudulent statements, data or information or claims to the National Health Board established under part 1 of subtitle F of title I of the Health Security Act, any other Federal agency, a State health care agency, a health alliance (under subtitle D of title I of such Act), or any other Federal, State or local agency charged with implementation or oversight of a health plan under such Act or a public program that the person knows or should know is fraudulent;".

(e) Modifications of Amounts of Penalties and Assessments. Section 1128A(a) (42 U.S.C. 1320a097a(a)), as amended by section 4041(a), subsection (a)(1), subsection (c), and subsection (d), is amended in the matter following paragraph (12)

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

(2) by inserting after "under paragraph (4), $50,000 for each such violation" the following: "; in cases under paragraph (5), $10,000 for each such offer, payment, or transfer; in cases

under paragraph (6), $10,000 for each day the prohibited relationship occurs; in cases under paragraphs (7) through (12), an amount not to exceed $50,000 for each such determination by the Secretary"; and

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

(f) Interest on Penalties. Section 1128A(f) (42 U.S.C. 1320a097a(f)) is amended by adding after the first sentence the following: "Interest shall accrue on the penalties and assessments imposed by a final determination of the Secretary in accordance with an annual rate established by the Secretary under the Federal Claims Collection Act. The rate of interest charged shall be the rate in effect on the date the determination becomes final and shall remain fixed at that rate until the entire amount due is paid. In addition, the Secretary is authorized to recover the costs of collection in any case where the penalties and assessments are not paid within 30 days after the determination becomes final, or in the case of a compromised amount, where payments are more than 90 days past due. In lieu of actual costs, the Secretary is authorized to impose a charge of up to 10 percent of the amount of penalties and assessments owed to cover the costs of collection.".

(g) Authorization To Act.

(1) In general. The first sentence of section 1128A(c)(1) (42 U.S.C. 1320a097a(c)(1)) is amended by striking all that follows "(b)" and inserting the following: "unless, within one year after the date the Secretary presents a case to the Attorney General for consideration, the Attorney General brings an action in a district court of the United States.".

(2) Effective date. The amendment made by this paragraph (1) shall apply to cases presented by the Secretary of Health and Human Services for consideration on or after the date of the enactment of this Act.

(h) Deposit of Penalties Collected into All-Payer Account. Section 1128A(f)(3) (42 U.S.C. 1320a097a(f)(3)) is amended by striking "as miscellaneous receipts of the Treasury of the United States" and inserting "in the All-Payer Health Care Fraud and Abuse Control Account established under section 5402 of the Health Security Act".

(i) Clarification of Penalty Imposed on Excluded Provider Furnishing Services. Section 1128A(a)(1)(D) (42 U.S.C. 1320a097a(a)(1)(D)) is amended by inserting "who furnished the service" after "in which the person".

Section 4044 EXCLUSIONS FROM PROGRAM PARTICIPATION.

(a) Mandatory Exclusion for Individual Convicted of Criminal Offense Related to Health Care Fraud. Section 1128 (42 U.S.C. 1320a097) is amended

(1) by amending paragraph (1) of subsection (a) to read as follows:

"(1) Convictions of program-related crimes and health care fraud.

"(A) Any individual or entity that has been convicted of a criminal offense related to the delivery of an item or service under title XVIII or under any State health care program; or

"(B) Any individual or entity that has been convicted, under Federal or State law, in connection with the delivery of a health care item or service of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct."; and

(2) in subsection (b)(1), by striking "in connection with the delivery of a health care item or service or".

(b) Establishment of Minimum Period of Exclusion for Certain Individuals and Entities Subject to Permissive Exclusion From Medicare and State Health Care Programs. Section 1128(c)(3) (42 U.S.C. 1320a097(c)(3)) is amended by adding at the end the following new subparagraphs:

"(D) In the case of an exclusion of an individual or entity under paragraphs (1), (2), or (3) of subsection (b), the period of exclusion shall be a minimum of 3 years, unless the Secretary determines that a longer period is appropriate because of aggravating circumstances.

"(E) In the case of an exclusion of an individual or entity under paragraph (4) or (5) of subsection (b), the period of the exclusion shall not be less than the period during which the individual's or entity's license to provide health care is

revoked, suspended, or surrendered, or the individual or the entity is excluded or suspended from a Federal or State health care program.

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

(c) Revision to Exclusion for Default on Health Education Loan or Scholarship Obligations. Section 1128(b)(14) (42 U.S.C. 1320a097(b)(14)) is amended by striking "all reasonable steps" and inserting "reasonable steps".

(d) Permissive Exclusion of Individuals With Ownership or Control Interest in Sanctioned Entities. Section 1128(b) (42 U.S.C. 1320a097(b)) is amended by adding at the end the following new paragraph:

"(15) Individuals controlling a sanctioned entity. Any individual who has a direct or indirect ownership or control interest of 5 percent or more, or an ownership or control interest (as defined in section 1124(a)(3)) in, or who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of, an entity

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

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

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

(e) Exclusions Based on Actions Under Alliance System. Section 1128 (42 U.S.C. 1320a097), as amended by subsections (a) and (d), is amended

(1) in subsection (a)(1)(A), by striking "XVIII or under a State health care program" and inserting "XVIII, a State health care program, or under an applicable health plan (as defined in section 1902(6) of the Health Security Act)";

(2) in subsection (b)(5)

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

(B) by adding "or" at the end of subparagraph (B), and

(C) by inserting after subparagraph (B) the following new subparagraph:

"(C) an applicable health plan (as defined in section 1902(6) of the Health Security Act) under section 5411 or 5412(b)(3) of such Act,";

(3) in subsection (b)(6)(B), by striking "XVIII or under a State health care program" and inserting "XVIII, a State health care program, or an applicable health plan (as defined in section 1902(6) of the Health Security Act)";

(4) in subsection (b)(7), by striking the period at the end and inserting ", or in section 5412 of the Health Security Act.";

(5) in subsection (b)(8)(B)

(A) in clause (ii), by striking "1128A" and inserting "1128A or under section 5412 of the Health Security Act", and

(B) in clause (iii), by striking "XVIII or under a State health care program" and inserting "XVIII, a State health care program, or under an applicable health plan (as defined in section 1902(6) of the Health Security Act)";

(6) in subsection (b)(9), by striking the period at the end and inserting ", or provide any information requested by the Inspector General of the Department of Health and Human Services to carry out the All-Payer Health Care Fraud and Abuse Control Program established under section 5401 of the Health Security Act.";

(7) in subsection (b)(11)

(A) by striking "title XVIII or a State health care program" and inserting "title XVIII, a State health care program, or an applicable health plan (as defined in section 1902(6) of the Health Security Act)",

(B) by striking "Secretary or the appropriate State

agency" and inserting "Secretary, the appropriate State agency, or plan sponsor", and

(C) by striking "Secretary or that agency" and inserting "Secretary, that agency, or that sponsor";

(8) in subsection (b)(12), by adding at the end the following new subparagraph:

"(E) Any entity authorized by law to (i) conduct on-site health, safety or patient care reviews and surveys or (ii) to investigate whether any violations of law have occurred, including violations under this section, section 1128A, section 1128B, or part 2 of subtitle E of title V of the Health Security Act.";

(9) in subsection (b)(14), by striking "XVIII or XIX" and inserting "XVIII, a State health care program, or an applicable health plan (as defined in section 1902(6) of the Health Security Act)"; and

(10) in subsection (b)(15)

(A) in subparagraph (B), by striking "1128A" and inserting "1128A or section 5412 of the Health Security Act", and

(B) in subparagraph (C), by striking "title XVIII or under a State health care program" and inserting "title XVIII, a State health care program, or an applicable health plan (as defined in section 1902(6) of the Health Security Act".

(f) Appeal of Exclusions to Court of Appeals. Section 1128(f)(1) (42 U.S.C. 1320a097(f)(1)) is amended by striking the period at the end and inserting the following: ", except that any action brought to appeal such decision shall be brought in the United States Court of Appeals for the judicial circuit in which the individual or entity resides or has a principal place of business (or, if the individual or entity does not reside or have a principal place of business within any such judicial circuit, in the United States Court of Appeals for the District of Columbia Circuit).".

Section 4045 SANCTIONS AGAINST PRACTITIONERS AND PERSONS FOR FAILURE TO COMPLY WITH STATUTORY OBLIGATIONS RELATING TO QUALITY OF CARE.

(a) Minimum Period of Exclusion for Practitioners and Persons Failing To Meet Statutory Obligations.

(1) In general. The second sentence of section 1156(b)(1) (42 U.S.C. 1320c-5(b)(1)) is amended by striking "may prescribe)" and inserting "may prescribe, except that such period may not be less than one year)".

(2) Conforming amendment. Section 1156(b)(2) (42 U.S.C. 1320c-5(b)(2)) is amended by striking "shall remain" and inserting "shall (subject to the minimum period specified in the second sentence of paragraph (1)) remain".

(b) Repeal of "Unwilling or Unable" Condition for Imposition of Sanction. Section 1156(b)(1) (42 U.S.C. 1320c-5(b)(1)) is amended

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

(2) by striking the third sentence.

(c) Amount of Civil Money Penalty. Section 1156(b)(3) (42 U.S.C. 1320c-5(b)(3)) is amended by striking "the actual or estimated cost" and inserting the following: "$50,000 for each instance".