for mental illness or mental retardation, and who has not continuously resided in a nursing facility for at least 30 months before the date of the determination, the State must, in consultation with the resident's family or legal representative and care-givers—

(I) arrange for the safe and orderly discharge of the resident from the facility, consistent with the requirements of subsection (c)(2),

(II) prepare and orient the resident for such discharge, and

(III) provide for (or arrange for the provision of) such specialized services for the mental illness or mental retardation.

(iii) RESIDENTS NOT REQUIRING NURSING FACILITY SERVICES AND NOT REQUIRING SPECIALIZED SERVICES.—In the case of a resident who is determined, under subparagraph (B), not to require the level of services provided by a nursing facility and not to require specialized services for mental illness or mental retardation, the State must—

(I) arrange for the safe and orderly discharge of the resident from the facility, consistent with the requirements of subsection (c)(2), and

(II) prepare and orient the resident for such discharge.

(iv) ANNUAL REPORT.—Each State shall report to the Secretary annually concerning the number and disposition of residents described in each of clauses (ii) and (iii).[189]

(D) DENIAL OF PAYMENT.—

(i) FOR FAILURE TO CONDUCT PREADMISSION SCREENING OR ANNUAL REVIEW.—No payment may be made under section 1903(a) with respect to nursing facility services furnished to an individual for whom a determination is required under subsection (b)(3)(F) or subparagraph (B) but for whom the determination is not made.

(ii) FOR CERTAIN RESIDENTS NOT REQUIRING NURSING FACILITY LEVEL OF SERVICES.—No payment may be made under section 1903(a) with respect to nursing facility services furnished to an individual (other than an individual described in subparagraph (C)(i)) who does not require the level of services provided by a nursing facility.

(E) PERMITTING ALTERNATIVE DISPOSITION PLANS.—With respect to residents of a nursing facility who are mentally retarded or mentally ill and who are determined under subparagraph (B) not to require the level of services of such a facility, but who require specialized services for mental illness or mental retardation, a State and the nursing facility shall be considered to be in compliance with the requirements of subparagraphs (A) through (C) of this paragraph if, before April 1, 1989, the State and the Secretary

[189] See Vol. II, P.L. 100-203, §4215 [as amended by P.L. 101-508, §4801(b)(5)(B)], with respect to the required annual report to Congress.

have entered into an agreement relating to the disposition of such residents of the facility and the State is in compliance with such agreement. Such an agreement may provide for the disposition of the residents after the date specified in subparagraph (C). The State may revise such an agreement, subject to the approval of the Secretary, before October 1, 1991, but only if, under the revised agreement, all residents subject to the agreement who do not require the level of services of such a facility are discharged from the facility by not later than April 1, 1994.

(F) APPEALS PROCEDURES.—Each State, as a condition of approval of its plan under this title, effective January 1, 1989, must have in effect an appeals process for individuals adversely affected by determinations under subparagraph (A) or (B).

(G) DEFINITIONS.—In this paragraph and in subsection (b)(3)(F):

(i) An individual is considered to be "mentally ill" if the individual has a serious mental illness (as defined by the Secretary in consultation with the National Institute of Mental Health) and does not have a primary diagnosis of dementia (including Alzheimer's disease or a related disorder) or a diagnosis (other than a primary diagnosis) of dementia and a primary diagnosis that is not a serious mental illness.

(ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded or a person with a related condition ~~(as described in section 1905(d))~~.

~~(iii) The term "specialized services" has the meaning given such term by the Secretary in regulations, but does not include, in the case of a resident of a nursing facility, services within the scope of services which the facility must provide or arrange for its residents under subsection (b)(4).~~

(f) RESPONSIBILITIES ~~OF SECRETARY~~ RELATING TO NURSING FACILITY REQUIREMENTS.—

a State with a Medigrant plan

(1) GENERAL RESPONSIBILITY.—It is the duty and responsibility of ~~the Secretary~~, to assure that requirements which govern the provision of care in nursing facilities under State plans approved under this title, and the enforcement of such requirements, are adequate to protect the health, safety, welfare, and rights of residents and to promote the effective and efficient use of public moneys.

(2) REQUIREMENTS FOR NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAMS AND FOR NURSE AIDE COMPETENCY EVALUATION PROGRAMS.—

~~(A) IN GENERAL.—~~For purposes of subsections (b)(5) and (e)(1)(A), the ~~Secretary~~ State shall establish, ~~by not later than September 1, 1988~~—

~~(A)~~(i) requirements for the approval of nurse aide training and competency evaluation programs, including requirements relating to ~~(I)~~ the areas to be covered in such a program (including at least basic nursing skills, personal care skills, recognition of mental health and

(i)

social service needs, care of cognitively impaired residents, basic restorative services, and residents' rights) and content of the curriculum, ~~(II)~~ minimum hours of initial and ongoing training and retraining ~~(including not less than 75 hours in the case of initial training)~~, ~~(III)~~ qualifications of instructors, and ~~(IV)~~ procedures for determination of competency;

~~(ii)~~ requirements for the approval of nurse aide competency evaluation programs, including requirement relating to the areas to be covered in such a program, including at least basic nursing skills, personal care skills, recognition of mental health and social service needs, care of cognitively impaired residents, basic restorative services, and residents' rights, and procedures for determination of competency;

~~(iii)~~ requirements respecting the minimum frequency and methodology to be used by a State in reviewing such programs' compliance with the requirements for such programs; and

~~(iv)~~ requirements, under both such programs, that—

~~(I)~~ provide procedures for determining competency that permit a nurse aide, at the nurse aide's option, to establish competency through procedures or methods other than the passing of a written examination and to have the competency evaluation conducted at the nursing facility at which the aide is (or will be) employed (unless the facility is described in subparagraph (B)(iii)(I)),

(II) prohibit the imposition on a nurse aide who is employed by (or who has received an offer of employment from) a facility on the date on which the aide begins either such program of any charges (including any charges for textbooks and other required course materials and any charges for the competency evaluation) for either such program, ~~and~~

(III) in the case of a nurse aide not described in subclause (II) who is employed by (or who has received an offer of employment from) a facility not later than 12 months after completing either such program, the State shall provide for the reimbursement of costs incurred in completing such program on a prorata basis during the period in which the nurse aide is so employed.

(B) APPROVAL OF CERTAIN PROGRAMS.—Such requirements—

(i) may permit approval of programs offered by or in facilities, as well as outside facilities (including employee organizations), and of programs in effect on the date of the enactment of this section[190];

(ii) shall permit a State to find that an individual who has completed (before July 1, 1989) a nurse aide training

[190]December 22, 1987 [P.L. 100-203; 101 Stat. 1330].

and competency evaluation program shall be deemed to have completed such a program approved under subsection (b)(5) if the State determines that, at the time the program was offered, the program met the requirements for approval under such paragraph; and

(iii) shall prohibit approval of such a program—

(I) offered by or in a nursing facility which, within the previous 2 years—

(a) has operated under a waiver under subsection (b)(4)(C)(ii) that was granted on the basis of a demonstration that the facility is unable to provide the nursing care required under subsection (b)(4)(C)(i) for a period in excess of 48 hours during a week;

(b) has been subject to an extended (or partial extended) survey under section 1819(g)(2)(B)(i) or subsection (g)(2)(B)(i); or

(c) has been assessed a civil money penalty described in section 1819(h)(2)(B)(ii) or subsection (h)(2)(A)(ii) of not less than $5,000, or has been subject to a remedy described in subsection (h)(1)(B)(i), clauses (i), (iii), or (iv) of subsection (h)(2)(A), clauses (i) or (iii) of section 1819(h)(2)(B), or section 1819(h)(4), or

(II) offered by or in a nursing facility unless the State makes the determination, upon an individual's completion of the program, that the individual is competent to provide nursing and nursing-related services in nursing facilities.

A State may not delegate (through subcontract or otherwise) its responsibility under clause (iii)(II) to the nursing facility.

(3) FEDERAL GUIDELINES FOR STATE APPEALS PROCESS FOR TRANSFERS AND DISCHARGES.—For purposes of subsections (c)(2)(B)(iii) and (e)(3), by not later than October 1, 1988, the Secretary shall establish guidelines for minimum standards which State appeals processes under subsection (e)(3) must meet to provide a fair mechanism for hearing appeals on transfers and discharges of residents from nursing facilities.

(4) SECRETARIAL STANDARDS QUALIFICATION OF ADMINISTRATORS.—For purposes of subsections (d)(1)(C) and (e)(4), the Secretary shall develop, by not later than March 1, 1988, standards to be applied in assuring the qualifications of administrators of nursing facilities.

State — any such standards must apply to administrators of hospital-based facilites as well as administators of free standing facilites.

(5) CRITERIA FOR ADMINISTRATION.—The Secretary shall establish criteria for assessing a nursing facility's compliance with the requirement of subsection (d)(1) with respect to—

(A) its governing body and management,

(B) agreements with hospitals regarding transfers of residents to and from the hospitals and to and from other nursing facilities,

(C) disaster preparedness,

(D) direction of medical care by a physician,

(E) laboratory and radiological services,

(F) clinical records, and

(G) resident and advocate participation.

(6) SPECIFICATION OF RESIDENT ASSESSMENT DATA SET AND INSTRUMENTS.—The Secretary shall—

(A) not later than January 1, 1989, specify a minimum data set of core elements and common definitions for use by nursing facilities in conducting the assessments required under subsection (b)(3), and establish guidelines for utilization of the data set; and

(B) by not later than April 1, 1990, designate one or more instruments which are consistent with the specification made under subparagraph (A) and which a State may specify under subsection (e)(5)(A) for use by nursing facilities in complying with the requirements of subsection (b)(3)(A)(iii).

(7) LIST OF ITEMS AND SERVICES FURNISHED IN NURSING FACILITIES NOT CHARGEABLE TO THE PERSONAL FUNDS OF A RESIDENT.—

(A) REGULATIONS REQUIRED.—Pursuant to the requirement of section 21(b) of the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977[191], the Secretary shall issue regulations, on or before the first day of the seventh month to begin after the date of enactment of this section[192], that define those costs which may be charged to the personal funds of residents in nursing facilities who are individuals receiving medical assistance with respect to nursing facility services under this title and those costs which are to be included in the payment amount under this title for nursing facility services.

(B) RULE IF FAILURE TO PUBLISH REGULATIONS.—If the Secretary does not issue the regulations under subparagraph (A) on or before the date required in that subparagraph, in the case of a resident of a nursing facility who is eligible to receive benefits for nursing facility services under this title, for purposes of section 1902(a)(28)(B), the Secretary shall be deemed to have promulgated regulations under this paragraph which provide that the costs which may not be charged to the personal funds of such resident (and for which payment is considered to be made under this title) include, at a minimum, the costs for routine personal hygiene items and services furnished by the facility.

(8) FEDERAL MINIMUM CRITERIA AND MONITORING FOR PREADMISSION SCREENING AND RESIDENT REVIEW.—

(A) MINIMUM CRITERIA.—The Secretary shall develop, by not later than October 1, 1988, minimum criteria for States to use in making determinations under subsections (b)(3)(F) and (e)(7)(B) and in permitting individuals adversely affected to appeal such determinations, and shall notify the States of such criteria.

(B) MONITORING COMPLIANCE.—The Secretary shall review, in a sufficient number of cases to allow reasonable inferences, each State's compliance with the requirements of subsection (e)(7)(C)(ii) (relating to discharge and placement

[191] See Vol. II, P.L. 95-142.
[192] December 22, 1987.

for active treatment of certain residents).

(9) CRITERIA FOR MONITORING STATE WAIVERS.—The Secretary shall develop, by not later than October 1, 1988, criteria and procedures for monitoring State performances in granting waivers pursuant to subsection (b)(4)(C)(ii).

(g) SURVEY AND CERTIFICATION PROCESS.—

(1) STATE AND FEDERAL RESPONSIBILITY.—

(A) IN GENERAL.—Under each State plan under this title, the State shall be responsible for certifying, in accordance with surveys conducted under paragraph (2), the compliance of nursing facilities (other than facilities of the State) with the requirements of subsections (b), (c), and (d). The Secretary shall be responsible for certifying, in accordance with surveys conducted under paragraph (2), the compliance of State nursing facilities with the requirements of such subsections.

(B) EDUCATIONAL PROGRAM.—Each State shall conduct periodic educational programs for the staff and residents (and their representatives) of nursing facilities in order to present current regulations, procedures, and policies under this section.

(C) INVESTIGATION OF ALLEGATIONS OF RESIDENT NEGLECT AND ABUSE AND MISAPPROPRIATION OF RESIDENT PROPERTY.—The State shall provide, through the agency responsible for surveys and certification of nursing facilities under this subsection, for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide of a resident in a nursing facility or by another individual used by the facility in providing services to such a resident. The State shall, after notice to the individual involved and a reasonable opportunity for a hearing for the individual to rebut allegations, make a finding as to the accuracy of the allegations. If the State finds that a nurse aide has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the nurse aide and the registry of such finding. If the State finds that any other individual used by the facility has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the appropriate licensure authority. A State shall not make a finding that an individual has neglected a resident if the individual demonstrates that such neglect was caused by factors beyond the control of the individual.

(D) CONSTRUCTION.—The failure of the Secretary to issue regulations to carry out this subsection shall not relieve a State of its responsibility under this subsection.

(2) SURVEYS.—

(A) ANNUAL STANDARD SURVEY.—

(i) IN GENERAL.—Each nursing facility shall be subject to a standard survey, to be conducted without any prior notice to the facility. Any individual who notifies (or causes to be notified) a nursing facility of the time or date on which such a survey is scheduled to be con-

ducted is subject to a civil money penalty of not to exceed $2,000. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). ~~The Secretary shall review each State's procedures for scheduling and conduct of standard surveys to assure that the State has taken all~~ reasonable steps to avoid giving notice of such a survey through the scheduling procedures and the conduct of the surveys themselves.

The State shall take all

(ii) CONTENTS.—Each standard survey shall include, for a case-mix stratified sample of residents—

(I) a survey of the quality of care furnished, as measured by indicators of medical, nursing, and rehabilitative care, dietary and nutrition services, activities and social participation, and sanitation, infection control, and the physical environment,

(II) written plans of care provided under subsection (b)(2) and an audit of the residents' assessments under subsection (b)(3) to determine the accuracy of such assessments and the adequacy of such plans of care, and

(III) a review of compliance with residents' rights under subsection (c).

(iii) FREQUENCY.—

(I) IN GENERAL.—Each nursing facility shall be subject to a standard survey not later than ~~15~~ 24 months after the date of the previous standard survey conducted under this subparagraph. ~~The statewide average interval between standard surveys of a nursing facility shall not exceed 12 months.~~

except that in the case of a facility which has been subjected to an extended survey under subparagraph (B), a standard survey shall be conducted not later than 12 months after the date of the preceding extended survey.

(II) SPECIAL SURVEYS.—If not otherwise conducted under subclause (I), a standard survey (or an abbreviated standard survey) may be conducted within 4 ~~2~~ months of any change of ownership, administration, management of a nursing facility, or director of nursing in order to determine whether the change has resulted in any decline in the quality of care furnished in the facility.

(B) EXTENDED SURVEYS.—

(i) IN GENERAL.—Each nursing facility which is found, under a standard survey, to have provided substandard quality of care shall be subject to an extended survey. Any other facility may, at ~~the Secretary's or~~ State's discretion, be subject to such an extended survey (or a partial extended survey).

(ii) TIMING.—The extended survey shall be conducted immediately after the standard survey (or, if not practicable, not later than 2 weeks after the date of completion of the standard survey).

(iii) CONTENTS.—In such an extended survey, the survey team shall review and identify the policies and

procedures which produced such substandard quality of care and shall determine whether the facility has complied with all the requirements described in subsections (b), (c), and (d). Such review shall include an expansion of the size of the sample of residents' assessments reviewed and a review of the staffing, of in-service training, and, if appropriate, of contracts with consultants.

(iv) CONSTRUCTION.—Nothing in this paragraph shall be construed as requiring an extended or partial extended survey as a prerequisite to imposing a sanction against a facility under subsection (h) on the basis of findings in a standard survey.

(C) SURVEY PROTOCOL.—Standard and extended surveys shall be conducted—

(i) based upon a protocol which the Secretary has developed, tested, and validated by not ~~later than~~ January 1, 1990, and

(ii) by individuals, of a survey team, who meet such minimum qualifications as the ~~Secretary~~ State establishes by not later than such date.

~~The failure of the Secretary to develop, test, or validate such protocols or to establish such minimum qualifications shall not relieve any State of its responsibility (or the Secretary of the Secretary's responsibility) to conduct surveys under this subsection.~~

(D) CONSISTENCY OF SURVEYS.—Each State shall implement programs to measure and reduce inconsistency in the application of survey results among surveyors.

(E) SURVEY TEAMS.—

(i) IN GENERAL.—Surveys under this subsection shall be conducted by a multidisciplinary team of professionals (including a registered professional nurse).

(ii) PROHIBITION OF CONFLICTS OF INTEREST.—A State may not use as a member of a survey team under this subsection an individual who is serving (or has served within the previous 2 years) as a member of the staff of, or as a consultant to, the facility surveyed respecting compliance with the requirements of subsections (b), (c), and (d), or who has a personal or familial financial interest in the facility being surveyed.

~~(iii) TRAINING.—The Secretary shall provide for the comprehensive training of State and Federal surveyors in the conduct of standard and extended surveys under this subsection, including the auditing of resident assessments and plans of care. No individual shall serve as a member of a survey team unless the individual has successfully completed a training and testing program in survey and certification techniques that has been approved by the Secretary.~~

(3) VALIDATION SURVEYS.—

(A) IN GENERAL.—The Secretary shall conduct onsite surveys of a representative sample of nursing facilities in each State, within ~~2~~ 4 months of the date of surveys conducted

under paragraph (2) by the State, in a sufficient number to allow inferences about the adequacies of each State's surveys conducted under paragraph (2). In conducting such surveys, the Secretary shall use the same survey protocols as the State is required to use under paragraph (2). If the State has determined that an individual nursing facility meets the requirements of subsections (b), (c), and (d), but the Secretary determines that the facility does not meet such requirements, the Secretary's determination as to the facility's noncompliance with such requirements is binding and supersedes that of the State survey.

(B) SCOPE.—With respect to each State, the Secretary shall conduct surveys under subparagraph (A) ~~each year~~ with respect to at least 5 percent of the number of nursing facilities surveyed by the State in the year, but in no case less than 5 nursing facilities in the State.

at least every third year

~~(C) REDUCTION IN ADMINISTRATIVE COSTS FOR SUBSTANDARD PERFORMANCE.—If the Secretary finds, on the basis of such surveys, that a State has failed to perform surveys as required under paragraph (2) or that a State's survey and certification performance otherwise is not adequate, the Secretary may provide for the training of survey teams in the State and shall provide for a reduction of the payment otherwise made to the State under section 1903(a)(2)(D) with respect to a quarter equal to 33 percent multiplied by a fraction, the denominator of which is equal to the total number of residents in nursing facilities surveyed by the Secretary that quarter and the numerator of which is equal to the total number of residents in nursing facilities which were found pursuant to such surveys to be not in compliance with any of the requirements of subsections (b), (c), and (d). A State that is dissatisfied with the Secretary's findings under this subparagraph may obtain reconsideration and review of the findings under section 1116 in the same manner as a State may seek reconsideration and review under that section of the Secretary's determination under section 1116(a)(1).~~

(C) SPECIAL SURVEYS OF COMPLIANCE.—Where the Secretary has ~~reason to question the compliance of a~~ nursing facility with any of the requirements of subsections (b), (c), and (d), the Secretary may conduct a survey of the facility and, on the basis of that survey, make ~~independent and binding~~ determinations concerning the extent to which the nursing facility meets such requirements.

found substantial evidence of a pattern of noncompliance by a

(4) INVESTIGATION OF COMPLAINTS AND MONITORING NURSING FACILITY COMPLIANCE.—Each State shall maintain procedures and adequate staff to—

(A) investigate complaints of violations of requirements by nursing facilities, and

(B) monitor, on-site, on a regular, as needed basis, a nursing facility's compliance with the requirements of subsections (b), (c), and (d), if—

(i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;

(ii) the facility was previously found not to be in compliance with such requirements, has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or

(iii) the State has reason to question the compliance of the facility with such requirements.

~~A State may maintain and utilize a specialized team (including an attorney, an auditor, and appropriate health care professionals) for the purpose of identifying, surveying, gathering and preserving evidence, and carrying out appropriate enforcement actions against substandard nursing facilities.~~

(5) DISCLOSURE OF RESULTS OF INSPECTIONS AND ACTIVITIES.—

(A) PUBLIC INFORMATION.—Each State, and the Secretary, shall make available to the public—

(i) information respecting all surveys and certifications made respecting nursing facilities, including statements of deficiencies, within ~~14 calendar days~~ after such information is made available to those facilities, and approved plans of correction,

(ii) copies of cost reports of such facilities filed under this title or under title XVIII,

(iii) copies of statements of ownership under section 1124, and

(iv) information disclosed under section 1126.

(B) NOTICE TO OMBUDSMAN.—Each State shall notify the State long-term care ombudsman (established under title III or VII of the Older Americans Act of 1965[193] in accordance with section 712 of the Act) of the State's findings of noncompliance with any of the requirements of subsections (b), (c), and (d), or of any adverse action taken against a nursing facility under paragraphs (1), (2), or (3) of subsection (h), with respect to a nursing facility in the State.

(C) NOTICE TO PHYSICIANS AND NURSING FACILITY ADMINISTRATOR LICENSING BOARD.—If a State finds that a nursing facility has provided substandard quality of care, the State shall notify—

(i) the attending physician of each resident with respect to which such finding is made, and

(ii) any State board responsible for the licensing of the nursing facility administrator of the facility.

(D) ACCESS TO FRAUD CONTROL UNITS.—Each State shall provide its State ~~medicaid~~ fraud and abuse control unit (established under section ~~1903(q)~~) with access to all information of the State agency responsible for surveys and certifications under this subsection.

(h) ENFORCEMENT PROCESS.—

(1) IN GENERAL.—If a State finds, on the basis of a standard, extended, or partial extended survey under subsection (g)(2) or otherwise, that a nursing facility no longer meets a requirement of subsection (b), (c), or (d), ~~and further finds that the facility's deficiencies~~ 1

[193] See Vol. II, P.L. 89-73.

If the State finds that the deficiencies

(B)~~(A)~~ immediately jeopardize the health or safety of its residents, the State shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in paragraph (2)(A)(iii), or terminate the facility's participation under the State plan and may provide, in addition, for one or more of the other remedies described in paragraph (2); ~~or~~ and

If the State finds that the facility's deficiencies

(C)~~(B)~~ do not immediately jeopardize the health or safety of its residents, the State may—

(i) terminate the facility's participation under the State plan,

(ii) provide for one or more of the remedies described in paragraph (2), or

(iii) do both.

~~Nothing in this paragraph shall be construed as restricting the remedies available to a State to remedy a nursing facility's deficiencies. If a State finds that a nursing facility meets the requirements of subsections (b), (c), and (d), but, as of a previous period, did not meet such requirements, the State may provide for a civil money penalty under paragraph (2)(A)(ii) for the days in which it finds that the facility was not in compliance with such requirements.~~

(2) SPECIFIED REMEDIES.—

(A) LISTING.—Except as provided in subparagraph (B)(ii), each State shall establish by law (whether statute or regulation) at least the following remedies:

(i) Denial of payment under the State plan with respect to any individual admitted to the nursing facility involved after such notice to the public and to the facility as may be provided for by the State.

(ii) A civil money penalty assessed and collected, with interest, for each day in which the facility is or was out of compliance with a requirement of subsection (b), (c), or (d). ~~Funds collected by a State as a result of imposition of such a penalty (or as a result of the imposition by the State of a civil money penalty for activities described in subsections (b)(3)(B)(ii)(I), (b)(3)(B)(ii)(II), or (g)(2)(A)(i)) shall be applied to the protection of the health or property of residents of nursing facilities that the State or the Secretary finds deficient, including payment for the costs of relocation of residents to other facilities, maintenance of operation of a facility pending correction of deficiencies or closure, and reimbursement of residents for personal funds lost.~~

(iii) The appointment of temporary management to oversee the operation of the facility and to assure the health and safety of the facility's residents, where there is a need for temporary management while—

(I) there is an orderly closure of the facility, or

(II) improvements are made in order to bring the facility into compliance with all the requirements of subsections (b), (c), and (d).

The temporary management under this clause shall not be terminated under subclause (II) until the State has

determined that the facility has the management capability to ensure continued compliance with all the requirements of subsections (b), (c), and (d).

(iv) The authority, in the case of an emergency, to close the facility, to transfer residents in that facility to other facilities, or both.

The State also shall specify criteria, as to when and how each of such remedies is to be applied, the amounts of any fines, and the severity of each of these remedies, to be used in the imposition of such remedies. ~~Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the remedies and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies. In addition, the State may provide for other specified remedies, such as directed plans of correction.~~

~~(B) DEADLINE AND GUIDANCE.—(i) Except as provided in clause (ii), as a condition for approval of a State plan for calendar quarters beginning on or after October 1, 1989, each State shall establish the remedies described in clauses (i) through (iv) of subparagraph (A) by not later than October 1, 1989. The Secretary shall provide, through regulations by not later than October 1, 1988, guidance to States in establishing such remedies; but the failure of the Secretary to provide such guidance shall not relieve a State of the responsibility for establishing such remedies.~~

(B) Alternative Remedies

(ii) A State may establish alternative remedies ~~(other than termination of participation)~~ other than those described in clauses (i) through (iv) of subparagraph (A), if the State demonstrates to the Secretary's satisfaction that the alternative remedies are as effective in deterring noncompliance and correcting deficiencies as those described in such subparagraph ~~(A)~~.

to the remedies

(C) ASSURING PROMPT COMPLIANCE.—If a nursing facility has not complied with any of the requirements of subsections (b), (c), and (d), within 3 months after the date the facility is found to be out of compliance with such requirements, the State ~~shall~~ may impose the remedy described in subparagraph (A)(i) for all individuals who are admitted to the facility after such date.

(D) REPEATED NONCOMPLIANCE.—In the case of a nursing facility which, on 3 consecutive standard surveys conducted under subsection (g)(2), has been found to have provided substandard quality of care, the State shall (regardless of what other remedies are provided)—

(i) impose the remedy described in subparagraph (A)(i), and

(ii) monitor the facility under subsection (g)(4)(B),

until the facility has demonstrated, to the satisfaction of the State, that it is in compliance with the requirements of subsections (b), (c), and (d), and that it will remain in compliance with such requirements.

~~(E) FUNDING.—The reasonable expenditures of a State to provide for temporary management and other expenses~~

associated with implementing the remedies described in clauses (iii) and (iv) of subparagraph (A) shall be considered, for purposes of section 1903(a)(7), to be necessary for the proper and efficient administration of the State plan.

(F) INCENTIVES FOR HIGH QUALITY CARE.—In addition to the remedies specified in this paragraph, a State may establish a program to reward, through public recognition, incentive payments, or both, nursing facilities that provide the highest quality care to residents who are entitled to medical assistance under this title. For purposes of section 1903(a)(7), proper expenses incurred by a State in carrying out such a program shall be considered to be expenses necessary for the proper and efficient administration of the State plan under this title.

(3) SECRETARIAL AUTHORITY.—

(A) FOR STATE NURSING FACILITIES.—With respect to a State nursing facility, the Secretary shall have the authority and duties of a State under this subsection, ~~including the authority to impose remedies described in clauses (i), (ii), and (iii) of paragraph (2)(A).~~

Nothing in this paragraph shall be construed as restricting the remedies available to the Secretary to remedy a nursing facility's deficiencies.

(B) OTHER NURSING FACILITIES.—With respect to any other nursing facility in a State, if the Secretary finds that a nursing facility no longer meets a requirement of subsection (b), (c), (d), or (e), and further finds that the facility's deficiencies—

(i) immediately jeopardize the health or safety of its residents, the Secretary shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in subparagraph (C)(iii), or terminate the facility's participation under the State plan and may provide, in addition, for one or more of the other remedies described in subparagraph (C); or

(ii) do not immediately jeopardize the health or safety of its residents, the Secretary may impose any of the remedies described in subparagraph (C).

~~Nothing in this subparagraph shall be construed as restricting the remedies available to the Secretary to remedy a nursing facility's deficiencies. If the Secretary finds that a nursing facility meets such requirements but, as of a previous period, did not meet such requirements, the Secretary may provide for a civil money penalty under subparagraph (C)(ii) for the days on which he finds that the facility was not in compliance with such requirements.~~

(C) SPECIFIED REMEDIES.—The Secretary may take the following actions with respect to a finding that a facility has not met an applicable requirement:

(i) DENIAL OF PAYMENT.—The Secretary may deny any further payments to the State for medical assistance furnished by the facility to all individuals in the facility or to individuals admitted to the facility after the effective date of the finding.

(ii) AUTHORITY WITH RESPECT TO CIVIL MONEY PENALTIES.—The Secretary may impose a civil money penalty in an amount not to exceed ~~$10,000~~ $5,000 for each day

see attached language page 7-60

sections (b), (c), and (d), within 3 months after the date the facility is found to be out of compliance with such requirements, the State may impose the remedy described in subparagraph (A)(i) for all individuals who are admitted to the facility after such date.

"(D) REPEATED NONCOMPLIANCE.—In the case of a nursing facility which, on 3 consecutive standard surveys conducted under subsection (g)(2), has been found to have provided substandard quality of care, the State shall (regardless of what other remedies are provided)—

"(i) impose the remedy described in subparagraph (A)(i), and

"(ii) monitor the facility under subsection (g)(4)(B), until the facility has demonstrated, to the satisfaction of the State, that it is in compliance with the requirements of subsections (b), (c), and (d), and that it will remain in compliance with such requirements.

"(3) SECRETARIAL AUTHORITY.—

"(A) FOR STATE NURSING FACILITIES.—With respect to a State nursing facility, the Secretary shall have the authority and duties of a State under this subsection. Nothing in this subparagraph shall be construed as restricting the remedies available to the Secretary to remedy a nursing facility's deficiencies.

"(B) OTHER NURSING FACILITIES.—With respect to any other nursing facility in a State, if the Secretary finds that a nursing facility no longer meets a requirement of subsection (b), (c), or (d), the Secretary shall notify the State of such deficiency. If, after a reasonable period of time after such notification is given, the Secretary finds that the State has failed to carry out the requirements of paragraph (1)(A) or paragraph (1)(B) (if appropriate) with respect to the deficiency involved, or that the deficiency remains uncorrected—

"(i) the Secretary shall require the facility to correct the deficiency involved;

"(ii) if the Secretary finds that the deficiency involved immediately jeopardizes the health or safety of its residents, the Secretary shall, in consultation with the State, take action to remove the jeopardy and correct the deficiencies through the remedy specified in subparagraph (C)(iii), or terminate the facility's participation under the State MediGrant plan and may provide, in addition, for one or more of the other remedies described in subparagraph (C); and

"(iii) in the case of a deficiency that remains uncorrected, if the Secretary finds that the deficiency involved does not immediately jeopardize the health or safety of its residents, the Secretary may impose any of the remedies described in subparagraph (C).

"(C) SPECIFIED REMEDIES.—The remedies specified in this subparagraph are as follows:

"(i) DENIAL OF PAYMENT.—Denial of any further payments to the State in accordance with section 2154(f) for medical assistance furnished by the facility to all individuals in the facility or to individuals admitted to the facility after the effective date of the finding.

"(ii) AUTHORITY WITH RESPECT TO CIVIL MONEY PENALTIES.—Imposition of a civil money penalty against the facility in an amount not to exceed $5,000 for each day of noncompliance. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

See (3)(B) on preceding page of current law

See (3)(c) on preceding page of current law

of noncompliance. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

appointment of temporary management

(iii) APPOINTMENT OF TEMPORARY MANAGEMENT.—~~(~~In consultation with the State~~)~~ ~~the Secretary may appoint temporary management~~ to oversee the operation of the facility and to assure the health and safety of the facility's residents, where there is a need for temporary management while—

(I) there is an orderly closure of the facility, or

(II) improvements are made in order to bring the facility into compliance with all the requirements of subsections (b), (c), and (d).

The temporary management under this clause shall not be terminated under subclause (II) until the Secretary has determined that the facility has the management capability to ensure continued compliance with all the requirements of subsections (b), (c), and (d).

The Secretary shall specify criteria, as to when and how each of such remedies is to be applied, the amounts of any fines, and the severity of each of these remedies, to be used in the imposition of such remedies. ~~Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the remedies and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies. In addition, the Secretary may provide for other specified remedies, such as directed plans of correction.~~

(4) Special Rules Regarding Payments to Facilities — see language on attached pg 7-61

~~(A)~~ (D) CONTINUATION OF PAYMENTS PENDING REMEDIATION.—The Secretary may continue payments, over a period of not longer than 6 months after the effective date of the findings, under this title with respect to a nursing facility not in compliance with a requirement of subsection (b), (c), or (d), if—

(i) the State survey agency finds that it is more appropriate to take alternative action to assure compliance of the facility with the requirements than to terminate the certification of the facility,

(ii) the State has submitted a plan and timetable for corrective action to the Secretary for approval and the Secretary approves the plan of corrective action, and

(iii) the State agrees to repay to the Federal Government payments received under this subparagraph if the corrective action is not taken in accordance with the approved plan and timetable.

The Secretary shall establish guidelines for approval of corrective actions requested by States under this subparagraph.

~~(B)~~ (A) EFFECTIVE PERIOD OF DENIAL OF PAYMENT.—A finding to deny payment under this subsection shall terminate when the State or Secretary (or both, as the case may be) finds that the facility is in substantial compliance with all the requirements of subsections (b), (c), and (d).

see attached page 7-61 - 7-62

(5) IMMEDIATE TERMINATION OF PARTICIPATION FOR FACILITY WHERE STATE OR SECRETARY FINDS NONCOMPLIANCE AND IMMEDIATE JEOPARDY.—If either the State or the Secretary finds that a nursing facility has not met a requirement of subsection (b), (c), or (d), and finds that the failure immediately jeopardizes the health or safety of its residents, the State or the Secretary, respectively shall notify the other of such finding, and the State or the Secretary, respectively, shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in paragraph (2)(A)(iii) or (3)(C)(iii), or terminate the facility's participation under the State plan. If the facility's participation in the State plan is terminated by either the State or the Secretary, the State shall provide for the safe and orderly transfer of the residents eligible under the State plan consistent with the requirements of subsection (c)(2).

(6) SPECIAL RULES WHERE STATE AND SECRETARY DO NOT AGREE ON FINDING OF NONCOMPLIANCE.—

(A) STATE FINDING OF NONCOMPLIANCE AND NO SECRETARIAL FINDING OF NONCOMPLIANCE.—If the Secretary finds that a nursing facility has met all the requirements of subsections (b), (c), and (d), but a State finds that the facility has not met such requirements and the failure does not immediately jeopardize the health or safety of its residents, the State's findings shall control and the remedies imposed by the State shall be applied.

(B) SECRETARIAL FINDING OF NONCOMPLIANCE AND NO STATE FINDING OF NONCOMPLIANCE.—If the Secretary finds that a nursing facility has not met all the requirements of subsections (b), (c), and (d), and that the failure does not immediately jeopardize the health or safety of its residents, but the State has not made such a finding, the Secretary—

(i) may impose any remedies specified in paragraph (3)(C) with respect to the facility, and

(ii) shall (pending any termination by the Secretary) permit continuation of payments in accordance with paragraph (3)(D).

(7) SPECIAL RULES FOR TIMING OF TERMINATION OF PARTICIPATION WHERE REMEDIES OVERLAP.—If both the Secretary and the State find that a nursing facility has not met all the requirements of subsections (b), (c), and (d), and neither finds that the failure immediately jeopardizes the health or safety of its residents—

(A)(i) if both find that the facility's participation under the State plan should be terminated, the State's timing of any termination shall control so long as the termination date does not occur later than 6 months after the date of the finding to terminate;

(ii) if the Secretary, but not the State, finds that the facility's participation under the State plan should be terminated, the Secretary shall (pending any termination by the Secretary) permit continuation of payments in accordance with paragraph (3)(D); or

(iii) if the State, but not the Secretary, finds that the facility's participation under the State plan should be termi-

nated, the State's decision to terminate, and timing of such termination, shall control; and

(B)(i) if the Secretary or the State, but not both, establishes one or more remedies which are additional or alternative to the remedy of terminating the facility's participation under the State plan, such additional or alternative remedies shall also be applied, or

(ii) if both the Secretary and the State establish one or more remedies which are additional or alternative to the remedy of terminating the facility's participation under the State plan, only the additional or alternative remedies of the Secretary shall apply.

(5) (8) CONSTRUCTION.—The remedies provided under this subsection are in addition to those otherwise available under State or Federal law and shall not be construed as limiting such other remedies, including any remedy available to an individual at common law. ~~The remedies described in clauses (i), (iii), and (iv) of paragraph (2)(A) may be imposed during the pendency of any hearing~~. The provisions of this subsection shall apply to a nursing facility (or portion thereof) notwithstanding that the facility (or portion thereof) also is a skilled nursing facility for purposes of title XVIII.

or is accredited by an entity pursuant to subsection (i)(2).

(9) SHARING OF INFORMATION.—Notwithstanding any other provision of law, all information concerning nursing facilities required by this section to be filed with the Secretary or a State agency shall be made available by such facilities to Federal or State employees for purposes consistent with the effective administration of programs established under this title and title XVIII, including investigations by State ~~medicaid~~ fraud control units. medigrant

(i) CONSTRUCTION.—Where requirements or obligations under this section are identical to those provided under section 1819 of this Act, the fulfillment of those requirements or obligations under section 1819 shall be considered to be the fulfillment of the corresponding requirements or obligations under this section.

(2) Effect on Accreditation see page 7-61 + 7-62 attached.

PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN

SEC. 1920. [42 U.S.C. 1396r-1] (a) A State plan approved under section 1902 may provide for making ambulatory prenatal care available to a pregnant woman during a presumptive eligibility period.

(b) For purposes of this section—

(1) the term "presumptive eligibility period" means, with respect to a pregnant woman, the period that—

(A) begins with the date on which a qualified provider determines, on the basis of preliminary information, that the family income of the woman does not exceed the applicable income level of eligibility under the State plan, and

(B) ends with (and includes) the earlier of—

(i) the day on which a determination is made with respect to the eligibility of the woman for medical assistance under the State plan, or

(ii) in the case of a woman who does not file an application by the last day of the month following the

"(iii) APPOINTMENT OF TEMPORARY MANAGEMENT.—Appointment of temporary management (in consultation with the State) to oversee the operation of the facility and to assure the health and safety of the facility's residents, where there is a need for temporary management while—

"(I) there is an orderly closure of the facility, or

"(II) improvements are made in order to bring the facility into compliance with all the requirements of subsections (b), (c), and (d).

The temporary management under this clause shall not be terminated under subclause (II) until the Secretary has determined that the facility has the management capability to ensure continued compliance with all the requirements of subsections (b), (c), and (d).

The Secretary shall specify criteria, as to when and how each of such remedies is to be applied, the amounts of any fines, and the severity of each of these remedies, to be used in the imposition of such remedies.

"(4) SPECIAL RULES REGARDING PAYMENTS TO FACILITIES.—

"(A) CONTINUATION OF PAYMENTS PENDING REMEDIATION.—The State or the Secretary, as appropriate, may continue payments, over a period of not longer than 6 months after the effective date of the findings, under this title with respect to a nursing facility not in compliance with a requirement of subsection (b), (c), or (d).

"(B) EFFECTIVE PERIOD OF DENIAL OF PAYMENT.—A finding to deny payment under this subsection shall terminate when the State or Secretary (as the case may be) finds that the facility is in substantial compliance with all the requirements of subsections (b), (c), and (d).

"(5) CONSTRUCTION.—The remedies provided under this subsection are in addition to those otherwise available under Federal or State law and shall not be construed as limiting such other remedies, including any remedy available to an individual at common law. The provisions of this subsection shall apply to a nursing facility (or portion thereof) notwithstanding that the facility (or portion thereof) also is a skilled nursing facility for purposes of title XVIII or is accredited by an entity pursuant to subsection (i)(2).

"(6) SHARING OF INFORMATION.—Notwithstanding any other provision of law, all information concerning nursing facilities required by this section to be filed with the Secretary or a State agency shall be made available by such facilities to Federal or State employees for purposes consistent with the effective administration of programs established under this title and title XVIII, including investigations by State MediGrant fraud control units.

"(i) CONSTRUCTION.—

"(1) MEDICARE REQUIREMENTS.—Where requirements or obligations under this section are identical to those provided under section 1819 of this Act, the fulfillment of those requirements or obligations under section 1819 shall be considered to be the fulfillment of the corresponding requirements or obligations under this section.

"(2) EFFECT OF ACCREDITATION.—

"(A) IN GENERAL.—At the option of a State, or the Secretary, as appropriate, if a nursing facility in the State is accredited by a national accrediting entity meeting such standards as the State or the Secretary may impose, such facility shall be deemed to have met the requirements of this section and the State shall be deemed to have met the survey and certification requirements under subsection (g).

"(B) REQUIREMENT FOR ACCREDITING ENTITY.—A State or the Secretary, as appropriate, may not find that an ac-

See pg 1826 of SSA

New

USA TODAY · WEDNESDAY, SEPTEMBER 27, 1995

Dropping federal regs is an invitation to tragedy

OUR VIEW **Everyone has heard the horror stories about the bad old days in nursing homes. Why go back to them?**

Eight years ago, after 15 years of argument, Republicans and Democrats in Congress got together to correct a public embarrassment. They passed a law to stop nursing home operators from abusing or neglecting the elderly.

They had ample incentive. Reports of residents lying in excrement, dehydrated, malnourished or overmedicated were commonplace. State regulation was a failure. Public outrage was high.

It should be just as high now. The regulations created by that law are about to be weakened or stripped away — victims of an ideological crusade to curb federal authority, good or bad.

Control would return to the states, despite their history of failure.

Those pushing the new plan, House and Senate Republicans, claim their legislation is not a repeal. They say the law is ineffective. And they say it's hugely expensive.

All three claims are fiction.

Not a repeal? Under existing regulations violators are subject to financial penalties, decertification, denial of payments or takeover by temporary managers if they violate health and safety standards. Proposed changes would weaken enforcement by states that are vulnerable to powerful lobby groups. The Senate wouldn't require inspections, nurse staffing or protections against restraints or medication.

Not effective? A government study of 269 homes in 10 states cited impressive results. The study found hospitalization of nursing home residents down 25%, use of restraints down 25%, and detection and punishment of abuses increasing.

Too expensive? Quite the contrary. A study of 9,000 Georgia nursing-home residents reports a monthly $76,738 savings by curtailing unnecessary drug therapy, thanks to the regulations. And that's not an isolated case. The National Citizens' Coalition for Nursing Home Reform, a resident advocacy group, says the changes saved billions in costs attributed to poor treatment.

Even the American Health Care Association, representing nursing home owners, says costs have not been a problem.

In fact, nursing home owners signed onto the legislation when it passed in 1987. So did consumer groups. So did state officials. So did the Institute of Medicine, research arm of the National Academy of Sciences, whose 1986 report on nursing home conditions led to the reform.

No credible evidence exists to justify reversing course. If changes are necessary they should be based on the same kind of thorough study and public hearings that produced the original regulations.

Seniors are in nursing homes because of advanced age, mental or physical disabilities, to recover from hospitalization or because they have no one to care for them. They are frail and vulnerable. They deserve all the protection the public can provide.

Stop the scare stories

OPPOSING VIEW **No one's going to torture grandma. The federal rules just aren't needed.**

By Thomas J. Bliley Jr.

The latest, most preposterous "Mediscare" horror story is that our plan to fix Medicaid will allow nursing homes to fire their nurses, tie patients to their beds and sedate them to keep them quiet.

Let's turn on the lights. There's no bogeyman hiding in this closet.

A key component of our "Medigrant" bill is a "Nursing Home Resident Bill of Rights" that includes the right "to be free from abuse, including verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion." Compliance is mandatory, and states are empowered to shut down those facilities in violation.

Rather than weaken protections for nursing home patients, our bill strengthens them by ending an eight-year experiment with "federalization" of standards that by all accounts has been a total failure — a bureaucratic nightmare that is confusing, expensive and counterproductive.

Take the federal requirement that states independently assess the need for nursing home placement. After separately assessing some 81,500 patients placed in nursing homes in 1989 — at a cost of $28.5 million — California concluded that only five placements were inappropriate. That works out to $5.7 million per misplacement. What's more, the federal requirement only duplicated existing California procedures that would have revised those patients' placements anyway.

As governor of Arkansas, even Bill Clinton joined the governors of 47 other states in 1989 to criticize the nursing home regulations as inflexible federal "micromanagement." Our bill does exactly what Clinton and the other governors recommended: require the states (which enforce the rules anyway) to enact their own standards under strict federal guidelines.

Under our proposal, no state will see a penny of federal "Medigrant" assistance unless it first enacts rigorous new nursing home standards including: safety; cleanliness and quality; staffing and employee training; protection of patient records, property and legal rights; and patient grievance procedures.

Nobody wants to go back to the days when nursing homes were unsafe and unsanitary, but we don't need a massive and expensive bureaucracy to protect patients. Let's recognize that all wisdom and compassion does *not* reside in Washington. The states are better suited to do this job.

Rep. Thomas J. Bliley Jr., R-Va., is chairman of the House Commerce Committee.

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OCT 4 1995

DATE: Oct 4

FAX COVER SHEET

TO: Carol Rasco

FAX NUMBER: 456-2878

FROM: Tess Moore

NGA FAX NUMBER: (202) 624-5825

NUMBER OF PAGES 6 (Including this cover sheet)

COMMENTS: (1) EC-27 is the policy they were referring to. It was adopted in Feb 1991 and is no longer NGA policy.

(2) Also attached is EC-8 which is our current Medicaid policy. (FYI)

Call if you need anything else.

IF YOU HAVE ANY PROBLEMS WITH THIS TRANSMISSION, PLEASE CALL:

Tess at (202) 624-5320

C-27. SHORT-TERM MEDICAID POLICY

27.1 Preface

The nation's Governors recognize that rapidly escalating health care costs in the face of the increasing need for health care access is the essence of the health care crisis that confronts our nation. The Governors are also aware of the varied and complex factors that must be dealt with if we are to achieve a solution to this crisis.

Currently, at least thirty states are struggling with budget shortfalls. A significant part of the fiscal pressure on states is coming from increased costs in the Medicaid program. In 1980, Medicaid spending accounted for 9 percent of states' budgets; in 1990, it accounted for nearly 14 percent of all state spending.

The increased costs of Medicaid not only represent the generally inflated cost of health care experienced by all purchasers, but are exacerbated by four years of Medicaid mandates.

States must have some immediate relief from the real and pressing problems presented by the Medicaid program if they are to move forward on long-term solutions. Therefore, the Governors call on Congress and the administration to work with us to immediately make the following changes to the Medicaid program.

- **Congress should delay the mandated implementation of the 1990 Medicaid mandates for two years.** This will give federal and state governments time to assess the depth of the recession and the opportunity to develop long-term solutions for the restructuring of the Medicaid program. Accountability based upon results is a better test of state performance than strict compliance with mandated procedures. In return for flexibility, the Governors seek to work with the administration and Congress to develop state-specific mutually acceptable agreements to measure accountability.
- **States must not be expected to implement any Medicaid program changes until the Health Care Financing Administration (HCFA) has published final regulations to guide program administration.**
- **States must be allowed to maintain their complete authority to raise funds to match federal Medicaid dollars without restriction from the federal government.**
- **To promote cost control and efficiency, states should be encouraged to continue innovations in provider payment methods.** Though Medicare and most private payers have moved away from cost-based reimbursement, federal legislation has mandated that certain Medicaid providers be paid on the basis of costs. In operating our Medicaid programs, states should not be denied cost control options available to the federal government in operating the Medicare program.

In addition, with respect to three particularly troublesome mandates over the last four years, the Governors call upon Congress and the administration to make the following specific, programmatic changes.

27.2 Qualified Medicare Beneficiaries (QMBs)

Congress should assume full financial responsibility for all low-income Medicare beneficiaries who are not otherwise Medicaid-eligible. Since the passage of the Medicare catastrophic legislation in 1988, the federal government has increasingly passed on to the states the responsibility to protect low-income Medicare beneficiaries.

27.3 Nursing Home Reform

States should be considered in compliance with the law if a comparable quality assurance program is in place or developed. In the Omnibus Reconciliation Act of 1987, Congress mandated extensive new quality assurance measures for the Medicaid nursing home program. The statutory language permits limited state flexibility and puts Congress in the position of micro-managing the program.

27.4 **Early Periodic Screening, Diagnosis, and Treatment (EPSDT)**

In "technical" amendments to the EPSDT program legislated in 1989, Congress added major costs to this program. Therefore, the Governors propose two technical amendments to the 1989 law to:

- **With regard to screening services, clarify that states have the authority to specify qualified screening providers and that states are permitted to insist that such a provider can be required to provide all screening services.**
- **Give states the authority to provide only those services identified in a screen that are currently offered in a state's Medicaid program.**

While these changes clearly will not resolve the nation's long-term struggle to restructure the Medicaid program, they will provide immediate and sensible relief in dire economic times. These changes also would mark the beginning of a new and real partnership between the federal government and state governments over the design and implementation of the Medicaid program.

Adopted February 1991.

NATIONAL GOVERNORS' ASSOCIATION

NGA Policy

EC-8. MEDICAID

8.1 **Preamble**

The Medicaid program is a state/federal program that serves as the primary source of acute health care coverage and long-term care for the poor. Because it is a national program serving more than 30 million beneficiaries, the Governors believe that quality services must be provided as efficiently and effectively as possible.

In 1994 approximately $141 billion will be spent in the Medicaid program. Of that amount, about $60 billion will be state funds. Medicaid is now one of the largest components of state budgets, comprising 18 percent of state spending. Not only is Medicaid growing in both absolute and relative terms, it remains the fastest-growing state expenditure. As a result, states are experiencing great difficulty in finding the money to fund Medicaid. Even more important, perhaps, is that increased Medicaid spending makes it difficult, if not impossible, to increase funding for other priorities, such as education. Finding ways to control Medicaid spending is a major priority for the Governors.

Medicaid financing and administration are shared jointly by the federal government and the states. Over the past five years, federal policymakers have narrowed the administrative flexibility of states and made legislative and regulatory changes that mandate greatly increased state expenditures. As a result, states increasingly view their relationship with the federal government not as a partnership, but as a relationship in which states have been forced to accept federal mandates that have great impact on state budgets and health policy initiatives.

States must have relief from the real and pressing problems presented by the Medicaid program if they are to move forward with long-term solutions. Therefore, the Governors call on Congress and the administration to work to immediately address the problems with this program. Included among those solutions must be an overall reduction in federal statutory and regulatory micro-management that has typified the program in the last decade.

8.2 **Programmatic Recommendations**

8.2.1 **Impose No Unilateral Caps for Federal Spending on Medicaid Entitlements.** A unilateral federal cap on the Medicaid program will shift costs to state and local governments that they simply cannot afford. The Governors adamantly oppose a cap on federal Medicaid spending. If Congress is serious about reducing the costs of the program, they must reexamine the authorizing legislation that has brought the program to the condition it is in today and restructure the program to make it consistent with congressional spending strategies.

8.2.2 **Allow States Greater Flexibility to Establish Managed Care Networks.** There is a national trend in health care service delivery toward organized systems of care. These systems or networks have been shown to provide cost-efficient, quality care while ensuring that the patient has a reliable place from which to seek primary care and to which specialty care can be directed. Systems of coordinated care have particular benefits for Medicaid beneficiaries. These systems ensure a medical home for beneficiaries, encourage primary and preventive care, and discourage the use of emergency rooms and specialists for routine medical care.

Although the private sector is moving aggressively toward these networks, the Medicaid program continues to require states, in virtually all cases, to apply for a waiver from fee-for-service care in order to enroll Medicaid beneficiaries in such networks. Although the Bush and

Clinton administrations have taken significant steps toward simplifying the application and renewal process, states still must apply for renewals every two years. Moreover, states have been unable to sustain networks where there is a predominance of Medicaid beneficiaries because, under current law, states are permitted only one nonrenewable three-year waiver to have beneficiaries served in a health maintenance organization (HMO) where more than 75 percent of the enrollees in the HMO are Medicaid beneficiaries. This requirement should be repealed.

If the nation is serious about controlling health care costs, it is essential to give states the opportunity to establish networks in Medicaid (including fully and partially capitated systems) through the regular plan amendment process. The Governors recognize the special significance of consumer protections and assurance of solvency in establishing these systems of care.

8.2.3 Give States Greater Leeway in Containing the Cost of Hospital and Long-Term Care Through the Boren Amendment. The Boren Amendment to the Medicaid provisions of the Social Security Act was passed in the early 1980s to give states greater flexibility in establishing reimbursement rates for hospitals and nursing homes and to encourage health care cost containment. Instead, it has led to havoc in the administration of Medicaid programs. The courts have interpreted the Boren Amendment to embody a restrictive and unrealistic set of requirements in setting reimbursement rates and have in effect given judges the power to establish reimbursement rates levels and criteria. Because of these decisions, states remain frustrated in their ability to bring discipline to their budgets and have been thwarted in their attempts to achieve the original purpose of the amendment.

8.2.3.1 **Statutory and Regulatory Changes.** The nation's Governors believe that any coherent approach to national health care reform must address the inflexible provider reimbursement standard of the Boren Amendment. The Governors support repeal of the Boren Amendment and urge alternative statutory protections for states. They believe that a statutory change is a necessary tool to bring Medicaid institutional costs under control. Therefore, the Governors urge the administration and Congress to adopt these changes or other strategies that will give states the relief they need.

The Governors agree that standards for establishing adequate reimbursement rates for hospitals, nursing facilities, and intermediate care facilities for people with mental retardation must be designed to promote access to care for Medicaid patients, quality of services, cost containment, and efficient service delivery. The Governors support a strategy that would replace the current cost-efficiency-based standard in the Boren Amendment with provisions that establish "safe harbor" standards, where a state meeting any of these "safe harbor" provisions would satisfy the statute. Standards might include the following.

- The payment rate is equal to the Medicare-based upper payment limit.
- The payment rate is no less than the rate agreed to by the facility for comparable services paid for by another payer (e.g., payment rates for Medicaid patients would not have to be higher than rates paid by any large managed care plans or large businesses).
- Regarding nursing facilities, the aggregate number of participating licensed and certified nursing home beds in the state (plus resources devoted to home- or community-based care for the elderly) is at least equal to a specified percentage of the population age 65 or over.
- The reimbursement rate is sufficient to cover at least 80 percent of the allowable costs of all facilities in the class in the state in the aggregate or is sufficient to cover the allowable costs of 50 percent of all facilities in the class in the state.
- The reimbursement rate is equal to a benchmark rate plus inflation, no less than the rate of inflation for the overall economy according to a general index (national or state) such as the consumer price index or the gross domestic product. The benchmark rate would be the approved rate as of the date of enactment of the statute or the current rate approved by the Health Care Financing Administration (HCFA). This standard is satisfied by a rate methodology currently in effect and approved by HCFA that contains a provision for inflation adjustments.

The Governors also believe that the Boren Amendment is not applicable when a hospital engages in rate negotiations as part of its participation in a network serving Medicaid beneficiaries.

The Governors also believe that the procedural requirements in the current Boren Amendment must be streamlined.

Finally, the Governors support strategies that would reduce or eliminate the costs of prolonged and costly litigation.

8.2.4 **Allow States to Manage Costs in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program By Providing Services Within Their State Medicaid Plan and Selecting Less Costly Alternatives for Diagnosis and Treatment Without Risking Quality.** Under current policy, states have no ability to limit the range or cost of services required in the EPSDT program. This open-ended requirement is driving up the cost of the Medicaid budget at uncontrollable rates. The U.S. Department of Health and Human Services needs to issue rules that allow states to efficiently manage case costs and utilize the least expensive alternatives for providing services without reducing the quality of care.

8.2.5 **Ensure that States Will Not Be Expected to Implement Any Medicaid Program Changes Until the Health Care Financing Administration Has Published Final Regulations to Guide Program Administration.** In too many cases, HCFA has failed completely to publish regulations associated with statutory changes in the Medicaid program or has done so after many years of delay. Too often, states have had to implement statutory changes and in some cases, have been held financially accountable for unclear laws, even though HCFA failed to provide clarification through implementing regulations.

8.2.6 **Promote Cost Control and Efficiency.** States should be encouraged to continue innovations in provider payment methods. Though Medicare and most private payers have moved away from cost-based reimbursement, federal legislation has mandated that certain Medicaid providers be paid on the basis of costs. Mandatory "reasonable cost" reimbursement strategies should be repealed.

In addition, with respect to three particularly troublesome mandates over the last four years, the Governors call upon Congress and the administration to make the following specific, programmatic changes.

8.2.7 **Assume Full Financial Responsibility for All Low-Income Medicare Beneficiaries Who Are Not Otherwise Medicaid-Eligible.** Since the passage of the Medicare catastrophic legislation in 1988, the federal government has increasingly passed on to the states the responsibility to protect low-income Medicare beneficiaries (e.g., the Qualified Medicare Beneficiary Program). The Medicare program is a federal program and the federal government should bear all of its costs.

8.2.8 **Reconsider the Nursing Home Reform Mandates in the Omnibus Reconciliation Act of 1987.** Congress mandated extensive new quality assurance measures for the Medicaid nursing home program. The statutory language permits limited state flexibility and puts Congress in the position of micro-managing the program. In addition, Congress should repeal the Preadmission Screening and Annual Resident Review (PASARR) requirements. Since enactment, states have found PASARR to be extremely cost-inefficient and have developed other strategies to ensure the appropriate placement of individuals with disabilities. In addition, the specialized annual resident review for mental illness and mental retardation is duplicative of existing annual review processes.

8.2.9 **Make Audit and Disallowance Policies More Equitable.** Under current law, federal audit and disallowance requirements do not discriminate between violations of "obscure policies" and those that have direct harm to beneficiaries. The statute should be revised to prohibit federal practices that impose heavy penalties when the violation constitutes no beneficiary harm.

8.2.10 **Allow Greater Flexibility in Medicaid Home- and Community-Based Care (HCBC) Programs.** Home- and community-based care is an important alternative to institutional care for the elderly and people with chronic and disabling conditions. Currently, every state in the country has at least one HCBC program. Existing Medicaid statutes require states to establish and administer these programs through waivers. The statutes must be revised to give states the authority to administer HCBC programs through a plan amendment process. However, states must be able to retain the authority to limit the number of beneficiaries receiving Medicaid home- and community-based care. Finally, Congress and the states must work together to restructure the Medicaid program to eliminate the incentive to place beneficiaries in institutional care when community care would be more appropriate and possibly more cost-efficient.

Time limited (effective Winter Meeting 1995-Winter Meeting 1997).
Adopted Winter Meeting 1995.

NATIONAL GOVERNORS ASSOCIATION

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Governor of Iowa
Chairman

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Executive Director

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August 1, 1989

Dear Member of Congress:

Today the nation's Governors took action calling on Congress and the White House to adopt a two year freese on the enactment of further Medicaid mandates. Our Resolution was based on our increasing concern with the impact of the last three years of Medicaid mandates on our budgets, and, consequently, on our ability to properly fund education and other important services.

The Governors continue to support state options to assure Medicaid eligibility to our most vulnerable populations. Moreover, we are keenly aware that 37 million Americans remain uninsured. Consequently, we believe now is the time to debate solutions to our national health care crisis that accomodate both access to quality health care for all Americans and the need to control spiraling health care costs.

The Governors propose to use the two-year freeze to work with Congress and the White House on a bipartisan basis, as we did on welfare reform, to find the best solutions to the health care crisis that confronts this nation.

Sincerely,

Terry E. Branstad
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IOWA

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DATE: Oct. 3

FAX COVER SHEET

TO: Carol Rasco

FAX NUMBER: _____

FROM: Tess Moore

NGA FAX NUMBER: (202) 624-5825

NUMBER OF PAGES 4 (Including this cover sheet)

COMMENTS:

This is the closest letter we could find for '89. Is this what you are looking for?

Thanks

IF YOU HAVE ANY PROBLEMS WITH THIS TRANSMISSION, PLEASE CALL:

Tess at (202) 624-5320

SUSPENSION

RESOLUTION* ON HEALTH CARE

(Proposed by the Committee on Human Resources)

BE IT RESOLVED, that the nation's Governors call on Congress and the White House not to enact any Medicaid mandates for a period of two years. Recent Medicaid mandates have put great stress on state budgets and undermined the states' ability to properly fund education and other important services.

Governors recognize that there is an urgent need to ensure the availability and quality of health care for all of our citizens, as well as to control health care costs. There are currently more than 37 million Americans -- most of them working families and children – without access to basic health care.

The accelerating costs of Medicaid, Medicare, and other health programs argue for a new look at health care financing options, including federalization of Medicaid or an aggressive effort to restructure the system.

Therefore, the Governors propose to use the two-year freeze to work with Congress and the White House on a bipartisan basis, as we did on welfare reform, to find the best solutions to stem escalating costs while ensuring access to needed health care services for all Americans.

*** based upon Policy C-5**

Adopted 1989 Annual Mtg.