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under sections 1320c–3, 1395b–1, 1395l, 1395m, 1395n, 1395x, 1395xI, and 1395ww of this title] are repealed and
the provisions of law amended or repealed by such sections
are restored or revived as if such sections had not been
enacted.

“(2) EXCEPTION.—Paragraph (1) shall not apply to sub-
sections (g) and (m)(4) of section 202 of MCCA [amend-
ing section 1395u of this title and enacting provisions
set out as a note under section 1395u of this title].”

STUDY AND REPORT ON INCENTIVE ARRANGEMENTS OFFERED TO PHYSICIANS

Section 9313(c)(3) of Pub. L. 99–509 directed Secretary
of Health and Human Services to report to Congress,
not later than Jan. 1, 1988, concerning incentive ar-
rangements offered by health maintenance organiza-
tions and competitive medical plans to physicians.

§ 1320a–7b. Criminal penalties for acts involving
Federal health care programs

(a) Making or causing to be made false state-
ments or representations

Whoever—

(1) knowingly and willfully makes or causes
the making of any false statement or representa-
tion of a material fact in any application for
any benefit or payment under a Federal health
care program (as defined in subsection (f) of
this section),

(2) at any time knowingly and willfully
makes or causes to be made any false state-
ment 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 ben-
efit 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 fraudu-
ently to secure such benefit or payment ei-
ther in a greater amount or quantity than is
due or when no such benefit or payment is au-
thorized,

(4) having made application to receive
any such benefit or payment for the use and ben-
efit of another and having received it, know-
ingly and willfully converts such benefit or
payment or any part thereof to a use other
than for the use and benefit of such other per-
son,

(5) presents or causes to be presented a claim
for a physician’s service for which payment
may be made under a Federal health care pro-
gram and knows that the individual who fur-

ished the service was not licensed as a physi-
cian, or

(6) for a fee knowingly and willfully counsels
or assists an individual to dispose of assets
(including by any transfer in trust) in order
for the individual to become eligible for med-
cal assistance under a State plan under sub-
chapter XIX of this chapter, if disposing of the
assets results in the imposition of a period of
ineligibility for such assistance under section
1396p(c) of this title,

shall (i) in the case of such a statement, rep-
resentation, 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 the program,
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, conceal-
ment, failure, conversion, or provision of coun-
sel or assistance 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 eligi-
ble for assistance under a Federal health care
program is convicted of an offense under the
preceding provisions of this subsection, the ad-
ministrator of such program may at its option
(notwithstanding any other provision of such
program) limit, restrict, or suspend the eligi-
bility of that individual for such period (not ex-
ceeding 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 be-
tween that individual and such other person.

(b) Illegal remunerations

(1) Whoever knowingly and willfully solicits or
receives any remuneration (including any kick-
back, 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 a Federal health care program,

(B) in return for purchasing, leasing, order-
ing, or arranging for or recommending pur-
chasing, leasing, or ordering any good, facili-
ty, service, or item for which payment may
be made in whole or in part under a Federal
health care program,

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 knowingly and willfully offers or
pays any remuneration (including any kick-
back, 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 a Federal
health care program, 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 a Federal
health care program,

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 ob-
tained by a provider of services or other entity
under a Federal health care program if the re-
duction in price is properly disclosed and ap-
propriately reflected in the costs claimed or charges made by the provider or entity under a Federal health care program;

(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) any amount paid by a vendor of goods or services to a person authorized to act as a purchasing agent for a group of individuals or entities who are furnishing services reimbursed under a Federal health care program if—

(i) the person has a written contract, with each such individual or entity, which specifies the amount to be paid the person, which amount may be a fixed amount or a fixed percentage of the value of the purchases made by each such individual or entity under the contract, and

(ii) in the case of an entity that is a provider of services (as defined in section 1396x(u) of this title), the person discloses (in such form and manner as the Secretary requires) to the Secretary the amount received from each such vendor with respect to purchases made by or on behalf of the entity;

(D) a waiver of any coinsurance under part B of subchapter XVIII of this chapter by a Federally qualified health care center with respect to an individual who qualifies for subsidized services under a provision of the Public Health Service Act; [42 U.S.C. 201 et seq.];

(E) any payment practice specified by the Secretary in regulations promulgated pursuant to section 14(a) of the Medicare and Medicaid Patient and Program Protection Act of 1987 or in regulations under section 1395w–104(e)(6) of this title;

(F) any remuneration between an organization and an individual or entity providing items or services, or a combination thereof, pursuant to a written agreement between the organization and the individual or entity if the organization is an eligible organization under section 1395w–104(e)(6) of this title or if the written agreement, through a risk-sharing arrangement, places the individual or entity at substantial financial risk for the cost or utilization of the items or services, or a combination thereof, which the individual or entity is obligated to provide;

(G) the waiver or reduction by pharmacies (including pharmacies of the Indian Health Service, Indian tribes, tribal organizations, and urban Indian organizations) of any cost-sharing imposed under part D of subchapter XVIII of this chapter, if the conditions described in clauses (i) through (iii) of section 1320a–7(a)(i)(6)(A) of this title are met with respect to the waiver or reduction (except that, in the case of such a waiver or reduction on behalf of a subsidy eligible individual (as defined in section 1395w–114(a)(3) of this title), section 1320a–7(a)(i)(6)(A) of this title shall be applied without regard to clauses (ii) and (iii) of that section);

(H) any remuneration between a federally qualified health center (or an entity controlled by such a health center) and an MA organization pursuant to a written agreement described in section 1395w–23(a)(4) of this title;

(I) any remuneration between a health center entity described under clause (i) or (ii) of section 1396d(i)(2)(B) of this title and any individual or entity providing goods, items, services, donations, loans, or a combination thereof, to such health center entity pursuant to a contract, lease, grant, loan, or other agreement, if such agreement contributes to the ability of the health center entity to maintain or increase the availability, or enhance the quality, of services provided to a medically underserved population served by the health center entity; and

(J) a discount in the price of an applicable drug (as defined in paragraph (2) of section 1395w–114a(g) of this title) of a manufacturer that is furnished to an applicable beneficiary (as defined in paragraph (1) of such section) under the Medicare coverage gap discount program under section 1395w–114a of this title.

(c) False statements or representations with respect to condition or operation of institutions

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, facility, or entity in order that such institution, facility, or entity may qualify (either upon initial certification or upon recertification) as a hospital, critical access hospital, skilled nursing facility, nursing facility, intermediate care facility for the mentally retarded, home health agency, or other entity (including an eligible organization under section 1395mm(b) of this title) for which certification is required under subchapter XVIII of this chapter or a State health care program (as defined in section 1320a–7(h) of this title), or with respect to information required to be provided under section 1320a–3a of 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) Illegal patient admittance and retention practices

Whoever knowingly and willfully—

(1) charges, for any service provided to a patient under a State plan approved under subchapter XIX of this chapter, money or other consideration at a rate in excess of the rates established by the State (or, in the case of services provided to an individual enrolled with a Medicaid managed care organization under subchapter XIX of this chapter under a contract under section 1396d(m) of this title or under a contractual, referral, or other arrangement under such contract, at a rate in excess of the rate permitted under such contract), or

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under subchapter XIX of this chapter, any gift, money, donation, or other consideration (other than a

1 See References in Text note below.
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, nursing facility, or intermediate care facility for the mentally retarded, 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.

(e) Violation of assignment terms

Whoever accepts assignments described in section 1395a(b)(3)(B)(i) of this title or agrees to be a participating physician or supplier under section 1395a(b)(4) of this title and knowingly, willfully, and repeatedly violates the term of such assignments or agreement, 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.

(f) “Federal health care program” defined

For purposes of this section, the term “Federal health care program” means—

(1) any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government (other than the health insurance program under chapter 89 of title 5); or

(2) any State health care program, as defined in section 1320a–7(h) of this title.

(g) Liability under subchapter III of chapter 37 of title 31

In addition to the penalties provided for in this section or section 1320a–7a of this title, a claim that includes items or services resulting from a violation of this section constitutes a false or fraudulent claim for purposes of subchapter III of chapter 37 of title 31.

(h) Actual knowledge or specific intent not required

With respect to violations of this section, a person need not have actual knowledge of this section or specific intent to commit a violation of this section.

This is a text transcription of a page from a document. The text is not provided, but it appears to be a legal document discussing provisions related to health care programs, including Medicaid and Medicare, and various penalties for violations.

The document mentions provisions related to Medicaid and Medicare, including penalties for acts involving Medicare or State health care programs. It references other sections and paragraphs, indicating a comprehensive legal structure.

The text is legally formatted, with references to other sections and paragraphs, indicating a comprehensive legal structure.

The document also includes references to various penalties, including fines and imprisonment, for activities related to furnishing items or services as constituting a misdemeanor or felony.

The page contains a variety of legal terms and phrases, such as "Medicare or State health care program," "Medicare or State health care program," and "Medicaid managed care organization."
EFFECTIVE DATE OF 2010 AMENDMENT

EFFECTIVE DATE OF 2003 AMENDMENT
Pub. L. 108–173, title II, §237(e), Dec. 8, 2003, 117 Stat. 2213, provided that: “The amendments made by this section [amending this section and sections 1395f, 1395w–21, 1395w–23, and 1395w–27 of this title] shall apply to services provided on or after January 1, 2006, and contract years beginning on or after such date.”

EFFECTIVE DATE OF 1997 AMENDMENT
Amendment by section 4201(c)(1) of Pub. L. 105–33 applicable to services furnished on or after Oct. 1, 1997, see section 4201(d) of Pub. L. 105–33, set out as a note under section 1395f of this title.

Amendment by section 4708(b) of Pub. L. 105–33 effective Aug. 5, 1997, and applicable to contracts entered into or renewed on or after Oct. 1, 1997, see section 4710 of Pub. L. 105–33, set out as a note under section 1396b of this title.

EFFECTIVE DATE OF 1996 AMENDMENT
Section 204(b) of Pub. L. 104–191 provided that: “The amendments made by this section [amending this section] shall take effect on January 1, 1997.”

Section 210(c) of Pub. L. 104–191 provided that: “The amendments made by subsection (a) [amending this section] shall apply to written agreements entered into on or after Jan. 1, 1997, without regard to whether regulations have been issued to implement such amendments.”


EFFECTIVE DATE OF 1994 AMENDMENT
Amendment by section 133(a)(2) of Pub. L. 103–432 applicable to items or services furnished on or after Jan. 1, 1995, see section 133(c) of Pub. L. 103–432, set out as a note under section 1395m of this title.

EFFECTIVE DATE OF 1990 AMENDMENT
Amendment by section 4161(a)(4) of Pub. L. 101–508 applicable to services furnished on or after Oct. 1, 1991, see section 4161(a)(6) of Pub. L. 101–508, set out as a note under section 1395k of this title.

Amendment by section 4161(b)(2) of Pub. L. 101–508 applicable with respect to items or services furnished on or after Jan. 1, 1991, in the case of items or services furnished by a provider who, on or before Nov. 5, 1990, has furnished items or services for which payment may be made under part B of subchapter XVIII of this chapter or Jan. 1, 1992, in the case of items or services furnished by any other provider, see section 4161(b)(4) of Pub. L. 101–508, set out as an Effective Date note under section 1320a–3a of this title.

EFFECTIVE DATE OF 1988 AMENDMENT
Except as specifically provided in section 411 of Pub. L. 100–360, amendment by Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA, Effective Date note under section 106 of Title I, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENTS
Amendment by section 4211(b)(1) of Pub. L. 100–203 applicable to nursing facility services furnished on or after Oct. 1, 1990, without regard to whether regulations implementing such amendment are promulgated by such date, except as otherwise specifically provided in section 1396r of this title, with transitional rule, see section 4211(a), (b)(2) of Pub. L. 100–203, as amended, set out as an Effective Date note under section 1396r of this title.

Amendment by Pub. L. 100–93 effective at end of fourteen-day period beginning Aug. 18, 1987, and inapplicable to administrative proceedings commenced before end of such period, see section 15(a) of Pub. L. 100–93, set out as a note under section 1320a–7 of this title.

EFFECTIVE DATE OF 1977 AMENDMENT
Section 4(d) of Pub. L. 95–142 provided that: “The amendments made by subsections (a) and (b) [amending this section] shall apply with respect to acts occurring and statements or representations made on or after the date of the enactment of this Act [Oct. 25, 1977].”

EFFECTIVE DATE
Section 242(d) of Pub. L. 92–600 provided that: “The provisions of amendments made by this section [enacting this section and section 1396h of this title and amending section 1396i of this title] shall not be applicable to any acts, statements, or representations made or committed prior to the enactment of this Act [Oct. 30, 1972].”

RULEMAKING FOR EXCEPTION FOR HEALTH CENTER ENTITY ARRANGEMENTS

“(1) Establishment.—

“(A) IN GENERAL.—The Secretary of Health and Human Services shall establish, on an expedited basis, standards relating to the exception described in section 1228(b)(3)(B) [now section 1228(b)(3)(D)] of the Social Security Act [42 U.S.C. 1320a–7b(d)(3)(B)], as added by subsection (a), for health center entity arrangements to the antikickback penalties.

“(B) FACTORS TO CONSIDER.—The Secretary shall consider the following factors, among others, in establishing standards relating to the exception for health center entity arrangements under subparagraph (A):

“(i) Whether the arrangement between the health center entity and the other party results in savings of Federal grant funds or increased revenues to the health center entity.

“(ii) Whether the arrangement between the health center entity and the other party restricts or limits an individual’s freedom of choice.

“(iii) Whether the arrangement between the health center entity and the other party protects a health care professional’s independent medical judgment regarding medically appropriate treatment.

“The Secretary may also include other standards and criteria that are consistent with the intent of Congress in enacting the exception established under this section.

“(2) DEADLINE.—Not later than 1 year after the date of the enactment of this Act [Dec. 8, 2003] the Secretary shall publish final regulations establishing the standards described in paragraph (1).”

NEGOTIATED RULEMAKING FOR RISK-SHARING EXCEPTION
Section 216(b) of Pub. L. 104–191 provided that:

“(1) Establishment.—

“(A) IN GENERAL.—The Secretary of Health and Human Services (in this subsection referred to as the ‘Secretary’) shall establish, on an expedited basis and using a negotiated rulemaking process under subchapter 3 (III) of chapter 5 of title 5, United States Code, standards relating to the exception for risk-sharing arrangements to the anti-kickback penalties described in section 1128B(b)(3)(F) of the Social Security Act [subsec. (b)(3)(F) of this section], as added by subsection (a).
“(B) Factors to consider.—In establishing standards relating to the exception for risk-sharing arrangements to the anti-kickback penalties under subparagraph (A), the Secretary shall—

“(i) consult with the Attorney General and representatives of the hospital, physician, other health practitioner, and health plan communities, and other interested parties; and

“(ii) shall take into account—

“(I) the level of risk appropriate to the size and type of arrangement;

“(II) the frequency of assessment and distribution of incentives;

“(III) the level of capital contribution; and

“(IV) the extent to which the risk-sharing arrangement provides incentives to control the cost and quality of health care services.

“(2) Publication of notice.—In carrying out the rulemaking process under this subsection, the Secretary shall publish the notice provided for under section 566(a) of title 5, United States Code, by not later than 45 days after the date of the enactment of this Act [Aug. 21, 1996].

“(3) Target date for publication of rule.—As part of the notice under paragraph (2), and for purposes of this subsection, the ‘target date for publication’ (referred to in section 566(a)(5) of such title) shall be January 1, 1997.

“(4) Abbreviated period for submission of comments.—In applying subsection 566(c) of such title under this subsection, ‘15 days’ shall be substituted for ‘30 days’.

“(5) Appointment of negotiated rulemaking committee and facilitator.—The Secretary shall provide for—

“(A) the appointment of a negotiated rulemaking committee under section 566(a) of such title by not later than 30 days after the end of the comment period provided for under section 566(c) of such title (as shortened under paragraph (4)), and

“(B) the nomination of a facilitator under section 566(c) of such title by not later than 10 days after the date of appointment of the committee.

“(6) Preliminary committee report.—The negotiated rulemaking committee appointed under paragraph (5) shall report to the Secretary, by not later than October 1, 1996, regarding the committee’s progress on achieving a consensus with regard to the rulemaking proceeding and whether such consensus is likely to occur before one month before the target date for publication of the rule. If the committee reports that the committee has failed to make significant progress toward such consensus or is unlikely to reach such consensus by the target date, the Secretary may terminate such process and provide for the publication of a rule under this subsection through such other methods as the Secretary may provide.

“(7) Final committee report.—If the committee is not terminated under paragraph (6), the rulemaking committee shall submit a report containing a proposed rule by not later than one month before the target publication date.

“(8) Interim final effect.—The Secretary shall publish a rule under this subsection in the Federal Register by not later than the target publication date. Such rule shall be effective and final immediately on a interim basis, but is subject to change and revision with such rule, the Secretary shall specify the process for the timely review and approval of applications of entities to be certified as provider-sponsored organizations pursuant to such rules and consistent with this subsection.

“(9) Publication of rule after public comment.—The Secretary shall provide for consideration of such comments and republication of such rule by not later than 1 year after the target publication date.”

§ 1320a–7c. Fraud and abuse control program

(a) Establishment of program

(1) In general

Not later than January 1, 1997, the Secretary, acting through the Office of the Inspector General of the Department of Health and Human Services, and the Attorney General shall establish a program—

(A) to coordinate Federal, State, and local law enforcement programs to control fraud and abuse with respect to health plans;

(B) to conduct investigations, audits, evaluations, and inspections relating to the delivery of and payment for health care in the United States;

(C) to facilitate the enforcement of the provisions of sections 1320a–7, 1320a–7a, and 1320a–7b of this title and other statutes applicable to health care fraud and abuse, and

(D) to provide for the modification and establishment of safe harbors and to issue advisory opinions and special fraud alerts pursuant to section 1320a–7d of this title.

(2) Coordination with health plans

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

(3) Guidelines

(A) In general

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

(B) Information guidelines

(i) In general

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

(ii) Confidentiality

Such guidelines shall include procedures to assure that such information is provided and utilized in a manner that appropriately protects the confidentiality of the information and the privacy of individuals receiving health care services and items.

(iii) Qualified immunity for providing information

The provisions of section 1320c–6(a) of this title (relating to limitation on liabili-