95TH CONGRESS } HOUSE OF REPRESENTATIVES { REPORT
1st Session } { No. 95-673

MEDICARE-MEDICAID ANTI-FRAUD AND ABUSE AMENDMENTS

OCTOBER 11, 1977.—Ordered to be printed

Mr. ULLMAN, from the committee of conference, submitted the following

CONFERENCE REPORT

[To accompany H.R. 3]

The committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 3) 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 met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment insert the following:

SHORT TITLE

SECTION 1. This Act may be cited as the "Medicare-Medicaid Anti-Fraud and Abuse Amendments".

PROHIBITION AGAINST ASSIGNMENT BY PHYSICIANS AND OTHERS OF CLAIMS FOR SERVICES; CLAIMS PAYMENT PROCEDURES FOR MEDICAID PROGRAM

SEC. 2. (a)(1) Section 1842(b)(5) of the Social Security Act is amended by adding at the end thereof the following new sentence: "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 govern-

mental agency or entity or is establishd 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.".

(2) Section 1815 of such Act is amended by adding at the end thereof the following new subsection:

"(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.".

(3) Section 1902(a)(32) of such Act is amended to read as follows:

"(32) provide that no payment under the plan for any care or service provided to an individual 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;".

(4) The amendments made by this subsection shall apply with respect to care and services furnished on or after the date of the enactment of this Act.

(b) (1) Section 1902(a) of the Social Security Act is amended—

(A) by striking out "and" at the end of paragraph (35);

(B) by striking out the period at the end of paragraph (36) and inserting in lieu thereof "; and";

(C) by inserting immediately after paragraph (36) the following new paragraph:

"(37) provide for claims payment procedures which (A) ensure that 90 per centum of claims for payment (for which no further written information or substantiation is required in order to make 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."; and

(D) by inserting at the end thereof the following paragraph:

"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.".

(2) The amendments made by paragraph (1) shall apply to calendar quarters beginning on and after July 1, 1978, with respect to State plans approved under title XIX of the Social Security Act.

DISCLOSURE OF OWNERSHIP AND RELATED INFORMATION

SEC. 3. (a) (1) Part A of title XI of the Social Security Act is amended by inserting immediately after section 1123 the following new section:

"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 dislosing 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 or in any subcontrator (as defined by the Secretary in regulations) in which the entity directly or indirectly has a 5 per centum or more ownership interest.

"(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, a renal disease facility, or a health maintenance organization (as defined in section 1301(a) of the Public Health Service Act);

"(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; 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) an 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.".

(2) Section 1861(j)(11) of such Act is amended to read as follows:

"(11) complies with the requirements of section 1124;".

(b) Clause (C) of section 1866(b)(2) of such Act is amended by inserting "(i)" after "failed", and by adding after "to verify such information," the following: "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,".

(c)(1) Section 1902(a) of such Act (as amended by section 2(b)(1) of this Act) is amended—

(A) by amending paragraph (35) to read as follows:

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

(B) by striking out "and" at the end of paragraph (36);

(C) by striking out the period at the end of paragraph (37) and inserting in lieu thereof "; and"; and

(D) by inserting after paragraph (37) the following new paragraph:

"(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.".

(2) Section 1903(i)(2) of such Act is amended by inserting before the semicolon at the end thereof the following: ", 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)".

(d)(1) Section 2003(d)(1) of such Act is amended—

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

(B) by striking out the period at the end of subparagraph (I) and inserting in lieu thereof "; and"; and

(C) by adding after subparagraph (I) the following new subparagraph:

"(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 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.".

(2) Section 2002(a) of such Act is amended by adding at the end thereof the following new paragraph:

"(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)(J), for so long as such entity remains in noncompliance with such request.".

(e) The amendment made by subsection (a)(1) shall apply with respect to certifications and recertifications made (and participation in the programs established by titles V, XVIII, XIX, and XX of the Social Security Act pursuant to certifications and recertifications made), and fiscal intermediary or agent agreements or contracts entered into or renewed, on and after the date of the enactment of this Act. The remaining amendments made by this section shall take effect on the date of the enactment of this Act; except that the amendments made by subsections (c) and (d) shall become effective January 1, 1978.

PENALTIES FOR DEFRAUDING MEDICARE AND MEDICAID PROGRAMS

SEC. 4. (a) Section 1877 of the Social Security Act is amended to read as follows:

"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 (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)(1) Whoever solicits or receives any remuneration (including any kickback, bribe, or rebate) 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 any item or service 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 any good, facility, service, or 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 any kickback, bribe, or rebate) 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 any item or service 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 any good, facility, service, or 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 recertification) as a hospital, skilled nursing facility, or home health agency (as those terms are defined in section 1861), 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.

"(d) Whoever accepts assignments described in section 1842(b)(3)(B)(ii) and knowingly, willfully, and repeatedly violates the term of such assignments specified in subclause (I) of such section, 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.".

(b) Section 1909 of such Act is amended to read as follows:

"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 (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)(1) Whoever solicits or receives any remuneration (including any kickback, bribe, or rebate) 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 any item or service 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 any good, facility, service, or 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 any kickback, bribe, or rebate) 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 any item or service 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 any good, facility, service, or 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 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 felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

"(d) Whoever knowingly and willfully—

"(1) charges, for any service provided to a patient under a State plan approved under this title, money or other consideration at a rate in excess of the rates established by the State, or

"(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this title, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)—

"(A) as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or

"(B) as a requirement for the patient's continued stay in such a facility,

when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan,

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.".

(c) Section 204(a) of Public Law 94–505 (42 U.S.C. 3524) (relating to annual reports of the Health, Education, and Welfare Inspector General) is amended by adding at the end thereof the following sentences: "Such report also shall include a detailed description of the cases referred by the Department of Health, Education, and Welfare to the Department of Justice during the period covered by the report, an evaluation of the performance of the Department of Justice 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 any recommendations with respect to improving the performance of such activities by the Department of Justice. Promptly, after the Inspector General submits such a report to Congress, the Attorney General shall report to Congress concerning the details of the dispostion of the cases referred to the Department of Justice and described in the Inspector General's report.".

(d) The amendments made by subsections (a) and (b) shall apply with respect to acts occurring and statements or representations made on or after the date of the enactment of this Act.

AMENDMENTS RELATED TO PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

SEC. 5. (a) Section 1152(e) of the Social Security Act is amended to read as follows:

"(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.".

(b)(1) Section 1154(b) of such Act is amended—

(A) by striking out "(which may not exceed 24 months)" in the first sentence and inserting in lieu thereof "(which may not exceed 48 months except as provided in subsection (c))";

(B) by inserting ", in addition to review of health care services provided by or in institutions," in the first sentence after "perform"; and

(C) by striking out "or ordered by physicians" and all that follows through "and organizations" in the second sentence and inserting in lieu thereof "by or in institutions (including ancillary services) and, in addition, review of such other health care services as the Secretary may require".

(2) Section 1154 of such Act is further amended by redesignating subsection (c) as subsection (d) and by inserting after subsection (b) the following new subsection:

"(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)(1) Section 1155 of such Act is amended—

(A) by striking out "directly or indirectly involved in" in subsection (a)(6)(A) and inserting in lieu thereof "directly responsible for";

(B) by striking out "any financial" in subsection (a)(6)(B) and inserting in lieu thereof "a significant financial";

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

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

(D) by striking out subsection (g) and inserting in lieu thereof the following new subsection:

"(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 earlier than the date the organization is designated as a Professional Standards Review Organization (other than under section 1154) and not later than two years after the date the organization has been so designated, 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.".

(2) Section 1101(a) of such Act is amended by inserting after paragraph (8) the following new paragraph:

"(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 colected 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(a) of the Public Health Service 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.".

(d)(1) Section 1158 of such Act is amended by adding at the end thereof the following new subsection:

"(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 specified 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.".

(2)(A) Section 1152(b)(2) of such Act is amended by striking out "submitted to him by the association, agency, or organization" and inserting in lieu thereof "which shall be developed and submitted by the association, agency, or organization in accordance with subsection (h)".

(B) Section 1152 of such Act is further amended by adding at the end thereof the following new subsection:

"(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 became effective.".

(C) Section 1154 of such Act (as amended by subsection (b)(2) of this section) is further amended by adding after subsection (d) the following new subsection:

"(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).".

(D) Part B of title XI of such Act is amended by adding after section 1170 the following new section:

"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 (c) 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, and for 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 to the extent that 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 appropriateness 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 appropriateness of care received by individuals under the State's plan approved under such title, unless the Secretary determines that the organization has taken appropriate corrective action, he shall immediately suspend such organization's authority in whole or in part under section 1158(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) until he (i) reevaluates such organization's performance of the responsibilities involved and determines that such performance does not have such unreasonable and detrimental impact, or (ii) determines that the organization has taken appropriate corrective action. Any determination made by the Secretary under this subparagraph 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.".

(3)(A) Section 1155(c)(1) of such Act is amended by striking out "of a hospital or other operating health care facility or organization" and inserting in lieu thereof "of a hospital (including any skilled nursing facility, as defined in section 1861(j), or intermediate care facility, as defined in section 1905(c), which is also a part of such hospital) or other operating health care facility or organization (other than such a skilled nursing facility or intermediate care facility which is not a part of a hospital)".

(B) Section 1155(a) of such Act is amended—

(i) by inserting "(except as provided in paragraph (7))" in paragraph (1) after "institutional and noninstitutional providers of health care services"; and

(ii) by inserting after paragraph (6) the following new paragraph:

"(7)(A) Except as provided in subparagraph (B), 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(c)) and in public institutions for the mentally retarded (described in section 1905(d)(1)) only if (i) 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, or (ii) the State requests such organization to assume such responsibility.

"(B) 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 in the State that are also skilled nursing facilities (as defined in section 1861(j)), to the extent that the Secretary finds that the performance of such function by the single State agency (described in subparagraph (A)) for that State is inefficient.".

(c) Section 1160(b)(1) of such Act is amended by striking out "practitioner or provider" and inserting in lieu thereof "health care practitioner or hospital, or other health care facility, agency, or organization" each time it appears therein.

(f) Section 1163(a)(2) of such Act is amended to read as follows: "(2) Members of the Council shall be appointed for a term of three years, except that the Secretary may provide, in the case of any terms scheduled to expire after January 1, 1978, for such shorter terms as will ensure that (on a continuing basis) the terms of no more than four members expire in any year. Members of the Council shall be eligible for reappointment.".

(g) Section 1163 of such Act is amended by striking out subsection (f).

(h) Section 1166 of such Act is amended—

(1) by striking out "or (2)" in subsection (a) and inserting in lieu thereof ", (2)";

(2) by inserting the following immediately before the period at the end of subsection (a): ", or (3) in accordance with subsection (b)";

(3) by redesignating subsection (b) as subsection (c);

(4) by inserting the following new subsection immediately after subsection (a):

"(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 subpena or discovery proceedings in a civilization.".

(i) Section 1167 of such Act is amended by adding the following new subsection at the end thereof:

"(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).".

(j) Section 1168 of such Act is amended by adding at the end thereof the following new sentence: "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.".

(k) Part B of title XI of such Act (as amended by subsection (d)(2)(D) of this section) is further amended by adding after section 1171 the following new section:

"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.".

(l)(1) Title XI of such Act (as amended by subsections (d)(2)(D) and (k) of this section) is further amended by adding after section 1172 the following new section:

"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.".

(2) The second sentence of section 1101(a)(1) of such Act is amended by inserting "and in part B of this title" after "title V".

(m) Section 1861(w)(2) of such Act is amended by inserting "part B of this title or under" immediately after "entitled to have payment made for such services under".

(n) Section 1167 of such Act is amended—

(1) by inserting "or to any Statewide Professional Standards Review Council" in subsection (a) after "Professional Standards Review Organization";

(2) by inserting "or such Council" in subsection (a) after "such Organization";

(3) by inserting "or of any Statewide Professional Standards Review Council" in subsection (b)(1) after "Professional Standards Review Organization";

(4) by inserting "or council" in subsection (b)(1) after "organization";

(5) by inserting "or of Statewide Professional Standards Review Councils" in subsection (b)(1) after "Review Organizations"; and

(6) by inserting "AND STATEWIDE PROFESSIONAL STANDARDS REVIEW COUNCILS" in the heading of the section after "PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS".

(o)(1) Section 1152(b)(1)(A) of such Act is amended by striking out "subsection (c)(i)" and inserting in lieu thereof "subsection (c)(1)".

(2) Section 1155(a)(1) of such Act is amended by striking out "(subject to the provisions of subsection (g))" in the matter preceding subparagraph (A).

(3) Section 1160(b)(1) of such Act is amended by inserting "or" after "permanently" in the matter following subparagraph (B).

(p) Section 1155(a)(5) of such Act is amended by striking out all that follows "Professional Standards Review Organization" and inserting in lieu thereof a period.

ISSUANCE OF SUBPENAS BY COMPTROLLER GENERAL

SEC. 6. Part A of title XI of the Social Security Act is amended by inserting after section 1124 (added by section 3(a) of this Act) the following new section:

"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 Comp-

troller General of the United States shall have power to sign and issue subpenas to any person requiring the production of any pertinent books, records, documents, or other information. Subpenas 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 subpena 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 subpena 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 subpena; 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.

"(c) No personal medical record in the possession of the General Accounting Office shall be subject to subpena or discovery proceedings in a civil action.".

SUSPENSION OF PRACTITIONERS CONVICTED OF MEDICARE- OR MEDICAID-RELATED CRIMES

SEC. 7. (a) Section 1862 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(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.".

(b) Section 1902(a) of such Act (as amended by sections 2(b) and 3(c) of this Act) is amended—

(1) by striking out "and" at the end of paragraph (37);

(2) by striking out the period at the end of paragraph (38) and inserting in lieu thereof "; and"; and

(3) by inserting after paragraph (38) the following new paragraph:

"(39) provide that, subject to subsection (g), whenever the single State agency which administers or supervises the administration of the State plan 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 the plan for not less than the period specified in such notice, and no payment may be made under the plan with respect to any item or service furnished by such physician or practitioner during the period of the suspension under this title.".

(c) Section 1902 of such Act is amended by adding after subsection (f) the following new subsection:

"(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 any item or service furnished by him during the period of such suspension, if the single State agency which administers or supervises the administration of the plan submits a request to the Secretary for such waiver and if the Secretary approves such request.".

(d) Section 332(c) of the Public Health Service Act (relating to considerations in the designation of health manpower shortage areas) is amended by inserting after paragraph (2) the following new paragraph:

"(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.".

(e)(1) The amendment made by subsection (d) shall apply with respect to determinations and designations made on and after the date of the enactment of this Act.

(2) *The amendment made by subsection (b) shall become effective on January 1, 1978.*

DISCLOSURE BY PROVIDERS OF OWNERS AND CERTAIN OTHER INDIVIDUALS CONVICTED OF CERTAIN OFFENSES

SEC. 8. (a) Part A of title XI of the Social Security Act is amended by inserting after section 1125 (added by section 6 of this Act) the following new section:

"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.".

(b)(1) Section 1866(a) of such Act is amended by adding at the end thereof the following new paragraph:

"(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 1126(b)) of such provider, is a person described in section 1126(a).".

(2) Section 1866(b)(2) of such Act is amended by inserting before the period at the end thereof the following: ", 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)".

(c) Section 1903 of such Act is amended by adding after subsection (m) the following new subsection:

"(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.".*

(d) Section 2002(a) of such Act (as amended by section 3(d) of this Act) is further amended by adding at the end thereof the following new paragraph:

"(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 the State 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.".*

(e) The amendments made by this section shall 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 beginning after the date of the enactment of this Act.

FEDERAL ACCESS TO RECORDS

SEC. 9. Section 1902(a)(27)(B) of the Social Security Act is amended by inserting "or the Secretary" after "State agency" each place it appears.

CLAIMS PROCESSING AND INFORMATION RETRIEVAL SYSTEMS FOR MEDICAID PROGRAMS

SEC. 10. (a) Section 1903(a)(3)(B) of the Social Security Act is amended by striking out "notice to each individual who is furnished services covered by the plan of the specific services so covered" and inserting in lieu thereof "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".

(b) The amendment made by subsection (a) shall apply with respect to calendar quarters beginning after the date of the enactment of this Act.

RESTRICTION ON FEDERAL MEDICAID PAYMENTS; ASSIGNMENT OF RIGHTS OF PAYMENT; INCENTIVE PAYMENTS

SEC. 11. (a) Section 1903 of the Social Security Act is amended by adding after subsection (n) (added by section 8(c) of this Act) the following new subsections:

"(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 of 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.".

(b) Title XIX of the Social Security Act is amended by adding at the end thereof the following new section:

"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 under the State plan to an individual who has the legal capacity to execute an assignment for himself, the individual is required—

"(A) to assign the State any rights, of the individual or of any other person who is eligible for medical assistance under this title and on whose behalf the individual has the legal authority to execute an assignment of such rights, to support (specified as support for the purpose of medical care

by a court or administrative order) and to payment for medical care from any third party; and

"(B) to cooperate with the State (i) in establishing the paternity of such person (referred to in subparagraph (A)) if the person is a child born out of wedlock, and (ii) in obtaining support and payments (described in subparagraph (A)) for himself and for such person, unless (in either case) the individual 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 (including financial arrangements), with any appropriate agency of any State (including, with respect to the enforcement and collection of rights of payment for medical care by or through a parent, with a State's agency established or designated under section 454 (3)) and with appropriate courts and law enforcement officials, to assist the agency or agencies administering the State plan with respect to (A) the enforcement and collection of rights to support or payment assigned under this section and (B) any other matters of common concern.

"(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 on behalf of an individual with respect to whom 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.".

(c) The amendment made by subsection (a) shall apply with respect to medical assistance provided, under a State plan approved under title XIX of the Social Security Act, on and after January 1, 1978.

STUDY AND REVIEW OF MEDICARE CLAIMS PROCESSING

SEC. 12. The Comptroller General of the United States shall conduct a comprehensive study and review of the administrative structure established for the processing of claims under title XVIII of the Social Security Act, for the purpose of determining whether and to what extent more efficient claims administration under such title could be achieved—

(1) by reducing the number of participating intermediaries and carriers;

(2) by making a single organization responsible for the processing of claims, under both part A and part B of such title, in a particular geographic area;

(3) by providing for the performance of claims processing functions on the basis of a prospective fixed price;

(4) by providing incentive payments for the most efficient organizations; or

(5) by other modifications in such structure and related procedures.

The Comptroller General shall submit to the Congress no later than July 1, 1979, a complete report setting forth the results of such study and review, together with his findings and his recommendations with respect thereto.

ABOLITION OF PROGRAM REVIEW TEAMS UNDER MEDICARE

SEC. 13. (a) Section 1862(d) of the Social Security Act is amended by striking out paragraph (4).

(b)(1) Section 1862(d)(1)(B) of such Act is amended by striking out ", with the concurrence of the appropriate program review team appointed pursuant to paragraph (4),".

(2) Section 1862(d)(1)(C) of such Act is amended to read as follows:

"(C) has furnished services or supplies which are determined by the Secretary, 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.".

(3) Clause (F) of section 1866(b)(2) of such Act is amended to read as follows: "(F) that such provider has furnished services or supplies which are determined by the Secretary 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) Section 1157 of such Act is amended by striking out the last sentence.

(c) The amendments made by this section shall take effect on the date of the enactment of this Act.

AMENDMENTS RELATING TO FISCAL INTERMEDIARIES

SEC. 14. (a) Section 1816 of the Social Security Act is amended—

(1) by inserting "(and to providers assigned to such agency or organization under subsection (e))" in the first sentence of subsection (a) after "to such providers" the second and third times it appears;

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

"(b) The Secretary shall not enter into or renew an agreement with any agency or organization under this section unless—

"(1) he finds—

"(A) after applying the standards, criteria, and procedures developed under subsection (f), that to do so is consistent with the effective and efficient administration of this part, and

"(B) that such agency or organization is willing and able to assist the providers to which payments are made through it under this part in the application of safeguards against unnecessary utilization of services furnished by them to individuals entitled to hospital insurance benefits under section 226, and the agreement provides for such assistance; and

"(2) such agency or organization agrees—

"(A) to furnish to the Secretary such of the information acquired by it in carrying out its agreement under this section, and

"(B) to provide the Secretary with access to all such data, information, and claims processing operations,

as the Secretary may find necessary in performing his functions under this part.";

(3) by inserting "after applying the standards, criteria, and procedures developed under subsection (f) and" in subsection (e)(2) before "after reasonable notice";

(4) by redesignating subsections (e), (f), and (g) as subsections (g), (h), and (i), respectively; and

(5) by inserting after subsection (d) the following new subsections:

"(e)(1) Notwithstanding subsections (a) and (d), the Secretary, after taking into consideration any preferences of providers of services, may assign or reassign any provider of services to any agency or organization which has entered into an agreement with him under this section, if he determines, after applying the standards, criteria, and procedures developed under subsection (f), that such assignment or reassignment would result in the more effective and efficient administration of this part.

"(2) Notwithstanding subsections (a) and (d), the Secretary may designate a national or regional agency or organization which has entered into an agreement with him under this section to perform functions under the agreement with respect to a class of providers of services in the Nation or region (as the case may be), if he determines, after applying the standards, criteria, and procedures developed under subsection (f), that such designation would result in more effective and efficient administration of this part.

"(3)(A) Before the Secretary makes an assignment or reassignment under paragraph (1) of a provider of services to other than the agency or organization nominated by the provider, he shall furnish (i) the provider and such agency or organization with a full explanation of the reasons for his determination as to the efficiency and effectiveness of the agency or organization to perform the functions required under this part with respect to the provider, and (ii) such agency or organization with opportunity for a hearing, and such determination shall be subject to judicial review in accordance with chapter 7 of title 5, United States Code.

"(B) Before the Secretary makes a designation under paragraph (2) with respect to a class of providers of services, he shall furnish (i) such providers and the agencies and organizations adversely affected by such designation with a full explanation of the reasons for his determination as to the efficiency and effectiveness of such agencies and organizations to perform the functions required under this part with respect to such providers, and (ii) the agencies and organizations adversely affected by such designation with opportunity for a hearing, and such determination shall be subject to judicial review in accordance with chapter 7 of title 5, United States Code.

"(f) In order to determine whether the Secretary should enter into, renew, or terminate an agreement under this section with an agency or

organization, whether the Secretary should assign or reassign a provider of services to an agency or organization, and whether the Secretary should designate an agency or organization to perform services with respect to a class of providers of services, the Secretary shall develop standards, criteria, and procedures to evaluate such agency's or organization's (1) overall performance of claims processing and other related functions required to be performed by such an agency or organization under an agreement entered into under this section, and (2) performance of such functions with respect to specific providers of services, and the Secretary shall establish, by regulation, standards and criteria with respect to the efficient and effective administration of this part. No agency or organization shall be found under such standards and criteria not to be efficient or effective or to be less efficient or effective solely on the ground that the agency or organization serves only providers located in a single State.".

(b) The Secretary of Health, Education, and Welfare shall develop the standards, criteria, and procedures described in subsection (f) of section 1816 of the Social Security Act (as added by subsection (a)(5)) not later than October 1, 1978.

(c) The amendment made by paragraphs (2) and (3) of subsection (a) to the extent that they require application of standards, criteria, and procedures developed under section 1816(f) of the Social Security Act shall apply to the entering into, renewal, or termination of agreements on and after October 1, 1978.

(d) Except as provided in subsection (c), the amendment made by subsection (a)(2) shall apply to agreements entered into or renewed on or after the date of enactment of this Act.

DISCLOSURE BY PROVIDERS OF THE HIRING OF CERTAIN FORMER EMPLOYEES OF FISCAL INTERMEDIARIES

SEC. 15. (a) Section 1866(a)(1) of the Social Security Act is amended—

(1) by striking out the period at the end of subparagraph (C) and inserting in lieu thereof ", and"; and

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

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

(b) The amendments made by subsection (a) shall apply with respect to agreements entered into or renewed on and after the date of enactment of this Act.

PAYMENT FOR DURABLE MEDICAL EQUIPMENT

SEC. 16. (a) Section 1833(f) of the Social Security Act is amended to read as follows:

"(f)(1) In the case of durable medical equipment to be furnished an individual as described in section 1861(s)(6), the Secretary shall de-

termine, 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.".

(b) The amendment made by subsection (a) shall apply with respect to durable medical equipment purchased or rented on or after October 1, 1977.

FUNDING OF STATE MEDICAID FRAUD CONTROL UNITS

SEC. 17. (a) Section 1903(a) of the Social Security Act is amended by redesignating paragraph (6) as paragraph (7) and by inserting after paragraph (5) the following new paragraph:

> *"(6) subject to subsection (b)(3), an amount equal to 90 per centum of the sums expended during each quarter beginning on or after October 1, 1977, and ending before October 1, 1980, 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 the establishment and operation of (including the training of personnel employed by) a State medicaid fraud control unit (described in subsection (q)); plus".*

(b) Section 1903(b) of such Act is amended by inserting after paragraph (2) the following new paragraph:

"(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.".*

(c) Section 1903 of such Act is further amended by inserting after subsection (p) (added by section 11(a) of this Act) the following new subsection:

"(q) For the purposes of this section, the term 'State medicaid 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, that (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) has a formal working relationship with the office of the State Attorney General and has formal procedures (including procedures for its referral of suspected criminal violations to such office) which are approved by the Secretary and which provide effective coordination of activities between the entity and such office with respect to the detection, investigation, and prosecution of suspected criminal violations relating to the program under this title.

"(2) The entity is separate and distinct from the 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 that are made under the State plan to health care facilities and that are 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 section."

(d) Section 402(a)(1) of the Social Security Amendments of 1967 (Public Law 90–248), as amended by section 222 of the Social Security Amendments of 1972 (Public Law 92–603), is amended—

(1) by striking out "and" at the end of subparagraph (H);

(2) by striking out the period at the end of subparagraph (I) and inserting in lieu thereof "; and"; and

(3) by adding after subparagraph (I) the following new subparagraph:

"(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.".

(e)(1) The amendment made by subsection (a) shall apply with respect to calendar quarters beginning after September 30, 1977.

(2) The Secretary of Health, Education, and Welfare shall establish such regulations, not later than ninety days after the date of enactment of this Act, as are necessary to carry out the amendments made by this section.

REPORT ON HOME HEALTH AND OTHER IN-HOME SERVICES

SEC. 18. (a) Not later than one year after the date of enactment of this Act, the Secretary of Health, Education, and Welfare shall submit to the appropriate committees of the Congress a report analyzing, evaluating, and making recommendations with respect to, all aspects (including the availability, administration, provision, reimbursement procedures, and cost) of the delivery of home health and other in-home services authorized to be provided under titles XVIII, XIX, and XX of the Social Security Act.

(b) Such report shall include an evaluation of the coordination of such services provided under the different titles, and shall also include recommendations for changes in regulations and legislation with respect to—

(1) the scope and definition of such services provided under such titles;

(2) the requirements for an individual to be eligible to receive such services under such titles;

(3) the standards for certification of providers of such services under such titles and (as appropriate) the uniformity of such standards for the programs under the different titles;

(4) procedures for control of utilization and assurance of quality of such services under such titles, including (as appropriate) the licensing and accreditation of agencies providing such services, a certificate of need program with respect to the offering of such services, and the development and use of norms and standards for review of the utilization and quality of such services;

(5) methods of reimbursement for such services, including (A) methods of comparing costs incurred by different providers of such services in order to determine the reasonableness of such costs and (B) methods which provide for more uniform reimbursement procedures under titles XIX of the Social Security Act; and

(6) the prevention of fraud and abuse in the delivery of such services under such titles,

the reasons for such recommendations, an analysis of the impact of implementing such recommendations on the cost of such services and the demand for such services, and the methods of financing any recommended increased provision of such services under such titles.

(c) In developing the report the Secretary shall consult with professional organizations, experts, and individual health professionals in the field of home health and other in-home services and with providers, private insurers, and consumers of such services.

ESTABLISHMENT OF UNIFORM REPORTING SYSTEMS FOR DIFFERENT TYPES OF HEALTH SERVICES FACILITIES AND ORGANIZATIONS; MAKING OF REPORTS UNDER MEDICARE AND MEDICAID PROGRAMS IN ACCORDANCE WITH SUCH SYSTEMS

SEC. 19. (a) Part A of title XI of this Social Security Act is amended by inserting after section 1120 the following new section:

"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 Sevice Act. In reporting under such a system, hospitals shall employ such chart of accounts, definitions, principles, and statistics as the Secretary may prescribe 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 demonstrations 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 systems 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.".

(b)(1) Section 1861(v)(1) of the Social Security Act is amended by adding after subparagraph (E) the following new subparagraph:

"(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.".

(2) Section 1902(a) of such Act (as amended by sections 2(b), 3(c), and 7(b) of this Act) is amended—

(A) by striking out "and" at the end of paragraph (38);

(B) by striking out the period at the end of paragraph (39) and inserting in lieu thereof "; and"; and

(C) by inserting after paragraph (39) the following new paragraph:

"(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.".

(c)(1) The Secretary of Health, Education, and Welfare shall establish the systems described in section 1121(a) of the Social Security Act (added by subsection (a) of this section) only after consultation with interested parties and—

(A) for hospitals, skilled nursing facilities, and intermediate care facilities, not later than the end of the one-year period, and

(B) for other types of health services facilities and organizations, not later than the end of the two-year period,

beginning on the date of enactment of this Act.

(2)(A) The amendments made by subsection (b) shall apply with respect to operations of a hospital, skilled nursing facility, or intermediate care facility, on and after the first day of its first fiscal year which begins after the end of the six-month period beginning on the date a uniform reportnig system is established (under section 1121(a) of the Social Security Act) for that type of health services facility.

(B) The amendments made by subsection (b) shall apply, with respect to the operation of a health services facility or organization which is neither a hospital, a skilled nursing facility, nor an intermediate care facility, on and after the first day of its first fiscal year which begins after such date as the Secretary of Health, Education, and Welfare determines to be appropriate for the implementation of the reporting requirement for that type of facility or organization.

(C) Except as provided in subparagraphs (A) and (B), the amendments made by subsection (b)(2) shall apply, with respect to State

plans approved under title XIX of the Social Security Act, on and after October 1, 1977.

DELAY IN, AND WAIVER OF, IMPOSITION OF REDUCTION OF FEDERAL MEDICAL ASSISTANCE PERCENTAGE DUE TO A STATE'S FAILURE TO HAVE AN EFFECTIVE MEDICAID UTILIZATION CONTROL PROGRAM

SEC. 20. (a) Section 1903(g) of the Social Security Act is amended—

(1) by striking out "With respect to" in the first sentence of paragraph (1) and inserting in lieu thereof "Subject to paragraph (3), with respect to";

(2) by striking out "by 33⅓ per centum thereof" in paragraph (1) and inserting in lieu thereof "by a per centum thereof (determined under paragraph (5))";

(3) by inserting "timely" in paragraph (2) before "sample onsite surveys"; and

(4) by adding after paragraph (2) the following new paragraphs:

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

"(i) if such reduction is due to the State's unsatisfactory or invalid showing made with respect to a calendar quarter beginning before January 1, 1977;

"(ii) before January 1, 1978;

"(iii) unless a notice of such reduction has been provided to the State at least 30 days before the date such reduction takes effect; or

"(iv) due to the State's unsatisfactory or invalid showing made with respect to a calendar quarter beginning after September 30, 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.

"(B) The Secretary shall waive application of any reduction in the Federal medical assistance percentage of a State otherwise required to be imposed under paragraph (1) because a showing by the State, made under such paragraph with respect to a calendar quarter ending after January 1, 1977, and before October 1, 1977, is determined to be either unsatisfactorty under such paragraph or invalid under paragraph (2), if the Secretary determines that the State's showing made under paragraph (1) with respect to the calendar quarter ending on December 31 1977, is satisfactory under such paragraph and is valid under paragraph (2).

"(4)(A) 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.

"(B) The Secretary shall find a showing of a State, with respect to a calendar quarter under paragraph (1), to be satisfactory under such pargaraph with respect to the requirement that the State conduct annual onsite inspections in mental hospitals, skilled nursing facilities, and intermediate care facilities under paragraph (26) and (31)

of section 1902(a), if the showing demonstrates that the State has conducted such an onsite inspection during the 12-month period ending on the last date of the calendar quarter—

"(i) in each of not less than 98 per centum of the number of such hospitals and facilities requiring such inspection, and

"(ii) in every such hospital or facility which has 200 or more beds,

and that, with respect to such hospitals and facilities not inspected within such period, the State has exercised good faith and due diligence in attempting to conduct such inspection, or if the State demonstrates to the satisfaction of the Secretary that it would have made such a showing but for failings of a technical nature only.

"(5) In the case of a State's unsatisfactory or invalid showing made with respect to a type of facility or institutional services in a calendar quarter, the per centum amount of the reduction of the State's Federal medical assistance percentage for that type of services under paragraph (1) is equal to 33⅓ per centum multiplied by a fraction, the denominator of which is equal to the total number of patients receiving that type of services in that quarter under the State plan in facilities or institutions for which a showing was required to be made under this subsection, and the numerator of which is equal to the number of such patients receiving such type of services in that quarter in those facilities or institutions for which a satisfactory and valid showing was not made for that calendar quarter.

"(6) The Secretary shall submit to Congress, not later than sixty 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.".

(b) Section 1902(a)(26) of the Social Security Act is amended by inserting after "social service personnel" the following: ", or, in the case of skilled nursing facilities, composed of physicians or registered nurses and other appropriate health and social service personnel".

(c)(1) Except as provided in paragraph (2), the amendments made by this section shall be effective on October 1, 1977, and the Secretary of Health, Education, and Welfare shall promptly adjust payments made to States under section 1903 of the Social Security Act to reflect the changes made by such amendments.

(2) The amount of any reduction in the Federal medical assistance percentage of a State, otherwise required to be imposed under section 1903(g)(1) of the Social Security Act because of an unsatisfactory or invalid showing made by the State with respect to a calendar quarter beginning on or after January 1, 1977, shall be determined under such section as amended by this section. Subparagraph (B) of paragraph (4) of section 1905(g) of such Act, as added by this section, shall apply to any showing made by a State under such section with respect to a calendar quarter beginning on or after January 1, 1977.

PROTECTION OF PATIENT FUNDS

SEC. 21. (a) Section 1861(j) of the Social Security Act is amended by striking out "and" at the end of paragraph (13) and inserting immediately after such paragraph (13) the following new paragraph:

"(14) establishes and maintains a system that (A) assures a full and complete accounting of its patients' personal funds, and (B) includes the use of such separate account for such funds as will preclude any commingling of such funds with facility funds or with the funds of any person other than another such patient; and".

(b) The Secretary of Health, Education, and Welfare shall, by regulation, define those costs which may be charged to the personal funds of patients in skilled nursing facilities who are individuals receiving benefits under the provisions of title XVIII, or under a State plan approved under the provisions of title XIX, of the Social Security Act, and those costs which are to be included in the reasonable cost or reasonable charge for extended care services as determined under the provisions of title XVIII, or for skilled nursing and intermediate care facility services as determined under the provisions of title XIX, of such Act.

(c)(1) The amendments made by subsection (a) shall be effective on the first day of the first calendar quarter which begins more than six months after the date of enactment of this Act.

(2) The Secretary of Health, Education, and Welfare shall issue the regulations required under subsection (b) within ninety days after the date of enactment of this Act.

PAYMENT FOR INSTITUTIONAL CARE BEYOND DATE DETERMINED MEDICALLY NECESSARY

SEC. 22. (a) Section 1158 of the Social Security Act is amended—

(1) by inserting "and subsection (d)" in subsection (a) after "section 1159"; and

(2) by adding after subsection (c) (as added by section 5(d)(1) of this Act) the following new subsection:

"(d) In any case in which a Professional Standards Review Organization disapproves (under subsection (a)) of inpatient hospital services or posthospital 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 postdischarge 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."

(b) The amendments made by subsection (a) shall be effective on the date of enactment of this Act.

PAYMENT UNDER THE MEDICARE PROGRAM FOR CERTAIN HOSPITAL SERVICES PROVIDED IN VETERANS' ADMINISTRATION HOSPITALS

SEC. 23. (a) Section 1814(c) of the Social Security Act is amended by inserting "or subsection (j)" after "subsection (d)".

(b) Section 1814 of such Act is further amended by adding at the end thereof the following new subsection:

"Payment 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 the hospital is a Federal provider of services if (A) the individual was not entitled to have the services furnished to him free of charge by the hospital, (B) the individual was admitted to the hospital in the reasonable belief on the part of the admitting authorities that the individual was a person who was entitled to have the services furnished to him free of charge, (C) the authorities of the hospital, in admitting the individual, and the individual, acted in good faith, and (D) the services were furnished during a period ending with the close of the day on which the authorities operating the hospital first became aware of the fact that the individual was not entitled to have the services furnished to him by the hospital free of charge, or (if later) ending with the first day on which it was medically feasible to remove the individual from the 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).".

(c) The amendments made by this section shall apply to inpatient hospital services furnished on and after July 1, 1974.

And the Senate agree to the same.

AL ULLMAN,
DAN ROSTENKOWSKI,
JAMES C. CORMAN,
OTIS G. PIKE.
CHARLES A. VANIK,
HARLEY O. STAGGERS,
PAUL G. ROGERS,
DAVID E. SATTERFIELD,
RICHARDSON PREYER,
JAMES H. SCHEUER,
BARBER B. CONABLE, JR.
JOHN J. DUNCAN,
TIM LEE CARTER,
EDWARD R. MADIGAN,

Managers on the Part of the House.

RUSSELL LONG,
H. E. TALMADGE,
ABE RIBICOFF,
CARL T. CURTIS,
BOB DOLE,

Managers on the Part of the Senate.

JOINT EXPLANATORY STATEMENT OF THE COMMITTEE OF CONFERENCE

The managers on the part of the House and the Senate at the conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 3) to strengthen the capability of the Government to detect, prosecute, and punish fraudulent activities under the medicare and medicaid programs, and for other purposes, submit the following joint statement to the House and the Senate in explanation of the effect of the action agreed upon by the managers and recommended in the accompanying conference report:

The Senate amendment struck out all of the House bill after the enacting clause and inserted a substitute text.

The House recedes from its disagreement to the amendment of the Senate with an amendment which is a substitute for the House bill and the Senate amendment. The differences between the House bill, the Senate amendment, and the substitute agreed to in conference are noted below, except for clerical corrections, conforming changes made necessary by agreements reached by the conferees, and minor drafting and clarifying changes.

1. REQUIREMENTS FOR TIMELY PAYMENT BY STATE MEDICAID AGENCIES (SECTION 2)

House bill.—The House bill requires States to make provision in their State medicaid plan for claims payment procedures which ensure that 90 percent of the bills submitted by eligible noninstitutionally-based providers will be reimbursed within 30 days, and 99 percent within 60 days. The State would not be cited for noncompliance if the Secretary found the State was acting in good faith to achieve this goal. The provision is effective for calendar quarters beginning on or after January 1, 1978.

Senate amendment.—The Senate amendment follows the House bill, except that it requires that 95 percent of claims be paid within 30 days, and 99 percent within 90 days. The provision is effective for calendar quarters beginning on or after July 1, 1978.

Conference agreement.—The conference agreement requires States to make provision in their State medicaid plan for claims payment procedures which assure that 90 percent of the bills submitted by eligible non-institutionally based providers will be reimbursed within 30 days, and 99 percent within 90 days. This standard would be applied to clean claims, that is, those not requiring further substantiation.

The conference agreement accepts the Senate amendment regarding the effective date.

2. INCENTIVE PAYMENT FOR STATE PROGRAMS OF EDUCATIONAL AND TECHNICAL ASSISTANCE TO EXPEDITE FILING AND PAYMENT OF CLAIMS (SECTION 2)

House bill.—The House bill authorizes 90 percent Federal matching from January 1978 through September 1980 for the costs attributable to the conduct of educational and technical assistance programs for health care practitioners which the Secretary determines are likely to expedite the filing and payment of claims, with a maximum on total quarterly Federal payments under the provision of $1.25 million.

Senate amendment.—The Senate amendment contains no comparable provision.

Conference agreement.—The conference agreement accepts the Senate position.

3. PROGRAMS SUBJECT TO DISCLOSURE (SECTION 3)

House bill.—The House bill requires disclosure of ownership information for specified entities in medicare (title XVIII), medicaid (title XIX), and the maternal and child health (title V) programs.

Senate amendment.—The Senate amendment is the same as House bill, but adds the social service grant program (title XX) to the list of programs requiring disclosure.

Conference agreement.—The conference agreement accepts the Senate amendment.

4. ENTITIES SUBJECT TO DISCLOSURE (SECTION 3)

House bill.—The House bill contains no provision relating to health maintenance organizations.

Senate amendment.—The Senate amendment adds health maintenance organizations to the list of entities required to disclose ownership under the bill.

Conference agreement.—The conference agreement accepts the Senate amendment.

5. SUBCONTRACTOR OWNERSHIP DISCLOSURE (SECTION 3)

House bill.—The House bill requires a provider of services (hospital, skilled nursing facility, or home health agency) to disclose information relating to the identity of subcontractors that are 5 percent or more owned by the provider.

Senate amendment.—The Senate amendment extends the subcontractor ownership disclosure of the House bill to include all other disclosing entities under the bill (i.e., other medicaid providers, intermediaries, carriers. HMO's, and title XX (social services) providers).

Conference agreement.—The conference agreement accepts the Senate amendment.

6. MEDICAID DISCLOSURE EFFECTIVE DATE (SECTION 3)

House bill.—The House bill provides for an effective date of October 1, 1977, for medicaid disclosure provisions.

Senate amendment.—The Senate amendment changes the effective date to January 1, 1978.

Conference agreement.—The conference agreement accepts the Sen-Senate amendment.

7. FORCED CONTRIBUTIONS FOR ADMISSION TO FACILITY (SECTION 4)

House bill.—The House bill defines as a felony instances where contributions are required as a condition of entry or continued stay at a hospital, skilled nursing facility, or intermediate care facility for patients whose care is financed in whole or in part by medicaid.

Senate amendment.—The Senate amendment deletes the provision.

Conference agreement.—The conference agreement accepts the House provision.

8. EMPLOYMENT PAYMENT EXCEPTION (SECTION 4)

House bill.—The House bill provides, in defining kickbacks in the penalty statutes, that remuneration that is an amount paid "by an employer to an employee for employment in the provision of covered items or services" is exempt.

Senate amendment.—The Senate amendment is the same as House bill, but adds clarifying language that the employee must have a "bona fide" employment relationship with the employer.

Conference agreement.—The conference agreement accepts the Senate amendment.

9. MEDICARE ASSIGNMENT MISDEMEANOR (SECTION 4)

House bill.—The House bill contains no provision.

Senate amendment.—The Senate amendment provides that it would be a misdemeanor for a physician to willfully and knowingly violate his agreement not to charge a medicare patient more than the coinsurance and any unmet deductible amount when he agrees to accept assignment of the patient's right to receive payment.

Conference agreement.—The conference agreement accepts the Senate amendment with a modification to make clear that this misdemeanor is to apply only to situations where an individual has knowingly, willfully and repeatedly violated medicare assignment agreements.

10. PSRO REIMBURSEMENT ARRANGEMENT (SECTION 5(C))

House bill.—The House bill provides that arrangements with PSRO's for reimbursement of the cost of review activities are to be made in a manner similar to that provided for medicare intermediaries.

Senate amendment.—The Senate amendment includes the provision of the House bill and further provides that arrangements with PSRO's for reimbursement of the cost of review activities may be in the form of an assistance agreement.

Conference agreement.—The conference agreement accepts the Senate amendment.

11. PSRO REVIEW METHODOLOGIES (SECTION 5(C))

House bill.—The House bill requires the development of ambulatory care review methodologies by the Secretary for use by PSRO's.

Senate amendment.—The Senate amendment deletes the requirement in the House bill.

Conference agreement.—The conference agreement accepts the Senate amendment.

12. PSRO AMBULATORY CARE REVIEW SECTION (5(C))

House bill.—The House bill requires each PSRO to undertake ambulatory care review not later than 2 years after it has achieved operational status.

Senate amendment.—The Senate amendment is the same as the House bill, but adds clarifying language to permit a qualified PSRO to undertake ambulatory care review at an earlier date where the PSRO requests authority to conduct such review and is found capable to do so by the Secretary, but in no case could the Secretary require a PSRO to conduct such reviews before it achieves operational status.

Conference agreement.—The conference agreement accepts the Senate amendment.

13. STANDARD STATE MUST MEET TO DEMONSTRATE UNSATISFACTORY PSRO PERFORMANCE, AND REQUIRED SECRETARIAL ACTION (SECTION 5(d))

House bill.—The House bill provides that when a State agency monitoring the performance of a PSRO submits reasonable documentation that the PSRO decisions have caused an unreasonable and detrimental impact on *either* total State medicaid expenditures *or* on the quality of care, the Secretary shall temporarily suspend the PSRO's binding review authority for medicaid within 30 days, pending Secretarial reevaluation of the PSRO performance.

Senate amendment.—The Senate amendment provides that when a State agency monitoring the performance of a PSRO submits reasonable documentation that the PSRO decisions have caused an unreasonable and detrimental impact on total State medicaid expenditures *and* on the quality of care, the Secretary shall make a determination of the reasonableness of the State allegation within 30 days; if he determines that the PSRO decisions have had an unreasonable and detrimental impact on expenditures and quality, he may suspend the PSRO's binding authority for medicaid. The Senate amendment further provides that such action by the Secretary is final and not subject to judicial review.

Conference agreement.—The conference agreement provides that when a State agency monitoring the performance of a PSRO submits reasonable documentation that the PSRO decisions have caused an unreasonable and detrimental impact on total State medicaid expenditures and on the appropriateness of care received, the Secretary shall make a determination of the reasonableness of the State allegation within 30 days. If he determines that the State allegation is correct, he must suspend the PSRO's binding authority under medicaid immediately, unless he determines corrective action has already been taken. The suspension is effective pending Secretarial reevaluation of the PSRO's performance and reinstatement of the PSRO's authority. The conferees would note that a demonstration that PSRO decisions have had a detrimental impact on medicaid program costs would not be grounds for removing the binding authority of a PSRO under title XIX unless it was also demonstrated that this occurred because the PSRO was approving inappropriate care or services with such regularity that program costs were significantly affected.

The conference agreement further provides that such action by the Secretary is final and not subject to judicial review.

14. PSRO DELEGATION REVIEW RESPONSIBILITY TO SKILLED NURSING FACILITY THAT IS PART OF A HOSPITAL (SECTION 5(d))

House bill.—The House bill provides that a PSRO may not delegate review responsibilities to the review committee of a skilled nursing facility.

Senate amendment.—The Senate amendment provides that a PSRO may not delegate review responsibilities to the review committee of a skilled nursing facility, unless that facility (or an intermediate care facility) is part of a hospital where the PSRO is utilizing the services of the hospital's review committee.

Conference agreement.—The conference agreement generally follows the Senate amendment with a modification clarifying that a PSRO may not delegate review responsibilities to a skilled nursing facility or an intermediate care facility unless that facility is part of a hospital to which the PSRO has delegated review.

15. PRIMACY FOR REVIEW OF SERVICES IN INTERMEDIATE CARE FACILITIES (SECTION 5(d))

House bill.—The House bill provides that a PSRO has responsibility for review of services in intermediate care facilities and in public institutions for the mentally retarded only if the Secretary finds that the State is not performing effective review of the quality and necessity of services in these facilities.

Senate amendment.—The Senate amendment follows the House provision, except it provides that a PSRO will perform review in an intermediate care facility where that facility is also a skilled nursing facility.

Conference agreement.—The conference agreement provides that a PSRO has responsibility for review of services in intermediate care facilities and in public institutions for the mentally retarded only if (i) the Secretary finds that the State is not performing effective review of the quality and necessity of services in these facilities, or (ii) the State requests that the PSRO be responsible for the review and waives its right to be the primary reviewer of intermediate care facility services. Additionally, in the case of facilities which provide both skilled nursing facility services and intermediate care facility services, if the Secretary finds that review of the skilled nursing facility services by the PSRO, and of the intermediate care facility services by the State, would be inefficient, he may assign review responsibility for all patients in the facility to the PSRO. The conferees understand that the Secretary may determine that the arrangement is sufficiently inefficient to justify assignment of review rights to the PSRO in any single joint facility, or in classes of facilities, such as those facilities where the proportion of intermediate care facility patients is such that separate review would pose an unjustified administrative burden.

16. NATIONAL COUNCIL MEMBERSHIP (SECTION 5(f))

House bill.—The House bill provides for staggered terms for members of the National Professional Standards Review Council effective with appointments made in 1979.

Senate amendment.—The Senate amendment is the same as the House bill, except that the effective date is changed to 1977.

Conference agreement.—The conference agreement provides for staggered terms for members of the Council beginning with any terms which, under existing law, expire on or after January 1, 1978.

17. ANNUAL REPORT ON PSRO PROGRAM (SECTION 5(*k*))

House bill.—The House bill requires the Secretary to submit an annual report to the Congress on the administration and cost of the PSRO program.

Senate amendment.—The Senate amendment is the same as the House bill, except that it modifies the description of specific data required to be included in the report with respect to medically unnecessary services and ambulatory care review methodologies.

Conference agreement.—The conference agreement accepts the Senate amendment.

18. PHYSICIAN REVIEW (SECTION 5(p))

House bill.—There is no provision in the House bill.

Senate amendment.—The Senate amendment deletes the restriction in present law which prevents physicians with staff privileges in a hospital from being responsible for review of services in the facility if review responsibilities have not been delegated to the hospital by the PSRO.

Conference agreement.—The conference agreement accepts the Senate amendment.

19. SCOPE OF GAO SUBPENA POWER (SECTION 6)

House bill.—The House bill authorizes the Comptroller General (GAO) to issue subpenas in his work on Social Securty Act health programs.

Senate amendment.—The Senate amendment authorizes the subpenas to be issued in connection with GAO work on any Social Security Act program.

Conference agreement.—The conference agreement accepts the Senate amendment.

20. GAO DISCLOSURE OF INFORMATION (SECTION 6)

House bill.—The House bill contains provisions relating to the disclosure by the GAO of medical records information in its possession.

Senate amendment.—The Senate amendment deletes this provision.

Conference agreement.—The conference agreement accepts the Senate amendment.

21. COURT ACCESS TO GAO INFORMATION (SECTION 6)

House bill.—The House bill contains a provision to exempt from subpena or discovery proceedings in a civil action personal medical records in the possession of the General Accounting Office.

Senate amendment.—The Senate amendment deletes this provision.

Conference agreement.—The conference agreement accepts the House provision.

22. EFFECTIVE DATE FOR SUSPENSION OF MEDICAID PROVIDERS (SECTION 7)

House bill.—In the House bill the effective date for the suspension provision under medicaid is October 1, 1977.

Senate amendment.—In the Senate amendment, the effective date is January 1, 1978.

Conference agreement.—The conference agreement accepts the Senate amendment.

23. ASSIGNMENT OF RIGHTS TO MEDICAL SUPPORT AS CONDITION OF MEDICAID ELIGIBILITY; ESTABLISHMENT OF STATE PROGRAM TO COLLECT SUPPORT (SECTION 11)

House bill.—The House bill contains no provision.

Senate amendment.—The Senate amendment adds a provision to establish 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. An incentive in the form of a federal payment of 15 percent of amounts collected (in place of amounts which would otherwise be provided for medical assistance) would be provided for localities to make collections for States, and for States to secure collections in behalf of other States.

Conference agreement.—The conference agreement accepts the Senate provision with an amendment to clarify that the State agency designated to administer the State plan for child support and establishment of paternity under part D of title IV of the Social Security Act may be used for the enforcement of rights due from or through an absent parent to pay for medical care. The conferees intend that the title IV part D agency should be used to the maximum extent feasible. It is not intended that title XIX agencies establish new and separate systems for collection and enforcement of support from absent parents for payment for medical care apart from child support enforcement programs which are already established in States under the provisions of part D of title IV, since doing so would foster duplication of effort, unnecessary expense, and administrative complexity. It is expected that the program established under this section will establish adequate procedures to safeguard information and assure that a timely and simple mechanism exists to reassign rights to medical support of the individual entitled to that support if the individual's eligibility for medical assistance under title XIX is terminated.

24. NOMINATION OF INTERMEDIARIES (SECTION 14)

House bill.—The House bill authorizes the Secretary, after applying appropriate standards and criteria, to assign providers to available intermediaries and to designate a regional or national intermediary for a class of providers where he determines that such actions will result in more effective and efficient administration of the program. In such cases, the Secretary must provide the intermediary an explanation of the reasons for his determination and opportunity for a hearing. Such determinations would be subject to judicial review.

Senate amendment.—The Senate amendment deletes this provision of the House bill and substitutes a provision under which the Secretary would be prohibited from refusing to enter into or renew an agreement with a provider-nominated intermediary solely because of the fact that such intermediary serves providers located only in a single State or that the provider could be served by a different intermediary which serves providers in more than one State.

Conference agreement.—The conference agreement accepts the House language with modification to clarify those areas for which the Secretary will have to establish standards, criteria and procedures to determine whether the Secretary should enter into, renew, or termi-

nate an agreement with an intermediary and to determine when to assign or reassign providers to intermediaries. This clarification also incorporates that part of the Senate amendment that provides that any standards and criteria established should not have the effect of excluding an agency or organization from being an intermediary solely because it operates in one State.

The clarification added by the conferees requires that the Secretary develop standards, criteria and procedures to serve as a basis for determining what constitutes effective and efficient administration. These standards and criteria would be applied in addition to those that he will also establish for the purpose of evaluating an intermediary's performance with respect to all providers or specific providers. Because of the random distribution of providers to intermediaries, both in numbers and by type of institution, there can be intermediaries with high administrative costs, lengthy processing times or other difficulties in handling claims and audit functions through no fault of their own. The intent is to make clear that the Secretary in such instances would have authority to assign or reassign providers to achieve a distribution of providers that would improve the efficiency and effectiveness of the medicare program as defined in criteria and standards.

25. AMOUNT OF INCENTIVES TO ESTABLISH STATE MEDICAID FRAUD UNITS (SECTION 17)

House bill.—The House bill provides incentives for the establishment and operation of State medicaid fraud units through the provision for 90 percent Federal funding for the period October 1, 1977, through September 30, 1980, subject to an annual maximum payment of 1 percent of medicaid expenditures in a State, or $500,000, whichever is greater.

Senate amendment.—The Senate amendment follows the House bill, except that it provides for 100 percent Federal funding during fiscal year 1978, 90 percent during fiscal year 1979, and 75 percent during fiscal year 1980, subject to the same maximum amounts in the House bill.

Conference agreement.—The conference agreement accepts the House provision with respect to the level of Federal funding. These Federal monies are to be paid directly to the qualifying State medicaid anti-fraud agency.

26. REQUIREMENT FOR LOCATION OF FRAUD UNIT (SECTION 17)

House bill.—The House bill provides that to be eligible for increased Federal matching payments, a fraud unit must be separate from the single State agency administering medicaid. In addition it must be (a) in an agency with statewide prosecuting authority, or (b) if the constitution prohibits statewide prosecuting authority, an agency with satisfactory procedures to assure prosecution by the appropriate authorities.

Senate amendment.—The Senate amendment provides that to be eligible for increased Federal matching, the unit must be separate from the medicaid operating agency, or (if different) the single State agency administering medicaid.

In addition, the unit must be: (a) in an agency with statewide prosecuting authority, or (b) if the constitution prohibits statewide

prosecuting authority, an agency with satisfactory procedures to assure prosecution, or (c) an entity with formal procedures and a working relationship, satisfactory to the Secretary, for coordination with the State attorney general's office.

Conference agreement.—The conference agreement deletes the Senate amendment regarding the placement of the unit relative to the State medicaid agency. The conferees note that the intent of the Senate amendment was the same as the House provision, and the conference action represents only a technical change.

The conference agreement includes the Senate amendment permitting increased matching for an entity with formal procedures and a working relationship, satisfactory to the Secretary, for coordination with the State attorney general's office.

27. DEMONSTRATION AUTHORITY FOR IMPROVED METHODS TO INVESTIGATE AND PROSECUTE FRAUD IN MEDICARE AND MEDICAID (SECTION 17)

House bill.—The House bill contains no provision.

Senate amendment.—The Senate amendment authorizes experiments and demonstrations to develop or demonstrate improved methods for investigation and prosecution of fraud in medicare and medicaid.

Conference agreement.—The conference agreement accepts the Senate amendment.

28. UNIFORM REPORTING (SECTION 19)

House bill.—The House 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.

Senate amendment.—The Senate amendment is the same as the House bill, with the additional requirement that hospitals shall use the chart of accounts, definitions, principles and statistics prescribed by the Secretary to reach a uniform reconciliation of financial and statistical data for reports to the Secretary.

Conference agreement.—The conference agreement accepts the Senate amendment. It is the intent of the conferees in agreeing to the Senate amendment that the reconciliation of data not be required on a day-to-day basis but only at such times as the uniform reports are required, and only for purposes of such reports.

29. CONDITIONS FOR WAIVER OF PAST PENALTIES FOR FAILURE TO PERFORM REQUIRED REVIEW OF INSTITUTIONAL CARE (SECTION 20)

House bill.—The House bill allows States additional time to meet the requirements of the current law concerning review of care delivered in long-term care institutions, by providing that if a State is in compliance for the calendar quarter ending December 31, 1977, the Secretary shall waive all previously assessed reductions which would otherwise be imposed on those States that failed to fulfill the requirements of the law during previous periods.

Senate amendment.—The Senate amendment provides for unconditional waiver of all reductions in medicaid payments due to an unsatisfactory or invalid showing made with respect to a calendar quarter beginning prior to January 1, 1978.

Conference agreement.—The conference agreement provides that all penalties assessed against States for unsatisfactory or invalid showings made with respect to calendar quarters beginning prior to January 1, 1977, shall be waived unconditionally. It further provides that if a State is in compliance with the requirements of the law for the calendar quarter ending December 31, 1977, the Secretary shall waive all penalties for unsatisfactory or invalid showings for quarters occurring in 1977; if the State is not in compliance on December 31 and past penalties are imposed, the penalty will be determined by taking into account the proportion of medicaid patients in homes that were not reviewed to all medical patients in homes to be reviewed.

30. FORMULA FOR REDUCTION IN FEDERAL MATCHING FOR FAILURE TO CARRY OUT REVIEW (SECTION 20)

House bill.—The House bill contains no provision. Therefore, it retains the current law formula for a one-third reduction of Federal matching funds for days of care beyond 60 in a hospital ,a skilled nursing facility, or an intermediate care facility, and beyond 90 in a mental hospital, if adequate review is not carried out in accordance with the requirements of the law.

Senate amendment.—The Senate amendment adjusts the reduction by the proportion of patients not reviewed to total patients in facilities to be reviewed.

Conference agreement.—The conference agreement accepts the Senate amendment, with clarification that (i) it is effective for quarters beginning after December 31, 1976, and (ii) that the reduction reflects the proportion of medicaid patients in facilities for which there is an unsatisfactory or invalid showing to total medicaid patients in facilities to be reviewed.

31. CONDITIONS FOR WAIVER OF REDUCTIONS FOR FAILURE TO PERFORM REVIEW (SECTION 20)

House bill.—The House bill specifies that if a State makes a good faith attempt to perform reviews of all institutions, and actually reviews all large institutions and 98 percent of all other institutions, it will be considered in full compliance with the requirements of the law.

Senate amendment.—The Senate amendment provides that the Secretary may waive any reduction in Federal matching percentage if he determines that the State's noncompliance is technical or due to circumstances beyond control of the State.

Conference agreement.—The conference agreement provides that good faith attempts to perform reviews of all institutions, and actually reviews all large institutions and 98 percent of all other institutions (or fails to meet this standard only for technical reasons), it will be considered in full compliance with the requirements of the law. The conferees stress that the intent of the law that *all* facilities be reviewed is not changed by this provision. If a facility is not reviewed, there will be a reduction in matching unless the Secretary finds there was a good faith attempt to review the institution, and there is no evidence that any institution, or kind or type of institution, is deliberately not reviewed.

32. COMPOSITION OF MEDICAL REVIEW TEAMS (SECTION 20)

House bill.—The House bill contains no provision.

Senate amendment.—The Senate amendment provides that medical review teams reviewing care in skilled nursing facilities may be composed of physicians *or* registered nurses (current law requires that physicians be on the team).

Conference agreement.—The conference agreement accepts the Senate amendment.

33. PROTECTION OF PATIENT FUNDS (SECTION 21, ADDED BY THE SENATE AMENDMENT

House bill.—The House bill contains no provision.

Senate amendment.—The Senate amendment requires that, as a condition for participation in the medicare and medicaid programs, a skilled nursing facility must establish and maintain a system to assure the proper accounting of personal funds. Such system must provide for separate and discreet accounting for each patient with a complete accounting of income and expenditures.

Conference agreement.—The conference agreement accepts the Senate amendment.

34. GRACE PERIOD FOR POST DISCHARGE CARE (SECTION 22, ADDED BY THE SENATE AMENDMENT)

House bill.—The House bill contains no provision.

Senate amendment.—The Senate amendment provides that when a PSRO determines that further institutional care is not medically necessary, payment may be made for only one additional day, except that a PSRO may authorize up to 3 additional days on a case-by-case basis where additional time is needed to arrange for necessary post-discharge care.

Conference agreement.—The conference agreement accepts the Senate amendment.

35. PROSECUTION OF CIVIL FRAUD BY INSPECTOR GENERAL (SECTION 23, ADDED BY THE SENATE AMENDMENT)

House bill.—The House bill contains no provision.

Senate amendment.—The Senate amendment 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 a formal referral of a case.

Conference agreement.—The conference agreement does not include the prosecution authority proposed by the Senate amendment but does provide that in addition to the requirements imposed on the Inspector General of the Department of Health, Education and Welfare by section 4(c) of the bill, the Inspector General shall annually include a report to the Congress information related to the Social Security Act cases referred by the Department of Health, Education and Welfare to the Department of Justice for prosecution. This information shall include for each case a description of the number of cases referred (without individual identifiers), the types of illegal activity involved, and the amount in controversy. The Attorney General shall be required to respond to the annual report of the Inspector General by specifying the date of referral, district to which referred, and disposition of each case

referred by the Department of Health, Education, and Welfare as specified in the report of the Inspector General to the Congress.

36. UTILIZATION REVIEW DEMONSTRATION PROJECTS (SECTION 24, AS ADDED BY THE SENATE AMENDMENT)

House bill.—The House bill contains no provision.

Senate amendment.—The Senate amendment directs the Secretary to establish demonstration projects to evaluate the effectiveness of PSRO reviews compared to alternative State review methods. It authorizes 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. It specifies that demonstration projects be conducted in PSRO areas which are representative of a State's medicaid population and that they be conducted in areas which comprise a significant proportion of medicaid patient days.

Conference agreement.—The conference agreement accepts the House position.

37. PAYMENT FOR CERTAIN HOSPITAL SERVICES PROVIDED IN VETERANS' ADMINISTRATION HOSPITALS (SECTION 25, ADDED BY THE SENATE AMENDMENT)

House bill.—The House bill contains no provision.

Senate amendment.—The Senate amendment authorizes, under certain circumstances, medicare reimbursement for care provided to a nonveteran medicare beneficiary in a Veterans' Administration hospital where the care was provided on the mistaken (but good faith) assumption that the beneficiary was an eligible veteran. The provision would be applicable to care furnished on or after July 1, 1974.

Conference agreement.—The conference agreement accepts the Senate amendment.

38. HOSPITAL INSURANCE FOR CERTAIN INDIVIDUALS, AGE 60 THROUGH 64 (SECTION 26, ADDED BY THE SENATE AMENDMENT)

House bill.—The House bill contains no provision.

Senate amendment.—The Senate amendment would make medicare protection (parts A and B) available on an optional basis for spouses aged 60–64 of medicare beneficiaries, others aged 60–64 who are entitled to retirement or other dependents' benefits under social security; and disability beneficiaries aged 60–64 not otherwise eligible for medicare. Persons who elect to enroll under this provision would pay the cost of such protection.

Conference agreement.—The conference agreement accepts the House position.

39. TREATMENT OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS FOR PURPOSES OF THE INTERNAL REVENUE CODE (SECTION 27, ADDED BY THE SENATE AMENDMENT)

House bill.—The House bill contains no provision.

Senate amendment.—The Senate amendment deems PSRO's, for purposes of determining tax-exempt status under section 501(c)(3) of the Internal Revenue Code, to be organizations organized and operated exclusively for charitable purposes.

Conference agreement.—The conference agreement accepts the House position.

40. POSTPONEMENT OF REQUIREMENT THAT STATE MEDICAID PROGRAMS PAY SKILLED NURSING FACILITIES AND INTERMEDIATE CARE FACILITIES ON A BASIS REASONABLY RELATED TO COST (SECTION 28, ADDED BY THE SENATE AMENDMENT)

House bill.—The House bill contains no provision.

Senate amendment.—The Senate amendment postpones the requirement for medicaid payments on a basis reasonably related to cost until January 1979, and provides protection against retroactive claims for failure to meet the current law requirements.

Conference agreement.—The conference agreement accepts the House position.

Managers on the Part of the Senate.

AL ULLMAN,
DAN ROSTENKOWSKI,
JAMES C. CORMAN,
OTIS G. PIKE,
CHARLES A. VANIK,
HARLEY O. STAGGERS,
PAUL G. ROGERS,
DAVID E. SATTERFIELD,
RICHARDSON PREYER,
JAMES H. SCHEUER,
BARBER B. CONABLE, Jr.,
JOHN J. DUNCAN,
TIM LEE CARTER,
EDWARD R. MADIGAN,

Managers on the Part of the House.

RUSSELL LONG,
H. E. TALMADGE,
ABE RIBICOFF,
CARL T. CURTIS,
BOB DOLE,

○