

Patient Safety and Abuse Prevention Act

Short Title (Section 1 of the Mark)

Current Law

No provision.

Chairman's Mark

The Mark sets forth the title of the Act as the Patient Safety and Abuse Prevention Act of 2008.

Findings (Section 2(a) of the Mark)

Current Law

No provision.

Chairman's Mark

The Mark describes the following findings of Congress:

- (1) Frail elders are a highly vulnerable population who often lack the ability to give consent or defend themselves. Since the best predictor of future behavior is past behavior, individuals with histories of abuse pose a definite risk to patients and residents of long-term care facilities.
- (2) Every month, there are stories in the media of health care employees who commit criminal misconduct on the job and are later found, through a background check conducted after the fact, to have a history of convictions for similar crimes.
- (3) A 2006 study conducted by the Department of Health and Human Services determined that--
 - (A) criminal background checks are a valuable tool for employers during the hiring process;
 - (B) the use of criminal background checks during the hiring process does not limit the pool of potential job applicants;
 - (C) 'a correlation exists between criminal history and incidences of abuse'; and
 - (D) the long-term care industry supports the practice of conducting background checks on potential employees in order to reduce the likelihood of hiring someone who has potential to harm residents.
- (4) In 2004, the staffs of State Adult Protective Services agencies received more than 500,000 reports of elder and vulnerable adult abuse, and an ombudsman report concluded that more than 15,000 nursing home complaints involved abuse, including nearly 4,000 complaints of physical abuse, more than 800 complaints of sexual abuse, and nearly 1,000 complaints of financial exploitation;

(5) The Department of Health and Human Services has determined that while 41 States now require criminal background checks on certified nurse aides prior to employment, only half of those (22) require criminal background checks at the Federal level.

Purposes (Section 2(b) of the Mark)

Current Law

No provision.

Chairman's Mark

The Mark defines the purposes of the Patient Safety and Abuse Prevention Act, as follows:

- (1) to lay the foundation for a coordinated, nationwide system of State criminal background checks that would greatly enhance the chances of identifying individuals with problematic backgrounds who move across State lines;
- (2) to stop individuals who have a record of substantiated abuse, or a serious criminal record, from preying on helpless elders and individuals with disabilities; and
- (3) to provide assurance to long-term care employers and the residents they care for that potentially abusive workers will not be hired into positions of providing services to the extremely vulnerable residents of our Nation's long-term care facilities.

Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-term Care Facilities and Providers (Section 3 of the Mark)

Current Law

Background Checks of FBI Records for Nursing Homes and Home Health Agencies. The Omnibus Consolidated and Emergency Supplemental Appropriations Act of 1999 (P. L. 105-277) allowed nursing homes and home health agencies to request, through their state agencies, that the Federal Bureau of Investigation (FBI) search its all-state national data bank of arrests and convictions for the criminal histories of job applicants who would provide direct patient care, as long as states establish mechanisms for processing these requests. Most states have enacted laws that require or allow nursing homes and home health agencies to conduct these criminal background checks for certain categories of potential employees. The Attorney General may charge nursing homes and home health agencies fees no greater than \$50 per request.

To conduct a criminal background check of FBI records, nursing homes and home health agencies must provide a copy of applicants' fingerprints, a statement signed by the applicant authorizing the search, and other information to the appropriate state agency.

Such information must be provided no later than 7 days after its acquisition by the nursing home or home health agency. Nursing facilities or home health care agencies that deny employment based on reasonable reliance on information from the Attorney General are exempt from liability for any action brought by the applicant. The information received from either the state or Attorney General may be used only for the purpose of determining the suitability of the applicant for employment by the agency in a position involved in direct patient care.

Healthcare Integrity and Protection Data Bank/ Health Care Fraud and Abuse Data Collection Program. The U.S. Department of Health and Human Services (HHS) maintains a national health care fraud and abuse data base, the Healthcare Integrity and Protection Data Bank (HIPDB), for the reporting of final adverse actions, including health care related civil judgments and criminal convictions of health care practitioners, providers and suppliers. This information is currently available for self-query by government agencies, health plans, health care providers, suppliers and practitioners. All states also maintain their own registries of persons who have completed nurse aide training and competency evaluation programs and other persons whom the state determines meet the requirements to work as a nurse aide. Included in these registries are data describing state findings of resident neglect, abuse and/or the misappropriation of resident property.

Long-Term Care Background Check Pilot Program. The Medicare Modernization Act of 2003 (MMA, P.L. 108-173) established a pilot program for national and state background checks on direct patient access employees of long-term care (LTC) facilities and providers. Specifically, the Secretary of HHS, in consultation with the Attorney General, was required to establish the pilot program in no more than 10 states.

The purpose of the pilot program was to identify efficient, effective, and economical procedures for these background checks. LTC facilities or providers are defined as certain facilities or providers that receive Medicare and/or Medicaid payment, including nursing homes, home health agencies, hospices, LTC hospitals, providers of personal care services, certain residential care providers, and intermediate care facilities for the mentally retarded (ICF/MRs). States in the pilot project may choose to require other LTC providers to also conduct background checks; however, providers paid through self-directed arrangements, or in arrangements in which patients employ the provider of services directly, are not included.

States that agree to participate in this pilot project will be responsible for (1) monitoring compliance, (2) establishing procedures for workers to appeal or dispute the findings of the background checks, (3) agreeing to review the results of state or national criminal background checks to determine whether the employee was convicted of a relevant crime, (4) reporting the results of the review to the provider, and (5) reporting any employees with relevant convictions to the HIPDB database. The Secretary will establish criteria for selecting those states seeking to participate to ensure geographic diversity, the inclusion of a variety of LTC providers, the evaluation of a variety of payment mechanisms, and the evaluation of enforcement penalties. In addition, the

Secretary is required to select at least one state that permits providers to hire provisional employees; at least one state that does not permit hiring of provisional employees; at least one state that establishes procedures for contracting with an employment agency to conduct background checks; and at least one state that includes training for managers and employees to prevent patient abuse.

Procedures established in a participating state should be designed to: (1) give notice to prospective employees about the background check requirement, (2) require the employee to produce a written statement disclosing any conviction for a relevant crime or finding of patient or resident abuse, (3) require the employee to authorize a criminal background check in writing, (4) require the employee to provide the facility with a rolled set of finger prints, (5) require any other information specified by the state, (6) require the provider to conduct checks of available registries that would be likely to contain disqualifying information about convictions for relevant crimes or findings of abuse, and (7) permit the provider to obtain criminal histories on prospective employees using a 10-fingerprint check from state criminal records and the Integrated Automated Fingerprint Identification system of the Federal Bureau of Investigation. Disqualifying information for employment includes any federal or state conviction for program-related crimes (those related to the delivery of an item or service under Medicare or under any other state health care program), a federal or state conviction for patient or resident abuse, a federal or state felony conviction related to health care fraud or a controlled substance, or an act of patient or resident abuse or neglect or misappropriation of patient or resident property, or other acts specified by states.

Under this pilot program, states may establish procedures for facilitating background checks through employment agencies. States may also impose penalties to enforce the requirements of the pilot program conducted in that state.

A LTC provider may not knowingly employ any direct patient access employee who has any disqualifying information; however, participating states may permit providers to provisionally employ workers pending completion of the national and state criminal history background checks subject to supervisory requirements established by the state. These supervisory requirements would take into account the cost or other burdens associated with small rural providers as well as the nature of care delivered by home health or hospice providers. Further, the information obtained from the check may only be used for the purpose of determining the suitability of the applicant for employment. States are required to ensure that providers are protected from liability for denying employment based on reasonable reliance on information from the background checks.

The Secretary, in consultation with the Attorney General, is required to conduct an evaluation of this pilot program. The evaluation should (1) review and identify those state procedures that are most efficient, effective, and economical; (2) assess the costs of conducting the checks; (3) consider the benefits and problems associated with requiring employees or provider to pay the costs of conducting background checks; (4) consider whether the costs should be allocated between the Medicare and Medicaid programs and

how to do so; (5) determine the extent to which the background checks may lead to unintended consequences, including a reduction in the available workforce; (6) review forms used by participating states to conduct a model form for background checks; (7) determine the effectiveness of background checks conducted by employment agencies; and (8) recommend appropriate procedures and payment mechanisms for implementing a national criminal background check program.

The Secretary is required to pay participating states out of funds in the Treasury for the costs of conducting the pilot program (reserving 4% of the payments for the program's evaluation). For fiscal years 2004 through 2007, \$25 million was appropriated from funds not otherwise appropriated.

Seven states were selected by the Secretary to participate in the pilot. They are Alaska, Idaho, Illinois, Michigan, Nevada, New Mexico and Wisconsin. All but Illinois and Wisconsin extended the program statewide. Pilots in each of these states concluded on September 30, 2007. The final evaluation of a three-year pilot has not yet been released by CMS.

Chairman's Mark

The Secretary would be required to expand the pilot program authorized under Section 307 of MMA. The program prohibited providers from knowingly employing any direct patient access employees with any disqualifying information as revealed by the background checks, and authorized participating states to impose penalties, as they deemed appropriate, to enforce the program's requirements.

State Agreements with the Secretary. States that are not already in the pilot would have the option to enter into agreements with the Secretary of Health and Human Services (HHS) to conduct background checks under the program on a statewide basis and to submit an application to the Secretary according to the Secretary's guidelines.

The Secretary would be required to enter into agreements with each state that participated in the pilot program that: (1) did not conduct background checks on a statewide basis; (2) agrees to conduct background checks under the new terms of the program on a statewide basis; and (3) submits an application to the Secretary containing such information and at such time as the Secretary may specify.

Section 307 of the MMA is modified per the following:

Required Fingerprint Check. Prior to employing a direct patient access employee that is first hired on or after the commencement date of the nationwide program, providers (or their designated agents) would be required to obtain state and national criminal history background checks on prospective employees using a search of state-based abuse and neglect registries and databases. These searches would include state-based abuse and neglect registries and databases of states in which a prospective employee previously resided; state criminal history records; records of proceedings in the

state that might contain disqualifying information (such as those of professional licensing and disciplinary boards and Medicaid Fraud Control Units); and federal criminal history records, including fingerprint checks using the FBI's Integrated Automated Fingerprint Identification System.

Additionally, a "rap back" capability by the state would also be required to be developed such that, if a direct patient access employee is convicted of a crime after the initial background check is conducted and the employee's fingerprints match the prints on file with the state law enforcement department, the department would immediately inform the state and the state would immediately inform the provider of the conviction.

State Requirements. States participating in the program would be required to monitor compliance with the requirements of the nationwide program and have procedures to: (1) conduct screening and criminal history background checks under the nationwide program; (2) monitor the compliance of LTC facilities and providers; (3) provide, as appropriate, for a provisional period (not to exceed 30 days) of employment of a direct patient access employee - pending completion of the required criminal background checks, or completion of an employee's appeal process regarding the results of the background check - during which the employee will be directly supervised on-site according to procedures established by the state; and (4) provide an independent appeals process by which provisional or other employees may dispute the accuracy of the information obtained in the background check, including specified criteria (which would be required to include consideration of the passage of time, extenuating circumstances, demonstration of rehabilitation, and relevancy of the particular disqualifying information with respect to the current employment of the individual) for appeals by employees found to have disqualifying information.

Further, states would be required to have procedures in place to designate a single state agency responsible for: (1) overseeing the coordination of state and national criminal history background checks requested by LTC facilities or providers (or their designated agents) using a search of state and federal criminal history records, including a fingerprint check of such records; (2) overseeing the design of privacy and security safeguards for use in the review of background check results regarding a prospective direct patient access employee to determine whether the employee has any conviction for a relevant crime; (3) immediately reporting the results of the background check reviews to the LTC facility or provider; and (4) reporting the existence of an employee's conviction for a relevant crime to the Health Care Fraud and Abuse Data Collection Program.

States would also need written procedures for determining which individuals are direct patient access employees; specifying offenses, including convictions for violent crimes, for purposes of the nationwide program; and developing and implementing the above-defined "rap back" capability such that the state agency will immediately inform the facility or provider when an employee is found to have a criminal conviction, and will provide, or require the provider to supply, the employee with a copy of the results of

the criminal history background check at no charge should the employee request such a copy.

Payments. As a condition of receiving the federal matching payment, newly participating states and previously participating states would be required to guarantee, as part of their application, that the state would make available (directly or through donations from public or private entities) a particular amount of non-Federal contributions for costs incurred by the state in carrying out the nationwide program. The Secretary would agree to provide federal matching payments for newly participating states that would be three times the guaranteed state amount, not to exceed \$3 million to each state. In addition, the Secretary would agree to provide federal matching payments for previously participating states that would be three times the guaranteed state amount, not to exceed \$1.5 million to each state.

Evaluation and Report. The Inspector General of the Department of Health and Human Services (HHS) would be required to conduct an evaluation and/or audit of the nationwide program and to submit a report to Congress with results of the evaluation and/or audit no later than 180 days after completion of the nationwide program.

Funding. The Secretary of HHS would be required to notify the Secretary of the Treasury of the amount necessary to carry out the nationwide program for fiscal years (FYs) 2009 through 2011, except that in no case would such amount exceed \$160 million. Out of any Treasury funds not otherwise appropriated, the Secretary of the Treasury would be required to provide for the transfer to the Secretary of the amount specified as necessary to carry out the nationwide program.

Mandatory State Use of National Correct Coding Initiative (Section 4 of the Mark)

Current law

The federal government pays a share of every state's spending on Medicaid services and program administration. The federal match for administrative expenditures does not vary by state and is generally 50%, but certain functions receive a higher amount. Section 1903(a)(3) of the Social Security Act authorizes a 90% match for expenditures attributable to the design, development, or installation of mechanized claims processing and information retrieval systems - referred to as Medicaid Management Information Systems (MMISs) - and a 75% match for the operation of MMISs that are approved by the Secretary of Health and Human Services (HHS). A 50% match is available for non-approved MMISs under Section 1903(a)(7). In order to receive payments under Section 1903(a) for the use of automated data systems in the administration of their Medicaid programs, states are required under Section 1903(r) to have an MMIS that meets specified requirements and that the Secretary has found

(among other things) is compatible with the claims processing and information retrieval systems used in the administration of the Medicare program.

The National Correct Coding Initiative (NCCI) is an editing system developed for the Medicare program by the Centers for Medicare and Medicaid Services within HHS to promote national correct coding methodologies and to prevent improper payment when incorrect code combinations are reported in Medicare Part B claims. It is based on coding conventions defined in the American Medical Association's CPT manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. Although the use of NCCI edits is mandatory in Medicare, state Medicaid agencies are not required to use these edits in processing their claims. In 2004, the HHS Office of Inspector General released a report indicating that most states do not use the Medicare NCCI edits and that 39 states paid \$54 million in 2001 for services that would have been denied based on those edits.

Chairman's Mark

The Mark would amend Section 1903(r) of the Social Security Act to require states to have an MMIS that, effective for claims filed on or after October 1, 2009, incorporates compatible elements of the NCCI (or any successor initiative) and such other elements of that Initiative (or such other national correct coding methodologies) as the Secretary identifies in accordance with specified requirements. Not later than September 1, 2009, the Secretary would be required to:

- identify those methodologies of the NCCI (or any successor initiative to promote correct coding and to control improper coding leading to inappropriate payment) which are compatible to claims filed under Medicaid;
- identify those methodologies of such Initiative (or such other national correct coding methodologies) that should be incorporated into claims filed under Medicaid with respect to items and services for which no national correct coding methodologies have been established under such Initiative with respect to Medicare;
- notify states of the elements identified (and of any other national correct coding methodologies identified) and how states are to incorporate such elements (and methodologies) into claims filed under Medicaid;
- submit a report to Congress that includes the notice to states and an analysis supporting the identification of the elements (or methodologies).

If the Secretary determines that state legislation is required in order for a Medicaid state plan to meet the additional requirements imposed by the provision, the state plan would not be regarded as failing to comply before the first day of the first calendar quarter beginning after the close of the first regular session of the state

legislature that begins after the date of enactment. In the case of a state that has a 2-year legislative session, each year of the session would be considered a separate regular session of the state legislature.

Funding for the Medicare Improvement Fund (Section 5 of the Mark)

Current Law

The Secretary will establish a Medicare Improvement Fund that will be available to the Secretary to make improvements under the original fee-for-service program under Parts A and B for Medicare beneficiaries. The Medicare Improvements for Patients and Providers Act of 2008 (P.L. 110-275, MIPPA), together with a provision in the Supplemental Appropriations Act, 2008 (P.L. 110-252), makes \$2.22 billion from the Part A and B Trust Funds available for services furnished during FY2014 and an additional \$19.9 billion available for fiscal years 2014 through 2017.

For purposes of carrying out the provisions of, and amendments made by MIPPA in addition to any other amounts provided in such provisions and amendments, additional funds will be made available to CMS. For fiscal years 2009 through 2013, the Secretary of Health and Human Services will transfer \$140 million from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund to the CMS Program Management Account. The amounts drawn from the funds will be in the same proportion as for Medicare managed care payments (Medicare Advantage), that is, in a proportion that reflects the relative weight that benefits under part A and under part B represent of the actuarial value of the total benefits.

Chairman's Mark

The Mark would continue to make \$2.22 billion available to the Fund for expenditures from the Fund for services furnished during FY 2014, but would increase the amount of funds available for FYs 2014 through 2017 by \$300 million, from \$19.9 billion to \$20.2 billion. The \$300 million is unspent savings from the offset identified in section 4 of the Mark.