Pauline –

This is an issue I worked on with a while back – plse put in her files for her return.

— thx – Molly

~~Pauline~~/Jen –

I'm sending the ANOVA file back for your keeping.

Enjoy!

— – Molly

AMERICAN NURSES ASSOCIATION

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Virginia Trotter Betts, JD, MSN, RN
President

Geri Mazzullo, MS, RN
Executive Director

TEN IMPERATIVES FOR ADMINISTRATION ACTION

1. **Take action on threats to patient safety and quality.**

As health care institutions and systems continue to cut down on use of professional nursing staff, even in the face of increasing patient acuity levels, a real threat to patient safety and quality care continues to increase. Unfortunately, information regarding nurse staffing and patient outcomes remains, for the most part, "proprietary" information that is inaccessible to regulators or to the public.

As important first steps toward accountability, **hospitals and other institutions that receive Medicare funds should be required, as part of the Medicare Conditions of Participation, to disclose data regarding nurse staffing and outcome data,** including numbers and mix of nursing staff and the ratios of nursing staff to patients. In addition, ANA is preparing to have introduced legislation on patient safety that would (1) require providers to make available to the public certain information regarding nurse staffing and patient outcomes; (2) protect "whistleblowers" employed by a health plan, who point out dangerous or potentially dangerous conditions; and (3) provide a process for the Secretary of Health and Human Services to review any application for merger by a provider of services, to determine its impact on patient care. **ANA requests the Administration's support for this legislation.**

We have noted with some interest recent reports of initiatives involving HCFA, the National Committee for Quality Assurance, public employee groups and large employers, to address the issue of quality within managed care programs. **ANA strongly believes that nursing must play a part in this process.**

ANA also believes that the Administration **must hold firm on current health and safety regulations**, including those issued under OBRA '87's nursing home reform provisions.

2. **Support legislation to provide reimbursement for services of all advanced practice nurses, regardless of geographic location or practice setting, under Medicare and Medicaid. Reject state Medicaid waiver applications that fail to ensure utilization of nurses as primary care providers.**

The Administration has previously shown its recognition of the fact that advanced practice nurses are a proven and valuable resource for providing needed primary and specialty care services, particularly to underserved populations. ANA appreciates the Administration's previous support for direct Medicare and Medicaid payment for all

advanced practice nurses, regardless of geographic location or practice setting. Legislation has been introduced in the 104th Congress to provide for coverage of advanced practice nursing services in all geographic locations and practice settings. These are: MEDICARE REIMBURSEMENT: H.R. 1750 (Ed Towns [D-NY] and Nancy Johnson [R-CT]); S.864 (Charles Grassley [R-IA] and Kent Conrad [D-ND]). MEDICAID REIMBURSEMENT: H.R. 1339 (Bill Richardson [D-NM]; S.972 (Tom Daschle [D-SD]. **ANA requests that the White House provide letters of support to the Congressional leadership for these bills**, which would do much to increase access to high-quality, cost-effective health care providers.

In addition, as we have previously discussed, some state Medicaid waiver programs have excluded advanced practice nurses from serving as primary care providers or have otherwise blocked their full participation. Generally, this has been as a result of reserving primary care or "gatekeeper" roles for physicians only. In some cases, this has been a feature of the state's waiver proposal itself. In others, it has been imposed by the insurers with whom the state has contracted to administer the program. **We call upon the Administration to reject any state Medicaid waiver proposals--under both Sections 1115 and 1915(b)--that fail to ensure the utilization of nurses as primary care providers.**

3. **Increase the number of nurses appointed to visible federal positions that affect public policy and to federal commissions.**

As you know, this area has already been the subject of discussion with you and other appropriate Administration officials. We have recently provided Bob Nash a preliminary list of names of nurses who are both highly qualified and readily available for appointment to key federal positions, and we are continuing a dialogue with Mr. Nash regarding open positions and available, qualified nurse candidates.

4. **HRSA should conduct a National Sample Survey of Registered Nurses beginning in 1995.**

The single most important need for health workforce planning is the availability of comparable data that spans long time periods. Because of rapid and ongoing changes in the health care industry, the demographics of the registered nurse population are changing dramatically. There is currently no reliable data to document and track these changes or to predict future changes. The National Sample Survey of Registered Nurses conducted every four years by the Division of Nursing is the largest and most comprehensive survey of the registered nurse workforce. This survey, which is scheduled to be done in 1996, incorporates all nurses in all practice settings and provides the data necessary for workforce planning. It will also allow for a more comprehensive understanding of some of the changes effected by unprecedented health care restructuring and a continued shift away from acute care services. It is important that this survey remain a priority and be adequately funded.

5. **Secretary Reich should allow the H-1A Visa Program to sunset, as scheduled, in September, 1995 as recommended by the Minority Report of the Immigration Nursing Relief Advisory Committee.**

The H-1A Visa Program was instituted at a time of an immense nursing shortage in the United States. There is simply no reason to continue the importation of nurses from other countries at a time when many current U.S. resident nurses are facing layoffs as a result of health care industry downsizing. The Department of Labor and its Secretary must support working registered nurses in the U.S.

6. **The U.S. Trade Representative should initiate discussions with Canada and Mexico to remove registered nurses and other health professionals from Appendix 1603.D.1 of the NAFTA.**

As noted above, many U.S. nurses are currently facing displacement as a result of health care restructuring and downsizing. The impact of the flow of Canadian and Mexican nurses into the United States on the domestic nursing workforce requires serious reconsideration of the inclusion of registered nurses on this list.

7. **Provide vocal support for funding of nursing education, including full reauthorization of the Nurse Education Act (S.555) as well as full funding of the Nurse Education Act. Support for continuation and funding of the Division of Nursing at HRSA, National Institute for Nursing Research and the Agency for Health Care Policy and Research and public health programs under the Health Resources and Services Administration.**

The rapidly evolving changes in our health care system call for the fullest utilization possible of the multi-disciplinary providers who care for patients and families in an ever-increasing array of settings; hospitals, subacute care facilities, long term care facilities, schools and universities, workplaces and communities. Federal support for nursing education through the Nurse Education Act is critical to meeting the health care needs of this country, particularly its primary health care needs. Support for nursing and health care research are also critical components of addressing this country's continued health care needs.

8. **Revamp HCFA guidelines for the "incident to" provision under Medicare B, to include removal of the requirement for on-site presence of a physician in order for "incident to" services to be covered.**

HCFA guidelines for Medicare Part B services provided "incident to" those of a physician should be re-examined and revamped. They currently include restrictive and archaic requirements, such as requiring a physician's on-site presence when services are provided. **This has greatly limited the use of registered nurses, including advanced practice nurses, in many ambulatory settings and in providing home visits. This has provided a barrier for access to care to many Medicare beneficiaries.**

9. **Support reauthorization of the Community Nursing Organization (CNO) project (due to sunset at end of 1996).**

As the nation moves further toward managed care, there is serious examination of the potential for safe, high quality, cost-efficient care in a capitated context. The Community Nursing Organization project, a Medicare demonstration project, serves Medicare beneficiaries through capitated healthcare services, in four sites across the country. Preliminary reports are exciting: the services have been well received by beneficiaries, outcomes have been good, and costs have been kept down. The CNO project is a model for Medicare managed care. **It deserves to be continued and expanded, and ANA requests Administration support for efforts to accomplish this goal.**

10. **Make the Chiefs of the military nursing services two-star flag officers instead of one-star.**

Military nursing leaders should be of equivalent rank as to those military leaders with comparable responsibilities. The Nurse Corps Chiefs/Directors command about 13,000 active duty troops, plus about 22,000 in the National Guard and Reserves. This is equivalent in size to other 2-star commands.

Moreover, the essential nature of the mission of the military nursing services should be appropriately recognized and acknowledged. In addition, the Nurse Corps Chiefs/Directors each have additional duties and command beyond their nursing-related functions--such as Deputy Surgeon General, Director of Personnel (for all medical officers), and Commander for Health Promotion and Preventive Medicine.

- Chris DeBrize
- Geri
-

Sept - conversation w/ Chris DeBrize

For Internal Use Only

ANA IMPERATIVES
Summary of Status

1. **Take Action on threats to patient safety and quality.**

Summary Response: Yes, the Administration has opposed threats to patient safety and quality -- in particular in the fight to maintain nursing home standards.
⇒ we are very supportive as evidenced
Breakdown of Imperative:

a) Request for Administration support for legislation (working with Wellstone on; not yet introduced?) that would:

Draft bill - education/mobilization

i) require providers to make available to the public certain information regarding nurse staffing and patient outcomes;

Doubtful, given VP's regulatory reform.

Steve Clemson - Rpt Card - state level

ii) protect "whistleblowers" employed by a health plan, who point out dangerous or potentially dangerous conditions;

HCFA strongly supports protection for whistleblowers; ANA given HCFA contact: Judy Berrick, HCFA

iii) require HHS to review merger applications to determine impact on patient care

Would add extra layer of regulatory review to DOJ and FTC merger reviews. Spoke to Bob Potter, Head of DOJ Antitrust Policy Office (514-2512) about consideration given to patient care -- they do consider quality and price in developing "efficiency" criteria. ANA given Bob Potter to discuss their concerns further.

b) Nurse involvement in HCFA managed care quality initiatives

HCFA would welcome. ANA given contact: Barbara Gagel, Director of Health Standards and Quality Bureau (410/786-6841)

c) Hold firm on current health and safety regulations, including those issued under OBRA 87's nursing home reform provisions.

Yes. *The President fought hard to protect nursing home standards. HCFA has conducted extensive monitoring of the implementation of the OBRA 87 nursing home enforcement regulation (implemented 7/1/95).*

2. a) Support legislation to provide reimbursement for services of all advanced practice nurses, regardless of geographic location or practice setting, under Medicare and Medicaid. b) Reject state Medicaid waiver applications that fail to ensure utilization of nurses as primary care providers.

(a) Yes (b) No.

maintains status quo

a) Our Medicare proposals allow nurse practitioners and clinical nurse specialists to bill directly, and list nurses as providers for provider-sponsored networks.

[The imperative requested support for specific legislation -- HR 1750/S 864 (Medicare Reimbursement) and HR 1339/S 972 (Medicaid reimbursement). HCFA's response was the following:

"Expanding direct reimbursement for advanced practice nurses and physician assistants would increase utilization of these services, and thereby increase Medicare costs. Neither HCFA nor CBO has estimated the cost of HR 1339/S 972, but CBO scored a similar provision in the Republican Conference agreement that increased costs by $300 million from FY 1996-2002. The President's proposal does not include this provision."]

* simple guidelines describing emphasis in urban areas

b) Reject Medicaid waivers --Unlikely, although HCFA does encourage reform that increases access and quality: "Before approving any 1115 or 1915(b) waiver, HCFA requires states to demonstrate the capacity to ensure that all required services are available and accessible to Medicaid beneficiaries, and that the services provided are of high quality. Certain services provided by advanced practice nurses, including nurse practitioner services and certified nurse midwife services, are mandatory services. In reviewing states' waiver applications and contracts with managed care plans, HCFA encourages states to contract with managed care plans that include nurse practitioners and other advanced practice nurses as primary care providers. However, the states, not HCFA, regulate health plans' contracts with advanced practice nurses. Further regulation of health plan contracts by HCFA may conflict with the Administration's policy of promoting state flexibility in Medicaid."

3. Increase number of nurses appointed to visible federal positions.

(Yes). *Bob Nash asked Peg Clark to monitor: Recently, Virginia Betts was offered a spot on OPM's Federal Salary Council; she suggested that ANA Executive Director Geraldine Marullo would be better. While the President has not yet signed off on it yet, she is expected to be named soon (there are 3 vacancies being filled; the other 2 are taking more time to clear).*

In addition, Helen Maramontes (an ANA pick) was named to the AIDS Commission . Peg has pushed HHS, but very few hires. ANA has been told to forward names to Peg Clark (6-7831).

4. HRSA should conduct National Sample Survey of Registered Nurses beginning in 1995.

Yes. Just today (1/24), the Division of Nursing received a funding certification for $650,000 for the survey. $250,000 was committed last year to fund and conduct the initial stage of survey. This next amount will allow all of the data collection to occur. A final installment will be needed sometime in 1997. (At a meeting with the ANA and other associations, Ciro suggested they assist in funding and/or assist in securing funding in appropriations--did anything come of this?).

The National Sample Survey is the only tool currently available to determine the status of the nursing workforce; the ANA believes tool particularly important given changes in health care industry.

5. Reich should allow H-1A Visa Program to sunset.

Yes. (The INS may allow a few nurses in under more restrictive requirements -- such as only allowing advanced practice degrees.)

The H-1 Visa Program allows nurses to enter the U.S. to work for a specific employer if they are licensed and if the employer meets seven specific criteria (e.g., the employment is temporary; the employer has not laid off any American citizens for a number of years). The program ended on August 31, 1995.

6. USTR should initiate discussions with Canada and Mexico to remove registered nurses and other health professionals from Appendix 1603.D.1 of the NAFTA.

DOL spoke directly

Yes, discussions *have been initiated. DOL made a presentation at the November meeting of the Temporary Entry Working Group. DOL is now gathering further data for future discussions (may be problematic since INS either does not have good data or does not collect data on this workforce).*

Canada in particular is resistant to the proposed change. Reportedly, there are also differences of opinion within the Administration: USTR and Commerce generally oppose changes to the NAFTA; DOL, INS, and State support this change.

Appendix 1603.D.1 of the NAFTA concerns "cross-border movement of professionals." Members of professions listed in the Appendix are eligible for expedited entry into the other NAFTA countries to practice their profession for a limited amount of time. Canada pushed for the inclusion of registered nurses on this list (approximately 25% of the Canadians who enter the U.S. pursuant to this Appendix are nurses).

NAFTA establishes a Temporary Entry Working Group in which all three countries participate. Adding or subtracting professions from the Appendix can be negotiated within the Working Group.

7. Provide vocal support for funding of nurse education, including full reauthorization and full funding of the Nurse Education Act (S 555); continuation and funding of the Division of Nursing at HRSA, the National Institute of Nursing Research, AHCPR, and public health programs under HRSA.

(The general concerns are that there be some federal presence in the development of the nurse workforce and some nurse involvement in developing overall health policy at HHS.)

General response: Yes.

a) Full reauthorization and full funding of the Nurse Education Act (S 555)

S.555 (Nurse Education Act/Reauthorization of Title VIII) was held up in Senate because of a Coats abortion amendment. Sec. Shalala sent a letter to Sen. Kassebaum expressing support of S. 555 in March.

b) continuation and funding of the Division of Nursing at HRSA (administers Title VIII).

Yes. Originally HHS zeroed out Title VII and VIII; but OMB pass back restored (to level requested by President in FY 96).

c) continuation and funding of the National Institute of Nursing Research

NINR is the smallest institute at NIH and none of the institutes get a specific allocation in the budget. However, NIH will fare relatively well in the budget process (the President requested a 4.4% increase).

A related concern is consolidation of the institutes within NINR. Conversations between NINR Director Pat Grady and Sen. Kassebaum have eased these concerns.

d) Continuation of funding for AHCPR.

AHCPR was funded at $159 million in FY 95. The FY 96 House-passed appropriations bill recommends $66 million; the Senate Committee bill includes $127 million. OMB protested the House level in our SAP to the Senate (listed as item of concern). HHS' FY 97 budget submission calls for $202 million.

AHCPR is currently covered under a CR that expires February 26 (at the lower of: the '95 or the House enacted level).

8. Revamp HCFA guidelines for "incident to" provision under Medicare B, to include removal of the requirement of on-site presence of a physician in order for "incident to" services to be covered.

No. HCFA cost estimates showed that it was too expensive.

HCFA guidelines for Medicare Part B regulate services provided "incident to" those of a physician. ANA believes that these guidelines are restrictive and archaic, such as requiring a physician's on-site presence when services are provided.

9. Support Reauthorization of Community Nursing Organization project (due to sunset at end of 1996)

Too early to indicate definite support. Interim evaluation report due in early 1996. This evaluation will examine whether the combination of capitated payment and nurse case management promotes the appropriate use of community nursing and ambulatory care services and reduces the use of acute care services. The evaluation will also compare the health status of beneficiaries enrolled in the project with the health status of the general Medicare population. Preliminary descriptive information indicates that approximately 95% of current demonstration enrollees have 0 to 1 ADL impairment; however, because outcome data is not available yet, we do not know the costs and impacts of the demonstration.

10. Make Chiefs of military nursing services two-star flag officers instead of one-star. (Allow chiefs of the nurse corps to compete for promotion to two-star.)

Currently, the Chiefs of the military Nurse Corps are one-star officers. However, according to General Nancy Adams, Chief of the Army Nurse Corps, the Army nurses don't want to be merely ordained as two-star flag officers. Rather they want the opportunity to compete for promotion to two-star generalships after they have been Corps Chiefs (currently, Army nurses are not permitted to compete for two-star positions, although the Navy and Air Force Nurse Corps Chiefs are).

Today, the Chiefs of the Nurse Corps have significant responsibility that integrate them into higher levels of medical divisions. However, Nurse Corps Chief is only a four year position, and after leaving the Nurse Corps as a one-star general, there is unlikely to be another slot for a one-star general in the medical division. Because they cannot compete for two-star status (and jobs that require a two-star general), outgoing Nurse Corps Chiefs are often forced into retirement.

The Army Nurse Corps are trying to get the rules changed so that nurses can compete for two-star generalships. (According to Gen. Adams, the change is working well in the Navy and Air Force.) General Alcid LaNoe, the Surgeon General of the Army, is sympathetic to the nurses' situation.

Gen. LaNoe discussed the matter with Gen. Dennis Reimer, the new Army Chief of Staff, at a meeting late this fall. While not opposing the change, Gen. Reimer asked for further information.

At the suggestion of Gen. Adams, I have discussed the issue with Mrs. Sara Lister, Assistant Secretary of the Army for Manpower and Reserve Affairs. She is considering whether there is anything further to be done.

* VA dissolving Office of Nursing

Create System heads → excludes nurses
limit to osteopath, dentist, phy

* Ginny Betts finishes up in June
—wants to work on campaign
or Administration

Backup documents

DEPARTMENT OF HEALTH & HUMAN SERVICES Chief of Staff

Washington D.C. 20201

FACSIMILE

DATE OCT 20 1995

TO: (NAME, ORGANIZATION, CITY/STATE AND PHONE NUMBER):

Molly Brostrom
Domestic Policy Office

~~456-5561~~

456-2249

FROM. (NAME, ORGANIZATION, CITY/STATE AND PHONE NUMBER):

Kevin Thurm
Chief of Staff

690-6133

RECIPIENT'S FAX NUMBER: ( ) 456-7028

NUMBER OF PAGES TO SEND (INCLUDING COVER SHEET): 2

COMMENTS:

-HHS strongly supports
-HHS works closely w/ Kennedy Hall
-DES signed March 27, 1995

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

The Honorable Nancy Kassebaum
Chairman, Committee on Labor
and Human Resources
United States Senate
Washington, D.C. 20510

Dear Madam Chairman:

As your Committee considers S. 555, the Health Professions Consolidation and Reauthorization Act of 1995, I want to take this opportunity to give the Administration's views on this legislation. The Administration is very supportive of this legislation.

S. 555 would consolidate, and extend through Fiscal Year 1999, some 45 existing programs of assistance to nursing and health professions schools and students. These program authorities would be grouped into six categories: Primary Care and Preventive Medicine Training; Minority and Disadvantaged Training; Community-Based Training in undeserved areas; Student Assistance; Nursing; and other priority areas. The health professions training provisions in S. 555 are consistent with the Administration's recommendations for reform in this area, as outlined by the Assistant Secretary for Health at the February 22 hearing held by your Committee.

Both your legislation and our proposals would permit the most effective use of resources by consolidating dozens of highly specific categorical authorities into a small number of functional categories. They would also serve many of the same objectives, such as, sharpening the focus of these programs on outcomes, encouraging collaboration among health and educational institutions, and simplifying program administration.

The Administration applauds the introduction of the Health Professions Consolidation and Reauthorization Act. We recommend further strengthening the bill by including authority for an incentive fund, which the agency could use to further encourage high-quality performance. This idea is a key component of the Administration's Performance Partnership proposals, and was included in the legislative specifications that I sent you on this bill last month. In addition, we believe the bill could be strengthened if you would consider the following suggestions:

1. Continue a discrete Family Medicine Capacity building program under a separate heading from that which applies to the other primary care disciplines.

2. Include general dentistry as a component of the Primary Care and Preventive Medicine Cluster.

S. 555 would assist us in strengthening the Federal Government's partnership with State and local governments, education institutions, professional groups, and community organizations to bring about needed changes in health workforce training and practice.

We applaud your commitment to health professions education and training. The strategy embodied in your bill represents an important program reform which will improve the quality of services offered by the Federal government and expand the availability of training opportunities and health care to resident of rural and undeserved communities.

The Office of Management and Budget has advised that there is no objection to the presentation of this report to the Congress, and that enactment of S. 555 would be consistent with the program of the President.

Sincerely,

Donna E. Shalala

HEALTH CARE FINANCING ADMINISTRATION

ADDRESSEE:	FROM: Jennifer Boulanger
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REMARKS:

RESPONSE TO WHITE HOUSE ON AMERICAN NURSES ASSOCIATION TEN IMPERATIVES FOR ADMINISTRATION ACTION

#2. Support legislation to provide reimbursement for services of all advanced practice nurses, regardless of geographic location or practice setting, under Medicare and Medicaid. Reject state Medicaid waiver applications that fail to ensure utilization of nurses as primary care providers.

ANA requests that the White House provide letters of support to the Congressional leadership for H.R. 1750/S. 972 (Medicare reimbursement) and H.R. 1339/S. 972 (Medicaid reimbursement).

ANA calls upon the Administration to reject any state Medicaid waiver proposals--under both Sections 1115 and 1915(b)--that fail to ensure the utilization of nurses as primary care providers.

MEDICAID:

Before approving any 1115 or 1915 (b) waiver, HCFA requires states to demonstrate the capacity to ensure that all required services are available and accessible to Medicaid beneficiaries, and that the services provided are of high quality. Certain services provided by advanced practice nurses, including nurse practitioner services and certified nurse midwife services, are mandatory services. HCFA reviews states' waiver applications and contracts with managed care plans to ensure that states will provide all mandatory services. When reviewing the waivers, HCFA encourages states to contract with managed care plans that include nurse practitioners and other advanced practice nurses as primary care providers. However, the states, not HCFA, regulate health plans' contracts with advanced practice nurses. Further regulation of health plan contracts by HCFA may conflict with the Administration's policy of promoting state flexibility in Medicaid.

MEDICARE:

Expanding direct reimbursement for advanced practice nurses and physician assistants would increase utilization of these services, and thereby increase Medicare costs. Neither HCFA nor CBO has estimated the cost of H.R. 1339/S. 972, but CBO has scored a similar provision in the Republican Conference agreement (section 8707). The Conference Agreement provision increases costs by $300 million from FY 1996-2002. The President's proposal does <u>not</u> include this provision.

However, the President's Health Security Act of 1993 <u>did</u> include a similar provision (sec. 4022). HCFA estimated the cost to be $ 2.2 billion between FY 1996-2000. CBO's estimate was substantially lower, $815 million between FY 1996-2000.

[Note: CBO's cost estimate of the Conference agreement provision is much lower than their cost estimate of the HSA provision. The large difference between the two CBO estimates may be the result of confusion over the effective date of the provision. The provision is effective in FY 1996, however CBO estimates the cost at zero until FY 2000.)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

NOV 8 1995

Ms. Iris Freeman
Executive Director
Minnesota Alliance for Health Care Consumers
2626 82nd Street, Suite 220
Bloomington, Minnesota 55425

Dear Iris:

I want to thank you for your dedicated interest and invaluable contributions during the first hundred days of implementing the nursing home reform enforcement regulation. Your consultation, as well as that of others -- together with extensive monitoring of the implementation -- has been extremely helpful to the Health Care Financing Administration's (HCFA's) continuing efforts to refine our policies and procedures to make this survey and enforcement system as effective as possible. I look forward to your continued participation as we move forward with the implementation process. HCFA will continue our efforts to improve both the nursing home services furnished to our beneficiaries and the survey enforcement system. In doing so, we continue to recognize that we all share a common commitment to ensuring that nursing home residents receive the best possible care.

Where our monitoring initiative has, as expected, identified some problems with enforcement procedures, we have introduced improvements to refine the process, and we are continuing to develop various strategies to further enhance our efforts. During the initial implementation period, as you know, we avoided the imposition of remedies except where deficiencies posed an immediate jeopardy to the residents, or where the facility had a history of poor performance in making and sustaining corrections. The collaboration by HCFA, providers, consumers, and State agencies which has characterized the history of this regulation throughout will continue as we address future issues as they are identified.

We are very pleased to see that the implementation is working well on the whole. Since the first of July, more than 5,600 standard surveys and 7,700 complaint surveys have been completed. States are conducting surveys on schedule. HCFA's central communications and operations center (situation room) has provided quick responses to questions and issues raised by the HCFA regional offices and State survey agencies. Our staff has collected and analyzed data on all surveys and has conducted in-depth reviews of more than 600 Statements of Deficiencies. These reviews show that States' survey findings are generally correct on issues of both substantial compliance and substandard quality of care. Almost 200 State agency surveys have been observed by HCFA's regional office staff, who report that the States are, in general, correctly following new survey procedures.

We have learned that, as planned, the new survey focuses more on resident outcomes than did the

previous survey, and that surveyors, ombudsmen, and providers all generally endorse the new survey process. However, there has been some concern expressed about diminished dialogue between surveyors and the facility staff during the surveys. This is both a learning curve and a training issue, and surveyors are being encouraged to discuss findings with staff.

The informal dispute resolution process is working. Providers are not abusing the processes by asking for frivolous reviews, and States are seriously considering information presented. States have conducted 691 informal dispute resolution cases; they affirmed survey findings in about half of these, while survey findings were adjusted for the remainder.

We especially value the comments and impressions we have received from you, from the enforcement procedures workgroup, and from our other observers. Our joint monitoring activities have helped to identify areas of the enforcement process where clear opportunities for improvement exist. We have already instituted several system improvements. These are:

1. Providing a clearer definition of "poor performing facility" than that offered previously. The workgroup has agreed on some mandatory and optional criteria for States to apply. We will reevaluate the definition in one year. In addition, it has been suggested that we consider a change in the term for "poor performing facilities."

2. Clarifying what constitutes "pattern" and "widespread" in determining the scope of cited deficiencies. This clarification will reduce the incidence of "widespread" deficiencies and thus change the deficiencies in some facilities away from substandard quality of care. We asked that the States reexamine the cases in which the "driving" deficiency is "widespread."

3. Providing guidance to States that a team of surveyors is not necessary to conduct a revisit in most cases. This will increase the number of revisits that the States can conduct.

Approximately 74 percent of facilities surveyed were found out of compliance at the time of the standard survey. Of these nursing homes, 95 percent have been given the opportunity to avoid the imposition of remedies if they demonstrate to HCFA that they will correct their deficiencies by a certain date. From the revisits done to date, it appears that all but 5 to 7 percent of nursing homes will achieve substantial compliance by the date of the revisit. However, the high percentage of facilities found out of compliance initially may be producing adverse public perceptions of some facilities and of the industry as a whole. Further questions have been raised about the process of imposing certain remedies. In addition to actions taken already, HCFA will make the following adjustments to the system:

- Deficiencies in categories D, E and F of the enforcement matrix will not result in use of the term "provider noncompliance" prior to the facility revisit. Rather, the terminology used will be "corrections required." Further, the terminology for deficiencies in categories

G, H, and I will be modified to "significant corrections required." While the obligation of facilities under the statute to remain in substantial compliance at all times is unchanged, such facilities will not be termed "noncompliant" until a revisit. If, at the time of the revisit, the facility is out of compliance, all actions, including remedies, will continue to be based on the original survey dates. It is anticipated that such a change in terminology will roughly halve the number of facilities currently termed noncompliant after the initial or standard survey. It will also focus attention on the nursing homes that provide poorer care than their peers, as has been our intention throughout the process of implementing OBRA 1987.

- While the statute requires a finding of "substandard" as the result of certain survey findings, HCFA will support legislation to modify the sanctions imposed as the result of such a finding. Current law requires that the State deny or withdraw a nursing home's nurse aide training in response to certain actions, such as identification of substandard quality of care and a resultant extended survey. Concern has been expressed that in rural areas the denial or withdrawal of nurse aide training makes access to such training difficult. The Administration's Reinventing Government II Initiative includes a legislative proposal that provides discretion to the States for approval of the nurse aide training program in rural areas, where such training programs might otherwise be unavailable.

- HCFA will work with you and our other partners to develop a legislative change in the statutory provision which effectively requires that, under certain circumstances, termination notices accompany the application of alternate remedies. In the interim, HCFA will seek use by the States of notification procedures similar to those now being used by the State of Oklahoma.

- HCFA will suspend imposition of Civil Monetary Penalties (CMPs) for facilities whose highest deficiencies fall into categories D, E, -- and, under specified circumstances[5], F and G -- until December 15 while we conduct a thorough review of the proportionality of the penalties proposed (that is, the relationship between the size of the penalties, the deficiencies cited and the circumstances of the situation) is done. CMPs will be proposed, but not imposed, pending the study. All other remedies provided for in the statute and regulation -- including directed in-service training, denial of payments for new admissions or all admissions, directed plans of correction, and State monitoring -- will be imposed according to the timetables established in regulation and manuals.

- For facilities whose deficiencies identified in the initial standard survey fall into categories

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[5] Specified circumstances: CMPs will not be suspended in substandard quality of care situations that fall in the F category. They will be suspended in cases of G level deficiencies only when those deficiencies represent isolated instances in a facility which otherwise is performing extremely well (as evidenced by very few other deficiencies).

D, E, and F, HCFA will explore (in consultation with providers, consumers and the States)

the development of alternatives to revisits for the purpose of certifying compliance. This should reduce the burden on State agencies during a period of extreme budget constraint.

- HCFA will monitor States that cite a large number of deficiencies compared to other States. In States with an unusually high number of deficiencies, HCFA's central office will review the Statement of Deficiencies and the proposed action before the regional office takes the enforcement action. HCFA will also conduct on-site monitoring in States with unusually low numbers of deficiencies, and work with those States on improvements in their processes.

- HCFA will field two national survey teams in 1996 to conduct surveys to ascertain the degree of national consistency in the system.

Overall, our nursing home standards are working well to protect beneficiaries and their families, although we must continue to monitor and evaluate the enforcement system. The joint effort which characterized the history of this regulation will continue. Both the Impact Assessment Advisors and the Enforcement Procedures workgroup will continue. I look forward to meeting with you in the near future. Again, thank you on behalf of all of us who have been working to fulfill the promise of OBRA 1987.

Sincerely,

Bruce C. Vladeck
Administrator

cc: Enforcement Procedures Workgroup

Roger Kramer works this issue at DOL (219-9098). He says that State (and Commerce?) would have concerns about reopening NAFTA.

MOLLY

- [illegible]
- [illegible]
- DOL, INS, Commerce

U.S. DEPARTMENT OF LABOR

SECRETARY OF LABOR
WASHINGTON, D.C.

APR 25 1995

Mr. John J. Sweeney
International President
Service Employees International Union
1313 L Street, N.W.
Washington, D.C. 20005

Dear Mr. Sweeney:

Thank you for your letter concerning temporary entry of healthcare workers under the North American Free Trade Agreement (NAFTA). We apologize for the delay in responding to your letter but we hoped to provide you with more recent information on the temporary admission of NAFTA Professionals.

In your letter, you specifically asked for admission and employment information about registered nurses who are currently employed in the U.S. as Professionals under NAFTA. Since the Agreement only entered into force in January 1994, data on temporary entry are still very limited. However, with the assistance of the Immigration and Naturalization Service (INS), my staff has collected information regarding temporary admission of registered nurses under NAFTA and its predecessor agreement, the U.S.-Canada Free Trade Agreement (CFTA). According to the latest available data from INS, which include the initial entry and subsequent entries of the same individual, a total of 4,728 Canadian nurses are reported to have entered the U.S. as professionals under the CFTA in calendar year 1993. Similarly, 4,146 NAFTA nurses (Canadian and Mexican) entered the U.S. during the months of January through July 1994.

Foreign nurses are also admitted into the U.S. under the Immigration Nursing Relief Act of 1989 (INRA). This five-year pilot program (H-1A Temporary Admission Program for Registered Nurses) was created by Congress to help alleviate a shortage of nurses which existed at the time in the U.S. In fiscal year 1993, there was a total of 6,437 entries, initial and subsequent, of H-1A foreign nurses into the U.S., of which 45 entered from Canada and 33 entered from Mexico. The Immigration Nursing Relief Advisory Committee, of which your organization is a member, is conducting a study to advise the Secretary of Labor on the impact of the H-1A program on the domestic workforce and the advisability of extending the program beyond the five-year pilot period. This study is expected to be completed by Spring, 1995.

With regard to your request for information about particular employers of NAFTA nurses, INS notes that employment information is both limited and incomplete. Presently, INS collects and maintains data on employers of NAFTA professionals when employers are required to petition on behalf of the worker and/or the employers apply to extend the temporary stay in the U.S. of the NAFTA worker. Thus, most of the employment data on NAFTA

professionals is collected from employers of Mexican professionals since employers of Canadian professionals are not required under the Agreement to file labor attestations with the Department of Labor (DOL) or petitions with INS. However, these requirements for Mexican professionals will be in force for a period no longer than ten years from the date the NAFTA went into effect.

The recent restructuring and downsizing of the healthcare industry may also have an impact on present and future employment availability for registered nurses. This development is of particular interest to DOL and there will be careful monitoring of any significant job displacement that occurs as a result of industry restructuring. While unpublished data from the Bureau of Labor Statistics still show a relatively low unemployment rate for registered nurses (annual rates ranging from 1.1% to 1.5% in the period 1988-94), the Department is aware of the difficulties facing recent graduates of nursing schools, as well as unemployed registered nurses, in obtaining employment.

Chapter Sixteen of NAFTA is administered through an interagency working group which consults with Congressional and labor advisors on a regular basis. Both Congressional staff and the Labor Advisory Committee for Trade Negotiation and Policy have been advised of your concerns regarding the current labor market conditions for healthcare professionals in the U.S. and also of your interest in initiating consultations on the advisability of removing registered nurses and other healthcare professionals from Appendix 1603.D.1 of the NAFTA. In the October 1994 trinational meeting of the NAFTA Temporary Entry Working Group, our Canadian and Mexican counterparts were also made aware of your views. This issue will also be discussed during the next trinational meeting of the Temporary Entry Working Group to be held in 1995.

I understand your concerns regarding the possible impact of temporary admissions under NAFTA on the U.S. healthcare profession, particularly the retention and retraining of U.S. nurses. DOL is committed to promoting the viability of the U.S. workforce and preparing it for an interdependent international labor market.

I hope that you will find this information useful. If you have any questions, please do not hesitate to contact Mr. Joaquin F. Otero, Deputy Under Secretary for International Affairs.

Sincerely,

Robert B. Reich

Robert B. Reich

SERVICE EMPLOYEES
INTERNATIONAL UNION, AFL-CIO, CLC
1313 L STREET N.W. · WASHINGTON, D.C. 20005 · (202) 898-3200

JOHN J. SWEENEY
INTERNATIONAL PRESIDENT

RICHARD W. CORDTZ
INTERNATIONAL SECRETARY-TREASURER

9400 20753

September 15, 1994

SEP 19 4 17 PM '94

The Honorable Robert B. Reich
Secretary of Labor
Frances Perkins Building
200 Constitution Avenue, N.W.
Washington, D.C. 20210

RE: Temporary Entry of Health-care Workers Under the North American Free Trade Agreement

Dear Secretary Reich:

SEIU strongly supports the President's goal of good jobs at good wages for everyone in the United States. Speaking for health-care workers - SEIU is the largest union in the health-care industry - we want to make certain that the accelerating restructuring of the health-care industry does not come at the expense of the workers. I look forward to a continuing dialogue with you on this issue.

Under Chapter Sixteen of the North American Free Trade Agreement (NAFTA), U.S. health-care employers are free to recruit the following categories of Baccalaureate-level health-care employees in Canada and in Mexico: Dietician; Medical Laboratory Technologist (post-secondary diploma and three years experience); Nutritionist; Pharmacist; Physiotherapist/Physical Therapist; Recreation Therapist; and Registered Nurse (State/provincial license; or *Licenciatura Degree*). These categories encompass only people working as employees -- although the NAFTA calls them "business persons" -- because individuals intending to start a business are forbidden from using the NAFTA Professional category.

SEIU represents workers employed in each of these occupations. I am not aware that there are demonstrated nationwide shortages in any of these occupations. Because employers of RN's already can use the H-1A Visa Program or can apply for H-1B visas, the inclusion of these occupations in the NAFTA is without justification.

The number of health-care workers who have entered under these provisions have increased dramatically since the U.S. Canada Free Trade Agreement first took effect. In 1993, 4,728 RN's entered from Canada (an amount equal to half the total number of H-1A entrants.) In 1992, 81,000 U.S. residents received their RN diplomas and entered the job market. In other words, the number of RN's entering from Canada alone each year under the NAFTA exceeds five percent of the total RN's newly diplomaed in the United States.

The health-care industry is undergoing a massive and far-reaching restructuring. The maximum cooperation of government, employers and workers will be required to ensure that those who need retraining can obtain it in order to promote re-employment of displaced health-care workers. The continued existence of this loophole permitting employers to recruit in Canada will only make that cooperative effort more difficult to achieve.

In June, Swedish Medical Center in Seattle announced plans to lay-off 225 SEIU-represented nurses, fully one-fifth of their nursing staff. In view of the growing number of layoffs of RN personnel across the country, the continued existence of this NAFTA loophole in our immigration laws is highly questionable. Similar concerns exist with respect to the other health-care professions listed. Enclosed is a copy of an article in the August 21, 1994, *New York Times* that describes the difficulties that many recently graduated RN's are experiencing when looking for work in the current environment.

Chapter Sixteen is administered through the ongoing consultation of the relevant agencies of the three countries. I understand that the next intergovernmental meeting will be held during October 1994 in Mexico City. I urge you to ensure that the agenda for this meeting includes discussion of the changed labor market for RN's and other health-care professionals in the United States.

Furthermore, I urge you to initiate consultations with the U.S. Trade Representative and other interested agencies regarding the advisability of removing RN's and the other health-care professions from Appendix 1603.D.1 of the NAFTA.

Additionally, in order that we can explore the potential for adverse impacts, I request that SEIU be supplied with the following information: (1) Which employers are using Chapter Sixteen to recruit RN's and where are they located, and (2) How many Chapter Sixteen RN's remain in the United States and where are they employed?

If you require further information about SEIU's views on this matter, please contact John Howley at 898-3343.

Sincerely,

John J. Sweeney
International President

JJS:jh:luc
Enclosure

opeiu#2
afl-cio,clc

DIVISION OF NURSING

DATE: SEP 20 1995			
TO:	Molly Brostrom The White House	**FROM:**	Marla E. Salmon, ScD, RN Director Division of Nursing Parklawn Bldg., Rm. 9-35 5600 Fishers Lane Rockville, MD 20857
TEL:	202-456-5561	**TEL:**	301-443-5786
FAX:	202-456-7028	**FAX:**	301-443-8586
Number of Pages (Including Cover):			

Per our conversation.

~~CONFIDENTIAL~~

DETERMINED TO BE AN ADMINISTRATIVE MARKING
INITIALS: MA DATE: 2-27-14

HEALTH RESOURCES AND SERVICES ADMINISTRATION
FY 1997 DHHS Submission

13-Sep-95 04:46:21 PM

Health Resources and Services (Dollars in thousands)	FY 1995 Approp. Revised (1)	FY 1996 President's Budget (2)	FY 1996 House Mark (3)	FY 1997 DHHS Final Allowance (4)
PRIMARY CARE				
Community & Migrant Health Centers	9750,519	9756,399	9750,519	9734,573
Programs for Special Populations	16,416	17,259	4,000	16,113
Hansen's Disease Center	20,826	20,826	17,500	20,826
Total, PRIMARY CARE	793,760	794,484	778,019	791,512
HEALTH PROFESSIONS				
Consolidated Health Professions	—	—	278,977	—
H.P. Workforce Development Cluster	129,851	127,218	120,186	125,266
Enhanced Area Health Ed Centers Cluster	48,448	38,768	...	35,000
Minority/Disadvantaged H.P. Cluster	91,176	89,450	—	89,450
Primary Care Medicine & P.H. Cluster	76,646	76,056	—	0
Nursing Education/Practice Cluster	58,540	66,760	—	66,760
National Pract Data Bank (User Fees)	(8,000)	(8,000)	(8,000)	(8,000)
Total, HEALTH PROFESSIONS	400,659	398,256	399,162	306,486
MATERNAL AND CHILD HEALTH				
MCH Block Grant	683,950	678,966	683,950	678,966
Emergency Medical Services Cluster	10,299	14,764	10,000	10,000
Healthy Start	104,229	100,000	50,000	0
Total, MATERNAL AND CHILD HEALTH	798,483	793,630	743,950	688,966
HEALTH RESOURCES DEVELOPMENT				
Health Teaching Facilities	411	411	411	297
Organ Transplantation	2,629	2,629	2,400	2,629
Health Care Facilities	10,000	2,000	0	0
Bone Marrow Donor Registry Program	15,360	15,360	15,360	15,360
Total, HEALTH RESOURCES DEVELOP	28,400	20,400	18,171	18,286
Program Management	120,909	114,546	120,546	114,546
Information Resources	—	—	—	3,000
Workforce Training	—	—	—	1,000
Women's/Minority Health	—	—	—	1,000
Total, PROGRAM MANAGEMENT	120,909	114,546	120,546	119,546
RURAL HEALTH:				
Rural Health Research	9,428	9,428	0	9,428
Rural Health Cluster	28,091	29,029	20,091	24,216
Total, RURAL HEALTH	38,517	38,456	25,091	33,642
Buildings & Facilities	933	933	933	933
AIDS:				
Ryan White:				
Emergency Relief - Title I	358,500	407,000	379,500	418,943
Comprehensive Care - Title II	198,147	221,897	198,147	228,954
HRSA/SAMHSA Joint Project	0	0	0	0
Early Intervention - Title III	52,318	62,566	52,318	62,566
Pediatric Demo Grants - Title IV	26,000	32,000	26,000	32,000
Subtotal, Ryan White	632,965	723,465	655,965	743,465
Education and Training Centers	16,287	16,287	0	16,287
AIDS Dental Services	6,937	6,937	6,937	6,937
Total, AIDS	656,189	746,689	662,902	766,689
Subtotal, HRSA BA	2,904,890	2,897,413	2,740,773	2,725,040
Family Planning	193,349	196,962	193,349	198,962
Undistributed Administrative Reduction	—	—	-16,000	—
Total, HRSA BA	3,028,179	3,096,395	2,927,122	2,924,922
Medical Facilities Guarantee & Loan Fund	0,000	8,000	8,000	7,500
HEAL Guarantee Authority	(375,000)	(250,000)	(210,000)	(187,000)
Liquidating Account (non-add)	(17,990)	(42,000)	(42,000)	(37,500)
Program Account	22,050	18,044	13,500	12,544
HEAL Credit Reform - Direct Ops	2,922	2,922	2,703	2,922
HEAL - Default Reduction	1,000	1,000	1,000	1,000
Total, HEAL	25,972	21,966	17,203	16,766
Vaccine - Pre-1988	110,000	110,000	110,000	110,000
Vac Improv Trust Fund (HRSA Claims)	54,476	58,721	58,721	58,721
VICTP Direct Ops - HRSA	3,000	3,000	3,000	3,000
TOTAL, HRSA	3,220,627	3,296,082	3,122,046	3,118,009
TOTAL, HRSA FTEs	(2,217)	(3,074)		(1,995)
Discretionary BA:				
Direct BA	3,028,179	3,096,395	2,927,122	2,924,922
HEAL Dir Ops	2,922	2,922	2,703	2,922
Discretionary BA	3,031,101	3,099,317	2,929,825	2,927,844

K:\FPB\FY97\DHHS\REDCAP4

FAX MEMORANDUM

TO: Molly Brostrom
Domestic Policy Council
The White House
TEL. 202-456-5561
FAX 202-456-7028

FROM: Marla Salmon
Division of Nursing
TEL. 301-443-5688
FAX. 301-443-8586

SUBJECT: NURSING IMPERITIVES

DATE: January 4, 1995

I have some information regarding the funding for the National Sample Survey:

1. The initial funding of 200K will run out in February, 1996.

2. The next installment, 400K will need to be made shortly after and was hoped to come out of FY 96 Title VIII dollars, if the appropriations language would allow it or from outside sources. (1% money, if appropriated, is always an option for both this and the next installment.)

3. The final installment, also 400K, will need to be paid in FY 97, with the same sources as FY 96.

23 pgs.

FAX MEMORANDUM

TO: Molly Brostrom
FAX 456-7028
PHONE 456-5561

FROM: Marla Salmon
FAX: 301-443-5688
Phone: 301-443-5688

Date: 2/16/96

SUBJECT: Update

Just to catch up on a few things... We have received a copy of the Bureau of Health Professions Director job announcement (attached). The elibility is broader than physicians, which I know has been a big question.

Also, I wanted to let you know what has been happening with NAFTA and the reauthorization of the Immigration bill, vis-a-vis nursing. Denise Geolot, my deputy has been working on this, as part of the Department's efforts. Our input to-date has reflected the "Report of the Department of Labor's Immigration Relief Advisory Committee", on which DHHS sat. I have attached sections of this that might be useful. As we understand it, NAFTA has provisions for Canadian nurses that essential provide relatively unencumbered access, when contrasted with Mexican nurses. (The last two pages of this FAX describe the TN category, which is relative to NAFTA and the H-1a, which is the one that is under much discussion). For Mexican nurses, they must still come in through the H-1a visa route. If the restrictions currently in place regarding passing the Council on Graduates of Foreign Nursing Schools as a prerequisite for visa elibigility were to be lifted, we anticipate that we would be again encountering the problems of the 80's that resulted in the development of that examination: language difficulties and high rates of failure on the RN licensure examinations. Organized nursing has expressed fears about this, as well as the possibility of massive job displacement of US nurses. Are there specific issues you would like for us to track for us on the immigration situation at this time?

Last item - we understand that OMB has given nursing a very favorable budget passback for 1997, well above last years and what we have most recently seen for 1996. Nursing should be very pleased if the proposed levels hold.

I hope that this is of help to you - have a good President's Day weekend! Marla

U.S. Department of Labor

Bureau of International Labor Affairs
Washington, D.C. 20210

January 24, 1996

Note for: Molly Drostrom
Domestic Policy Council

From: Marcia Eugenio ME
USDOL/ILAB

Subject: Admissions of Registered Nurses under NAFTA

Per our telephone conversation, attached is a discussion paper which was drafted in preparation for the NAFTA Trinational Temporary Entry Working Group meeting in November 1995. The paper provides background information on the temporary entry provisions of the NAFTA, a brief overview of the employment situation for nurses in the U.S., and makes some recommendations on how to respond to requests for deletion of registered nurses from the list of professionals eligible for admission under NAFTA. Most of these recommendations have been implemented and we are currently awaiting a response from the Immigration and Naturalization Service regarding admission and employment data for NAFTA nurses.

I hope this information is useful. I will keep inform of any significant developments. Please do not hesitate to contact me at 202-219-9098 if you have any questions.

Attachment

~~CONFIDENTIAL~~

TRADE POLICY STAFF COMMITTEE

DRAFT DOCUMENT
January 24, 1996

SUBJECT:

TEMPORARY ADMISSION AND EMPLOYMENT OF REGISTERED NURSES UNDER THE NORTH AMERICAN FREE TRADE AGREEMENT

SUBMITTED BY:

U.S DEPARTMENT OF LABOR

ISSUE:

The Administration needs to develop a strategy for responding to requests from a number of interested parties that registered nurses (RNs) be deleted from the list of occupations that may enter under the "Professionals" category of Chapter 16 of the NAFTA--Temporary Entry of Business Persons.

RECOMMENDATION:

1. At the upcoming November 7-8 meeting of the trilateral NAFTA Temporary Entry Working Group, the U.S. Delegation should :

- o Indicate to Mexico and Canada that we have had several requests to remove registered nurses (RNs) from the list of professional occupations covered by Appendix 1603 D.1.

- o Indicate that we are in the process of reviewing the employment situation for nurses in the United States in light of recent structural changes in our healthcare industry, with a view to determining how any employment problems could be addressed in the context of Chapter 16.

- o Seek information from the other NAFTA parties on their domestic employment situation for registered nurses, including any factors which may be influencing the temporary emigration of registered nurses from their countries. Information should also be requested from them on the number of U.S. registered nurses and other healthcare professionals admitted to Canada and Mexico under the temporary entry provisions of the NAFTA and the type of healthcare facilities in which they are employed.

2. Statistics should be collected on the numbers of nurses granted temporary entry status (TN) under the NAFTA (as well as other nonimmigrant programs) and the location and type of employer (e.g., hospital, long term care facility, nursing employment agency, etc.) in order to assess the impact of immigration on the U.S. labor market for registered nurses.

3. The Department of Labor should develop further analysis of the current and future employment situation for registered nurses (RNs) in the United States and the direct or indirect impact that admission of foreign RNs entering under NAFTA have on the labor market for U.S. nurses.

4. The results of the above should be expeditiously reviewed in order to develop options for addressing this issue including whether some action might be appropriate in the context of Chilean accession to the temporary entry provisions of the NAFTA.

PRIVATE SECTOR AND CONGRESSIONAL ADVICE:

During consultations with the Labor Advisory Committee on Trade Negotiations and Trade

Policy (LAC) on October 14, 1994, members of the LAC expressed their opposition to adding any additional occupations[1] in the healthcare field to the list of professionals in Appendix 1603.D.1. Furthermore, in repeated occasions since this meeting, the LAC has specifically requested that registered nurses and certain other healthcare workers be removed from the NAFTA list.

In November 1994, interested Congressional committees/subcommittees were briefed on the progress of the NAFTA Temporary Entry Working Group. Congressional staff were briefed on concerns that had been raised by the Service Employees International Union (SEIU) regarding the admission of healthcare workers, and in particular registered nurses, under the temporary entry provisions of the NAFTA. The staff was also briefed on the proposed addition of occupations[1] to the list of NAFTA professionals. They questioned the necessity for adding these occupations to the coverage of the Agreement and whether these occupations require a baccalaureate degree. The staff also requested information as to how persons should be temporarily admitted to perform medical patient care service. (Further consultations with the Congress on the issue of temporary entry under NAFTA have not been undertaken; however, USTR is in the process of scheduling a briefing for Congressional staff.)

On April 28, 1995, in response to USTR's request for advice on the negotiation of Chile's accession to the NAFTA, Mr. Mark Anderson of the AFL-CIO Task Force on Trade stated that the temporary entry provisions of the NAFTA should be renegotiated in order to remove registered nurses and certain other healthcare professionals from the list of eligible occupations. While most of the other labor advisors have addressed issues related to their particular union, most have made it clear that they endorse Mark Anderson's statement in full.

On October 31, 1994, Representative Olympia Snowe (Maine) wrote to U.S. Trade Representative Kantor requesting a description of the impact of NAFTA on the U.S. nursing profession and expressing concerns about the increased numbers of Canadian nurses entering Maine under the facilitated cross-border entry provisions of NAFTA.

On July 11, 1995, Representative Larry Combest (Texas) inquired in a letter to USTR whether NAFTA temporary entry provisions were causing changes in hiring practices that are detrimental to U.S. registered nurses.

The Department of Labor has not received any inquiries from industry groups on the temporary admission or employment of registered nurses under the provisions of Chapter 16 of the NAFTA. However, the Department has requested a meeting with the American Hospital Association/National Organization of Nurse Executives to request information on the

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[1]Eight occupations have been proposed for addition to Appendix 1603.D.1 of the NAFTA. They include: Actuary, Plant Pathologist, Podiatrist, Radiation Therapist, Radiologic Technologist, Respiratory Therapist, Nuclear Medicine Technologist, and Speech/Language Pathologist and Audiologist.

employment of NAFTA nurses and to provide them with an opportunity to express their views on this issue.

BACKGROUND:

I. NAFTA Professionals:

Chapter 16 of the NAFTA provides for the temporary entry of four categories of business persons--business visitors, traders and investors, intracompany transferees, and professionals--on a reciprocal basis. This chapter was based on the temporary entry provisions of the U.S.-Canada Free Trade Agreement (CFTA). Both the CFTA and NAFTA professional categories are based on the former H-1 nonimmigrant program. Chapter 16 facilitates the temporary entry of business persons by removing some procedural requirements (e.g., visas, petitions, labor attestations, and numerical restrictions) which are generally applicable to the admission of professionals into the United States.

A NAFTA professional (TN nonimmigrant classification) is defined as a Canadian or Mexican citizen seeking admission to engage in a business activity at a professional level in an occupation listed in Appendix 1603.D.1 of Chapter 16. Registered Nurses (RNs) were admitted under the temporary entry provisions of the CFTA and are currently being admitted as NAFTA professionals. The admission criteria for registered nurses under the NAFTA is a State/provincial license (for U.S./Canadian nurses) or a *Licenciatura* Degree (for Mexican nurses). Pre-arranged employment is also required as one of the conditions for entry under Chapter 16.

II. Temporary Entry Working Group and Consultations with Interested Parties:

Article 1605 of NAFTA created a Temporary Entry Working Group (TEWG) to administer the implementation of the temporary entry provisions of the Agreement. The trinational TEWG has met three times since the inception of the NAFTA. Among the issues that have been discussed is the modification of Appendix 1603.D.1 to add eight occupations to the list of professionals. When requests for modification of Appendix 1603.D.1 are received from professional associations and/or NAFTA parties, the U.S. delegation is required to consult with interested parties in the U.S. before formulating an official U.S. Government position. The consultation process usually includes meetings/briefings with Congressional staff and members of the Labor Advisory Committee for Trade Negotiations and Trade Policy, and discussions with professional associations and other interested groups including Government agencies. Modification of Appendix 1603.D.1 of the NAFTA (whether it is to add or delete professions from the list) requires consensus of all NAFTA parties. To date, only one occupation, journalist, has been removed from the list of professionals admitted under the temporary entry provisions of the CFTA; none, so far, has been added or deleted from the NAFTA. Journalists petitioned the Canadian and U.S. governments to be deleted from the CFTA because they felt that inclusion in the list of professionals impose upon them the government's criteria for who should be considered a "professional" journalist.

III. Safeguards:

Although the NAFTA recognizes the right of each country to protect its domestic labor market and permanent employment, and to implement its own immigration policy (Article 1601), there are no procedures in the Agreement which allow a NAFTA country to address shifting labor market conditions in a particular occupation. After the entry into force of the CFTA but prior to the negotiation of the NAFTA, Congress added labor attestation requirements to the admission of professionals in specialty occupations (H-1Bs) into the United States in order to provide protections for the domestic labor force. The Immigration Act of 1990 imposed an annual cap of 65,000 H-1B workers and a maximum duration of stay of 6 years; a minimum educational requirement for a baccalaureate degree or its equivalent was already imposed under the H-1 program. In addition, the law required that H-1B workers be paid the prevailing wage or actual wage at the facility (whichever is higher) and that working conditions do not have an adverse impact on similarly employed U.S. workers. The enactment of Immigration Nursing Relief Act of 1989 (INRA) also imposed labor attestation requirements on the temporary admission of registered nurses into the United States. These requirements included the following provisions: attestation from the U.S. employer that a substantial disruption in the delivery of healthcare services would occur without the services of H-1A nurses; no adverse effect on the wages and working conditions of U.S. registered nurses; timely and significant steps to recruit and retain sufficient U.S. nurses; no strike or lockout in the facility; and no lay off. (The H-1A program expired on September 1, 1995).

Similar provisions were also added to the U.S. commitments on movement of natural persons under the World Trade Organization's General Agreement on Trade in Services (GATS). Due to CFTA obligations, the H-1B and H-1A labor attestation requirements do not apply to NAFTA professionals from Canada. They do, however, apply to Mexican professionals for a transitional period of up to 10 years. Mexican professionals must comply with visa and INS petition requirements and an annual numerical limitation of 5,500 professionals. While these additional provisions for Mexican professionals constitute limited "safeguards" or protections for U.S. workers, these are only temporary provisions and do not apply to the largest users of the NAFTA Professional category, Canadian registered nurses.

The above-mentioned procedures are also important because they provide essential information for assessing the impact that foreign workers have on the domestic labor market. It is also significant to note that after the transitional measures for Mexico are removed, the NAFTA will essentially have created a common labor market for the temporary entry of those occupations listed in Appendix 1603.D.1 since Canadian and Mexican professionals will be in open and direct competition with U.S. workers. This seems to be contrary to Administration policy that employment-based immigration programs should be used primarily to fill skill gaps or shortages in the domestic labor market.

DISCUSSION:

I. Summary of Requests for Deletion of Nurses:

Representatives of organized labor have consistently requested that nurses and other health care workers be removed from the NAFTA temporary entry provisions.

In a letter to the Secretary of Labor, dated September 15, 1994, Mr. John Sweeney, President of the AFL-CIO's Service Employees International Union (and recently elected President of the AFL-CIO), requested that consideration be given to the possibility of removing registered nurses and the other healthcare occupations from the list of professionals in Appendix 1603.D.1. Mr. Sweeney cited as his main reasons the current uncertainty in the healthcare industry, the fact that other programs already allow for the admission of nurses, and the lack of a clear link to commercial trade.

In a May 26, 1995, letter to the Secretary of Labor, the American Nurses Association urged Secretary Reich to work with USTR and other relevant agencies to initiate discussions with the Governments of Canada and Mexico with the intent of removing registered nurses and other health care professionals from Appendix 1603.D.1. of the NAFTA.

The Department of Labor has also received numerous inquiries from individuals concerned with the employment situation for registered nurses and the very liberal entry provisions of the NAFTA.

II. Employment Situation for Nurses:

In the mid 1980s, there was a perceived nursing shortage in the United States. At the time, hospitals in urban areas were experiencing very high vacancy rates for nurses and there was a fear that if the shortage persisted there could be significant disruptions in the provision of healthcare services in the United States. The U.S. Congress attempted to address this shortage by enacting the Immigration Nursing Relief Act of 1989 (INRA) which established a five-year pilot program for nonimmigrant registered nurses (H-1A) to be temporarily admitted and employed in the United States. INRA also required U.S. employers to reduce their dependence on foreign nurses and to encourage the further development of the domestic nursing labor pool by adding requirements for retraining, recruiting and retaining U.S. nurses. The Congress also created an advisory committee to study the impact of the H-1A program on the U.S. nursing profession. The committee's study of March 1995, concluded with both a majority recommendation to extend the program past its August 31, 1995 deadline and a minority recommendation to let the program expire. The program expired on September 1, 1995 and registered nurses are now admitted into the United States under the provisions of the H-1B program described earlier. While there appeared to be differing opinions regarding the impact or future need of INRA for the nursing profession, the advisory committee agreed on the fact that currently there is no national shortage of

registered nurses, though some specialty and locality shortages still exist.

The current employment situation for registered nurses is very different than it was in the 1980s. According to data from the Bureau of Labor Statistics (BLS), there are currently 2,239,816 registered nurses in the United States compared with 1,662,382 in 1980. Total employment of registered nurses in the U.S. was 1,906,055 in 1994 which suggests that there might be a labor surplus for this occupation. Another indicator of employment opportunities for RNs is the vacancy job rate in hospitals. According to the latest report of the American Hospital Association on hospital human resources, the vacancy rate for RNs in hospitals declined from 12.7% in 1988 to 5.3% in 1992. While the national vacancy rate for RNs may remain relatively high, certain States are experiencing lower rates; for instance, the vacancy rate in Massachusetts for RNs at hospitals in 1995 is only 1.9% down from 10.1% in 1988. (Boston Globe, 2/19/95) This is of particular importance since two-thirds of RNs are usually employed by hospitals.

Furthermore, during the past year, a number of studies, reports and journal articles have detailed what appears to be a trend towards reduction in healthcare personnel in the Nation's hospitals:

- A study by the Bureau of Health Resources Development of the New York State Department of Health, estimated that about 3,000 RNs would lose hospital jobs between 1995-97 in New York City. (New York Times, December 1, 1994)

- An American Hospital Association study found 27% of hospital managers have planned workforce reductions, and among hospitals with 500 or more beds, the figure was 51%, with cuts primarily targeting service staff, administration and registered nurses. (Medicine and Health Perspectives, June 6, 1994).

- In a 1994 Modern Healthcare survey of 700 hospitals in the U.S., 38% of the respondents said that they were in the process of trimming their workforces as opposed to 27% in the previous year. In implementing these reductions in workforce, many hospitals were targeting specific services or departments. About 27% of the hospitals in the survey said that nurses were targeted for layoffs, compared with 19% in 1993. (Modern Healthcare, December 12, 1994)

- In a 1994 survey of the American Nurses Association, more than 68% of the 1,800 survey respondents report that their institutions have cut RN positions in the past year. (Immigration Nursing Relief Advisory Committee Minority Report)

- A 1994 study of the Governor's Council on Economic Growth and Technology predicted that thousands of Massachusetts' 100,000 nursing positions will be eliminated in the next three to five years. (Boston Globe, February 19, 1995)

- The American Hospital Association estimates that 75,000 hospital employees have

been laid off during 1994. And some hospitals are replacing nurses with lower-paid, less trained employees. (National Journal, July 29, 1995)

The above mentioned studies and reports also suggest that hospital downsizing is due to a number of factors, including the "growth of managed care, attempts by insurance companies to reduce expensive hospital use and changes in technology that allow more medical procedures to be done in office and clinic-based setting." (Boston Globe, Feb. 19, 1995). The increasing number of hospital mergers and acquisitions (often accompanied by hospital closures) are also adding to the potential for job loss in the nursing profession. However, it is important to point out, that while hospital jobs may be reduced, there may be increasing employment opportunities for RNs in community settings (outpatient care, HMOs, nursing homes, and home care). Nevertheless, these changes could probably mean lower salaries and compensation packages for nurses.

It also appears that hospitals are not only reducing healthcare personnel but also changing the traditional duties for RNs. Nursing responsibilities have been changing from bedside care to more administrative duties. The American Nursing Association asserts that as a cost-containment initiative, hospitals are delegating hands-on patient care work to lower paid unlicensed support personnel.

The future labor market for registered nurses in the United States seems to be uncertain at best. Although published data from BLS shows a potential growth of over 40% in the nursing profession through 2005, this projection was based on information that predated the recent restructuring of the healthcare industry. Unpublished data from BLS shows that this projection will be revised downward to 25% growth within the next year to account for industry changes. The high growth could still be explained by growth in non-hospital employment and the future need for highly specialized nurses. With regard to a possible shortage of specialty nurses, the *Seventh Report to the President and Congress on the Status of Health Personnel in the United States* concluded in 1990 that the mix of nurses by educational level was out of balance with national needs; the report estimated that by the year 2000, the Nation could face a substantial shortage of nurses educated at the baccalaureate and graduate levels while having an excess supply of nurses with less than a baccalaureate education (Journal of the American Medical Association, Vol. 273; No. 19; Pg. 1528; May 17, 1995). The imbalance in the educational training and labor demand of nurses appears to still be a problem today.

III. Admission and Employment Statistics for Foreign Nurses:

According to the latest statistics from the Immigration and Nationality Service (INS), there were 6,822 admissions of registered nurses reported in 1994 under the provisions of the NAFTA. Only one (1) admission was from Mexico. The number of admissions in 1994 represents a 30% increase from 1993, when 4,728 Canadian RNs admissions were reported under the temporary entry provisions of the CFTA. It is important to note that INS admissions include both initial entry and subsequent entries of the same individual within the

year. Therefore the admission number does not accurately reflect the total number of NAFTA nurses in the United States in any particular year or how many remain employed in the country. Another relevant issue regarding INS admission data is that the point of entry and intended place of employment are not currently collected. Given the limitations of the data, it is very difficult to assess the impact of admission of Canadian RNs on the labor market for U.S. nurses.

Prepared by: USDOL/ILAB
Date: January 24, 1996
File: h:\work\doc\nafta-te\nurses.tsp

DIVISION OF NURSING

DATE: MAR 28 1996			
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Number of Pages (Including Cover): 3			

Per my phone message of today. Please call me if you have any questions or need additional information.

Marla

FAX MEMORANDUM

TO: Ken Choe
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FROM: Marla Salmon, Director
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301-443-5688
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SUBJECT: Policy stances regarding nurses

DATE: March 28, 1996

This is our initial response to ANA's questions, given the very brief turn around time. We will continue to flesh these out and are happy to be of help to you in any way that we can. Thank you for the opportunity.

Immigration position: The administration is very concerned that its immigration policy relating to nurses accomplishes two overall policy goals: (1) assuring that all people, regardless of location or other factors, have expert nursing services available to them; and, (2) that work opportunities for nurses who are United States citizens continue to be available. Given this policy framework, the Administration did not support the blanket extension of the H1A Visa program, under which most foreign nurses were admitted to the United States.

Given the cyclical nature of nursing shortages and some remaining spot shortages, the Administration has supported the continuation of the highly restricted H1B visa program. Its support is consistent with ANA's position on this matter.

In all instances, the Administration has sought to assure that foreign nurses were treated equitably in both previous H1A program and in discussions relating to the new immigration law in which the H1B visa remains the primary, highly limited vehicle for admission of foreign nurses.

In the case of NAFTA, the administration has consistently sought to assure that nurses from Mexico or Canada coming to the US meet the same rigorous standards for admission as those falling into the existing other visa mechanisms. It has also worked to assure that US nurses have employment opportunities in both Mexico and Canada.

With respect to preservation of career opportunities and position for US nurses, this Administration has consistently voiced the view that foreign nurses are to be viewed only as temporary employees who are needed to avoid substantial disruptions in health care services. Further, the administration has worked to assure that the employment of these nurses will not

adversely affect the employment of US nurses. The administration has been in favor of protection of US nurses wages through assuring that foreign are paid at the same level and that employers document that attempts to recruit US nurses have been unsuccessful.

Finally, the administration has supported the requirement that all foreign nurses must meet licensing standards as a US nurse. Further, in its support for the H1B Visa, the Administration advocated the Baccalaureate Degree as a requirement for entrance, mirroring ANA's own recent position on this matter.

What has the administration has done for nurses: This Administration has shown the strongest commitment to nursing since before the Reagan administration. Unlike his Republic predecessor, the President has sought to strengthen nursing through a policy of strong involvement of nursing in the development of overall health policy in this country. An example of this was the large number of nurses involved in the White House Task Force on Health Care Reform and the President's selection of a nurse, Dr. Shirley Cater, to the position of Commissioner of the Social Security Administration.
In addition, the Health Security Act itself proposed support for major improvements for nurses in both education and practice, including the reduction of practice barriers for advanced practice nurses and the dramatically increased financial support for nursing education.

Most recently, the President proposed an approximately 15 million dollar increase in funding for nursing through his budget support for the Division of Nursing and that National Institute for Nursing Research. The proposed 14 million dollar increase for the Division of Nursing, which focuses on practice and education issues, was several million dollars greater than previously authorized or appropriated. This increase represents a dramatic policy shift from the previous three administrations which consistently proposed either proposed no funding or very restricted funding for nursing (significantly less than authorized by Congress.

ANA Talking Points

6/13/96

1. Celebration of two major milestones:

   -100 Years of service as nursing's professional organization
   -50 Years representing nursing in collective bargaining

2. Recognition of ANA's important contributions to the health of American's

   -History of working to improve nursing care
   -History of working to assure that all peoples receive nursing and health care
   -History of advocating for the rights of patients and underserved peoples

3. Recent contributions to Administration's work in improving health care for American's

   -ANA led the way in developing "Nursing's Agenda for Health Care Reform", which was adopted by numerous nursing and other organizations in 1991 (see attached)

   - universal access
   - community involvement and personal responsibility
   - reduction of health care costs
   - insurance reform
   - establishment of quality assurance mechanisms

   -ANA worked in partnership with the Administration to achieve reforms in health care, both in the Health Care Reform Taskforce activities and specific legislative and programmatic initiatives

4. ANA plays a critical role today in the rapidly changing health care system

   -Advocates for the safety and wellbeing of patients, families and communities
   -Advocates for improvement of the health care system toward the shared goals of reduced cost, improved quality and universal access
   -Serves as the lead voice for nurses at the bedside and in communities who work hard to assure the best patient care possible for all people

5. The Clinton Administration has a special regard for ANA and all of nursing

-Views nursing as the backbone and heart of the health care system
-Has made important commitments of resources and opportunities to assure that nursing care is available to all people

-Increased the Division of Nursing's Budget by 14 million dollars to enhance nursing education and practice
-Made possible the Institute of Medicine Study on the Adequacy of Nurse Staffing
-Is developing a research agenda to help "capture" nursing's contributions to the the care of people
-Has appointed nurses to key positions, including naming Shirley Chater to head the Social Security Administration and two nurses as the Administrators for two of the Federal Regions

6. Very special time for nursing nationally and in the Federal Government

-Along with ANA's 100th Anniversary, it is the Federal Division of Nursing's 50th Anniversary

-Division of Nursing is the key federal focus for nursing education and practice

-Year of celebration and recognition for the important work that the Division has done - which has in some way touched the lives of every nurse in this country

-Geri Marullo, ANA's Executive Director, is a member of the National Advisory Council on Nurse Education and Practice, which advises the Division of Nursing and the Secretary for HHS

-Along with the 50th Anniversary of the Division of Nursing is a reaffirmation of the commitment of the Federal Government to nursing - as the Division of Nursing's motto says: "Caring for the Nation through Nursing"

Nursing's Agenda for Health Care Reform

EXECUTIVE SUMMARY

America's nurses have long supported our nation's efforts to create a health care system that assures access, quality, and services at affordable costs. This document presents nursing's agenda for immediate health care reform. We call for a basic "core" of essential health care services to be available to everyone. We call for a restructured health care system that will focus on the consumers and their health, with services to be delivered in familiar, convenient sites, such as schools, workplaces, and homes. We call for a shift from the predominant focus on illness and cure to an orientation toward wellness and care. The basic components of nursing's "core of care" include:

- A restructured health care system which:
  - -- Enhances consumer access to services by delivering primary health care in community-based settings.
  - -- Fosters consumer responsibility for personal health, self care, and informed decision making in selecting health care services.
  - -- Facilitates utilization of the most cost-effective providers and therapeutic options in the most appropriate settings.

- A federally-defined standard package of essential health care services available to all citizens and residents of the United States, provided and financed through an integration of public and private plans and sources:
  - -- A public plan, based on federal guidelines and eligibility requirements, will provide coverage for the poor and create the opportunity for small businesses and individuals, particularly those at risk because of preexisting conditions an those potentially medically indigent, to buy into the plan.
  - -- A private plan will offer, at a minimum, the nationally standardized package of essential services. This standard package could be enriched as a benefit of employment or individuals could purchase additional services if they so choose. If employers do not offer private coverage, they must pay into the public plan for their employees.

- A phase-in of essential services, in order to be fiscally responsible:
  - -- Coverage of pregnant women and children is critical. This first step represents a cost-effective investment in the future health and prosperity of the nation.
  - -- One early step will be to design services specifically to assist vulnerable populations who have had limited access to our nation's health care system. A "Healthstart Plan" is proposed to improve the health status of these individuals.

- Planned change to anticipate health service needs that correlate with changing national demographics.

- Steps to reduce health care costs include:
  - -- Required usage of managed care in the public plan and encouraged in private plans.
  - -- Incentives for consumers and providers to utilize managed care arrangements.
  - -- Controlled growth of the health care system through planning and prudent resource allocation.
  - -- Incentives for consumers and providers to be more cost efficient in exercising health care options.
  - -- Development of health care policies based on effectiveness and outcomes research.
  - -- Assurance of direct access to a full range of qualified providers.
  - -- Elimination of unnecessary bureaucratic controls and administrative procedures.

- Case management will be required for those with continuing health care needs. Case management will reduce the fragmentation of the present system, promote consumers' active participation in decisions about their health, and create an advocate on their behalf.

- Provisions for long-term care, which include:
  - -- Public and private funding for services of short duration to prevent personal impoverishment.
  - -- Public funding for extended care if consumer resources are exhausted.
  - -- Emphasis on the consumers' responsibility to financially plan for their long-term care needs, including new personal financial alternatives and strengthened private insurance arrangements.

- Insurance reforms to assure improved access to coverage, including affordable premiums, reinsurance pools for catastrophic coverage, and other steps to protect both insurers and individuals against excessive costs.

- Access to services assured by no payment at the point of service and elimination of balance billing in both public and private plans.

- Establishment of public/private sector review -- operating under federal guidelines and including payers, providers, and consumers -- to determine resource allocation, cost reduction approaches, allowable insurance premiums, and fair and consistent reimbursement levels for providers. This review would progress in a climate sensitive to ethical issues.

Additional resources will be required to accomplish this plan. While significant dollars can be obtained through restructuring and other strategies, responsibility for any new funds must be shared by individuals, employers, and government, phased in over several years to minimize the impact.