

**THE REPUBLICAN MEDICAID PROPOSALS ONLY PRETENDED
TO PROTECT SENIORS FROM SPOUSAL IMPOVERISHMENT**

- I. Current law protects spouses and their families from poverty. Federal law ensures that spouses of people needing nursing home care do not have to lose everything they have in order for their spouse to qualify for Medicaid:**
- States must let spouses keep income equal to 150% of the national poverty level -- about \$15,000 per year.
 - States must let spouses keep a minimum amount of their assets. The minimum is set by the state and may range from about \$15,000 to \$75,000. The value of the spouse's home and car are not counted toward the asset limit, which protects spouses from having to sell these items to qualify for Medicaid.
 - Since this federal law went into effect in 1989, it has protected about 450,000 spouses of nursing home residents. Most of these spouses are women.
- II. Earlier versions of the Republican Medicaid Block Grant proposals repealed these spousal impoverishment protections.** Under the initial House and Senate Republican plans, any state government could force people whose husbands or wives have to go into nursing homes to give up their car, their furniture -- even their home before their spouse can qualify for any medical support.
- III. The President protested the elimination of these protections.**
- "Congress should strip these outrageous provisions from the budget bill. They're inconsistent with our core values. They're not what America is all about, and they are certainly not necessary to balance the budget." -- President Clinton, Radio Address, September 30, 1995
- IV. Responding to the President's criticisms, Republicans modified their plans. But they only passed an empty shell -- their bills still did not protect against spousal impoverishment.**
- Since both bills repeal the current Medicaid guarantee of nursing home care, there is also no guarantee of spousal impoverishment protections.
 - Both House and Senate bills repeal current national requirements for beneficiary rights to notification, administrative hearings, and appeals.
 - Under the House bill, eligible individuals who are not receiving the spousal impoverishment protections can no longer sue the State to obtain these essential protections. Specifically, Section 2117 of the House bill states: "no person (including an applicant, beneficiary, provider, or health plan) shall have a cause of action under Federal law against a State in relation to a State's compliance (or failure to comply) with the provisions of this title or of a MediGrant plan."
 - Both House and Senate bills made it more difficult for the Federal government to ensure that States comply with any beneficiary protection requirements.
- V. The vetoed Republican budget still did not protect spouses. It adopted the House proposal that eliminated the ability of individuals to enforce spousal impoverishment protections in federal court when they believe that have been wrongfully denied, *making the protections unenforceable*. It also still made it more difficult for the federal government to ensure that states protect spouses. Moreover, it also still repealed the Medicaid guarantee of nursing home care.**



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September 20, 1996

FROM : Richard Price
Specialist in Social Legislation
Education and Public Welfare Division

SUBJECT : Long-Term Care Provisions in Medicaid Restructuring Legislation

You asked that we account for certain long-term care provisions in Medicaid restructuring legislation considered by the 104th Congress. The bills that we reviewed include the Medicaid Transformation Act of 1995, as reported by the House Commerce Committee in September, 1995; the conference agreement on the Balanced Budget Act, H.R. 2491, as passed by the Congress and vetoed by the President at the end of 1995; and H.R. 3734, the Welfare and Medicaid Reform Act of 1996, as reported by the House Budget Committee in June 1996. The provisions that we examined include spousal impoverishment protections, adult children responsibility for their parents' nursing home care; nursing home reform law; and lien and estate recovery provisions. A brief description of current Medicaid law has been included as background for each of these provisions.

Spousal Impoverishment Protections

Current Law. Current Medicaid law includes rules known as "spousal impoverishment protections" for the treatment of resources and income of married couples when one of the spouses requires nursing home care and the other remains in the community. From a couple's combined resources, an amount is protected for the spouse remaining in the community. This amount is the greater of one-half of the couple's resources at the time the institutionalized spouse entered the nursing home, up to a maximum, or a standard established by the state. Currently, the state resource standard may be no lower than \$15,348 and no greater than \$76,740. After eligibility has been determined, states are required to recognize a minimum maintenance needs allowance for the living expenses of the community spouse. Currently this minimum is \$1,295 per month. States may set the minimum maintenance needs allowance as high as \$1,918 per month. These amounts may be increased, depending on the amount of the community spouse's actual shelter costs and whether a minor or dependent adult child or certain other persons are living with the community spouse.

For persons in nursing homes and other institutions, Medicaid requires that states reserve from a beneficiary's income a personal needs allowance. This is an amount that is considered reasonable to cover incidental expenses for items not included in the institution's basic charge,

CRS-2

e.g., clothing and other personal needs items. Medicaid law requires that states set aside a minimum of \$30 per month for individuals and \$60 per month for couples.

Medicaid Transformation Act, as reported from Commerce Committee. The bill did not contain current law spousal impoverishment protections. Instead it required only that states describe in their MediGrant plans the eligibility standards they would use to protect the income and resources of a married individual living in the community and whose spouse resided in an institution, in order to prevent the impoverishment of the community spouse.

H.R. 2491. The bill contained current law spousal impoverishment protections.

H.R. 3734. The bill contains current law spousal impoverishment protections and increases the minimum personal needs allowance for nursing home residents to \$40 per month for individuals and \$80 for couples.

Adult Children Responsibility for Parents Long-Term Care Expenses

Current Law. Medicaid law provides that a state plan must include reasonable standards for determining Medicaid eligibility that do not take into account the financial responsibility of any individual for any applicant or recipient of Medicaid unless the applicant or recipient is the individual's spouse, or a child under age 21, or a child over age 21 who is blind or disabled.

Medicaid Transformation Act, as reported from Commerce Committee. The bill required states to describe in their MediGrant plans beneficiary cost-sharing (if any), including the financial responsibilities of parents of recipients under 21 and spouses of recipients.

H.R. 2491. The bill prohibited a state's MediGrant plan from requiring an adult child with family income below the state median income (as determined by the state) to contribute to the cost of a parent's covered nursing facility services and other long-term care services.

H.R. 3734. States would be prohibited from requiring adult children or any other individual (other than the applicant or recipient of services or the applicant's or recipient's spouse) to contribute to the cost of covered nursing facility, other long-term care services, and hospital and other institutional services. In addition, for such services, states could hold financially responsible only the applicant's or recipient's spouse, or the parent of a child who is under age 21 or is disabled.

Nursing Home Reform Law

Current Law. The Omnibus Budget Reconciliation Act of 1987 comprehensively revised the requirements nursing homes must meet in order to participate in Medicaid. These provisions, collectively referred to as nursing home reform law, have three major parts that establish requirements at the federal level: (1) requirements that nursing homes must meet in order to be certified to participate in Medicaid, including requirements about assessments of residents, available services, nurse staffing, nurse aide training, and resident rights; (2) provisions revising the survey and certification process that state survey agencies must use

CRS-3

for determining whether nursing homes comply with the requirements for participation; and (3) provisions that expand the range of sanctions and penalties that states and the Secretary of HHS may impose against nursing homes found to be out of compliance with the requirements for participation.

Medicaid Transformation Act, as reported from Commerce Committee. The new MediGrant program replaced current nursing home reform law with fewer and more general requirements that gave states greater authority to establish standards for nursing homes, to certify that nursing homes met standards, and to sanction facilities not meeting standards.

H.R. 2491. The bill followed current law requirements, making, however, numerous substantive changes.

H.R. 3734. With certain exceptions, the bill follows current law. Major changes include the following. The bill repeals provisions prohibiting facilities from admitting mentally ill and mentally retarded persons who had not first been determined by states as needing nursing facility services. States would be required to operate preadmission screening program for mentally ill and mentally retarded persons admitted to nursing facilities to determine whether they required the level of care provided by the facilities, but would not be required to review such residents annually for the appropriate level of care needed. Residents of facilities would have the right to choose a personal attending physician, but states would not be precluded from requiring a resident to choose a personal attending physician who participates in a managed care network with which the state has a contract. Facilities would not be required to have written policies and procedures for advance directives. Under certain circumstances, states or the Secretary would be able to continue payments over a period of not more than 6 months to a noncompliant facility, while the facility takes actions to correct its deficiencies. The prohibition on approval for certain nurse aide training programs would not apply to programs offered in (but not by) nursing facilities if a state determined that there would be no other program offered within a reasonable distance, assured through an oversight effort that an adequate environment exists for the program, and provided notice of the approval and assurances to the state long-term care ombudsman.

Liens and Estate Recovery

Current Law. States are barred, except under certain circumstances, from placing a lien on the property of a Medicaid beneficiary prior to death because of Medicaid claims correctly paid on the individual's behalf. However, states may place a lien at any time on both real and personal property following a court judgment that claims were incorrectly paid (e.g., for a person who should not have been eligible for Medicaid). A state may also place a lien on real property of institutionalized Medicaid beneficiaries who, when the state determines after notice and opportunity for hearing, are reasonably likely to remain in a nursing home for the remainder of their lives. States may not place a lien on the home of a Medicaid recipient if the spouse or a child under 21 or disabled child is residing in the home. Further, the state may not place a lien if the beneficiary has a sibling in the home who has an equity interest in the home and was residing there continuously for at least 1 year prior to the recipient's admission to the facility. Any lien dissolves if the individual is discharged from the medical institution and returns home.

CRS-4

States are required to operate estate recovery programs to recover amounts paid by Medicaid for services needed by certain recipients. Estates are defined to include all real and personal property and other assets included within an individual's estate, as defined under state laws governing the treatment of inheritance. At the option of the state, recoverable estates can also include any other real or personal property and other assets in which the individual has any legal right, title, or interest at the time of death, including such assets conveyed to a survivor, heir, or assignee of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangements. In the case of persons 55 years or older, states must recover amounts paid for nursing home care, home and community-based care, and related hospital and prescription drug services, or at the option of the state, any items or services covered under the state's plan. Recovery may be made only after the death of the recipient's spouse and only at the time there is no dependent or disabled child. Furthermore, states may not recover on a lien of an institutionalized recipient's property if (a) a sibling residing in the home has lived there for at least 1 year prior to the recipient's institutionalization; or (b) a recipient's adult child residing in the home has lived there for at least 2 years prior to the recipient's admission to the nursing home and was providing care that delayed institutionalization of the recipient. States are required to establish procedures for waiving the application of these rules in cases of undue hardship.

Medicaid Transformation Act, as reported from Commerce Committee. The bill authorized a state to take such actions as it considers appropriate to adjust or recover from the individual or the individual's estate any amounts paid as medical assistance to or on behalf of a recipient, including the imposition of liens against the property or estate of the recipient.

H.R. 2491. The bill authorized a state to take such actions as it considers appropriate to adjust or recover from the individual or the individual's estate any amounts paid as medical assistance to or on behalf of a recipient, including the imposition of liens against the property or estate of the recipient.

H.R. 3734. The bill authorizes a state to take such actions as it considers appropriate to adjust or recover from the individual or the individual's estate any amounts paid as medical assistance to or on behalf of a recipient, including the imposition of liens against the property or estate of the recipient. However, liens could only be imposed under circumstances identical to current law.

The history of Republican attempts to eliminate financial protections for Medicaid patients' families

1. Spousal/Family Impoverishment and Imposition of Liens

In the context of individual entitlement for nursing home care, current law (Section 1924 (pg. 1242)) establishes rules that States must use in determining how much of a couple's income and assets must be protected for the maintenance of the community spouse (the remainder may be applied to the cost of nursing home care for the Medicaid-eligible institutionalized spouse, thereby lowering the payment that the State must make to the nursing home. Beneficiaries and spouses may bring actions against a state in Federal court to enforce compliance. (Spouses remaining in the community may keep about \$1,200 per month in income and about \$15,000 in savings to maintain his or her independence).

Section 1917 (pg. 1186) prohibits States from placing a lien on a nursing home resident's home or family farm if a spouse, dependent or disabled child lives in the home.

Since 1965, Medicaid (Section 1902(a)(17)) has prohibited States from making adult children financially responsible for the cost of nursing home, or other long-term care covered by Medicaid for their parent or parents. Twenty nine states have laws on the books which hold adult children financially liable and would prevail if these federal protections are repealed.

- a) Senate Finance Committee Mark - repealed Title XIX (Medicaid) and did not maintain any of the protections against spousal impoverishment, family impoverishment, or the imposition of liens. On September 28, 1996, Senator Conrad introduced an amendment to retain current law protections against impoverishment for spouses of nursing home residents who remain in the community. The amendment passed by voice vote. On the same day, Senators Baucus and Chafee introduced an amendment prohibiting states from imposing liens against a home of moderate value or family farm, as a condition of the spouse of the individual receiving nursing home care or other long-term care benefits. It was accepted without objection.
- b) Commerce Committee Mark - (September 22, 1995) Repealed rules that States must use in determining how much of a couple's income and assets must be protected for the maintenance of the community spouse; repealed current law prohibition against financial responsibility requirements for adult children; repealed current law protections against liens; and barred Federal court actions by beneficiaries, applicants, or adult children to enforce their rights against States. Required only that States receiving block grant funds provide a "description" of the eligibility standards they use "to prevent the impoverishment of the community spouse."

Mr. Markey's amendment to maintain current law provisions relating to spousal impoverishment failed on a party-line vote, 18-23. Mr. Klink's amendment to maintain current law provisions with respect to adult children failed on a party-line vote of 17-23.

- c) House-passed bill - Repealed individual entitlement to nursing home care. Repealed current law protections against placing a lien against the home of a nursing home resident, even if the home was occupied by a spouse of dependent child. Repealed protections against requiring adult children to pay for cost of parent's care, unless the child had income below the median for the state. Restored spousal impoverishment protections, but no right of action by individual in Federal courts to enforce protections. Moreover, spousal impoverishment provisions were rendered meaningless by repeal of provisions preventing nursing homes from charging families amounts in addition to Medicaid payments. On October 26, 1995, the House passed the bill 227-203.
- d) Senate-passed bill - Restored some current law protections against spousal impoverishment (sec 2116, pg. S16235), but did not include protections against holding families financially liable for the cost of nursing facility and other long-term care services for the child's parent. The bill included the limited provision prohibiting states from imposing liens against a home of moderate value or family farm (Section 2135(g)(2) pg. S16244). On October 28, 1995, the Senate passed the bill 52-47. Senator Dole voted in favor of the bill.
- e) Final Conference agreement - Repealed individual entitlement to nursing home care. Repealed protection against requiring an adult child with a family income above the median income (as defined by the state) to contribute to the cost of covered nursing facility services and other long-term-care services (Sec. 2115(f)). Section 2135 (g) of the final bill expressly allowed States to "stake such actions as it considers appropriate to adjust or recover from the individual or the individual's estate any amounts paid as medical assistance to or on behalf of the individual under the MediGrant plan, including through the imposition of liens against the property or estate of the individual." Thus, there were no protections against the imposition of liens on nursing home residents' homes, even when a spouse or dependent child is living in the home.

Included current law protections against spousal impoverishment (Sec. 2115), but rendered them meaningless by repeal of provisions preventing nursing homes from charging families amounts in addition to Medicaid payments.

On November 17, 1996, the Senate passed the conference agreement 54-45. Senator Dole voted in favor of final passage. On December 6, 1995, President Clinton vetoed the bill.

ENDING MEDICAID PROTECTIONS AGAINST SPOUSAL IMPOVERISHMENT

The House Republican Medicaid plan would repeal the common ground law signed by President Reagan to protect spouses from having to *give up everything they have -- their car, their home, and all their savings* -- in order to pay for nursing home care for their sick spouse.

Current Law Protects Spouses and Their Families from Poverty

Current federal law ensures that spouses of people needing nursing home care do not have to lose everything they have in order for their spouse to qualify for Medicaid:

- States must let spouses keep income equal to 150% of the national poverty level -- about \$15,000 per year.
- States must let spouses keep a minimum amount of their assets. The minimum is set by the state and may range from about \$15,000 to \$75,000. The value of the spouse's home and car are not counted toward the asset limit, which protects spouses from having to sell these items to qualify for Medicaid.

Since this federal law went into effect in 1989, it has protected about 450,000 spouses of nursing home residents. Most of these spouses are women. It also protects their families from being forced to pay the nursing home costs and from having to support the spouse not needing nursing home care.

Background and Legislative History

Most Americans must pay for nursing home care with their own funds for as long as they can. Medicare provides minimal long-term care coverage, and Medicaid only covers nursing home care after one has "spent down" and meets Medicaid's eligibility requirements. Prior to enactment of the protections against spousal impoverishment in 1988, spouses, most often wives, of people needing nursing home care, were often forced into poverty before they qualified for Medicaid. To avoid poverty, many elderly couples were forced to take desperate steps, such as divorcing or suing their sick spouse for support.

These current protections against spousal impoverishment were enacted as part of the Medicare Catastrophic Coverage Act of 1988, and were one of the few provisions retained when the Act was repealed in 1989. The Senate voted 99-0 and the House voted 349-57 to retain the spousal impoverishment and a few other provisions.

Republican Medicaid Block Grant Ends Spousal Impoverishment Protection

The House Medicaid block grants as introduced repeal the protections against spousal impoverishment. When House Democrats offered an amendment in the Commerce Committee to restore these protections, *the amendment was defeated on a party-line vote*. Senate Democrats offered a similar amendment in the Finance Committee and the amendment was adopted.

Medicaid is the largest payor of long-term care, covering *over two-thirds* of all nursing home residents. Without the current federal protections against spousal impoverishment, there would be no federal assurance that spouses could keep a minimum amount of their income and assets. The spouses and families of nursing home residents could be faced with the costs of their sick relatives' nursing home care -- care which now *costs an average of \$38,000 a year*. Nursing home costs could once again ruin the lives of spouses and their families.

Because Republicans also propose to slash Medicaid by \$182 billion over seven years, cutting federal Medicaid payments to states by 30% in 2002, states may be forced to offset the loss of federal funding by not protecting the income and assets of spouses of nursing home residents. Spouses could be forced to sell their home, car and other essential assets, and to spend everything including their Social Security check on their spouse's nursing home care.

Questions on Spousal Impoverishment etc.

- (1) Where are changes in enforcement of spousal impoverishment? → Private right? Fed. enforcement ^{1902(a)(17) - (a)(4)} _{→ SUBTITLE D BE}
- (2) Family farms -- Is that reference to the family responsibilities §? Adult child's income doesn't count if family income below state median. [Don Johnson / Lefty Carpenter]
- What happens to § 1917 of Title XIX?

(p. 1143)? Repeat? Yes

Susan Hill
690-8170

- (3) NH Quality -- Is the relevant § re no fed. enforcement 2137(f) (p. 256)? [Also Call A. Schneider]

- (4) States ~~do~~ or don't have ICF/MR standards?
→ only stds in fed. regulation - ^{by wiping out Title XIX} fed. stds gone
- Medigant § 2154(e)(1) Only Sec. may compel a state. No ^{Cause} ~~part~~ of action may be filed ag. a state.

p. 1209
§ E of Current Law

- Resp. of Sec. → .. A state w/ a Medigant plan . . .
- But fed. reqs.
- Give auth. to Sec. to do look behind - but must tell state and give state "reas. time to act"



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OFFICE OF THE ASSISTANT SECRETARY FOR LEGISLATION
OFFICE OF HEALTH LEGISLATION**

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TO: SEE BELOW

☒ HOLLY BODE

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☐ SHARON CLARKIN

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☐ NICKY LAWRENCE

DATE: _____

☐ ANDREA LEVARIO

PAGES: 19

(INCLUDING COVER)

☐ JUDY LEWIS

☐ ROGER MCCLUNG

REMARKS: Karen asked that
we send you the following:

☐ MARC SMOLONSKY

☐ DEBRA SPEIGHT

☐ CARL TAYLOR

☐ _____

① Spousal impoverishment

② N.H. quality

③ liens/estate recovery

④ Family responsibility

"(d) **FAMILY PLANNING SERVICES.**—The MediGrant plan shall provide pre-pregnancy planning services and supplies as specified by the State.

"(e) **PREEXISTING CONDITION EXCLUSIONS.**—Notwithstanding any other provision of this title—

"(1) a MediGrant plan may not deny or exclude coverage of any item or service for an eligible individual for benefits under the MediGrant plan for such item or service on the basis of a preexisting condition; and

"(2) if a State contracts or makes other arrangements (through the eligible individual or through another entity) with a capitated health care organization, insurer, or other entity, for the provision of items or services to eligible individuals under the MediGrant plan and the State permits such organization, insurer, or other entity to exclude coverage of a covered item or service on the basis of a preexisting condition, the State shall provide, through its MediGrant plan, for such coverage (through direct payment or otherwise) for any such covered item or service denied or excluded on the basis of a preexisting condition.

"(3) **COVERAGE RESPONSIBILITY.**—A MediGrant plan may not require an individual with a family income below the State median income (as determined by the State) applicable to a family of the same size to contribute to the cost of covered nursing facility care and other long-term care services for the child's parent or guardian.

"(f) **SOLVENCY STANDARDS FOR CAPITATED HEALTH CARE ORGANIZATIONS.**—

"(1) **IN GENERAL.**—A State may not contract with a capitated health care organization, as defined in section 2114(c)(1), for the provision of medical assistance under a MediGrant plan under which the organization is—

"(A) at full financial risk, as defined by the State, unless the organization meets solvency standards established by the State for private health maintenance organizations, or

"(B) is not at such risk, unless the organization meets solvency standards that are established under the MediGrant plan.

"(2) **TREATMENT OF PUBLIC ENTITIES.**—Paragraph (1) shall not apply to an organization that is a public entity or if the solvency of such organization is guaranteed by the State.

"(3) **TRANSITION.**—In the case of a capitated health care organization that as of the date of the enactment of this title has entered into a contract with a State for the provision of medical assistance under title XIX under which the organization assumes full financial risk and is receiving capitation payments, paragraph (1) shall not apply to such organization until 3 years after the date of the enactment of this title.

"SEC. 2112. **SET-ASIDES OF FUNDS.**

"(a) **FOR TARGETED LOW-INCOME FAMILIES.**—

"(1) **IN GENERAL.**—Subject to subsection (f), a MediGrant plan shall provide that the amount of funds expended under the plan for medical assistance for targeted low-income families (as

"(A) to analyze and project health care expenditures and utilization for individuals enrolled (or to be enrolled) in such an organization under the MediGrant plan, and

"(B) to develop capitation payment rates, including a brief description of the general methodologies used by actuaries.

"(2) **QUALIFICATIONS OF ORGANIZATIONS.**—The general qualifications, including any accreditation, State licensure or certification, or provider network standards, required by the State for participation of capitated health care organizations under the MediGrant plan.

"(3) **DISSEMINATION PROCESS.**—The process used by the State under subsection (b) and otherwise to disseminate, before entering into contracts with capitated health care organizations, actuarial information to such organizations on the historical fee-for-service costs (or, if not available, other recent financial data associated with providing covered services) and utilization associated with individuals described in paragraph (1)(A).

"(b) **PUBLIC NOTICE AND COMMENT.**—Under the MediGrant plan the State shall provide a process for providing, before the beginning of each contract year—

"(1) public notice of—

"(A) the amounts of the capitation payments (if any) made under the plan for the contract year preceding the public notice, and

"(B)(i) the information described under subsection (a)(1) with respect to capitation payments for the contract year involved, or (ii) amounts of the capitation payments the State expects to make for the contract year involved, unless such information is designated as proprietary and not subject to public disclosure under State law, and

"(2) an opportunity for receiving public comment on the amounts and information for which notice is provided under paragraph (1).

"(c) **DEFINITIONS.**—In this title:

"(1) **CAPITATED HEALTH CARE ORGANIZATION.**—The term 'capitated health care organization' means a health maintenance organization or any other entity (including a health insuring organization, managed care organization, prepaid health plan, integrated service network, or similar entity) which under State law is permitted to accept capitation payments for providing (or arranging for the provision of) a group of items and services including at least inpatient hospital services and physicians' services.

"(2) **CAPITATION PAYMENT.**—The term 'capitation payment' means, with respect to payment, payment on a prepaid capitation basis or any other risk basis to an entity for the entity's provision (or arranging for the provision) of a group of items and services, including at least inpatient hospital services and physicians' services.

***SEC. 111A. PREVENTING SPOUSAL IMPOVERISHMENT.**

"(a) **SPECIAL TREATMENT FOR INSTITUTIONALIZED SPOUSES.**—

"(1) **SUPERSEDES OTHER PROVISIONS.**—In determining the eligibility for medical assistance of an institutionalized spouse

(as defined in subsection (h)(1)), the provisions of this section supersede any other provision of this title which is inconsistent with them.

"(2) **DOES NOT AFFECT CERTAIN DETERMINATIONS.**—Except as this section specifically provides, this section does not apply to—

"(A) the determination of what constitutes income or resources, or

"(B) the methodology and standards for determining and evaluating income and resources.

"(3) **NO APPLICATION IN COMMONWEALTHS AND TERRITORIES.**—This section shall only apply to a State that is one of the 50 States or the District of Columbia.

"(b) **RULES FOR TREATMENT OF INCOME.**—

"(1) **SEPARATE TREATMENT OF INCOME.**—During any month in which an institutionalized spouse is in the institution, except as provided in paragraph (2), no income of the community spouse shall be deemed available to the institutionalized spouse.

"(2) **ATTRIBUTION OF INCOME.**—In determining the income of an institutionalized spouse or community spouse for purposes of the post-eligibility income determination described in subsection (d), except as otherwise provided in this section and regardless of any State laws relating to community property or the division of marital property, the following rules apply:

"(A) **NON-TRUST PROPERTY.**—Subject to subparagraphs (C) and (D), in the case of income not from a trust, unless the instrument providing the income otherwise specifically provides—

"(i) if payment of income is made solely in the name of the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse,

"(ii) if payment of income is made in the names of the institutionalized spouse and the community spouse, $\frac{1}{2}$ of the income shall be considered available to each of them, and

"(iii) if payment of income is made in the names of the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest (or, if payment is made with respect to both spouses and no such interest is specified, $\frac{1}{2}$ of the joint interest shall be considered available to each spouse).

"(B) **TRUST PROPERTY.**—In the case of a trust—

"(i) except as provided in clause (ii), income shall be attributed in accordance with the provisions of this title; and

"(ii) income shall be considered available to each spouse as provided in the trust, or, in the absence of a specific provision in the trust—

"(1) if payment of income is made solely to the institutionalized spouse or the community spouse,

the income shall be considered available only to that respective spouse.

"(II) if payment of income is made to both the institutionalized spouse and the community spouse, $\frac{1}{2}$ of the income shall be considered available to each of them, and

"(III) if payment of income is made to the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest (or, if payment is made with respect to both spouses and no such interest is specified, $\frac{1}{2}$ of the joint interest shall be considered available to each spouse).

"(C) PROPERTY WITH NO INSTRUMENT.—In the case of income not from a trust in which there is no instrument establishing ownership, subject to subparagraph (D), $\frac{1}{2}$ of the income shall be considered to be available to the institutionalized spouse and $\frac{1}{2}$ to the community spouse.

"(D) REBUTTING OWNERSHIP.—The rules of subparagraphs (A) and (C) are superseded to the extent that an institutionalized spouse can establish, by a preponderance of the evidence, that the ownership interests in income are other than as provided under such subparagraphs.

"(c) RULES FOR TREATMENT OF RESOURCES.—

"(1) COMPUTATION OF SPOUSAL SHARE AT TIME OF INSTITUTIONALIZATION.—

"(A) TOTAL JOINT RESOURCES.—There shall be computed (as of the beginning of the first continuous period of institutionalization of the institutionalized spouse)—

"(i) the total value of the resources to the extent either the institutionalized spouse or the community spouse has an ownership interest, and

"(ii) a spousal share which is equal to $\frac{1}{2}$ of such total value.

"(B) ASSESSMENT.—At the request of an institutionalized spouse or community spouse, at the beginning of the first continuous period of institutionalization of the institutionalized spouse and upon the receipt of relevant documentation of resources, the State shall promptly assess and document the total value described in subparagraph (A)(i) and shall provide a copy of such assessment and documentation to each spouse and shall retain a copy of the assessment for use under this section. If the request is not part of an application for medical assistance under this title, the State may, at its option as a condition of providing the assessment, require payment of a fee not exceeding the reasonable expenses of providing and documenting the assessment. At the time of providing the copy of the assessment, the State shall include a notice indicating that the spouse will have a right to a fair hearing under subsection (e)(2).

"(2) ATTRIBUTION OF RESOURCES AT TIME OF INITIAL ELIGIBILITY DETERMINATION.—In determining the resources of an in-

stitutionalized spouse at the time of application for medical assistance under this title, regardless of any State laws relating to community property or the division of marital property—

"(A) except as provided in subparagraph (B), all the resources held by either the institutionalized spouse, community spouse, or both, shall be considered to be available to the institutionalized spouse, and

"(B) resources shall be considered to be available to an institutionalized spouse, but only to the extent that the amount of such resources exceeds the amount computed under subsection (f)(2)(A) (as of the time of application for medical assistance).

"(3) ASSIGNMENT OF SUPPORT RIGHTS.—The institutionalized spouse shall not be ineligible by reason of resources determined under paragraph (2) to be available for the cost of care where—

"(A) the institutionalized spouse has assigned to the State any rights to support from the community spouse,

"(B) the institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment but the State has the right to bring a support proceeding against a community spouse without such assignment, or

"(C) the State determines that denial of eligibility would work an undue hardship.

"(4) SEPARATE TREATMENT OF RESOURCES AFTER ELIGIBILITY FOR MEDICAL ASSISTANCE ESTABLISHED.—During the continuous period in which an institutionalized spouse is in an institution and after the month in which an institutionalized spouse is determined to be eligible for medical assistance under this title, no resources of the community spouse shall be deemed available to the institutionalized spouse.

"(5) RESOURCES DEFINED.—In this section, the term 'resources' does not include—

"(A) resources excluded under subsection (a) or (d) of section 1613, and

"(B) resources that would be excluded under section 1613(a)(2)(A) but for the limitation on total value described in such section.

"(d) PROTECTING INCOME FOR COMMUNITY SPOUSE.—

"(1) ALLOWANCES TO BE OFFSET FROM INCOME OF INSTITUTIONALIZED SPOUSE.—After an institutionalized spouse is determined or redetermined to be eligible for medical assistance, in determining the amount of the spouse's income that is to be applied monthly to payment for the costs of care in the institution, there shall be deducted from the spouse's monthly income the following amounts in the following order:

"(A) A personal needs allowance (described in paragraph (2)(A)), in an amount not less than the amount specified in paragraph (2)(C).

"(B) A community spouse monthly income allowance (as defined in paragraph (3)), but only to the extent income of the institutionalized spouse is made available to (or for the benefit of) the community spouse.

"(C) A family allowance, for each family member, equal to at least $\frac{1}{3}$ of the amount by which the amount described in paragraph (4)(A)(i) exceeds the amount of the monthly income of that family member.

"(D) Amounts for incurred expenses for medical or remedial care for the institutionalized spouse as provided under paragraph (6).

In subparagraph (C), the term 'family member' only includes minor or dependent children, dependent parents, or dependent siblings of the institutionalized or community spouse who are residing with the community spouse.

"(2) PERSONAL NEEDS ALLOWANCE.—

"(A) IN GENERAL.—The MediGrant plan must provide that, in the case of an institutionalized individual or couple described in subparagraph (B), in determining the amount of the individual's or couple's income to be applied monthly to payment for the cost of care in an institution, there shall be deducted from the monthly income (in addition to other allowances otherwise provided under the plan) a monthly personal needs allowance—

"(i) which is reasonable in amount for clothing and other personal needs of the individual (or couple) while in an institution, and

"(ii) which is not less (and may be greater) than the minimum monthly personal needs allowance described in subparagraph (C).

"(B) INSTITUTIONALIZED INDIVIDUAL OR COUPLE DEFINED.—In this paragraph, the term 'institutionalized individual or couple' means an individual or married couple—

"(i) who is an inpatient (or who are inpatients) in a medical institution or nursing facility for which payments are made under this title throughout a month, and

"(ii) who is or are determined to be eligible for medical assistance under the State MediGrant plan.

"(C) MINIMUM ALLOWANCE.—The minimum monthly personal needs allowance described in this subparagraph is \$40 for an institutionalized individual and \$80 for an institutionalized couple (if both are aged, blind, or disabled, and their incomes are considered available to each other in determining eligibility).

"(3) COMMUNITY SPOUSE MONTHLY INCOME ALLOWANCE DEFINED.—

"(A) IN GENERAL.—In this section (except as provided in subparagraph (B)), the community-spouse monthly income allowance for a community spouse is an amount by which—

"(i) except as provided in subsection (e), the minimum monthly maintenance needs allowance (established under and in accordance with paragraph (4)) for the spouse, exceeds

"(ii) the amount of monthly income otherwise available to the community spouse (determined without regard to such an allowance).

"(B) COURT ORDERED SUPPORT.—If a court has entered an order against an institutionalized spouse for monthly income for the support of the community spouse, the community spouse monthly income allowance for the spouse shall be not less than the amount of the monthly income so ordered.

"(4) ESTABLISHMENT OF MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE.—

"(A) IN GENERAL.—Each State shall establish a minimum monthly maintenance needs allowance for each community spouse which, subject to subparagraph (B), is equal to or exceeds—

"(i) 150 percent of $\frac{1}{12}$ of the poverty line applicable to a family unit of 2 members, plus

"(ii) an excess shelter allowance (as defined in paragraph (4)).

A revision of the poverty line referred to in clause (i) shall apply to medical assistance furnished during and after the second calendar quarter that begins after the date of publication of the revision.

"(B) CAP ON MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE.—The minimum monthly maintenance needs allowance established under subparagraph (A) may not exceed \$1,500 (subject to adjustment under subsections (e) and (g)).

"(5) EXCESS SHELTER ALLOWANCE DEFINED.—In paragraph (4)(A)(ii), the term 'excess shelter allowance' means, for a community spouse, the amount by which the sum of—

"(A) the spouse's expenses for rent or mortgage payment (including principal and interest), taxes and insurance and, in the case of a condominium or cooperative, required maintenance charge, for the community spouse's principal residence, and

"(B) the standard utility allowance (used by the State under section 5(e) of the Food Stamp Act of 1977) or, if the State does not use such an allowance, the spouse's actual utility expenses,

exceeds 30 percent of the amount described in paragraph (4)(A)(i), except that, in the case of a condominium or cooperative, for which a maintenance charge is included under subparagraph (A), any allowance under subparagraph (B) shall be reduced to the extent the maintenance charge includes utility expenses.

"(6) TREATMENT OF INCURRED EXPENSES.—With respect to the post-eligibility treatment of income under this section, there shall be disregarded reparation payments made by the Federal Republic of Germany and, there shall be taken into account amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—

"(A) Medicare and other health insurance premiums, deductibles, or coinsurance, and

"(B) necessary medical or remedial care recognized under State law but not covered under the State MediGrant

plan under this title, subject to reasonable limits the State may establish on the amount of these expenses.

"(e) NOTICE AND HEARING.—

"(1) NOTICE.—Upon—

"(A) a determination of eligibility for medical assistance of an institutionalized spouse, or

"(B) a request by either the institutionalized spouse, or the community spouse, or a representative acting on behalf of either spouse,

each State shall notify both spouses (in the case described in subparagraph (A)) or the spouse making the request (in the case described in subparagraph (B)) of the amount of the community spouse monthly income allowance (described in subsection (d)(1)(B)), of the amount of any family allowances (described in subsection (d)(1)(C)), of the method for computing the amount of the community spouse resources allowance permitted under subsection (f), and of the spouse's right to a hearing under the MediGrant plan respecting ownership or availability of income or resources, and the determination of the community spouse monthly income or resource allowance.

"(2) RESULTS OF HEARING.—

"(A) REVISION OF MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE.—If either such spouse establishes in a hearing under this subsection that the community spouse needs income, above the level otherwise provided by the minimum monthly maintenance needs allowance, due to exceptional circumstances resulting in significant financial distress, there shall be substituted, for the minimum monthly maintenance needs allowance in subsection (d)(2)(A), an amount adequate to provide such additional income as is necessary.

"(B) REVISION OF COMMUNITY SPOUSE RESOURCE ALLOWANCE.—If either such spouse establishes in such a hearing that the community spouse resource allowance (in relation to the amount of income generated by such an allowance) is inadequate to raise the community spouse's income to the minimum monthly maintenance needs allowance, there shall be substituted, for the community spouse resource allowance under subsection (f)(2), an amount adequate to provide such a minimum monthly maintenance needs allowance.

"(f) PERMITTING TRANSFER OF RESOURCES TO COMMUNITY SPOUSE.—

"(1) IN GENERAL.—An institutionalized spouse may, without regard to any other provision of the MediGrant plan to the contrary, transfer an amount equal to the community spouse resource allowance (as defined in paragraph (2)), but only to the extent the resources of the institutionalized spouse are transferred to, or for the sole benefit of, the community spouse. The transfer under the preceding sentence shall be made as soon as practicable after the date of the initial determination of eligibility, taking into account such time as may be necessary to obtain a court order under paragraph (3).

"(2) COMMUNITY SPOUSE RESOURCE ALLOWANCE DEFINED.—In paragraph (1), the 'community spouse resource allowance' for a community spouse is an amount (if any) by which—

"(A) the greatest of—

"(i) \$12,000 (subject to adjustment under subsection (g)), or, if greater (but not to exceed the amount specified in clause (ii)(II)) an amount specified under the State MediGrant plan,

"(ii) the lesser of (I) the spousal share computed under subsection (c)(1), or (II) \$60,000 (subject to adjustment under subsection (g)), or

"(iii) the amount established under subsection (e)(2);

exceeds

"(B) the amount of the resources otherwise available to the community spouse (determined without regard to such an allowance).

"(g) INDEXING DOLLAR AMOUNTS.—For services furnished during a calendar year after 1989, the dollar amounts specified in subsections (d)(3)(C), (f)(2)(A)(i), and (f)(2)(A)(ii)(II) shall be increased by the same percentage as the percentage increase in the consumer price index for all urban consumers (all items; U.S. city average) between September 1988 and the September before the calendar year involved.

"(h) DEFINITIONS.—In this section:

"(1) INSTITUTIONALIZED SPOUSE.—The term 'institutionalized spouse' means an individual—

"(A)(i) who is in a medical institution or nursing facility, or

"(ii) at the option of the State (I) who would be eligible under the MediGrant plan under this title if such individual was in a medical institution, (II) with respect to whom there has been a determination that but for the provision of home or community-based services such individual would require the level of care provided in a hospital, nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the plan, and (III) who will receive home or community-based services pursuant to the plan; and

"(B) is married to a spouse who is not in a medical institution or nursing facility;

but does not include any such individual who is not likely to meet the requirements of subparagraph (A) for at least 30 consecutive days.

"(2) COMMUNITY SPOUSE.—The term 'community spouse' means the spouse of an institutionalized spouse.

"SEC. 2111. STATE FLEXIBILITY IN BENEFITS, PROVIDER PAYMENTS, GEOGRAPHICAL COVERAGE AREA, AND SELECTION OF PROVIDERS.—

Nothing in this title (other than subsections (c) and (d) of section 2111) shall be construed as requiring a State—

"(1) to provide medical assistance for any particular items or services,

an employer may withhold less than such employee's share of such premiums.

"(D) A law that prohibits an insurer from imposing requirements on a State agency, which has been assigned the rights of an individual eligible for medical assistance under this title and covered for health benefits from the insurer, that are different from requirements applicable to an agent or assignee of any other individual so covered.

"(E) A law that requires an insurer, in any case in which a child has health coverage through the insurer of a noncustodial parent—

"(i) to provide such information to the custodial parent as may be necessary for the child to obtain benefits through such coverage,

"(ii) to permit the custodial parent (or provider, with the custodial parent's approval) to submit claims for covered services without the approval of the noncustodial parent, and

"(iii) to make payment on claims submitted in accordance with clause (ii) directly to such custodial parent, the provider, or the State agency.

"(F) A law that permits the State agency under this title to garnish the wages, salary, or other employment income of, and requires withholding amounts from State tax refunds to, any person who—

"(i) is required by court or administrative order to provide coverage of the costs of health services to a child who is eligible for medical assistance under this title,

"(ii) has received payment from a third party for the costs of such services to such child, but

"(iii) has not used such payments to reimburse, as appropriate, either the other parent or guardian of such child or the provider of such services,

to the extent necessary to reimburse the State agency for expenditures for such costs under its plan under this title, but any claims for current or past-due child support shall take priority over any such claims for the costs of such services.

"(2) **DEFINITION.**—For purposes of this subsection, the term 'insurer' includes a group health plan, as defined in section 607(1) of the Employee Retirement Income Security Act of 1974, a health maintenance organization, and an entity offering a service benefit plan.

"(g) **ESTATE RECOVERIES AND LIENS PERMITTED.**—A State may take such actions as it considers appropriate to adjust or recover from the individual or the individual's estate any amounts paid as medical assistance to or on behalf of the individual under the MediGrant plan, including through the imposition of liens against the property or estate of the individual.

SEC. 1136. ASSIGNMENT OF RIGHTS OF PAYMENT.

"(a) **IN GENERAL.**—For the purpose of assisting in the collection of medical support payments and other payments for medical care owed to recipients of medical assistance under the MediGrant plan, each MediGrant plan shall—

"(1) provide that, as a condition of eligibility for medical assistance under the plan to an individual who has the legal capacity to execute an assignment for himself, the individual is required—

"(A) to assign the State any rights, of the individual or of any other person who is eligible for medical assistance under the plan and on whose behalf the individual has the legal authority to execute an assignment of such rights, support (specified as support for the purpose of medical care by a court or administrative order) and to payment for medical care from any third party,

"(B) to cooperate with the State (i) in establishing the paternity of such person (referred to in subparagraph (A) if the person is a child born out of wedlock, and (ii) in obtaining support and payments (described in subparagraph (A)) for himself and for such person, unless (in either case) the individual is a pregnant woman or the individual is found to have good cause for refusing to cooperate as determined by the State, and

"(C) to cooperate with the State in identifying, and providing information to assist the State in pursuing, any third party who may be liable to pay for care and services available under the plan, unless such individual has good cause for refusing to cooperate as determined by the State, and

"(2) provide for entering into cooperative arrangements, including financial arrangements, with any appropriate agency of any State (including, with respect to the enforcement and collection of rights of payment for medical care by or through a parent, with a State's agency established or designated under section 454(3)) and with appropriate courts and law enforcement officials, to assist the agency or agencies administering the plan with respect to—

"(A) the enforcement and collection of rights to support or payment assigned under this section, and

"(B) any other matters of common concern.

"(b) **USE OF AMOUNTS COLLECTED.**—Such part of any amount collected by the State under an assignment made under the provisions of this section shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of an individual with respect to whom such assignment was executed (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing of such medical assistance), and the remainder of such amount collected shall be paid to such individual.

SEC. 1137. QUALITY ASSURANCE REQUIREMENTS FOR NURSING FACILITIES.

"(a) **NURSING FACILITY DEFINED.**—In this title, the term 'nursing facility' means an institution (or a distinct part of an institution) which—

"(1) is primarily engaged in providing to residents—

"(A) skilled nursing care and related services for residents who require medical or nursing care,

"(B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or

"(C) on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities,

and is not primarily for the care and treatment of mental diseases;

"(2) has in effect a transfer agreement (meeting the requirements of section 1861(l) with one or more hospitals having agreements in effect under section 1866; and

"(3) meets the requirements for a nursing facility described in subsections (b), (c), and (d) of this section.

Such term also includes any facility which is located in a State on an Indian reservation and is certified by the Secretary as meeting the requirements of paragraph (1) and subsections (b), (c), and (d).

"(b) REQUIREMENTS RELATING TO PROVISION OF SERVICES.—

"(1) QUALITY OF LIFE.—

"(A) IN GENERAL.—A nursing facility must care for its residents in such a manner and in such an environment as will reasonably promote maintenance or enhancement of the quality of life of each resident.

"(B) QUALITY ASSESSMENT AND ASSURANCE.—A nursing facility must maintain a quality assessment and assurance committee, consisting of the director of nursing services, a physician designated by the facility, and at least 3 other members of the facility's staff, which (i) meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary and (ii) develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this subparagraph.

"(2) SCOPE OF SERVICES AND ACTIVITIES UNDER PLAN OF CARE.—A nursing facility must provide services and activities in accordance with a written plan of care which—

"(A) describes the medical, nursing, and psychosocial needs of the resident and how such needs will be met;

"(B) is initially prepared, with the participation to the extent practicable of the resident or the resident's family or legal representative, by a team which includes the resident's attending physician and a registered professional nurse with responsibility for the resident; and

"(C) is periodically reviewed and revised by such team after each assessment under paragraph (3).

"(3) RESIDENTS' ASSESSMENT.—

"(A) REQUIREMENT.—A nursing facility must conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity, which assessment—

"(i) describes the resident's capability to perform daily life functions and significant impairments in functional capacity;

"(ii) uses an instrument which is specified by the State under subsection (c)(5); and

"(iii) includes the identification of medical problems.

"(B) CERTIFICATION.—

"(i) IN GENERAL.—Each such assessment must be conducted or coordinated (with the appropriate participation of health professionals) by a registered professional nurse who signs and certifies the completion of the assessment. Each individual who completes a portion of such an assessment shall sign and certify as to the accuracy of that portion of the assessment.

"(ii) PENALTY FOR FALSIFICATION.—

"(I) An individual who willfully and knowingly certifies under clause (i) a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 with respect to each assessment.

"(II) An individual who willfully and knowingly causes another individual to certify under clause (i) a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 with respect to each assessment.

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

"(iii) USE OF INDEPENDENT ASSESSORS.—If a State determines, under a survey under subsection (g) or otherwise, that there has been a knowing and willful certification of false assessments under this paragraph, the State may require (for a period specified by the State) that resident assessments under this paragraph be conducted and certified by individuals who are independent of the facility and who are approved by the State.

"(C) FREQUENCY.—

"(i) IN GENERAL.—Such an assessment must be conducted—

"(I) promptly upon (but no later than 14 days after the date of) admission for each individual admitted;

"(II) promptly after a significant change in the resident's physical or mental condition; and

"(III) in no case less often than once every 12 months.

"(ii) RESIDENT REVIEW.—The nursing facility must examine each resident no less frequently than once every 3 months and, as appropriate, revise the resi-

dent's assessment to assure the continuing accuracy of the assessment.

"(D) **USE.**—The results of such an assessment shall be used in developing, reviewing, and revising the resident's plan of care under paragraph (2).

"(E) **COORDINATION.**—Such assessments shall be coordinated with any State-required preadmission screening program to the maximum extent practicable in order to avoid duplicative testing and effort. In addition, a nursing facility shall notify the State mental health authority or State mental retardation or developmental disability authority, as applicable, promptly after a significant change in the physical or mental condition of a resident who is mentally ill or mentally retarded.

"(4) **PROVISION OF SERVICES AND ACTIVITIES.**—

"(A) **IN GENERAL.**—To the extent needed to fulfill all plans of care described in paragraph (2), a nursing facility must provide (or arrange for the provision of)—

"(i) nursing and related services and specialized rehabilitative services;

"(ii) medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of residents;

"(iii) pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of residents;

"(iv) dietary services that assure that the meals meet the daily nutritional and special dietary needs of residents;

"(v) an on-going program, directed by a qualified professional, of activities designed to meet the interests and the physical, mental, and psychosocial well-being of residents; and

"(vi) routine dental services (to the extent covered under the State MediGrant plan) and emergency dental services to meet the needs of residents.

The services provided or arranged by the facility must meet professional standards of quality.

"(B) **QUALIFIED PERSONS PROVIDING SERVICES.**—Services described in clauses (i), (ii), (iii), (iv), and (vi) of subparagraph (A) must be provided by qualified persons in accordance with each resident's written plan of care.

"(C) **REQUIRED NURSING CARE; FACILITY WAIVERS.**—

"(i) **GENERAL REQUIREMENTS.**—A nursing facility—

"(I) except as provided in clause (ii), must provide 24-hour licensed nursing services which are sufficient to meet the nursing needs of its residents, and

"(II) except as provided in clause (ii), must use the services of a registered professional nurse for at least 8 consecutive hours a day, 7 days a week.

"(ii) **WAIVER BY STATE.**—To the extent that a facility is unable to meet the requirements of clause (i), a

State may waive such requirements with respect to the facility if—

"(I) the facility demonstrates to the satisfaction of the State that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel,

"(II) the State determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility,

"(III) the State finds that, for any such periods in which licensed nursing services are not available, a registered professional nurse or a physician is obligated to respond immediately to telephone calls from the facility,

"(IV) the State agency granting a waiver of such requirements provides notice of the waiver to the State long-term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965) and the protection and advocacy system in the State for the mentally ill and the mentally retarded, and

"(V) the nursing facility that is granted such a waiver by a State notifies residents of the facility (or, where appropriate, the guardians or legal representatives of such residents) and members of their immediate families of the waiver.

A waiver under this clause shall be subject to annual review and to the review of the Secretary and subject to clause (iii) shall be accepted by the Secretary for purposes of this title to the same extent as is the State's certification of the facility. In granting or renewing a waiver, a State may require the facility to use other qualified, licensed personnel.

"(iii) **ASSUMPTION OF WAIVER AUTHORITY BY SECRETARY.**—If the Secretary determines that a State has shown a clear pattern and practice of allowing waivers in the absence of diligent efforts by facilities to meet the staffing requirements, the Secretary shall assume and exercise the authority of the State to grant waivers.

"(5) **REQUIRED TRAINING OF NURSE AIDES.**—

"(A) **IN GENERAL.**—(i) Except as provided in clause (ii), a nursing facility must not use on a full-time basis any individual as a nurse aide in the facility, for more than 4 months unless the individual—

"(I) has completed a training and competency evaluation program, or a competency evaluation program, approved by the State under subsection (e)(1)(A), and

"(II) is competent to provide nursing or nursing-related services.

"(ii) A nursing facility must not use on a temporary, per diem, leased, or on any other basis other than as a permanent employee any individual as a nurse aide in the fa-

cility, unless the individual meets the requirements described in clause (i).

"(B) OFFERING COMPETENCY EVALUATION PROGRAMS FOR CURRENT EMPLOYEES.—A nursing facility must provide, for individuals used as a nurse aide by the facility, for a competency evaluation program approved by the State under subsection (e)(1) and such preparation as may be necessary for the individual to complete such a program.

"(C) COMPETENCY.—The nursing facility must not permit an individual, other than in a training and competency evaluation program approved by the State, to serve as a nurse aide or provide services of a type for which the individual has not demonstrated competency and must not use such an individual as a nurse aide unless the facility has inquired of any State registry established under subsection (e)(2)(A) that the facility believes will include information concerning the individual.

"(D) RE-TRAINING REQUIRED.—For purposes of subparagraph (A), if, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual performed nursing or nursing-related services for monetary compensation, such individual shall complete a new training and competency evaluation program, or a new competency evaluation program.

"(E) REGULAR IN-SERVICE EDUCATION.—The nursing facility must provide such regular performance review and regular in-service education as assures that individuals used as nurse aides are competent to perform services as nurse aides, including training for individuals providing nursing and nursing-related services to residents with cognitive impairments.

"(F) NURSE AIDE DEFINED.—In this paragraph, the term 'nurse aide' means any individual providing nursing or nursing-related services to residents in a nursing facility, but does not include an individual—

"(i) who is a licensed health professional (as defined in subparagraph (G)) or a registered dietician,

"(ii) who volunteers to provide such services without monetary compensation, or

"(iii) who is trained, whether compensated or not, to perform a task-specific function which assists residents in their daily activities.

"(G) LICENSED HEALTH PROFESSIONAL DEFINED.—In this paragraph, the term 'licensed health professional' means a physician, physician assistant, nurse practitioner, physical, speech, or occupational therapist, physical or occupational therapy assistant, registered professional nurse, licensed practical nurse, or licensed or certified social worker.

"(6) PHYSICIAN SUPERVISION AND CLINICAL RECORDS.—A nursing facility must—

"(A) require that the health care of every resident be provided under the supervision of a physician (or, at the option of a State, under the supervision of a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician);

"(B) provide for having a physician available to furnish necessary medical care in case of emergency; and

"(C) maintain clinical records on all residents, which records include the plans of care (described in paragraph (2)) and the residents' assessments (described in paragraph (3)).

"(c) REQUIREMENTS RELATING TO RESIDENTS' RIGHTS.—

"(1) GENERAL RIGHTS.—

"(A) SPECIFIED RIGHTS.—A nursing facility must protect and promote the rights of each resident, including each of the following rights:

"(i) FREE CHOICE.—The right to choose a personal attending physician, to be fully informed in advance about care and treatment, to be fully informed in advance of any changes in care or treatment that may affect the resident's well-being, and (except with respect to a resident adjudged incompetent) to participate in planning care and treatment or changes in care and treatment.

"(ii) FREE FROM RESTRAINTS.—The right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. Restraints may only be imposed—

"(I) to ensure the physical safety of the resident or other residents, and

"(II) only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances specified by the Secretary until such an order could reasonably be obtained).

"(iii) PRIVACY.—The right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of resident groups.

"(iv) CONFIDENTIALITY.—The right to confidentiality of personal and clinical records and to access to current clinical records of the resident upon request by the resident or the resident's legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request.

"(v) ACCOMMODATION OF NEEDS.—The right—

"(I) to reside and receive services with reasonable accommodation of individual needs and preferences, except where the health or safety of the in-

dividual or other residents would be endangered, and

"(II) to receive notice before the room or roommate of the resident in the facility is changed unless a delay in changing the room or roommate while notice is given would endanger the resident or others.

"(vi) GRIEVANCES.—The right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances and the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

"(vii) PARTICIPATION IN RESIDENT AND FAMILY GROUPS.—The right of the resident to organize and participate in resident groups in the facility and the right of the resident's family to meet in the facility with the families of other residents in the facility.

"(viii) PARTICIPATION IN OTHER ACTIVITIES.—The right of the resident to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.

"(ix) EXAMINATION OF SURVEY RESULTS.—The right to examine, upon reasonable request, the results of the most recent survey of the facility conducted by the Secretary or a State with respect to the facility and any plan of correction in effect with respect to the facility.

"(x) OTHER RIGHTS.—Any other right established by the Secretary.

Clause (iii) shall not be construed as requiring the provision of a private room.

"(B) NOTICE OF RIGHTS.—A nursing facility must—

"(i) inform each resident, orally and in writing at the time of admission to the facility, of the resident's legal rights during the stay at the facility and of the requirements and procedures for establishing eligibility for medical assistance under this title, including the right to request an assessment under section 2115(c)(1)(B);

"(ii) make available to each resident, upon reasonable request, a written statement of such rights (which statement is updated upon changes in such rights) including the notice (if any) of the State developed under subsection (e)(6);

"(iii) inform each resident who is entitled to medical assistance under this title—

"(I) at the time of admission to the facility or, if later, at the time the resident becomes eligible for such assistance, of the items and services that are included in nursing facility services under the State MediGrant plan and for which the resident may not be charged, and of those other items and services that the facility offers and for which the

resident may be charged and the amount of the charges for such items and services, and

"(II) of changes in the items and services described in subclause (I) and of changes in the charges imposed for items and services described in that subclause; and

"(iv) inform each other resident, in writing before or at the time of admission and periodically during the resident's stay, of services available in the facility and of related charges for such services, including any charges for services not covered under title XVIII or by the facility's basic per diem charge.

The written description of legal rights under this subparagraph shall include a description of the protection of personal funds under paragraph (6) and a statement that a resident may file a complaint with a State survey and certification agency respecting resident abuse and neglect and misappropriation of resident property in the facility.

"(C) RIGHTS OF INCOMPETENT RESIDENTS.—In the case of a resident adjudged incompetent under the laws of a State, the rights of the resident under this title shall devolve upon, and, to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the resident's behalf.

"(D) USE OF PSYCHOPHARMACOLOGIC DRUGS.—Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the written plan of care described in paragraph (2)) designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually an independent, external consultant reviews the appropriateness of the drug plan of each resident receiving such drugs.

"(2) TRANSFER AND DISCHARGE RIGHTS.—

"(A) IN GENERAL.—A nursing facility must permit each resident to remain in the facility and must not transfer or discharge the resident from the facility unless—

"(i) the transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility;

"(ii) the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

"(iii) the safety of individuals in the facility is endangered;

"(iv) the health of individuals in the facility would otherwise be endangered;

"(v) the resident has failed, after reasonable and appropriate notice, to pay (or to have paid under this title or title XVIII on the resident's behalf) for a stay at the facility; or

"(vi) the facility ceases to operate.

In each of the cases described in clauses (i) through (iv), the basis for the transfer or discharge must be documented in the resident's clinical record. In the cases described in clauses (i) and (ii), the documentation must be made by the resident's physician, and in the case described in clause (iv) the documentation must be made by a physician. For purposes of clause (v), in the case of a resident who becomes eligible for assistance under this title after admission to the facility, only charges which may be imposed under this title shall be considered to be allowable.

"(B) PRE-TRANSFER AND PRE-DISCHARGE NOTICE.—

"(i) IN GENERAL.—Before effecting a transfer or discharge of a resident, a nursing facility must—

"(I) notify the resident (and, if known, an immediate family member of the resident or legal representative) of the transfer or discharge and the reasons therefor;

"(II) record the reasons in the resident's clinical record (including any documentation required under subparagraph (A)), and

"(III) include in the notice the items described in clause (iii).

"(ii) TIMING OF NOTICE.—The notice under clause (i)(I) must be made at least 30 days in advance of the resident's transfer or discharge except—

"(I) in a case described in clause (iii) or (iv) of subparagraph (A);

"(II) in a case described in clause (ii) of subparagraph (A), where the resident's health improves sufficiently to allow a more immediate transfer or discharge;

"(III) in a case described in clause (i) of subparagraph (A), where a more immediate transfer or discharge is necessitated by the resident's urgent medical needs;

"(IV) in a case where a resident has not resided in the facility for 30 days; or

"(V) in a case where the provision of a 30-day notice would be impossible or impracticable.

In the case of such exceptions, notice must be given as many days before the date of the transfer or discharge as is practicable.

"(iii) ITEMS INCLUDED IN NOTICE.—Each notice under clause (i) must include—

"(I) notice of the resident's right to appeal the transfer or discharge under the State process established under subsection (e)(3);

"(II) the name, mailing address, and telephone number of the State long-term care ombudsman (established under title III or VII of the Older Americans Act of 1965);

"(III) in the case of residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection

and advocacy system for developmentally disabled individuals established under part C of the Developmental Disabilities Assistance and Bill of Rights Act; and

"(IV) in the case of mentally ill residents (as defined in subsection (e)(7)(G)(i)), the mailing address and telephone number of the agency responsible for the protection and advocacy system for mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.

"(iv) EXCEPTION.—This subparagraph shall not apply to a voluntary transfer or discharge or a transfer or discharge necessitated by a medical emergency.

"(C) ORIENTATION.—A nursing facility must provide reasonable preparation and orientation to residents to promote safe and orderly transfer or discharge from the facility.

"(D) NOTICE ON BED-HOLD POLICY AND READMISSION.—

"(i) NOTICE BEFORE TRANSFER.—Before a resident of a nursing facility is transferred for hospitalization or therapeutic leave, a nursing facility must provide written information to the resident and an immediate family member or legal representative concerning—

"(I) the provisions of the State MediGrant plan under this title regarding the period (if any) during which the resident will be permitted under the State MediGrant plan to return and resume residence in the facility, and

"(II) the policies of the facility regarding such a period, which policies must be consistent with clause (iii).

"(ii) NOTICE UPON TRANSFER.—At the time of transfer of a resident to a hospital or for therapeutic leave, a nursing facility must provide written notice to the resident and an immediate family member or legal representative of the duration of any period described in clause (i).

"(iii) PERMITTING RESIDENT TO RETURN.—A nursing facility must establish and follow a written policy under which a resident—

"(I) who is eligible for medical assistance for nursing facility services under a State MediGrant plan,

"(II) who is transferred from the facility for hospitalization or therapeutic leave, and

"(III) whose hospitalization or therapeutic leave exceeds a period paid for under the State MediGrant plan for the holding of a bed in the facility for the resident,

will be permitted to be readmitted to the facility immediately upon the first availability of a bed in a room (not including a private room) in the facility if, at the

time of readmission, the resident requires the services provided by the facility.

"(3) ACCESS AND VISITATION RIGHTS.—A nursing facility must—

"(A) permit immediate access to any resident by any representative of the Secretary, by any representative of the State, by an ombudsman or agency described in subclause (II), (III), or (IV) of paragraph (2)(B)(iii), or by the resident's individual physician;

"(B) permit immediate access to a resident, subject to the resident's right to deny or withdraw consent at any time, by immediate family or other relatives of the resident;

"(C) permit immediate access to a resident, subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, by others who are visiting with the consent of the resident, unless such access would endanger the health or safety of the resident or others in the facility;

"(D) permit reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and

"(E) permit representatives of the State ombudsman (described in paragraph (2)(B)(iii)(II)), with the permission of the resident (or the resident's legal representative) and consistent with State law, to examine a resident's clinical records.

"(4) EQUAL ACCESS TO QUALITY CARE.—

"(A) IN GENERAL.—A nursing facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services required under the State MediGrant plan for all individuals regardless of source of payment.

"(B) CONSTRUCTION.—

"(i) NOTHING PROHIBITING ANY CHARGES FOR NON-MEDIGRANT PATIENTS.—Subparagraph (A) shall not be construed as prohibiting a nursing facility from charging any amount for services furnished, consistent with the notice in paragraph (1)(B) describing such charges.

"(ii) NO ADDITIONAL SERVICES REQUIRED.—Subparagraph (A) shall not be construed as requiring a State to offer additional services on behalf of a resident than are otherwise provided under the State MediGrant plan.

"(5) PROTECTION OF RESIDENT FUNDS.—

"(A) IN GENERAL.—The nursing facility—

"(i) may not require residents to deposit their personal funds with the facility, and

"(ii) upon the written authorization of the resident, must hold, safeguard, and account for such personal funds under a system established and maintained by the facility in accordance with this paragraph.

"(B) MANAGEMENT OF PERSONAL FUNDS.—Upon written authorization of a resident under subparagraph (A)(ii), the

facility must manage and account for the personal funds of the resident deposited with the facility as follows:

"(i) DEPOSIT.—The facility must deposit any amount of personal funds in excess of \$250 with respect to a resident in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts and credits all interest earned on such separate account to such account. With respect to any other personal funds, the facility must maintain such funds in a non-interest bearing account or petty cash fund.

"(ii) ACCOUNTING AND RECORDS.—The facility must assure a full and complete accounting of each such resident's personal funds, maintain a written record of all financial transactions involving the personal funds of a resident deposited with the facility, and afford the resident (or a legal representative of the resident) reasonable access to such record.

"(iii) CONVEYANCE UPON DEATH.—Upon the death of a resident with such an account, the facility must convey promptly the resident's personal funds (and a final accounting of such funds) to the individual administering the resident's estate. All other personal property, including medical records, shall be considered part of the resident's estate and shall only be released to the administrator of the estate.

"(C) ASSURANCE OF FINANCIAL SECURITY.—The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the State, to assure the security of all personal funds of residents deposited with the facility.

"(D) LIMITATION ON CHARGES TO PERSONAL FUNDS.—The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under this title or title XVIII.

"(E) LIMITATION ON CHARGES IN CASE OF MEDIGRANT-ELIGIBLE INDIVIDUALS.—A nursing facility may not impose charges, for certain MediGrant-eligible individuals for nursing facility services covered by the State under its plan under this title, that exceed the payment amounts established by the State for such services under this title.

"(F) POSTING OF SURVEY RESULTS.—A nursing facility must post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility conducted under subsection (g).

"(d) REQUIREMENTS RELATING TO ADMINISTRATION AND OTHER MATTERS.—

"(1) ADMINISTRATION.—

"(A) IN GENERAL.—A nursing facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident (consistent with requirements established under subsection (f)(5)).

"(B) REQUIRED NOTICES.—*If a change occurs in—*

"(i) the persons with an ownership or control interest (as defined in section 1124(a)(3)) in the facility,

"(ii) the persons who are officers, directors, agents, or managing employees (as defined in section 1126(b)) of the facility,

"(iii) the corporation, association, or other company responsible for the management of the facility, or

"(iv) the individual who is the administrator or director of nursing of the facility,

the nursing facility must provide notice to the State agency responsible for the licensing of the facility, at the time of the change, of the change and of the identity of each new person, company, or individual described in the respective clause.

"(C) NURSING FACILITY ADMINISTRATOR.—*The administrator of a nursing facility, whether freestanding or hospital-based, must meet such standards as are established by the Secretary.*

"(2) LICENSING AND LIFE SAFETY CODE.—

"(A) LICENSING.—*A nursing facility must be licensed under applicable State and local law.*

"(B) LIFE SAFETY CODE.—*A nursing facility must meet such provisions of such edition (as specified by the Secretary in regulation) of the Life Safety Code of the National Fire Protection Association as are applicable to nursing homes; except that—*

"(i) the Secretary may waive, for such periods as he deems appropriate, specific provisions of such Code which if rigidly applied would result in unreasonable hardship upon a facility, but only if such waiver would not adversely affect the health and safety of residents or personnel; and

"(ii) the provisions of such Code shall not apply in any State if the Secretary finds that in such State there is in effect a fire and safety code, imposed by State law, which adequately protects residents of and personnel in nursing facilities.

"(3) SANITARY AND INFECTION CONTROL AND PHYSICAL ENVIRONMENT.—*A nursing facility must—*

"(A) establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in which residents reside and to help prevent the development and transmission of disease and infection, and

"(B) be designed, constructed, equipped, and maintained in a manner to protect the health and safety of residents, personnel, and the general public.

"(4) MISCELLANEOUS.—

"(A) COMPLIANCE WITH FEDERAL, STATE, AND LOCAL LAWS AND PROFESSIONAL STANDARDS.—*A nursing facility, whether freestanding or hospital-based, must operate and provide services in compliance with all applicable Federal, State, and local laws and regulations (including the re-*

quirements of section 1124) and with accepted professional standards and principles which apply to professionals providing services in such a facility.

"(B) OTHER.—*A nursing facility must meet such other requirements relating to the health and safety of residents or relating to the physical facilities thereof as the Secretary may find necessary.*

"(e) STATE REQUIREMENTS RELATING TO NURSING FACILITY REQUIREMENTS.—*A State with a MediGrant plan shall provide for the following:*

"(1) SPECIFICATION AND REVIEW OF NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAMS AND OF NURSE AIDE COMPETENCY EVALUATION PROGRAMS.—*The State must—*

"(A) specify those training and competency evaluation programs, and those competency evaluation programs, that the State approves for purposes of subsection (b)(5); and that meet the requirements established under subsection (f)(2), and

"(B) provide for the review and reapproval of such programs, at a frequency and using a methodology consistent with the requirements established under subsection (f)(2)(A)(iii).

"(2) NURSE AIDE REGISTRY.—

"(A) IN GENERAL.—*The State shall establish and maintain a registry of all individuals who have satisfactorily completed a nurse aide training and competency evaluation program, or a nurse aide competency evaluation program, approved under paragraph (1) in the State, or any individual described in subsection (f)(2)(B)(ii) or in subparagraph (B), (C), or (D) of section 6901(b)(4) of the Omnibus Budget Reconciliation Act of 1989.*

"(B) INFORMATION IN REGISTRY.—*The registry under subparagraph (A) shall provide for the inclusion of specific documented findings by a State under subsection (g)(1)(C) of resident neglect or abuse or misappropriation of resident property involving an individual listed in the registry, as well as any brief statement of the individual disputing the findings. The State shall make available to the public information in the registry. In the case of inquiries to the registry concerning an individual listed in the registry, any information disclosed concerning such a finding shall also include disclosure of any such statement in the registry relating to the finding or a clear and accurate summary of such a statement.*

"(C) PROHIBITION AGAINST CHARGES.—*A State may not impose any charges on a nurse aide relating to the registry established and maintained under subparagraph (A).*

"(3) STATE APPEALS PROCESS FOR TRANSFERS AND DISCHARGES.—*The State must provide for a fair mechanism, meeting the guidelines established under subsection (f)(3), for hearing appeals on transfers and discharges of residents of such facilities.*

"(4) NURSING FACILITY ADMINISTRATOR STANDARDS.—*The State must implement and enforce the nursing facility admini-*

trator standards developed under subsection (f)(4) respecting the qualification of administrators of nursing facilities. Any such standards promulgated shall apply to administrators of hospital-based facilities as well as administrators of freestanding facilities.

"(5) SPECIFICATION OF RESIDENT ASSESSMENT INSTRUMENT.—The State shall specify the instrument to be used by nursing facilities in the State in complying with the requirement of subsection (b)(3)(A)(iii).

"(6) NOTICE OF MEDIGRANT RIGHTS.—Each State shall develop (and periodically update) a written notice of the rights and obligations of residents of nursing facilities (and spouses of such residents) under this title.

"(7) STATE REQUIREMENTS FOR PREADMISSION SCREENING AND RESIDENT REVIEW.—

"(A) PREADMISSION SCREENING.—

"(i) IN GENERAL.—The State must have in effect a preadmission screening program, for identifying mentally ill and mentally retarded individuals (as defined in subparagraph (B)) who are admitted to nursing facilities.

"(ii) STATE REQUIREMENT FOR RESIDENT REVIEW.—The State shall notify the State mental health authority or the State mental retardation or developmental disability authority, as appropriate, of the individuals so identified.

"(B) DEFINITIONS.—In this paragraph:

"(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.

"(f) RESPONSIBILITIES RELATING TO NURSING FACILITY REQUIREMENTS.—

"(1) GENERAL RESPONSIBILITY.—It is the duty and responsibility of a State with a MediGrant plan under this title to assure that requirements which govern the provision of care in nursing facilities under the plan, 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 money.

"(2) REQUIREMENTS FOR NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAMS AND FOR NURSE AIDE COMPETENCY EVALUATION PROGRAMS.—For purposes of subsections (b)(5) and (e)(1)(A), the State shall establish—

"(A) 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 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, (iii) qualifications of instructors, and (iv) procedures for determination of competency;

"(B) 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;

"(C) 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

"(D) 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, and

"(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.

"(3) QUALIFICATION OF ADMINISTRATORS.—For purposes of subsections (d)(1)(C) and (e)(4), the State shall develop standards to be applied in assuring the qualifications of administrators of nursing facilities. Any such standards must apply to administrators of hospital-based facilities as well as administrators of freestanding facilities.

"(g) SURVEY AND CERTIFICATION PROCESS.—

"(1) STATE AND FEDERAL RESPONSIBILITY.—

"(A) IN GENERAL.—Under each State MediGrant plan under this title, the State shall be responsible for certifying, in accordance with surveys conducted under paragraph (2), the compliance of nursing facilities 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) 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.

"(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 conducted 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 State shall take all reasonable steps to avoid giving notice of such a survey through the scheduling procedures and the conduct of the surveys themselves.

"(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 24 months after the date of the previous standard sur-

vey conducted under this subparagraph, 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 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 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 the protocol which the Secretary has developed, tested, and validated, as of the date of the enactment of this title, and

"(ii) by individuals, of a survey team, who meet such minimum qualifications as the State establishes.

"(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.

"(3) **VALIDATION SURVEYS.**—

"(A) **IN GENERAL.**—The Secretary shall conduct onsite surveys of a representative sample of nursing facilities in each State, within 4 months of the date of surveys conducted under paragraph (2) by the State, in a sufficient number to allow inferences about the adequacy 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) at least every third 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.

"(C) **SPECIAL SURVEYS OF COMPLIANCE.**—Where the Secretary has found substantial evidence of a pattern of noncompliance by 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 determinations concerning the extent to which the nursing facility meets such requirements.

"(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.

"(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 a reasonable time 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 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 MediGrant fraud and abuse control unit (established under section 2134) 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)—

"(A) the State shall require the facility to correct the deficiency involved;

"(B) if the State finds that the facility's deficiencies 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 MediGrant plan and may provide, in addition, for one or more of the other remedies described in paragraph (2); and

"(C) if the State finds that the facility's deficiencies do not immediately jeopardize the health or safety of its residents, the State may—

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

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

"(iii) do both.

"(2) SPECIFIED REMEDIES.—

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

"(i) Denial of payment under the State MediGrant 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).

"(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.

"(B) ALTERNATIVE REMEDIES.—A State may establish alternative remedies to the remedies described in 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.

"(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 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 sec-

tion 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).

"(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 accrediting entity meets standards under subparagraph (A) unless such entity applies standards for accreditation for facilities that meet or exceed the requirements of this section.

"**SEC. 2138. OTHER PROVISIONS PROMOTING PROGRAM INTEGRITY.**

"(a) **PUBLIC ACCESS TO SURVEY RESULTS.**—Each MediGrant plan shall provide that upon completion of a survey of any health care facility or organization by a State agency to carry out the plan, the agency shall make public in readily available form and place the pertinent findings of the survey relating to the compliance of the facility or organization with requirements of law.

"(b) **RECORD KEEPING.**—Each MediGrant plan shall provide for agreements with persons or institutions providing services under the plan under which the person or institution agrees—

"(1) to keep such records, including ledgers, books, and original evidence of costs, as are necessary to fully disclose the extent of the services provided to individuals receiving assistance under the plan, and

"(2) to furnish the State agency with such information regarding any payments claimed by such person or institution for providing services under the plan, as the State agency may from time to time request.

"(c) **QUALITY ASSURANCE.**—Each MediGrant plan shall provide a program to assure the quality of services provided under the plan, including such services provided to individuals with chronic mental or physical illness.

"**PART E—ESTABLISHMENT AND AMENDMENT OF MEDIGRANT PLANS**

"**SEC. 2151. SUBMITTAL AND APPROVAL OF MEDIGRANT PLANS.**

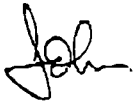
"(a) **SUBMITTAL.**—As a condition of receiving funding under part C, each State shall submit to the Secretary a MediGrant plan that meets the applicable requirements of this title.

"(b) **APPROVAL.**—Except as the Secretary may provide under section 2154, a MediGrant plan submitted under subsection (a)—

"(1) shall be approved for purposes of this title, and

"(2) shall be effective beginning with a calendar quarter that is specified in the plan, but in no case earlier than the first

November 30, 1995

TO: Jennifer Klein
FROM: John Spiegel 
SUBJECT: Spousal Impoverishment

I have attached legislative language on spousal impoverishment from three different sources:

- o the conference bill (pages 1-7)
- o section 1614 of the Social Security Act (current law referenced by the conference agreement; pages 8-11), and
- O section 1924 of the current law Medicaid statute (pages 12-19).

Herc's the way this works.

The Republicans, in response to our criticisms, added the current law provisions dealing with spousal impoverishment into the conference bill. These provisions incorporate by reference certain provisions of the Social Security Act that deal with assets and property (section 1614). Together these provisions are identical to what exists now (section 1924). The only bad thing we can say about their spousal impoverishment provisions is that these protections are not guaranteed because there is no right to sue the state to gain enforcement.

There would still be some oversight responsibility for the Secretary; however, if one were to judge based on the history of the program since 1965, the likelihood that these authorities would be used by the Secretary is remote at best. You could probably count on one hand the number of times the Secretary has proceeded with an actual compliance hearing. You might even have fingers left over. In today's world of increased flexibility, the states are holding even more cards than before. Nonetheless, the authority does exist, and the Republicans could hide behind it.

(Title VII—Medicaid)

S.L.C.

7-12

"(B) to develop capitation payment rates, including a brief description of the general methodologies used by actuaries.

"(2) **QUALIFICATIONS OF ORGANIZATIONS.**—The general qualifications, including any accreditation, State licensure or certification, or provider network standards, required by the State for participation of capitated health care organizations under the MediGrant plan.

"(3) **DISSEMINATION PROCESS.**—The process used by the State under subsection (b) and otherwise to disseminate, before entering into contracts with capitated health care organizations, actuarial information to such organizations on the historical fee-for-service costs (or, if not available, other recent financial data associated with providing covered services) and utilization associated with individuals described in paragraph (1)(A).

"(b) **PUBLIC NOTICE AND COMMENT.**—Under the MediGrant plan the State shall provide a process for providing, before the beginning of each contract year—

"(1) public notice of—

"(A) the amounts of the capitation payments (if any) made under the plan for the contract year preceding the public notice, and

"(B)(i) the information described under subsection (a)(1) with respect to capitation payments for the contract year involved, or (ii) amounts of the capitation payments the State expects to make for the contract year involved, unless such information is designated as proprietary and not subject to public disclosure under State law, and

"(2) an opportunity for receiving public comment on the amounts and information for which notice is provided under paragraph (1).

"(c) **DEFINITIONS.**—In this title:

"(1) **CAPITATED HEALTH CARE ORGANIZATION.**—The term 'capitated health care organization' means a health maintenance organization or any other entity (including a health insuring organization, managed care organization, prepaid health plan, integrated service network, or similar entity) which under State law is permitted to accept capitation payments for providing (or arranging for the provision of) a group of items and services including at least inpatient hospital services and physicians' services.

"(2) **CAPITATION PAYMENT.**—The term 'capitation payment' means, with respect to payment, payment on a prepaid capitation basis or any other risk basis to an entity for the entity's provision (or arranging for the provision) of a group of items and services, including at least inpatient hospital services and physicians' services.

"SEC. 2115. PREVENTING SPOUSAL IMPOVERISHMENT.

"(a) **SPECIAL TREATMENT FOR INSTITUTIONALIZED SPOUSES.**—

"(1) **SUPERSEDES OTHER PROVISIONS.**—In determining the eligibility for medical assistance of an institutionalized spouse (as defined in subsection (h)(1)), the provisions of this section supersede any other provision of this title which is inconsistent with them.

"(2) **DOES NOT AFFECT CERTAIN DETERMINATIONS.**—Except as this section specifically provides, this section does not apply to—

"(A) the determination of what constitutes income or resources, or

"(B) the methodology and standards for determining and evaluating income and resources.

"(3) **NO APPLICATION IN COMMONWEALTHS AND TERRITORIES.**—This section shall only apply to a State that is one of the 50 States or the District of Columbia.

"(b) **RULES FOR TREATMENT OF INCOME.**—

CONFERENCE
AGREEMENT

①

"(1) SEPARATE TREATMENT OF INCOME.—During any month in which an institutionalized spouse is in the institution, except as provided in paragraph (2), no income of the community spouse shall be deemed available to the institutionalized spouse.

"(2) ATTRIBUTION OF INCOME.—In determining the income of an institutionalized spouse or community spouse for purposes of the post-eligibility income determination described in subsection (d), except as otherwise provided in this section and regardless of any State laws relating to community property or the division of marital property, the following rules apply:

"(A) NON-TRUST PROPERTY.—Subject to subparagraphs (C) and (D), in the case of income not from a trust, unless the instrument providing the income otherwise specifically provides—

"(i) if payment of income is made solely in the name of the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse,

"(ii) if payment of income is made in the names of the institutionalized spouse and the community spouse, $\frac{1}{2}$ of the income shall be considered available to each of them, and

"(iii) if payment of income is made in the names of the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest (or, if payment is made with respect to both spouses and no such interest is specified, $\frac{1}{2}$ of the joint interest shall be considered available to each spouse).

"(B) TRUST PROPERTY.—In the case of a trust—

"(i) except as provided in clause (ii), income shall be attributed in accordance with the provisions of this title; and

"(ii) income shall be considered available to each spouse as provided in the trust, or, in the absence of a specific provision in the trust—

"(I) if payment of income is made solely to the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse,

"(II) if payment of income is made to both the institutionalized spouse and the community spouse, $\frac{1}{2}$ of the income shall be considered available to each of them, and

"(III) if payment of income is made to the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest (or, if payment is made with respect to both spouses and no such interest is specified, $\frac{1}{2}$ of the joint interest shall be considered available to each spouse).

"(C) PROPERTY WITH NO INSTRUMENT.—In the case of income not from a trust in which there is no instrument establishing ownership, subject to subparagraph (D), $\frac{1}{2}$ of the income shall be considered to be available to the institutionalized spouse and $\frac{1}{2}$ to the community spouse.

"(D) REBUTTING OWNERSHIP.—The rules of subparagraphs (A) and (C) are superseded to the extent that an institutionalized spouse can establish, by a preponderance of the evidence, that the ownership interests in income are other than as provided under such subparagraphs.

"(c) RULES FOR TREATMENT OF RESOURCES.—

"(1) COMPUTATION OF SPOUSAL SHARE AT TIME OF INSTITUTIONALIZATION.—

7-14

"(A) **TOTAL JOINT RESOURCES.**—There shall be computed (as of the beginning of the first continuous period of institutionalization of the institutionalized spouse)—

"(i) the total value of the resources to the extent either the institutionalized spouse or the community spouse has an ownership interest, and

"(ii) a spousal share which is equal to $\frac{1}{2}$ of such total value.

"(B) **ASSESSMENT.**—At the request of an institutionalized spouse or community spouse, at the beginning of the first continuous period of institutionalization of the institutionalized spouse and upon the receipt of relevant documentation of resources, the State shall promptly assess and document the total value described in subparagraph (A)(i) and shall provide a copy of such assessment and documentation to each spouse and shall retain a copy of the assessment for use under this section. If the request is not part of an application for medical assistance under this title, the State may, at its option as a condition of providing the assessment, require payment of a fee not exceeding the reasonable expenses of providing and documenting the assessment. At the time of providing the copy of the assessment, the State shall include a notice indicating that the spouse will have a right to a fair hearing under subsection (e)(2).

"(2) **ATTRIBUTION OF RESOURCES AT TIME OF INITIAL ELIGIBILITY DETERMINATION.**—In determining the resources of an institutionalized spouse at the time of application for medical assistance under this title, regardless of any State laws relating to community property or the division of marital property—

"(A) except as provided in subparagraph (B), all the resources held by either the institutionalized spouse, community spouse, or both, shall be considered to be available to the institutionalized spouse, and

"(B) resources shall be considered to be available to an institutionalized spouse, but only to the extent that the amount of such resources exceeds the amount computed under subsection (f)(2)(A) (as of the time of application for medical assistance).

"(3) **ASSIGNMENT OF SUPPORT RIGHTS.**—The institutionalized spouse shall not be ineligible by reason of resources determined under paragraph (2) to be available for the cost of care where—

"(A) the institutionalized spouse has assigned to the State any rights to support from the community spouse,

"(B) the institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment but the State has the right to bring a support proceeding against a community spouse without such assignment, or

"(C) the State determines that denial of eligibility would work an undue hardship.

"(4) **SEPARATE TREATMENT OF RESOURCES AFTER ELIGIBILITY FOR MEDICAL ASSISTANCE ESTABLISHED.**—During the continuous period in which an institutionalized spouse is in an institution and after the month in which an institutionalized spouse is determined to be eligible for medical assistance under this title, no resources of the community spouse shall be deemed available to the institutionalized spouse.

"(5) **RESOURCES DEFINED.**—In this section, the term 'resources' does not include—

✓ "(A) resources excluded under subsection (a) or (d) of section 1613, and

✓ "(B) resources that would be excluded under section 1613(a)(2)(A) but for the limitation on total value described in such section.

"(d) **PROTECTING INCOME FOR COMMUNITY SPOUSE.**—

XREF →

See attached
copy of section 1613.

7-15

"(1) ALLOWANCES TO BE OFFSET FROM INCOME OF INSTITUTIONALIZED SPOUSE.—After an institutionalized spouse is determined or redetermined to be eligible for medical assistance, in determining the amount of the spouse's income that is to be applied monthly to payment for the costs of care in the institution, there shall be deducted from the spouse's monthly income the following amounts in the following order:

"(A) A personal needs allowance (described in paragraph (2)(A)), in an amount not less than the amount specified in paragraph (2)(C).

"(B) A community spouse monthly income allowance (as defined in paragraph (3)), but only to the extent income of the institutionalized spouse is made available to (or for the benefit of) the community spouse.

"(C) A family allowance, for each family member, equal to at least $\frac{1}{3}$ of the amount by which the amount described in paragraph (4)(A)(i) exceeds the amount of the monthly income of that family member.

"(D) Amounts for incurred expenses for medical or remedial care for the institutionalized spouse as provided under paragraph (6).

In subparagraph (C), the term 'family member' only includes minor or dependent children, dependent parents, or dependent siblings of the institutionalized or community spouse who are residing with the community spouse.

"(2) PERSONAL NEEDS ALLOWANCE.—

"(A) IN GENERAL.—The MediGrant plan must provide that, in the case of an institutionalized individual or couple described in subparagraph (B), in determining the amount of the individual's or couple's income to be applied monthly to payment for the cost of care in an institution, there shall be deducted from the monthly income (in addition to other allowances otherwise provided under the plan) a monthly personal needs allowance—

"(i) which is reasonable in amount for clothing and other personal needs of the individual (or couple) while in an institution, and

"(ii) which is not less (and may be greater) than the minimum monthly personal needs allowance described in subparagraph (C).

"(B) INSTITUTIONALIZED INDIVIDUAL OR COUPLE DEFINED.—In this paragraph, the term 'institutionalized individual or couple' means an individual or married couple—

"(i) who is an inpatient (or who are inpatients) in a medical institution or nursing facility for which payments are made under this title throughout a month, and

"(ii) who is or are determined to be eligible for medical assistance under the State MediGrant plan.

"(C) MINIMUM ALLOWANCE.—The minimum monthly personal needs allowance described in this subparagraph is \$40 for an institutionalized individual and \$80 for an institutionalized couple (if both are aged, blind, or disabled, and their incomes are considered available to each other in determining eligibility).

"(3) COMMUNITY SPOUSE MONTHLY INCOME ALLOWANCE DEFINED.—

"(A) IN GENERAL.—In this section (except as provided in subparagraph (B)), the community spouse monthly income allowance for a community spouse is an amount by which—

"(i) except as provided in subsection (e), the minimum monthly maintenance needs allowance (established under and in accordance with paragraph (4)) for the spouse, exceeds

7-16

"(ii) the amount of monthly income otherwise available to the community spouse (determined without regard to such an allowance).

"(B) COURT ORDERED SUPPORT.—If a court has entered an order against an institutionalized spouse for monthly income for the support of the community spouse, the community spouse monthly income allowance for the spouse shall be not less than the amount of the monthly income so ordered.

"(4) ESTABLISHMENT OF MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE.—

"(A) IN GENERAL.—Each State shall establish a minimum monthly maintenance needs allowance for each community spouse which, subject to subparagraph (B), is equal to or exceeds—

"(i) 150 percent of $\frac{1}{12}$ of the poverty line applicable to a family unit of 2 members, plus

"(ii) an excess shelter allowance (as defined in paragraph (4)).

A revision of the poverty line referred to in clause (i) shall apply to medical assistance furnished during and after the second calendar quarter that begins after the date of publication of the revision.

"(B) CAP ON MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE.—The minimum monthly maintenance needs allowance established under subparagraph (A) may not exceed \$1,500 (subject to adjustment under subsections (e) and (g)).

"(5) EXCESS SHELTER ALLOWANCE DEFINED.—In paragraph (4)(A)(ii), the term 'excess shelter allowance' means, for a community spouse, the amount by which the sum of—

"(A) the spouse's expenses for rent or mortgage payment (including principal and interest), taxes and insurance and, in the case of a condominium or cooperative, required maintenance charge, for the community spouse's principal residence, and

"(B) the standard utility allowance (used by the State under section 5(e) of the Food Stamp Act of 1977) or, if the State does not use such an allowance, the spouse's actual utility expenses,

exceeds 30 percent of the amount described in paragraph (4)(A)(i), except that, in the case of a condominium or cooperative, for which a maintenance charge is included under subparagraph (A), any allowance under subparagraph (B) shall be reduced to the extent the maintenance charge includes utility expenses.

"(6) TREATMENT OF INCURRED EXPENSES.—With respect to the post-eligibility treatment of income under this section, there shall be disregarded reparation payments made by the Federal Republic of Germany and, there shall be taken into account amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—

"(A) medicare and other health insurance premiums, deductibles, or coinsurance, and

"(B) necessary medical or remedial care recognized under State law but not covered under the State MediGrant plan under this title, subject to reasonable limits the State may establish on the amount of these expenses.

"(e) NOTICE AND HEARING.—

"(1) NOTICE.—Upon—

"(A) a determination of eligibility for medical assistance of an institutionalized spouse, or

"(B) a request by either the institutionalized spouse, or the community spouse, or a representative acting on behalf of either spouse,

7-17

Each State shall notify both spouses (in the case described in subparagraph (A)) or the spouse making the request (in the case described in subparagraph (B)) of the amount of the community spouse monthly income allowance (described in subsection (d)(1)(B)), of the amount of any family allowances (described in subsection (d)(1)(C)), of the method for computing the amount of the community spouse resources allowance permitted under subsection (f), and of the spouse's right to a hearing under the MediGrant plan respecting ownership or availability of income or resources, and the determination of the community spouse monthly income or resource allowance.

"(2) RESULTS OF HEARING.—

"(A) REVISION OF MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE.—If either such spouse establishes in a hearing under this subsection that the community spouse needs income, above the level otherwise provided by the minimum monthly maintenance needs allowance, due to exceptional circumstances resulting in significant financial duress, there shall be substituted, for the minimum monthly maintenance needs allowance in subsection (d)(2)(A), an amount adequate to provide such additional income as is necessary.

"(B) REVISION OF COMMUNITY SPOUSE RESOURCE ALLOWANCE.—If either such spouse establishes in such a hearing that the community spouse resource allowance (in relation to the amount of income generated by such an allowance) is inadequate to raise the community spouse's income to the minimum monthly maintenance needs allowance, there shall be substituted, for the community spouse resource allowance under subsection (f)(2), an amount adequate to provide such a minimum monthly maintenance needs allowance.

"(f) PERMITTING TRANSFER OF RESOURCES TO COMMUNITY SPOUSE.—

"(1) IN GENERAL.—An institutionalized spouse may, without regard to any other provision of the MediGrant plan to the contrary, transfer an amount equal to the community spouse resource allowance (as defined in paragraph (2)), but only to the extent the resources of the institutionalized spouse are transferred to, or for the sole benefit of, the community spouse. The transfer under the preceding sentence shall be made as soon as practicable after the date of the initial determination of eligibility, taking into account such time as may be necessary to obtain a court order under paragraph (3).

"(2) COMMUNITY SPOUSE RESOURCE ALLOWANCE DEFINED.—In paragraph (1), the 'community spouse resource allowance' for a community spouse is an amount (if any) by which—

"(A) the greatest of—

"(i) \$12,000 (subject to adjustment under subsection (g)), or, if greater (but not to exceed the amount specified in clause (ii)(II)) an amount specified under the State MediGrant plan,

"(ii) the lesser of (I) the spousal share computed under subsection (c)(1), or (II) \$60,000 (subject to adjustment under subsection (g)), or

"(iii) the amount established under subsection (e)(2);

exceeds

"(B) the amount of the resources otherwise available to the community spouse (determined without regard to such an allowance).

"(g) INDEXING DOLLAR AMOUNTS.—For services furnished during a calendar year after 1989, the dollar amounts specified in subsections (d)(3)(C), (f)(2)(A)(i), and (f)(2)(A)(ii)(II) shall be increased by the same percentage as the percentage increase in the consumer price index for all urban consumers (all items; U.S. city average) be-

7-18

September 1988 and the September before the calendar year ended.

(N) DEFINITIONS.—In this section:

"(1) INSTITUTIONALIZED SPOUSE.—The term 'institutionalized spouse' means an individual—

"(A)(i) who is in a medical institution or nursing facility, or

"(ii) at the option of the State (I) who would be eligible under the MediGrant plan under this title if such individual was in a medical institution, (II) with respect to whom there has been a determination that but for the provision of home or community-based services such individual would require the level of care provided in a hospital, nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the plan, and (III) who will receive home or community-based services pursuant the plan; and

"(B) is married to a spouse who is not in a medical institution or nursing facility;

but does not include any such individual who is not likely to meet the requirements of subparagraph (A) for at least 30 consecutive days.

"(2) COMMUNITY SPOUSE.—The term 'community spouse' means the spouse of an institutionalized spouse.

"SEC. 2116. STATE FLEXIBILITY.

"(a) STATE FLEXIBILITY IN BENEFITS, PROVIDER PAYMENTS, GEOGRAPHICAL COVERAGE AREA, AND SELECTION OF PROVIDERS.—Nothing in this title (other than subsections (c) and (d) of section 2111) shall be construed as requiring a State—

"(1) to provide medical assistance for any particular items or services,

"(2) to provide for any payments with respect to any specific health care providers or any level of payments for any services,

"(3) to provide for the same medical assistance in all geographical areas or political subdivisions of the State, so long as medical assistance is made available in all such areas or subdivisions,

"(4) to provide that the medical assistance made available to any individual eligible for medical assistance must not be less in amount, duration, or scope than the medical assistance made available to any other such individual, or

"(5) to provide that any individual eligible for medical assistance with respect to an item or service may choose to obtain such assistance from any institution, agency, or person qualified to provide the item or service.

"(b) STATE FLEXIBILITY WITH RESPECT TO MANAGED CARE.—Nothing in this title shall be construed—

"(1) to limit a State's ability to contract with, on a capitated basis or otherwise, health care plans or individual health care providers for the provision or arrangement of medical assistance,

"(2) to limit a State's ability to contract with health care plans or other entities for case management services or for coordination of medical assistance, or

"(3) to restrict a State from establishing capitation rates on the basis of competition among health care plans or negotiations between the State and one or more health care plans.

"PART C—PAYMENTS TO STATES

"SEC. 2121. ALLOTMENT OF FUNDS AMONG STATES.

"(a) ALLOTMENTS.—

"(1) COMPUTATION.—The Secretary shall provide for the computation of State obligation and outlay allotments in accordance with this section for each fiscal year beginning with fiscal year 1996.

7

*cross reference
from Conference
language*

CURRENT LAW

SOCIAL SECURITY ACT— §1612(a) 8

RESOURCES

Exclusions From Resources²²

SEC. 1613. [42 U.S.C. 1382b] (a) In determining the resources of an individual (and his eligible spouse, if any) there shall be excluded—
(1) the home (including the land that appertains thereto);

²²See Vol. II, P.L. 79-396, §12(c), with respect to exclusion from income and resources of assistance to children.

See Vol. II, P.L. 81-171, §521(a)(1)(E), with respect to exclusion from income and resources of certain assistance rendered to provide occupant-owned, rental and cooperative housing.

See Vol. II, P.L. 86-525, §8(b), with respect to exclusion from income and resources of the value of food stamps.

See Vol. II, P.L. 89-329, §479B, with respect to exclusion from income or resources of certain student financial assistance.

See Vol. II, P.L. 89-642, §11(b), with respect to the exclusion from income and resources of the value of assistance to children.

See Vol. II, P.L. 93-113, §404(g), with respect to exclusion from income and resources of payments to volunteers.

See Vol. II, P.L. 93-124, §97 and 8, with respect to exclusion from income and resources of certain judgment funds to any Indian tribe.

See Vol. II, P.L. 93-288, §312(d), with respect to exclusion from income and resources of certain Federal major disaster and emergency assistance.

See Vol. II, P.L. 94-114, §6, with respect to exclusion from income and resources of property and receipts from submarginal land to certain Indians.

See Vol. II, P.L. 94-375, §2(h), with respect to exclusion from income and resources of the value of assistance paid with respect to a dwelling unit, for purposes of this title of this act. Also see Vol. II:

P.L. 73-479, §§231(a), (b), and (f); 235(a); 236(a) and (b); and 237(a) and (b);

P.L. 75-112, §§5(j) and 9(b);

P.L. 81-171, §521(a)(1)(B), (C), and (E); and

P.L. 89-117, §101.

See Vol. II, P.L. 95-483, §2, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 95-498, §6, with respect to an income and resources exclusion applicable to the Pueblo of Santa Ana Indians, New Mexico.

See Vol. II, P.L. 95-499, §6, with respect to an income and resources exclusion applicable to the Pueblo of Zia Indians, New Mexico.

See Vol. II, P.L. 97-35, §2605(f), with respect to exclusion from income and resources of home energy assistance payments or allowances.

See Vol. II, P.L. 98-64, §2(a), with respect to exclusion from income and resources of per capita payments to Indians.

See Vol. II, P.L. 98-432, §5(e), with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 98-500, §8, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 98-602, §106(d), with respect to exclusion from income and resources of certain funds distributed per capita.

See Vol. II, P.L. 99-130, §8, with respect to exclusion from income and resources of certain funds.

See Vol. II, P.L. 99-146, §5(b), with respect to exclusion from income and resources of certain funds.

See Vol. II, P.L. 99-264, §16, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 99-346, §4(b), with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 99-377, §4(b), with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 100-129, §4(h)(6), with respect to exclusion of benefits as basis for denial of eligibility.

See Vol. II, P.L. 100-383, §§105(a)(2) and 306(d)(2), with respect to exclusion from income and resources of certain payments to certain individuals.

See Vol. II, 31 U.S.C. 9803(c)(2)(C), with respect to benefits not affected by P.L. 100-383.

See Vol. II, P.L. 100-407, §105(c), with respect to the effect of financial assistance under that Act.

See Vol. II, P.L. 100-409, §5, with respect to the effect of this Act on P.L. 92-203 or P.L. 96-387.

See Vol. II, P.L. 100-411, §2(d)(3)(B), with respect to the effect of per capita payments.

See Vol. II, P.L. 100-581, §§601, 602(b)(1), and 503, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 101-41, §10(b)(4)(d), with respect to eligibility for Federal programs and treatment of funds, assets, and income.

See Vol. II, P.L. 101-42, §3, with respect to the restoration of Federal recognition, rights, and privileges.

See Vol. II, P.L. 101-201, §1, with respect to Agent Orange settlement payments.

See Vol. II, P.L. 101-239, §10405, with respect to Agent Orange settlement payments excluded from countable income and resources under Federal means-tested programs.

See Vol. II, P.L. 101-277, §8(b), with respect to exclusion, from income or resources, of funds held in trust or distributed to Seminole Indians.

SECURITY ACT— §1618(a)

RESOURCES

Exclusions From Resources²²

§82b] (a) In determining the resources of an individual (or spouse, if any) there shall be excluded—
 (1) the land that appertains thereto;

(2) with respect to exclusion from income and resources of

(A) with respect to exclusion from income and resources of the occupant-owned, rental and cooperative housing,

(B) with respect to exclusion from income and resources of the value of

(C) with respect to exclusion from income or resources of certain

(D) with respect to the exclusion from income and resources of the

(E) with respect to exclusion from income and resources of payments

(F) with respect to exclusion from income and resources of certain

(G) with respect to exclusion from income and resources of certain

(H) with respect to exclusion from income and resources of property and

(I) with respect to exclusion from income and resources of the value of

(J) with respect to exclusion from income and resources of the value of

(K) with respect to exclusion from income and resources of the value of

(L) with respect to exclusion from income and resources of certain

(M) with respect to an income and resources exclusion applicable to the

(N) with respect to an income and resources exclusion applicable to the

(O) with respect to exclusion from income and resources of home

(P) with respect to exclusion from income and resources of per capita

(Q) with respect to exclusion from income and resources of certain

(R) with respect to exclusion from income and resources of certain

(S) with respect to exclusion from income and resources of certain

(T) with respect to exclusion from income and resources of certain

(U) with respect to exclusion from income and resources of certain

(V) with respect to exclusion from income and resources of certain

(W) with respect to exclusion from income and resources of certain

(X) with respect to exclusion from income and resources of certain

(Y) with respect to exclusion of benefits as basis for denial of

(Z) with respect to exclusion from income and resources of certain

(AA) with respect to benefits not affected by P.L. 100-383.

(AB) with respect to the effect of financial assistance under that Act

(AC) with respect to the effect of this Act on P.L. 92-203 or P.L. 96-487.

(AD) with respect to the effect of per capita payments.

(AE) with respect to the effect of per capita payments.

(AF) with respect to the effect of per capita payments.

(AG) with respect to the effect of per capita payments.

(AH) with respect to the effect of per capita payments.

(AI) with respect to the effect of per capita payments.

(AJ) with respect to the effect of per capita payments.

(AK) with respect to the effect of per capita payments.

(AL) with respect to the effect of per capita payments.

(AM) with respect to the effect of per capita payments.

(AN) with respect to the effect of per capita payments.

(AO) with respect to the effect of per capita payments.

(AP) with respect to the effect of per capita payments.

(AQ) with respect to the effect of per capita payments.

(AR) with respect to the effect of per capita payments.

(AS) with respect to the effect of per capita payments.

(AT) with respect to the effect of per capita payments.

(AU) with respect to the effect of per capita payments.

SOCIAL SECURITY ACT— §1618(a)(Cont.)

583

(2)(A) household goods, personal effects, and an automobile, to the extent that their total value does not exceed such amount as the Secretary determines to be reasonable; and

(B) the value of any burial space or agreement (including any interest accumulated thereon) representing the purchase of a burial space²³ (subject to such limits as to size or value as the Secretary may by regulation prescribe) held for the purpose of providing a place for the burial of the individual, his spouse, or any other member of his immediate family;

(3) other property which is so essential to the means of self-support of such individual (and such spouse) as to warrant its exclusion, as determined in accordance with and subject to limitations prescribed by the Secretary, except that the Secretary shall not establish a limitation on property (including the tools of a tradesperson and the machinery and livestock of a farmer) that is used in a trade or business or by such individual as an employee;²⁴

(4) such resources of an individual who is blind or disabled and who has a plan for achieving self-support approved by the Secretary, as may be necessary for the fulfillment of such plan;

(5) in the case of Natives of Alaska, shares of stock held in a Regional or a Village Corporation, during the period of twenty years in which such stock is inalienable, as provided in section 7(h) and section 8(c) of the Alaska Native Claims Settlement Act²⁵;

(6) assistance referred to in section 1612(b)(11) for the 9-month period beginning on the date such funds are received (or for such longer period as the Secretary shall by regulations prescribe in cases where good cause is shown by the individual concerned for extending such period); and, for purposes of this paragraph, the term "assistance" includes interest thereon which is excluded from income under section 1612(b)(12);

(7) any amount received from the United States which is attributable to underpayments of benefits due for one or more prior months, under this title or title II, to such individual (or spouse) or to any other person whose income is deemed to be included in such individual's (or spouse's) income for purposes of this title; but the application of this paragraph in the case of any such individual (and eligible spouse if any), with respect to any amount so received from the United States, shall be limited to the first 6 months following the month in which such amount is received (or to the first 9 months following such month with respect to any amount so received during the period beginning October 1, 1987, and ending September 30, 1989), and written notice of this limitation shall be given to the recipient concurrently with the payment of such amount;²⁶

²² P.L. 101-239, §801(h)(1), inserted "or agreement (including any interest accumulated thereon) representing the purchase of a burial space", effective April 1, 1990.

²³ P.L. 101-239, §801(h)(1), amended this paragraph in its entirety, effective May 1, 1990. [For paragraph (3) as it formerly read, see Vol. III, P.L. 101-239.]

²⁴ P.L. 92-203.

²⁵ P.L. 101-508, §5031(b)(1), struck out "and".

²⁶ See Vol. II, P.L. 101-508, §5041(1), with respect to notification of certain individuals eligible to receive retroactive benefits.

584

SOCIAL SECURITY ACT— §1613(b)

(8) the value of assistance referred to in section 1612(b)(14), paid with respect to the dwelling unit occupied by such individual (or such individual and spouse);²⁷

(9) for the 9-month period beginning after the month in which received, any amount received by such individual (or such spouse) from a fund established by a State to aid victims of crime, to the extent that such individual (or such spouse) demonstrates that such amount was paid as compensation for expenses incurred or losses suffered as a result of a crime; and²⁸

(10) for the 9-month period beginning after the month in which received, relocation assistance provided by a State or local government to such individual (or such spouse), comparable to assistance provided under title II of the Uniform Relocation Assistance and Real Property Acquisitions Policies Act of 1970 which is subject to the treatment required by section 216 of such Act.²⁹

In determining the resources of an individual (or eligible spouse) an insurance policy shall be taken into account only to the extent of its cash surrender value; except that if the total face value of all life insurance policies on any person is \$1,500 or less, no part of the value of any such policy shall be taken into account.

Disposition of Resources

(b)(1) The Secretary shall prescribe the period or periods of time within which, and the manner in which, various kinds of property must be disposed of in order not to be included in determining an individual's eligibility for benefits. Any portion of the individual's benefits paid for any such period shall be conditioned upon such disposal; and any benefits so paid shall (at the time of the disposal) be considered overpayments to the extent they would not have been paid had the disposal occurred at the beginning of the period for which such benefits were paid.

(2) Notwithstanding the provisions of paragraph (1), the Secretary shall not require the disposition of any real property for so long as it cannot be sold because (A) it is jointly owned (and its sale would cause undue hardship, due to loss of housing, for the other owner or owners), (B) its sale is barred by a legal impediment, or (C) a determined under regulations issued by the Secretary, the owner's reasonable efforts to sell it have been unsuccessful.

Notification of Medicaid Policy Restricting Eligibility of Institutionalized Individuals for Benefits Based on Disposal of Resources for Less Than Fair Market Value

(c)(1) At the time an individual (and the individual's eligible spouse, if any) applies for benefits under this title, and at the time the eligibility of an individual (and such spouse, if any) for such benefits is redetermined, the Secretary shall—

(A) inform such individual of the provisions of section 1917(c) providing for a period of ineligibility for benefits under title XI

²⁷P.L. 101-508, §5031(b)(2), struck out a period and substituted "; and".

²⁸P.L. 101-508, §5033(b)(1), struck out "and".

²⁹P.L. 101-508, §5031(b)(3), added paragraph (10), applicable to benefits for months beginning on or after May 1, 1991.

³⁰P.L. 101-508, §5033(b)(2), struck out a period and substituted "; and".

³¹P.L. 101-508, §5033(b)(3), added paragraph (10), applicable to benefits for calendar months beginning in the 3-year period that begins on May 1, 1991.

URITY ACT— §1613(b)

nce referred to in section 1612(b)(14),
welling unit occupied by such individu-
spouse);³⁷

od beginning after the month in which
received by such individual (or such
ablished by a State to aid victims of
at such individual (or such spouse)
amount was paid as compensation for
es suffered as a result of a crime; and³⁸
riod beginning after the month in which
instance provided by a State or local
vidual (or such spouse), comparable to
er title II of the Uniform Relocation
roperty Acquisitions Policies Act of 1970
eatment required by section 216 of such

of an individual (or eligible spouse) an
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t that if the total face value of all life
son is \$1,500 or less, no part of the value
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individual (and the individual's eligible
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Secretary shall—

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f ineligibility for benefits under title XIX

period and substituted "and";

nd";
graph (1), applicable to benefits for months beginning on or

period and substituted "and";
graph (1), applicable to benefits for calendar months
ns on May 1, 1991.

SOCIAL SECURITY ACT— §1614(a)

585

for individuals who make certain dispositions of resources for
less than fair market value, and inform such individual that
information obtained pursuant to subparagraph (B) will be made
available to the State agency administering a State plan under
title XIX (as provided in paragraph (2)); and

(B) obtain from such individual information which may be
used by the State agency in determining whether or not a period
of ineligibility for such benefits would be required by reason of
section 1917(c) if such individual (or such spouse, if any) enters a
medical institution or nursing facility.

(2) The Secretary shall make the information obtained under
paragraph (1)(B) available, on request, to any State agency admin-
istering a State plan approved under title XIX.

Funds Set Aside for Burial Expenses

(d)(1) In determining the resources of an individual, there shall be
excluded an amount, not in excess of \$1,500 each with respect to such
individual and his spouse (if any), that is separately identifiable and
has been set aside to meet the burial and related expenses of such
individual or spouse.

(2) The amount of \$1,500, referred to in paragraph (1), with respect
to an individual shall be reduced by an amount equal to (A) the total
face value of all insurance policies on his life which are owned by
him or his spouse and the cash surrender value of which has been
excluded in determining the resources of such individual or of such
individual and his spouse, and (B) the total of any amounts in an
irrevocable trust (or other irrevocable arrangement) available to
meet the burial and related expenses of such individual or his
spouse.

(3) If the Secretary finds that any part of the amount excluded
under paragraph (1) was used for purposes other than those for which
it was set aside in cases where the inclusion of any portion of the
amount would cause the resources of such individual, or of such
individual and spouse, to exceed the limits specified in paragraph (1)
or (2) (whichever may be applicable) of section 1611(a), he shall
reduce any future benefits payable to the eligible individual (or to
such individual and his spouse) by an amount equal to such part.

(4) The Secretary may provide by regulations that whenever an
amount set aside to meet burial and related expenses is excluded
under paragraph (1) in determining the resources of an individual,
any interest earned or accrued on such amount (and left to accumu-
late), and any appreciation in the value of prepaid burial arrange-
ments for which such amount was set aside, shall also be excluded (to
such extent and subject to such conditions or limitations as such
regulations may prescribe) in determining the resources (and the
income) of such individual.

MEANING OF TERMS

Aged, Blind, or Disabled Individual

Sec. 1614. [42 U.S.C. 1382c] (a)(1) For purposes of this title, the
term "aged, blind, or disabled individual" means an individual who—

EXISTING MEDICAID
STATUTE

SOCIAL SECURITY ACT—§1924(b)

which the expenditures described in section 1903(a) in the State in the fiscal year exceed such expenditures in the previous fiscal year.^{52a}

TREATMENT OF INCOME AND RESOURCES FOR CERTAIN
INSTITUTIONALIZED SPOUSES^{52b}

SEC. 1924. [42 U.S.C. 1396r-5] (a) SPECIAL TREATMENT FOR INSTITUTIONALIZED SPOUSES.—

(1) SUPERSEDES OTHER PROVISIONS.—In determining the eligibility for medical assistance of an institutionalized spouse (as defined in subsection (h)(1)), the provisions of this section supersede any other provision of this title (including sections 1902(a)(17) and 1902(f)) which is inconsistent with them.

(2) NO COMPARABLE TREATMENT REQUIRED.—Any different treatment provided under this section for institutionalized spouses shall not, by reason of paragraph (10) or (17) of section 1902(a), require such treatment for other individuals.

(3) DOES NOT AFFECT CERTAIN DETERMINATIONS.—Except as this section specifically provides, this section does not apply to—

(A) the determination of what constitutes income or resources, or

(B) the methodology and standards for determining and evaluating income and resources.

(4) APPLICATION IN CERTAIN STATES AND TERRITORIES.—

(A) APPLICATION IN STATES OPERATING UNDER DEMONSTRATION PROJECTS.—In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115, the Secretary shall require the State to meet the requirements of this section in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this title.

(B) NO APPLICATION IN COMMONWEALTHS AND TERRITORIES.—This section shall only apply to a State that is one of the 50 States or the District of Columbia.

(5) APPLICATION TO INDIVIDUALS RECEIVING SERVICES FROM ORGANIZATIONS RECEIVING CERTAIN WAIVERS.—This section applies to individuals receiving institutional or noninstitutional services from any organization receiving a frail elderly demonstration project waiver under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986.

(b) RULES FOR TREATMENT OF INCOME.—

(1) SEPARATE TREATMENT OF INCOME.—During any month in which an institutionalized spouse is in the institution, except as provided in paragraph (2), no income of the community spouse shall be deemed available to the institutionalized spouse.

(2) ATTRIBUTION OF INCOME.—In determining the income of an institutionalized spouse or community spouse for purposes of the post-eligibility income determination described in subsection (d), except as otherwise provided in this section and regardless of

^{52a}P.L. 102-234, §3(b)(1), added subsection (f), effective January 1, 1992.
See P.L. 102-234, §3(e)(2), with respect to the proposed rule promulgated by the Secretary on October 31, 1991 (Appendix B).
^{52b}See Vol. II, P.L. 99-509, §9412(b)(4) [as added by P.L. 101-508, §4744(b)(2)], with respect to certain waivers.

State growth amounts for all DSH States for the fiscal year;

ns to State DSH allotments the ll be attributable to paragraph

L BASED ON TOTAL MEDICAID EX- ASSISTANCE.—The supplemental al year is equal to the lesser of— amount determined under sub- atio of—

unt of expenditures made under ler this title for medical assist- al year, to

unt of expenditures made under der this title for medical assist- al year for all States which are s in the fiscal year, or

would raise the State DSH allot- m permitted under paragraph

ction:

term "high DSH State" means, which the State base allotment al amount of expenditures made this title for medical assistance

ate" means only the 50 States i but does not include any State r this title is operated under a i 1115.

T.—The term "State base allot- o a State, the greater of—

of payment adjustments made ler the State plan during fiscal y such payment adjustments for y be made under paragraph

(i) shall be determined by the only payment adjustments de- (1).

NT.—The term "State growth t to a State for a fiscal year, the

State growth factor and the t for the previous fiscal year, or hich 12 percent of the total s made under the State plan al assistance during the fiscal DSH allotment for the previous

—The term "State growth fac- fiscal year, the percentage by

1194D SOCIAL SECURITY ACT—§1924(b) (Cont.)

any State laws relating to community property or the division of marital property, the following rules apply:

(A) NON-TRUST PROPERTY.—Subject to subparagraphs (C) and (D), in the case of income not from a trust, unless the instrument providing the income otherwise specifically provides—

(i) if payment of income is made solely in the name of the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;

(ii) if payment of income is made in the names of the institutionalized spouse and the community spouse, one-

(13)

community property or the division of
rules apply:

—Subject to subparagraphs (C)
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income otherwise specifically

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onsidered available only to that

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and the community spouse, one-

half of the income shall be considered available to each
of them; and

(iii) if payment of income is made in the names of the
institutionalized spouse or the community spouse, or
both, and to another person or persons, the income shall
be considered available to each spouse in proportion to
the spouse's interest (or, if payment is made with
respect to both spouses and no such interest is specified,
one-half of the joint interest shall be considered avail-
able to each spouse).

(B) TRUST PROPERTY.—In the case of a trust—

(i) except as provided in clause (ii), income shall be
attributed in accordance with the provisions of this title
(including sections 1902(a)(17) and 1902(k)), and

(ii) income shall be considered available to each
spouse as provided in the trust, or, in the absence of a
specific provision in the trust—

(I) if payment of income is made solely to the
institutionalized spouse or the community spouse,
the income shall be considered available only to
that respective spouse;

(II) if payment of income is made to both the
institutionalized spouse and the community spouse,
one-half of the income shall be considered available
to each of them; and

(III) if payment of income is made to the institu-
tionalized spouse or the community spouse, or both,
and to another person or persons, the income shall
be considered available to each spouse in proportion
to the spouse's interest (or, if payment is made with
respect to both spouses and no such interest is
specified, one-half of the joint interest shall be
considered available to each spouse).

(C) PROPERTY WITH NO INSTRUMENT.—In the case of income
not from a trust in which there is no instrument estab-
lishing ownership, subject to subparagraph (D), one-half of
the income shall be considered to be available to the
institutionalized spouse and one-half to the community
spouse.

(D) REBUTTING OWNERSHIP.—The rules of subparagraphs
(A) and (C) are superseded to the extent that an institu-
tionalized spouse can establish, by a preponderance of the
evidence, that the ownership interests in income are other
than as provided under such subparagraphs.

(C) RULES FOR TREATMENT OF RESOURCES.—

(1) COMPUTATION OF SPOUSAL SHARE AT TIME OF
INSTITUTIONALIZATION.—

(A) TOTAL JOINT RESOURCES.—There shall be computed (as
of the beginning of the first continuous period of institu-
tionalization (beginning on or after September 30, 1989)³³¹ of
the institutionalized spouse)—

³³¹P.L. 101-508, §4714(c), struck out "a continuous period of institutionalization" and substituted
"the first continuous period of institutionalization (beginning on or after September 30, 1989)",
effective as if included in the enactment of P.L. 100-360, §302.

(i) the total value of the resources to the extent either the institutionalized spouse or the community spouse has an ownership interest, and

(ii) a spousal share which is equal to 1/2 of such total value.

(15) (B) **ASSESSMENT.**—At the request of an institutionalized spouse or community spouse, at the beginning of the first continuous period of institutionalization (beginning on or after September 30, 1989)³³³ of the institutionalized spouse and upon the receipt of relevant documentation of resources, the State shall promptly assess and document the total value described in subparagraph (A)(i) and shall provide a copy of such assessment and documentation to each spouse and shall retain a copy of the assessment for use under this section. If the request is not part of an application for medical assistance under this title, the State may, at its option as a condition of providing the assessment, require payment of a fee not exceeding the reasonable expenses of providing and documenting the assessment. At the time of providing the copy of the assessment, the State shall include a notice indicating that the spouse will have a right to a fair hearing under subsection (e)(2).

(2) **ATTRIBUTION OF RESOURCES AT TIME OF INITIAL ELIGIBILITY DETERMINATION.**—In determining the resources of an institutionalized spouse at the time of application for benefits under this title, regardless of any State laws relating to community property or the division of marital property—

(A) except as provided in subparagraph (B), all the resources held by either the institutionalized spouse, community spouse, or both, shall be considered to be available to the institutionalized spouse, and

(B) resources shall be considered to be available to an institutionalized spouse, but only to the extent that the amount of such resources exceeds the amount computed under subsection (f)(2)(A) (as of the time of application for benefits).

(3) **ASSIGNMENT OF SUPPORT RIGHTS.**—The institutionalized spouse shall not be ineligible by reason of resources determined under paragraph (2) to be available for the cost of care where—

(A) the institutionalized spouse has assigned to the State any rights to support from the community spouse;

(B) the institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment but the State has the right to bring a support proceeding against a community spouse without such assignment; or

(C) the State determines that denial of eligibility would work an undue hardship.

(4) **SEPARATE TREATMENT OF RESOURCES AFTER ELIGIBILITY FOR BENEFITS ESTABLISHED.**—During the continuous period in which an institutionalized spouse is in an institution and after the month in which an institutionalized spouse is determined to be

³³³P.L. 101-508, §471(c), struck out "a continuous period of institutionalization" and substituted "the first continuous period of institutionalization (beginning on or after September 30, 1989)", effective as if included in the enactment of P.L. 100-360, §303.

1198

SOCIAL SECURITY ACT—§ 1924(e)

(17)

(i) the applicable percent (described in subparagraph (B)) of 1/12 of the income official poverty line (defined by the Office of Management and Budget and revised annually in accordance with sections 652 and 673(2) of the Omnibus Budget Reconciliation Act of 1981⁴²⁴) for a family unit of 2 members; plus

(ii) an excess shelter allowance (as defined in paragraph (4)).

A revision of the official poverty line referred to in clause (i) shall apply to medical assistance furnished during and after the second calendar quarter that begins after the date of publication of the revision.

(B) APPLICABLE PERCENT.—For purposes of subparagraph (A)(i), the "applicable percent" described in this paragraph, effective as of—

(i) September 30, 1989, is 122 percent,

(ii) July 1, 1991, is 133 percent, and

(iii) July 1, 1992, is 150 percent.

(C) CAP ON MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE.—The minimum monthly maintenance needs allowance established under subparagraph (A) may not exceed \$1,500 (subject to adjustment under subsections (e) and (g)).

(4) EXCESS SHELTER ALLOWANCE DEFINED.—In paragraph (3)(A)(ii), the term "excess shelter allowance" means, for a community spouse, the amount by which the sum of—

(A) the spouse's expenses for rent or mortgage payment (including principal and interest), taxes and insurance and, in the case of a condominium or cooperative, required maintenance charge, for the community spouse's principal residence, and

(B) the standard utility allowance (used by the State under section 5(e) of the Food Stamp Act of 1977⁴²⁵) or, if the State does not use such an allowance, the spouse's actual utility expenses,

exceeds 30 percent of the amount described in paragraph (3)(A)(i), except that, in the case of a condominium or cooperative, for which a maintenance charge is included under subparagraph (A), any allowance under subparagraph (B) shall be reduced to the extent the maintenance charge includes utility expenses.

(5) COURT ORDERED SUPPORT.—If a court has entered an order against an institutionalized spouse for monthly income for the support of the community spouse, the community spouse monthly income allowance for the spouse shall be not less than the amount of the monthly income so ordered.

(e) NOTICE AND FAIR HEARING.—

(1) NOTICE.—Upon—

(A) a determination of eligibility for medical assistance of an institutionalized spouse, or

(B) a request by either the institutionalized spouse, or the community spouse, or a representative acting on behalf of either spouse,

⁴²⁴See Vol. II, P.L. 97-35, §§652 and 673(2).
⁴²⁵P.L. 88-525.

ACT—§ 1924(e)

SOCIAL SECURITY ACT—§ 1924(f)

1199

18

cent (described in subparagraph (A)) or the spouse making the request (in the case described in subparagraph (B)) of the amount of the community spouse monthly income allowance (described in subsection (d)(1)(B)), of the amount of any family allowances (described in subsection (d)(1)(C)), of the method for computing the amount of the community spouse resources allowance permitted under subsection (f), and of the spouse's right to a fair hearing under this subsection respecting ownership or availability of income or resources, and the determination of the community spouse monthly income or resource allowance.

erty line referred to in clause (i) allowance furnished during and after that begins after the date of

For purposes of subparagraph (A) described in this paragraph,

is 122 percent, percent, and percent.

MONTHLY MAINTENANCE NEEDS—The amount of the community spouse's monthly maintenance needs (as defined in subparagraph (A)) may not exceed the amount under subsections (e) and (f).

ALLOWANCE DEFINED.—In paragraph (A), the term "allowance" means, for a spouse, the sum of—

for rent or mortgage payment (interest), taxes and insurance and, if the spouse is a member of a cooperative, required contribution for the community spouse's principal residence.

allowance (used by the State under the Social Security Act of 1977) or, if the State does not have such an allowance, the spouse's actual utility expenses.

amount described in paragraph (A) of a condominium or cooperative is included under subparagraph (B) shall be substituted, for the minimum monthly maintenance charge includes utility expenses.

If a court has entered an order for the community spouse's monthly income for the community spouse, the community spouse's monthly income shall be not less than the amount ordered.

ability for medical assistance of the institutionalized spouse, or the representative acting on behalf of the spouse.

each State shall notify both spouses (in the case described in subparagraph (A)) or the spouse making the request (in the case described in subparagraph (B)) of the amount of the community spouse monthly income allowance (described in subsection (d)(1)(B)), of the amount of any family allowances (described in subsection (d)(1)(C)), of the method for computing the amount of the community spouse resources allowance permitted under subsection (f), and of the spouse's right to a fair hearing under this subsection respecting ownership or availability of income or resources, and the determination of the community spouse monthly income or resource allowance.

(2) FAIR HEARING.—

(A) **IN GENERAL.**—If either the institutionalized spouse or the community spouse is dissatisfied with a determination of—

- (i) the community spouse monthly income allowance;
- (ii) the amount of monthly income otherwise available to the community spouse (as applied under subsection (d)(2)(B));
- (iii) the computation of the spousal share of resources under subsection (c)(1);
- (iv) the attribution of resources under subsection (c)(2);

or (v) the determination of the community spouse resource allowance (as defined in subsection (f)(2));

such spouse is entitled to a fair hearing described in section 1902(a)(3) with respect to such determination if an application for benefits under this title has been made on behalf of the institutionalized spouse. Any such hearing respecting the determination of the community spouse resource allowance shall be held within 30 days of the date of the request for the hearing.

(B) **REVISION OF MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE.**—If either such spouse establishes that the community spouse needs income, above the level otherwise provided by the minimum monthly maintenance needs allowance, due to exceptional circumstances resulting in significant financial duress, there shall be substituted, for the minimum monthly maintenance needs allowance in subsection (d)(2)(A), an amount adequate to provide such additional income as is necessary.

(C) **REVISION OF COMMUNITY SPOUSE RESOURCE ALLOWANCE.**—If either such spouse establishes that the community spouse resource allowance (in relation to the amount of income generated by such an allowance) is inadequate to raise the community spouse's income to the minimum monthly maintenance needs allowance, there shall be substituted, for the community spouse resource allowance under subsection (f)(2), an amount adequate to provide such a minimum monthly maintenance needs allowance.

(f) PERMITTING TRANSFER OF RESOURCES TO COMMUNITY SPOUSE.—

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SOCIAL SECURITY ACT—§ 1924(g)

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(1) IN GENERAL.—An institutionalized spouse may, without regard to section 1917(c)(1)²²⁶, transfer an amount equal to the community spouse resource allowance (as defined in paragraph (2)), but only to the extent the resources of the institutionalized spouse are transferred to (or for the sole benefit of) the community spouse. The transfer under the preceding sentence shall be made as soon as practicable after the date of the initial determination of eligibility, taking into account such time as may be necessary to obtain a court order under paragraph (3).

(2) COMMUNITY SPOUSE RESOURCE ALLOWANCE DEFINED.—In paragraph (1), the "community spouse resource allowance" for a community spouse is an amount (if any) by which—

(A) the greatest of—

(i) \$12,000 (subject to adjustment under subsection (g)), or, if greater (but not to exceed the amount specified in clause (ii)(II)) an amount specified under the State plan,

(ii) the lesser of (I) the spousal share computed under subsection (c)(1), or (II) \$60,000 (subject to adjustment under subsection (g)),

(iii) the amount established under subsection (e)(2); or

(iv) the amount transferred under a court order under paragraph (3);

exceeds

(B) the amount of the resources otherwise available to the community spouse (determined without regard to such an allowance);

(3) TRANSFERS UNDER COURT ORDERS.—If a court has entered an order against an institutionalized spouse for the support of the community spouse, section 1917 shall not apply to amounts of resources transferred pursuant to such order for the support of the spouse or a family member (as defined in subsection (d)(1)).

(g) INDEXING DOLLAR AMOUNTS.—For services furnished during a calendar year after 1989, the dollar amounts specified in subsections (d)(3)(C), (f)(2)(A)(i), and (f)(2)(A)(ii)(II) shall be increased by the same percentage as the percentage increase in the consumer price index for all urban consumers (all items; U.S. city average) between September 1988 and the September before the calendar year involved.

(h) DEFINITIONS.—In this section:

(1) The term "institutionalized spouse" means an individual who—

(A) is in a medical institution or nursing facility or who (at the option of the State) is described in section 1902(a)(10)(A)(ii)(VI), and

(B) is married to a spouse who is not in a medical institution or nursing facility;

but does not include any such individual who is not likely to meet the requirements of subparagraph (A) for at least 30 consecutive days.

(2) The term "community spouse" means the spouse of an institutionalized spouse.

²²⁶P.L. 101-508, §4714(b), struck out "1917" and substituted "1917(c)(1)", effective as if included in the enactment of P.L. 100-360, §303.

**HEALTH CARE FINANCING ADMINISTRATION
OFFICE OF LEGISLATIVE AND INTER-GOVERNMENTAL AFFAIRS**

M E M O R A N D U M

TO: Chris Jennings, Nancy-Ann Min

FROM: Debbie Chang

DATE: 11/28/95

RE: Medicaid Block Grant Impacts

Attached is a short description of the impact of the Block grant on Medicaid beneficiaries out-of-pocket cost. It has been cleared in the Department. May we have your clearance on it as soon as possible so it can be used in our efforts to educate the Hill about the effects of the conference agreement on Medicaid? Please send your clearance or comments to me (690-5960), Don Johnson (690-7762), or Letty Carpenter (690-5460).

cc:

Bruce Vladeck

Jerry Klepner

Jack Ebeler

John Callahan

Kathy K.

Tom G.

Sally R.

Karen P.

Sharon C.

John S.

Christy S.

John Monahan

Bob Knouss

Michael Mahsetky

DRAFT November 28, 1995

WHO PAYS FOR MEDICAID REFORM:

COST SHIFTING TO BENEFICIARIES

The proposed spending cuts are so big that States may be forced to shift costs of care to beneficiaries and their families.

The bill reported by conference included provisions that were supposed to protect beneficiaries from such costs. They were added in response to criticisms about the potential impact of the proposals on low-income persons. These protections include:

- o Prohibition on providers billing patients or families for amounts above the Medigant rate for covered services.
- o Mandatory protection of income and assets, as Federally defined, for spouses of institutionalized beneficiaries.
- o Prohibition against States requiring families with income below the State's median to contribute to the cost of their parent's long-term care.

These protections will not accomplish their intended purpose because:

- o No Guarantee of Coverage: The protections only apply to those who are eligible for benefits. States will have a virtually free hand in determining who qualifies for benefits, including eligibility rules on such issues as how they count the home or other assets. Therefore, people who are now entitled to benefits could lose them, leaving them and their families to pay all costs and receive none of the Medigant protections.

Examples:

- + Anyone with "excess" home equity, as defined by the State, could be considered altogether ineligible. Thus, Medigant protections would be irrelevant for these people because they would not be covered at all.
- + Facilities could deny admission to those with limited private resources, i.e. those who might become eligible for Medicaid. Facilities could charge beneficiaries or their families) large up-front payments as the price of admission.

- o No Guarantee of Benefits: States will have similarly broad flexibility to decide what they will cover.

Examples:

- + If a State defined the nursing home benefit very narrowly, the only way a beneficiary might obtain such items and services as personal hygiene, laundry, and various therapies, which States now pay for, would be to ask relatives for financial aid.
- + Elderly and disabled Medicare beneficiaries whose Medicare cost-sharing is now paid by Medicaid could be forced to pay these expenses out-of-pocket if their State chose to reduce current benefit levels.
- o Reduced Provider Participation: States may pay so little that providers will drop out of the program. Therefore, individuals and families may have to either pay for private care themselves or do without. Those who do find a provider willing to accept Medicaid may face quality of care concerns as the least qualified providers become increasingly concentrated in the Medicaid program.
- o No Protections from Liens: The prohibition in the Senate bill against liens on family farms or residences of modest value was not included by the conference committee. All current law restrictions on liens and estate recoveries are repealed. In deciding whether and how to recover from individuals or their families, States would be free to:
 - use liens as a recovery tool;
 - recover while the person (or spouse or child) is alive or after the death of the individual (or spouse or child); or
 - recover or adjust the State's share of cost of care currently being provided. For example, the State could reduce its share of cost for those with home equity or other State-determined potential sources of funding, shifting costs to the individual, who would actually have to figure out how to pay the elevated share of cost.
- o Spousal Impoverishment: Retaining the current law protections against spousal impoverishment will have little or no effect because:
 - + The protections would apply to Medicaid beneficiaries. In the absence of current Medicaid entitlement to nursing home care, which the Conference agreement repeals, individuals may not qualify for Medicaid benefits in their State in the first place.
 - + The agreement does not provide for any means of redress for persons who believe their State has wrongfully denied them this protection. Thus, the provision creates an unenforceable guarantee against spousal impoverishment.
- o Cost Sharing Would Increase: States could increase the share of medical costs that low-income persons must pay for care even if they qualify for assistance under the Republican plan.

- Current protections against excessive cost-sharing requirements and premiums for all groups except children and pregnant women in families with incomes below poverty would be repealed.
- Current limits on how much nursing home residents are expected to contribute to the cost of their care would no longer exist.
- Nursing facilities could charge residents for services in addition to the payment the facility will already receive from the State for covered services.

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REPUBLICAN MEDICAID PROPOSALS

SPOUSAL IMPOVERISHMENT ENFORCEMENT ISSUES

Devoid of the current law context of Medicaid, House and Senate provisions intended to protect spouses of nursing home residents from impoverishment are an empty shell. Although both bills include provisions to protect spouses from being impoverished which appear to be taken from current law, they do not in fact continue to protect such spouses because:

- o Individuals protected under current law could lose coverage completely. Both bills repeal the current Medicaid entitlement to nursing home care, as well as to all other services.
 - The bills leave it entirely up to States to determine which persons in which institutions will receive Medicaid assistance in the first place.
 - States would define what the term "institutionalized services" mean. They could employ a narrow definition that would exclude people who are now protected.
 - Persons denied Medicaid coverage whether or not they would be considered an "institutionalized" individual or a "community" spouse would receive no protection whatever.
- o Under both bills, individuals who believe that their State has acted wrongly have limited means to seek redress.
 - The bills prohibit individuals from suing their State on the grounds that the State has failed to comply with this or any other requirement of law.
 - The bills repeal current beneficiary rights to notification, administrative hearings, and appeals. Determining whether and what kinds of rights would exist for beneficiaries would be left to States.

Background -- Current law:

States are required to protect minimum amounts of a couple's income and assets for the at-home spouse when the other spouse enters a nursing home or other institution for a long-term stay.

- o **Income:** States are required to protect a monthly income for the at-home spouse of up to \$1,870. Figures are for 1995, and are updated annually for inflation.
- o **Assets:** "Assets" include things like savings accounts, investments, but not such assets as the home, automobile, or certain limited insurance policies, which

are protected for all persons eligible for Medicaid and their spouses. In addition, persons can have up to \$2000 in savings (typical amount) and still be eligible for Medicaid.

The minimum amount of protected assets for the community spouse is \$14,964 (higher at State option). The maximum is \$74,820. Community spouses can petition for more. Figures are for 1995, and are updated annually for inflation.

Amounts above the protected levels of assets and, in some cases income, are expected to be used to defray the cost of nursing home care.

CLEARED 10/26/95

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EXECUTIVE OFFICE OF THE PRESIDENT

Washington, D. C.

FAX TRANSMITTAL COVER SHEET

DATE: 08-Nov-95

TO: JEN KLEIN

SUBJECT: SPOUSAL IMPOVERISHMENT

FROM: PAULINE M. ABERNATHY 456-5374
NATIONAL ECONOMIC COUNCIL

If there are any problems receiving this transmission,
please call the sender, or (202) 395-7370.

**THE REPUBLICAN MEDICAID PROPOSALS ONLY PRETEND
TO PROTECT SENIORS FROM SPOUSAL IMPOVERISHMENT**

I. Current law protects spouses and their families from poverty. Federal law ensures that spouses of people needing nursing home care do not have to lose everything they have in order for their spouse to qualify for Medicaid:

- ? States must let spouses keep income equal to 150% of the national poverty level -- about \$15,000 per year.
- ? States must let spouses keep a minimum amount of their assets. The minimum is set by the state and may range from about \$15,000 to \$75,000. The value of the spouse's home and car are not counted toward the asset limit, which protects spouses from having to sell these items to qualify for Medicaid.
- ? Since this federal law went into effect in 1989, it has protected about 450,000 spouses of nursing home residents. Most of these spouses are women.

II. Earlier versions of the Republican Medicaid Block Grant proposals repealed these spousal impoverishment protections. Under the initial House and Senate plans any state government could force people whose husbands or wives have to go into nursing homes to give up their car, their furniture -- even their home before their spouse can qualify for any medical support.

III. The President protested the elimination of these protections.

"Congress should strip these outrageous provisions from the budget bill. They're inconsistent with our core values. They're not what America is all about, and they are certainly not necessary to balance the budget."

-President William Jefferson Clinton

Radio Address to the Nation, September 30, 1995

IV. Responding to the President's criticisms, Republicans modified their plans. But they only passed an empty shell -- their bill still does not protect against spousal impoverishment.

- ? Since both bills repeal the current Medicaid guarantee of nursing home care, there is also no guarantee of spousal impoverishment protections.
- ? Both House and Senate bills repeal current national requirements for beneficiary rights to notification, administrative hearings, and appeals.
- ? Under the House bill, eligible individuals who are not receiving the spousal impoverishment protections can no longer sue the State to obtain these essential protections.

-- Section 2117 of the House bill states: "no person (including

an applicant, beneficiary, provider, or health plan) shall have a cause of action under Federal law against a State in relation to a State's compliance (or failure to comply) with the provisions of this title or of a MediGrant plan."

- ? Both bills make it more difficult for the Federal government to ensure that States comply with any beneficiary protection requirements.