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94TH CONGRESS 2d Session | SENATE | REPORT No. 94-1240

REPEAL OF CONSENT TO SUITS RESPECTING HOSPITAL PROVIDER COST UNDER MEDICAID; AND MEDICARE-MEDICAID ANTIFRAUD AMENDMENTS

SEPTEMBER 16, 1976.—Ordered to be printed

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

REPORT

[To accompany H.R. 12961]

The Committee on Finance, to which was referred the bill (H.R. 12961) to amend the Social Security Act to repeal the requirement that a State's plan for medical assistance under title XIX of such act include a provision giving consent of the State to certain suits brought with respect to payment for inpatient hospital services, having considered the same, reports favorably thereon with an amendment and with an amendment to the title and recommends that the bill as amended do pass.

I. SUMMARY OF THE BILL

H.R. 12961 as passed by the House contained a provision to repeal the requirement that a State's plan for medical assistance under the medicaid program include a provision giving consent of the State to certain suits brought with respect to payment for inpatient hospital services. The Committee approved this repeal without modification, but added certain provisions dealing with fraud and abuse.

OFFICE OF CENTRAL FRAUD AND ABUSE CONTROL

The first provision establishes within the Department of Health, Education and Welfare an Office of Central Fraud and Abuse Control. This unit would have overall responsibility to direct, coordinate and make policy with respect to fraud and abuse monitoring and investigation at all Federal organizational levels in Medicare and Medicaid.

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PROHIBITION AGAINST ASSIGNMENT OF CLAIMS FOR SERVICES

This Committee provision clarifies that the prohibition against assigning Medicare and Medicaid claims to third parties, such as factoring firms, also applies to situations where a hospital or doctor tries to bypass the prohibition by using a power of attorney.

DISCLOSURE OF OWNERSHIP AND FINANCIAL INFORMATION

The next Committee provision would require disclosure by providers and suppliers of services under Medicare and Medicaid—including so-called Medicaid mills—to the Secretary of HEW and the Comptroller General of full and complete information as to the owners of the facilities; those sharing in the proceeds or fees (to the extent that interests exceed five percent or more); business dealings between the facilities and owners, and where appropriate certified cost reports.

This provision would also require the Secretary and the States to have agreements with independent laboratories, independent pharmacies and independent durable medical equipment suppliers, who are paid directly with Government funds, under which such organizations would agree to provide access to their books and records pertaining to billing and paying for goods and services. Additionally, Federal personnel and the Comptroller General would have direct access to provider records under Medicaid and could duplicate such records during the course of an investigation.

PENALTY FOR FRAUD

The Committee amendment would define fraudulent acts and false reporting as felonies punishable by up to five years imprisonment and up to $25,000 in fines.

PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

The final Committee provision would require the Secretary to give priority to requests from a PSRO which desires to undertake review of care in "shared health care facilities"—the so-called Medicaid mills.

This provision further clarifies that, where the Secretary has delegated review responsibility to a PSRO, this review is binding for both Medicare and Medicaid; all other duplicative review requirements under other provisions of law terminate; and reiterates the legislative intent that the costs of PSRO operation are to be financed wholly by the Federal Government with respect to Medicare and Medicaid review activities.

The amendment would also require the Secretary to make payment for expenses incurred in defense of any suit, action or proceeding brought against a PSRO or to any member or employee in the performance of their duties and functions under the law.

II. General Explanation of the Bill

REPEAL OF CONSENT TO SUIT REQUIREMENT

(Sec. 1 of the Bill)

Medicaid law requires a State to pay hospitals on a reasonable cost basis in accordance with methods and standards developed by the State. The reasonable cost under those methods and standards may not exceed the amount which would be determined reasonable under Medicare. States which wish to use alternatives to Medicare's cost reimbursement principles are required to have approval from the Secretary of HEW before they can employ an alternative. During 1975, several States instituted alternative payment mechanisms without first obtaining Secretarial approval. Generally these methods were adopted in response to budgetary pressures in the States. Hospitals claimed the methods resulted in "less than reasonable cost" payment but, under existing law, they had no recourse to compel State compliance with the statute.

Public Law 94–182, signed on December 31, 1975, included an amendment to Medicaid intended to deal with this problem. Section 111 requires States to amend their Medicaid plans to include consent by the States to be sued in Federal courts by or on behalf of hospitals on questions relating to the payment of reasonable costs for hospital services. A State which fails to include such a provision in its State plan would, beginning January 1, 1976, be subject to a reduction of ten percent in the amount of the Federal share of its Medicaid funds. The Committee bill does not modify the House bill which repeals this section.

In acting to repeal Section 1902(g) of the Social Security Act (Section 111 of Public Law 94–182), the Committee remains aware of the problems to which this provision was originally addressed. Current law requires that providers of Medicaid services be reimbursed at a reasonable level for the costs of providing health care services to the medically indigent. Under laws and regulations enacted prior to the passage of Section 1902(g), State Medicaid plans were (and are) required to provide for the payment of the costs of inpatient hospital services at reasonable rates of reimbursement. However, the definition of reasonableness in reimbursement remains imprecise. For various reasons, several states have apparently failed to reimburse providers at adequate levels. Unfortunately, other than Section 1902(g), few mechanisms exist for providers to assert a claim to reimbursement at reasonable rates.

Section 1902(g), which requires that States waive their constitutional immunity to suits for money judgments in federal court, was designed to afford providers access to a judicial remedy for purposes of enforcing their legal rights. However, upon reconsideration of this matter, the Committee is unconvinced as is the House of Representatives of the desirability of compelling States to waive their constitutional immunity

to suit or of the feasibility of assessing monetary sanctions against States failing to do so in a time of economic stringency at all governmental levels. For this reason, the Committee strongly recommends that the Senate act expeditiously in repealing this well-intentioned but, in retrospect, inappropriate legislation.

The Committee believes, nonetheless, that some alternative mechanism for the adjudication of disputes concerning Medicaid reimbursement rates should be developed. The Committee has recommended to the Department of Health, Education, and Welfare that existing regulations be modified to deal with this problem. It should be noted that the Department shares this concern and has drafted and issued a proposed regulatory change. The Committee suggests that the following three subjects be addressed forthrightly in the final regulation:

(a) A way of measuring the "reasonableness" of any State departure from the Medicare reasonable cost approach. With the enactment of the Social Security Amendments of 1972, the Department was charged with the development of suitable criteria for determining whether rates established by State Medicaid agencies are in fact reasonable. For whatever reason, such standards have not yet been developed and promulgated. In spite of the complexity of this task, the Committee believes that it must be accomplished in the most timely fashion practicable. Where a State Medicaid plan denies providers adequate reimbursement according to the criteria of reasonableness the Secretary or his designee should not approve such a plan.

(b) In those cases where a State Medicaid agency proposes revisions of general reimbursement rates, providers should be formally notified and given the opportunity to comment on such proposals. Further, such comments by providers and the record of the State Medicaid agency's consideration of such comments should be preserved in written form for transmittal to the Secretary or his designee for his use in the consideration of whether the State agency's revision of reimbursement rates should be approved; and

(c) In cases where a significant proportion of providers of Medicaid services believe that a recently-established rate of reimbursement is injurious to them, a formal administrative hearing by the State Medicaid agency should be afforded them. If the providers and the State agency fail to reconcile their differences at the administrative hearing, the Secretary of Health, Education, and Welfare or his designee could resolve such dispute by approving or disapproving the revision of the State Medicaid plan's reimbursement rate in a timely fashion, say, within sixty days of the revised plan's submission to him.

The development and promulgation of these regulations should not be construed as in any way contravening or constraining the rights of the providers of Medicaid services, the State Medicaid agencies, or the Department to seek prospective, injunctive release in a federal or state judicial forum. Neither should the repeal of Section 1902(g) be interpreted as placing constraints on the rights of the parties involved to seek such prospective, injunctive relief.

OFFICE OF CENTRAL FRAUD AND ABUSE CONTROL

(Sec. 3 of the Bill)

Recent Congressional investigations have underscored the widespread and deep-rooted nature of fraud and abuse in the Medicaid and Medicare programs and the inability, to date, of the Department of Health, Education, and Welfare to adequately curtail such practices. While precise figures are not available, fraud and abuse are estimated to represent a significant percentage of estimated Medicaid expenditures and a somewhat smaller amount under Medicare.

Fraud cheats virtually everyone. It cheats the taxpayers of this Nation who see billions of dollars going down the drain. It cheats the elderly who often receive what can best be characterized as marginal care from the fast buck artists. It cheats our State and local governments, many of which are desperately trying to maintain fiscal stability. And, it cheats the large majority of health care practitioners and institutions who are doing an honest professional job. While the large majority of doctors, hospitals, and others are honest, it should be noted that those who practice fraud and abuse receive a disproportionate amount of payments.

Fraud and abuse have been shown to take a number of forms under the programs. Recent investigations of so-called "Medicaid mills"—unregulated and poorly equipped storefront units located in ghetto areas—have documented the pervasive nature of fraudulent and abusive practices and the woefully inadequate and substandard care rendered in such locations. The most common violations in the "mills" include:

(1) "ping-ponging"—referral of patients from one practitioner to another within the facility even though there is no medical reason for doing so;

(2) "ganging"—billing for multiple services to the same family on the same day;

(3) "upgrading"—billing for a service more extensive than that actually provided;

(4) "steering"—direction of a patient to a particular pharmacy, a violation of his freedom of choice; and

(5) billing for services not rendered—either adding services not performed onto an invoice carrying legitimate billings or submitting a totally fraudulent claim.

Other documented violations included billing for work performed by others or by unlicensed practitioners; making multiple copies of Medicaid cards; soliciting, offering, or receiving kick-backs; double billing; and billing both Medicare and Medicaid for the same service.

Fraudulent and abusive practices are not limited to Medicaid mills; clinical laboratories are another location where pervasive violations have been shown to occur. Recent investigations of such facilities found that kick-backs are so prevalent that in some areas laboratories refusing to take them are practically unable to secure the business of physicians or clinics treating Medicaid patients. Kick-backs take a number of forms including cash, gifts, long-term credit arrangements, supplies, equipment, and furnishing business machines. The most common practice, however, involves the supposed rental of a small

office space in a medical clinic. The billing practices employed by these laboratories are also often highly questionable. Techniques which constitute abuse or actual fraudulent practices include charging for services not ordered by the physician; charging for inappropriate tests not ordered by the patient's physician; charging Medicaid more than private patients; billing Medicaid patients for automated parts of profile tests; and use of forms supplied by the laboratory which make it impossible for physicians to order certain lab tests without ordering related tests. Profiteering, at the expense of patients, has also been shown to exist in the country's nursing homes where gang visits, kick-backs, collecting duplicate payments from Medicare and Medicaid, and billing for deceased or discharged patients are not unusual practices.

Despite the evidence that has accumulated in the last several years on fraud and abuse in the Medicare and Medicaid programs, the Department of Health, Education, and Welfare has been unable to take effective or timely action, particularly in the case of the Medicaid program. (By this, the Committee does not intend to disparage nor discourage recent anti-fraud efforts by the Department.) But, the Committee bill would provide for an immediate strengthening, restructuring, and an addition to the current Department activities in this area. The Committee intends that violators be prosecuted and removed from program participation, and that scarce program funds not be used to finance the relatively small percentage of providers, who generate a disproportionately large amount of the services—those providers who are cheating both the programs and the patients.

The Committee bill establishes within the Department of Health, Education, and Welfare an Office of Central Fraud and Abuse Control. This unit would have overall responsibility to direct, coordinate and make policy with respect to fraud and abuse monitoring and investigation at all organizational levels in Medicare and Medicaid. Unit personnel could also initiate and conduct investigations of alleged fraud and abuse. The establishment of such a unit has been recommended by the Comptroller General of the United States.

To meet the needs of U.S. Attorneys and State prosecutors, the unit, at the request of prosecutors, would be required to the maximum extent practicable to provide all appropriate investigative support and assistance, including temporary assignment of Federal personnel to assist U.S. and State prosecutors in the development of fraud cases arising out of Medicare and Medicaid.

The Committee expects that the Central Fraud and Abuse Unit would be established promptly upon enactment of this legislation with adequate staffing, including a fairly large number of trained and experienced investigators assigned to immediately handle the crisis situations which have been identified throughout the country. It is expected that the Director of the new Office will be immediately responsible to the Secretary and that the Director of such Office will restructure or revise current Department fraud and abuse activities, as necessary, to effectively discharge his responsibilities.

The Committee recognizes the importance of full utilization of the knowledge and experience of program integrity personnel in the operating programs. The Committee expects that these present pro-

gram functions, to the extent found effective in their present form and location by the Office of Central Fraud and Abuse Control, will continue as a basic part of anti-fraud and abuse activities under the general direction of the Office of Central Fraud and Abuse Control.

The Committee expects the Office, upon the request of the Congress, to periodically provide timely information on its activities including the number of suspected cases of fraud and abuse identified, the number referred for prosecution, and the disposition of such cases.

PROHIBITION AGAINST ASSIGNMENT BY PHYSICIANS AND OTHERS OF CLAIMS FOR SERVICES

(Sec. 4 of the Bill)

In 1972, the Committee noted that some physicians and other persons providing services under Medicare and Medicaid reassigned their rights to other organizations or groups under conditions whereby such organizations or groups submitted claims and received payments in their own name. Such reassignments became a significant source of incorrect and inflated claims by services paid for by Medicare and Medicaid. In addition, the Committee also found cases of fraudulent, billings by collection agencies and substantial overpayments to these so-called "factoring" agencies.

The Committee recommended and the Senate and House agreed that such arrangements were not in the best interest of the government or the beneficiaries served by the Medicare and Medicaid programs. The Social Security Amendments of 1972, P.L. 92-603, therefore, included the expressed prohibition against the reassignment of claims to benefits to anyone other than the patient, his physician, or other person who provided the service, unless the physician or other person was required as a condition of his employment to turn his fees over to his employer, or unless the physician or other person had an arrangement with a facility in which the services were provided and the facility billed for such services.

Despite these efforts to stop factoring of Medicare and Medicaid bills, some practitioners and other persons have circumvented the intent of law by use of the device of power of attorney. The Committee believes, as does the Comptroller General of the United States, that such use of power of attorney in these instances negates the purpose of the statutory prohibition against reassignment of Medicare and Medicaid claims and continues to result in the program abuses which factoring activities have been shown to produce in the past. The Committee also believes that the conditions which have fostered factoring practices—e.g., delays in payments—are being overcome, thereby minimizing or eliminating significant cash flow problems.

The Committee bill, therefore, amends existing law to preclude reassignments of benefits under Medicare and Medicaid by use of the device of power of attorney (other than an assignment to a governmental entity or establishment, or an assignment established by or pursuant to the order of a court of comparable jurisdiction from a physician or other person furnishing services). The bill also provides for similar prohibitions with respect to billings for care provided by institutions under Medicare and Medicaid. However, the bill would

not preclude the agent of a physician or other person furnishing services from receiving any payment, if (but only if) such agent does so pursuant to an agreement under which the compensation paid the agent for his services or for the billings or collections of payments is unrelated (direct or indirect) to the amount of the billings or payments, and is not dependent upon the actual collection of any such payments. Thus, the use of efficient billing agents by doctors and others, when paid on a basis related to the cost of doing business and not amounts billed or collected would not be impaired.

DISCLOSURE OF OWNERSHIP AND FINANCIAL INFORMATION

(Sec. 5 of the Bill)

The Committee bill contains disclosure requirements designed to assist in the detection and investigation of the kinds of overcharging, kick-backs and rebates that have been revealed by Congressional hearings and investigations. The new provisions apply to non-governmental providers or suppliers of health care (including shared health facilities as defined in the bill) which furnish or arrange for the furnishing of a significant volume of services for which Medicare or Medicaid reimbursement is claimed. They also apply to Medicare intermediaries and carriers and to Medicaid fiscal agents. Under the bill, these entities would be required to comply with requests made by the Secretary or the Comptroller General of the United States for information concerning the identity of persons having direct or indirect equity (at least 5 percent) in the entity, lease or rental agreements, the names of any officers or partners and similar information, and information concerning business dealings between these individuals and the entity. After appropriate notice, Federal funds would be withheld from entities that do not fully respond to such requests; Medicare agreements with any of its fiscal agents that fail to respond will be terminated.

It is not intended that the term "shared health facility" include hospital shared services organizations such as those meeting the requirements of Section 501(e) of the Internal Revenue Code, other arrangements whereby a group of hospitals acting together provide services to the members of the group, nor to one tax-exempt nonprofit hospital providing services to another such tax-exempt nonprofit hospital.

The bill would further provide that no Medicare benefits would be paid on the basis of an assignment, and no Federal funds would be provided under Medicaid of items or services provided by an independent pharmacy, an independent laboratory, or an independent supplier of durable medical equipment unless the entity agrees, if requested to do so, to provide the Secretary or the Comptroller General reasonable access to the books and records which pertain to the entity's provision of billing and payment related to Medicare and Medicaid.

PENALTY FOR DEFRAUDING MEDICARE AND MEDICAID PROGRAMS

(Sec. 6 of the Bill)

Existing law provides specific penalties under the Medicare and Medicaid programs for certain practices that have long been regarded

by professional organizations as unethical, as well as unlawful in some jurisdictions, and which contribute significantly to the cost of the programs. Such practices as the soliciting, offering, or acceptance of kick-backs or bribes, including rebates or a portion of fees or charges for patient referrals, are currently misdemeanors under present law. Also defined as misdemeanors are such crimes as submission of false claims or the making of false statements concerning material facts with respect to the condition or operation of a health care facility. Recent hearings, however, have indicated that such penalties have not proved to be adequate deterrents against illegal practices by some individuals who provide services under Medicare and Medicaid.

The Committee bill, therefore, would increase current penalties by changing the classification and penalties for such crimes from misdemeanors to felonies, increasing terms of imprisonment from one year to five years and maximum fines to $25,000. The Committee believes that the defrauding of the Government in Medicare and Medicaid is not dissimilar to similar practices involving fraud under the income tax laws, and should be dealt with just as severely. The committee also expects that, by increasing the criminal penalties for illegal acts under Medicare and Medicaid, more aggressive prosecution of such illegal practices will be undertaken by U.S. attorneys and other State and local law enforcement agencies.

AMENDMENTS RELATED TO PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

(Sec. 7 of the Bill)

The Committee bill would make a number of changes in the Social Security Act that would clarify the nature and scope of the PSRO's review responsibilities and facilitate these activities. These changes should enhance the capability of PSRO's to carry out their responsibilities under present law with special emphasis on early capability to review care and deal with any abuse in the so-called "Medicaid mills."

The Committee recognizes that the Professional Standards Review Organization is not primarily a fraud detection organization, and the PSRO will not be expected to operate in that fashion. A PSRO can bring the expertise of the medical profession directly to bear on these responsibilities which have already been given to it under present law. It can make those decisions about the medical necessity and quality of care furnished which only the medical profession, organized through a PSRO, can provide.

The Committee is well aware that in asking PSRO's to offer their review services with respect to these facilities that it is asking for a difficult task to be performed. Moreover, the Committee recognizes that initial efforts, while less than that required, will expand.

It is the intent of the Committee that the Secretary, utilizing the various waiver provisions under present law, cut through as much "red tape" as possible to facilitate prompt assumption by PSRO's of review responsibility for services in "shared health facilities." Additionally, where necessary, the Secretary is expected to reimburse any reasonable security costs required to protect personnel involved in these review activities.

Nonetheless, PSRO's have shown the capability and interest in meeting the obligations of the medical profession to assure the quality of the care provided, in the medicaid mills and elsewhere.

Under present law, a PSRO is required to review only care provided by or in institutions unless it requests to review other kinds of health services and the Secretary approves the request. The bill provides that the Secretary will give priority to requests made by conditionally designated or fully qualified PSRO's to review services furnished in shared health facilities, with the highest priority to be given to requests from PSRO's in areas that have a substantial number of these so-called "Medicaid mills."

Under present law, PSRO's may discharge their review responsibilities with respect to hospital care in one of two ways—they can delegate the review responsibility to a hospital where they find that hospital capable of carrying out the review, or they can perform the review directly. Review activities delegated to the hospitals are reimbursed by the Medicare trust fund to the hospital as a part of such a hospital's Medicare costs. Prior to the enactment earlier this year of P.L. 94–182, direct review activities carried out by the PSRO were not reimbursed as part of hospital costs, with the result that the PSRO was required to fund such direct review activities from its own administrative budget. This resulted, in some cases, in a disincentive for the PSRO's to perform direct review and inappropriate delegation of the review process.

P.L. 94–182 permitted PSRO's to be reimbursed by hospitals for costs which the PSRO's incur in performing direct review with respect to hospital inpatients. Payments are made by the hospital to the PSRO with the hospital, in turn, receiving reimbursement in full for these payments from Medicare. The Committee would utilize this payment method for PSRO review activities involving hospital outpatients.

Under present law, Medicare payments and the Federal share of Medicaid payments may not generally be made for health care services which a PSRO has, in the proper exercise of its duties, disapproved. To clarify the PSRO's authority in this area and to avoid unnecessary and disruptive duplicative reviews by Medicare agents and Medicaid agencies, the bill provides that where a conditionally designated or a qualified PSRO 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 and is performing such reviews, determinations as to the quality, necessity or appropriateness made in connection with such reviews will constitute the conclusive determination on those issues for purposes of payment. The bill provides further that no reviews with respect to such services of providers, or practitioners shall be conducted by carriers, intermediaries, or State agencies for the purpose of determining in specific cases whether payment is or is not to be allowed by Medicare intermediaries and carriers or by Medicaid State agencies or their fiscal agents.

Under present law, the Secretary is authorized to waive any or all of the review, certification or similar activities otherwise required under the law where he finds, on the basis of substantial evidence of the effective performance of review and control activities by PSRO's, that the activity or activities are no longer needed for the provision

of adequate review and control. This provision was intended to avoid duplication of functions and unnecessary review and control activities.

The bill would permit the Secretary to waive one or more of these statutory review and certification requirements on a selective basis, where he finds that a given PSRO is competent on the basis of performance to assume review responsibilities with respect to specified providers or types of health services, he could waive any of a number of specified requirements with respect to those specific providers or services at the time the PSRO undertakes those review responsibilities, but only to the extent that they would represent duplicative review and certification activities. For example, the Secretary could waive, with respect to some or all of the facilities in a PSRO's service area, the requirement that physicians certify that their skilled nursing facility patients needed skilled nursing or skilled rehabilitation services on a daily basis if the Secretary finds that the PSRO can competently review the needs of the Medicare skilled nursing facility patients and the services they receive, and will properly apply the programs' level of care requirements.

In addition, the Secretary could waive any or all of the Medicare physician certification requirements related to other types of covered institutional care, home health services, and certain outpatient services; the Medicare requirement that psychiatric and tuberculosis hospital records establish that a covered level of care has been provided; the Medicare provisions relating to the existence or activities of utilization review committees; the Medicare requirement that participating skilled nursing facilities cooperate in programs of medical evaluation and audit; the Medicaid requirement that State plans provide for a program for the medical review of each skilled nursing facility and mental hospital patient's needs; the Medicaid requirement that State plans provide for methods and procedures related to the utilization of, and payment for, covered services; the Medicaid requirement that State plans provide for independent professional review of care in intermediate care facilities; the Medicaid requirement that State plans provide for the State health agency to establish a plan for the review of covered services; and the Medicaid provisions for reducing or denying Federal matching in certain cases where the State does not effectively control utilization.

Under present law, any data or information acquired by a PSRO in the exercise of its duties must be held in confidence and may not be disclosed to any person except (1) to the extent that may be necessary to carry out the purposes of the PSRO provisions, or (2) in such cases and under such circumstances as the Secretary shall by regulations provide to assure adequate protection of the rights and interests of patients, health care practitioners, or providers of health care. The bill provides that such information as may be disclosed by a PSRO shall be provided to the responsible State and Federal agencies, at their request, to assist them in identifying or investigating cases of suspected cases or patterns of fraud or abuse.

Under present law, a PSRO is authorized to examine pertinent records of any practitioner or provider of health care that is subject to PSRO review; the bill would also permit the PSRO to abstract from such records to facilitate review of the premises of the party that

furnished the care. This authority may be especially important in the review of shared health facilities.

Under present law, expenses incurred by PSRO's are made payable from Medicare trust funds and from funds appropriated to carry out the other health care provision of the Social Security Act. The bill would make it clear that it is not intended that States or local governmental entities contribute toward these expenses.

The bill would also make clarifying changes in the provisions of law under which the Secretary may, at the recommendation of a PSRO, withdraw a medical care provider's eligibility to participate in Social Security Act medical care programs where it is determined that they are not willing, or cannot, carry out their obligations to order and provide only necessary care of acceptable quality. The bill would make it clear that the provisions in question apply to any health care practitioner, or any hospital or other health care facility, agency or organization which is subject to PSRO review.

Under present law, a PSRO or a member or employee of a PSRO (including a person who furnishes professional counsel or advice to a PSRO) may be sued in connection with the performance of duties provided for under the social security law. The Committee bill provides for the Federal Government to reimburse the sued party for expenses incurred in connection with defending such a suit.

III. Costs of Carrying Out the Bill

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

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

For obvious reasons, it is difficult to supply specific or even approximate dollar amounts of savings. It is certainly fair to say, again assuming reasonable implementation, that cost-savings would far outweigh any administrative expenses involved. The Budget Committees of the Congress have assumed that a reduction of $100 million in Medicaid expenditures would result from enactment of this bill.

IV. Vote of Committee in Reporting the Bill

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

V. Changes in Existing Law Made by the Bill, as Reported

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

TITLE VII—ADMINISTRATION

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DUTIES OF THE SECRETARY

SEC. 702. (a) * * *

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(b) There shall be established, within the Department of Health, Education, and Welfare, an Office of Central Fraud and Abuse Control. Such Office shall have the overall responsibility for (i) directing, coordinating, monitoring, and establishing policies with respect to the undertaking of activities which are designed to deal with fraud and abuse, at all Federal organizational levels of the various programs established by or pursuant to titles V, XVIII, and XIX, and the renal disease program established by section 226, (ii) initiating and conducting investigations with respect to alleged, actual, or potential fraud or abuse in any of such programs, and (iii) assisting State agencies, at their request, in the establishment and operation of State antifraud and abuse activities. Such Office shall also provide all appropriate investigative support and assistance (including temporary delegation and assignment of personnel) to United States attorneys and State law enforcement authorities, upon their request, in the development of fraud cases arising out of any of such programs.

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TITLE XI—GENERAL PROVISIONS AND PROFESSIONAL STANDARDS REVIEW

PART A—GENERAL PROVISIONS

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DISCLOSURE OF OWNERSHIP AND FINANCIAL INFORMATION

SEC. 1132. (a)(1) The Secretary shall by regulations (or by contract provision) provide that any entity (other than a public agency) which is—

(A) a provider or supplier of items or services (including any "shared health facility" as defined in section 1133, or any practitioner or supplier affiliated with such a facility), which furnishes, or which arranges for the furnishing of, items or services with respect to which payment is claimed under title XVIII, under any program established pursuant to title V, or under a State plan approved under title XIX; or

(B)(i) a party to an agreement with the Secretary entered into pursuant to section 1816 or 1842 (a), or (ii) a party to an agreement, with a State agency administering or supervising the administration of a State plan approved under title XIX, under which such party serves as a fiscal agent for the State in the operation of such plan;

shall promptly comply with any request, made by the Secretary or the Comptroller General of the United States for any or all of the following:

(C) full and complete information as to the identity (i) of persons having (directly or indirectly) five percent or more ownership interests or lease or rental interests in such entity and the nature and extent thereof or (except in the case of a supplier not affiliated through direct or indirect common ownership or control in whole or part, with

a provider of services) who is the owner (in whole or in part) of an interest of five percent or more any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by such entity or any of the property or assets thereof, (ii) in case such entity is organized as a corporation, of each officer and director of the corporation, and (iii) in case such entity is organized as a partnership, of each partner;

(D) full and complete information (except in the case of a supplier not affiliated through direct or indirect common ownership or control in whole or part, with a provider of services) as to any business dealings between such entity (and, in the case of a shared health facility, between any practitioner or supplier affiliated therewith) and persons referred to in clause (C), and

(E) except in the case of a supplier or a shared health facility not affiliated through direct or indirect common ownership or control, in whole or part, with a provider of services, a consolidated certified costs report with respect to its costs and charges, including costs and charges of related organizations (as that term is employed for purposes of title XVIII);

except that, in the administration of this paragraph, no such request shall be made of an entity described in paragraph (A) if such entity does not furnish a significant volume (as defined by regulations of the Secretary) of the items or services referred to in such paragraph.

(2)(A) If at the close of the sixty-day period which begins on the date a request (as described in paragraph (1)) is made of an entity described in paragraph (1) (A), or (B), such request has not been fully complied with, then—

(i) in case such entity is an entity described in paragraph (1)(A), the Secretary may notify such entity that no payment will be made to such entity under title XVIII, and no Federal funds shall be available with respect to any expenditures made under or pursuant to title V or XIX (or a program or plan approved thereunder), for or on account of any services furnished by such entity on or after the first calendar month which begins not less than thirty days after the date such notice is sent.

(ii) In case such entity is an entity described in paragraph (1) (B)(i), the Secretary may notify such entity that any agreement between such entity and the Secretary entered into pursuant to section 1816 or section 1842 is terminated effective on the first day of the first calendar month which begins not less than thirty days after the date such notice is sent, and

(iii) in case such entity is an entity described in paragraph (1) (B)(ii), the Secretary may notify the State having an agreement with such entity that no Federal funds shall be available with respect to any expenses incurred to compensate such entity for or on account of services performed by it pursuant to such agreement (or any similar agreement) on or after the first calendar month which begins not less than thirty days after the date such notice is sent.

In case the Comptroller General makes a request (as described in paragraph (1)) which is not fully complied with prior to the sixty-day period described in the preceding sentence, then he shall, at the earliest practicable date after the close of such period, advise the Secretary of the fact that such request was made by him and was not complied with within such period, so that the Secretary may notify the entity involved as provided in clause (i), (ii), or (iii).

(B) Notwithstanding any other provision of law—

(i) payments otherwise authorized to be made under title XVIII, and Federal funds otherwise available with respect to expenditures under or pursuant to title V or XIX (or a program or plan approved thereunder) shall be subject to the limitations referred to in a notice sent by the Secretary pursuant to subparagraph (A)(i),

(ii) agreements referred to in subparagraph (A)(ii) shall be terminated as indicated by the Secretary in a notice sent by him pursuant to subparagraph (A)(ii), and

(iii) Federal funds otherwise available with respect to expenditures under a State plan approved under title XIX shall be subject to the limitations referred to in a notice sent by the Secretary pursuant to subparagraph (A)(iii);

except that the Secretary, for good cause shown, may terminate the application of such limitation.

(b) Notwithstanding any other provision of law—

(1) no payment shall be made on the basis of an assignment of benefits under title XVIII, and

(2) no Federal funds shall be available under title V or XIX with respect to expenditures made under a State program or plan approved thereunder,

for goods and services furnished, on or after the first day of the first calendar month which begins not less than ninety days after the date of enactment of this subsection, to a patient (directly or indirectly) by any entity which is an independent pharmacy, independent laboratory, or an independent supplier of durable medical equipment unless such entity agrees to give the Secretary or in the case of title XIX the State agency under which such entity agrees to provide to the Secretary (or any authorized officer or employee of the Department of Health, Education, and Welfare) and to the Comptroller General reasonable access to the books and records thereof which pertain to the provision of billing and payment for goods and services supplied or rendered by such entity."

SHARED HEALTH FACILITY

SEC. 1133. For purposes of this Act, the term "shared health facility" means any arrangement whereby two or more health care practitioners, one or more of whom receives payment on a fee for service basis under titles V, XVIII, and XIX of this Act which are substantial in amount (as determined in accordance with regulations of the Secretary)—

(a) (1) practice their professions at a common physical location; or where a substantial number of the patients of one or more practitioners are referred to such practitioner(s) by other practitioners or persons at a common physical location;

(2) share (i) common waiting areas, examining rooms, treatment rooms or other space, (ii) the services of supporting staff, or (iii) equipment, and

(3) a person other than all of such practitioners 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 such practitioners to their patients, or a person makes available to such practitioners the services of supporting staff who are not employees of such practitioners;

except that such term does not include a provider of services (as defined in section 1861(u)) or a health maintenance organization (as defined in section 1876), or an arrangement under which two or more health care practitioners practice their profession as a partnership, professional service corporation, or other legal entity, if members of the supporting staff are employees of such legal entity and in case there is an office manager, or person with similar title, he is an employee of the legal entity whose compensation is customary and not excessive for such services and there is no person described in clause (3), or

(b) where a person referred to in subsection (a)(3) is compensated, in whole or part, for the use of such physical location or services pertaining thereto on a basis related to amounts charged or collected for the services rendered or ordered at such location.

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PART B—PROFESSIONAL STANDARDS REVIEW

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DESIGNATION OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

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SEC. 1152. (e)*(1)* * * *

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(2) Such a waiver shall not be required where the Secretary finds a Professional Standards Review Organization (whether conditionally designated or qualified) to be competent on the basis of performance to assume review responsibilities with respect to specified providers of health care services. Upon such an assumption of review responsibilities by a Professional Standards Review Organization (whether conditionally designated or qualified), the following provisions of this Act (but only to the extent they involve duplicative review and certification activities) shall not (except to the extent otherwise specified by the Secretary):

(A) the provisions with respect to physician certifications required under section 1814(a) (2) through (7), (h), and (i), and section 1835(a)(2),

(B) the provisions with respect to utilization review plans required under section 1861 (e)(6) and (j)(8),

(C) the provisions with respect to medical evaluation and audit procedures required under section 1861(j)(12), and

(D) the provisions of section 1902(a) (26), (30), (31), and (33), and section 1903 (g) and (i)(4).

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DUTIES AND FUNCTIONS OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

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SEC. 1155. (b) * * *

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(3) examine *or abstract* the pertinent records of any practitioner or provider of health care services providing services with respect to which such organization has a responsibility for review under subsection (a)(1); and

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SEC. 1155. (g) Notwithstanding any other provision of this part, the responsibility for review of health care services of any Professional Standards Review Organization shall be the review of health care services provided by or in institutions, unless such Organization shall have made a request to the Secretary that it be charged with the duty and function of reviewing other health care services and the Secretary shall have approved such request. *The Secretary, where a Professional Standards Review Organization (whether conditionally designated or qualified) requests review responsibility with respect to services furnished in shared health facilities (as determined by the Secretary), shall give priority to such request, with the highest priority being assigned to areas with substantial numbers of shared health facilities.*

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REQUIREMENT OF REVIEW APPROVAL AS CONDITION OF PAYMENT OF CLAIMS

SEC. 1158. * * *

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(c) Where a Professional Standards Review Organization (whether conditionally designated or qualified) is 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 for purposes of payment under this Act, and no reviews with respect to such services, providers, or practitioners shall be conducted with respect to those issues relating to specific patients 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 State agencies administering or supervising the administration of State plans approved under title XIX.

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

SEC. 1160. (a) * * *

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(b)(1) If after reasonable notice and opportunity for discussion with the [practitioner or provider] *health care practitioners or any hospital, or other health care facility, agency, or organization* concerned, any Professional Standards Review Organization submits a report and recommendations to the Secretary pursuant to section 1157 (which report and recommendations shall be submitted through the Statewide Professional Standards Review Council, if such Council has been established, which shall promptly transmit such report and recommendations together with any additional comments and recommendations thereon as it deems appropriate) and if the Secretary determines that such [practitioner or provider], *health care practitioners or any*

hospital, or other health care facility, agency, or organization in providing health care services over which such organization has review responsibility and for which payment (in whole or in part) may be made under this Act has—

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

(B) by grossly and flagrantly violating any such obligation in one or more instances,

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

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PROHIBITION AGAINST DISCLOSURE OF INFORMATION

SEC. 1166. (a) * * *

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(b) A Professional Standards Review Organization (whether conditionally designated or qualified) shall provide data and information unless such data or information are confidential and not to be disclosed pursuant to Sec. 1166) to the responsible State and Federal agencies, at any such agency's request, to assist such agencies in identifying or investigating suspected cases or patterns of fraud or abuse.

[(b)](c) It shall be unlawful for any person to disclose any such information other than for such purposes, and any person violating the provisions of this section shall, upon conviction, be fined not more than $1,000, and imprisoned for not more than six months, or both, together with the costs of prosecution.

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

SEC. 1167. (a) * * *

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(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 professional counsel or services to such organization, 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).

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

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

(a) funds in the Federal Hospital Insurance Trust Fund;

(b) funds in the Federal Supplementary Medical Insurance Trust Fund; and

(c) funds appropriated to carry out the health care provisions of the several titles of this Act;

in such amounts from each of the sources of funds (referred to in subsections (a), (b), and (c)) as the Secretary shall deem to be fair and equitable after taking into consideration the costs attributable to the administration of this part with respect to each of such plans and programs. *Nothing herein shall be construed to authorize or require any contribution by a State (or any political subdivision thereof) toward, or as a condition of the availability for purposes of the administration of this part, any of the funds described in clause (c) of the preceding sentence.* The Secretary shall make such transfers of moneys between the funds, referred to in clauses (a), (b) and (c) of the preceding sentence, as may be appropriate to settle accounts between them in cases where expenses properly payable from the funds described in one such clause have been paid from funds described in another of such clauses.

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TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

PART A—HOSPITAL INSURANCE FOR THE AGED AND DISABLED

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PAYMENT TO PROVIDERS OF SERVICES

SEC. 1815. (a) * * *

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(c) *Any payment for a service, which under the provisions of this title may be made directly to a provider of service furnishing such service, may not be made to a person claiming such payment under an assignment, including a power of attorney (other than an assignment to a governmental entity or establishment, or an assignment established by or pursuant to the order of a court of competent jurisdiction from the provider of service furnishing such service); but nothing in this subsection shall be construed to preclude any agent, of the provider of service furnishing such 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 any such payment is unrelated (directly or indirectly) to the amount of the billing or payment (or the aggregate of similar billings or payments), and is not dependent upon the actual collection of any such payment (or the aggregate of such payments).*

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

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USE OF CARRIERS FOR ADMINISTRATION OF BENEFITS

SEC. 1842. (a) * * *

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(b)(5) No payment under this part for a service provided to any individual shall (except as provided in section 1870) be made to anyone other than such individual or (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) the physician or other person who provided the service, except that payment may be made (A) to the employer of such physician or other person if such physician or other person is required as a condition of his employment to turn over his fee for such service to his employer, or (B) (where the service was provided in a hospital, clinic, or other facility) to the facility in which the service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such service. *Any payment for a service, which under the provisions of the preceding sentence may be made directly to the physician or other person furnishing such service, may not be made to a person claiming such payment under an assignment, including a power of attorney (other than an assignment to a governmental entity or establishment, or an assignment established by or pursuant to the order of a court of competent jurisdiction from such physician or other person furnishing such service); but nothing in this paragraph shall be construed to preclude an agent, of the physician or other person furnishing 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 any such payment is unrelated (directly or indirectly) to the amount of the billings or payments (or the aggregate of similar billings or payments), and is not dependent upon the actual collection of any such payment (or the aggregate of such payments).*

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PART C—MISCELLANEOUS PROVISIONS

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DEFINITION OF SERVICES, INSTITUTIONS, ETC.

SEC. 1861. * * *

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ARRANGEMENTS FOR CERTAIN SERVICES

(W)(1) * * *

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(2) Utilization review activities conducted, in accordance with the requirements of the program established under part B of title XI of the Social Security Act with respect to services furnished by a hospital

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

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PENALTIES

SEC. 1877. (a) Whoever—

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

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

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

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

shall be guilty of a [misdemeanor] *felony* and upon conviction thereof shall be fined not more than [$10,000] *$25,000* or imprisoned for not more than [one year] *five years*, or both.

(b) Whoever furnishes *or arranges for the furnishing of* items or services to an individual for which payment is or may be made under this title and who solicits, offers, or receives any—

(1) kickback or bribe (*in cash or in kind*) in connection with the furnishing *or arragnement for the furnishing* of such items or services or the making or receipt of such payment, or

(2) [rebate of any fee or charge] *rebate of any fee, charge, or portion of any payment in cash or in kind* for referring any such individual to another person for the furnishing *or arrangement for the furnishing* of such items or services,

shall be guilty of a [misdemeanor] *felony* and upon conviction thereof shall be fined not more than [$10,000] *$25,000* or imprisoned for not more than [one year] *five years*, or both.

(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 [misdemeanor] *felony* and upon conviction thereof shall be fined not more than [$2,000] *$25,000* or imprisoned for not more than [6 months] *five years*, or both.

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TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

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STATE PLANS FOR MEDICAL ASSISTANCE

SEC. 1902. (a) * * *

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(32) provide that (*A*) no payment under the plan for any care or service provided to an individual by a physician, dentist, or other individual practitioner shall be made to anyone other than such individual or such physician, dentist, or practitioner, except that payment may be made [(A)] (*i*) to the employer of such physician, dentist, or practitioner if such physician, dentist, or practitioner is required as a condition of his employment to turn over his fee for such care or service to his employer, or [(B)] (*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) any payment for a service, which may be made directly to the physician or other person furnishing such service, may not be made to a person claiming such payment under an assignment, including a power of attorney (other than an assignment to a governmental entity or establishment, or an assignment established by or pursuant to the order of a court of competent jurisdiction from such physician or other person furnishing such service); but nothing in this paragraph shall be construed to preclude any agent, of the physician or other person furnishing 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 and/or collection of any such payment is unrelated (directly or indirectly) to the amount of the payment (or the aggregate of similar billings and/or payments) and is not dependent upon the actual collection of any such payment (or the aggregate of such payments);*

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TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

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SEC. 1902. (a) * * *

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[(g) Notwithstanding any other provisions of this title, a State plan for medical assistance must include a consent by the State to the exercise of the judicial power of the United States in any suit brought against the State or a State officer by or on behalf of any provider of services (as defined in section 1861(u)) with respect to the application of subsection (a)(13)(D) to services furnished under such plan after June 30, 1975, and a waiver by the State of any immunity from such a suit conferred by the 11th amendment to the Constitution or otherwise.]

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SEC. 1903. (a) * * *

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[(l) Notwithstanding any other provision of this section, the amount payable to any State under this section with respect to any quarter beginning after December 31, 1975, shall be reduced by 10 percentum of the amount determined with respect to such quarter under the preceding provisions of this section if such State is found by the Secretary not to be in compliance with section 1902(g).]

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PENALTIES

SEC. 1909. (a) Whoever—

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

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

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

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

shall be guilty of a [misdemeanor] *felony* and upon conviction thereof shall be fined not more than [$10,000] *$25,000* or imprisoned for not more than [one year] *five years*, or both.

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

(1) kickback or bribe *in cash or in kind* in connection with the furnishing *or arrangement for the furnishing* of such items or services or the making or receipt of such payment, or

(2) [rebate of any fee or charge] *rebate of any fee, charge, or portion of any payment, in cash or kind,* for referring any such individual to another person for the furnishing *or arrangement for the furnishing* of such items or services shall be guilty of a [misdemeanor] *felony* and upon conviction thereof shall be fined not more than [$10,000] *$25,000* or imprisoned for not more than [one year] *five years,* or both.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or a presentation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facility, or home health agency (as those terms are employed in this title) shall be guilty of a [misdemeanor] *felony* and upon conviction thereof shall be fined not more than [$2,000] *$25,000* or imprisoned for not more than [6 months] *5 years,* or both.

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