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PATIENT SAFETY AND ABUSE PREVENTION ACT

SEPTEMBER 22 (legislative day, SEPTEMBER 17), 2008.—Ordered to be printed

Mr. BAUCUS, from the Committee on Finance, submitted the following

R E P O R T

[To accompany S. 1577]

[Including cost estimate of the Congressional Budget Office]

The Committee on Finance, to which was referred the bill (S. 1577) to amend titles XVIII and XIX of the Social Security Act to require screening, including national criminal history background checks, of direct patient access employees of skilled nursing facilities, nursing facilities, and other long-term care facilities and providers, and to provide for nationwide expansion of the pilot program for national and State background checks on direct patient access employees of long-term care facilities or providers, reports favorably thereon with an amendment in the nature of a substitute and recommends the bill, as amended, do pass.

I. BACKGROUND

Background checks [1] for job applicants have long been used as an important tool to help reduce the rates of abuse among vulnerable populations. During the 1990s, the National Child Protection Act was enacted to allow states to conduct background checks and suitability reviews of employees or volunteers of entities that provide services to children, the elderly and disabled persons. At the State level, many states routinely require individuals seeking to work with children to undergo background checks as part of the pre-employment process.

[1] In this report, the term "background check" refers to comprehensive pre-employment screening of long-term care workers using a combination of State-based registries, state-based criminal history checks (name-based, fingerprint-based, or both), and FBI criminal history checks (fingerprint-based).

69–010

MILLIONS OF ELDERLY AND DISABLED INDIVIDUALS ARE NOT ADEQUATELY PROTECTED

Although national surveys often exclude institutional settings such as nursing homes and adult day care centers, evidence shows that abuse in institutions is "extensive and alarming."[2] A recent analysis of Medicaid Fraud Control Unit cases of elder abuse concluded that among 801 cases of nursing home abuse analyzed, about two-thirds were due to physical abuse.[3] Elder abuse can take the form of physical abuse (battery, assault and rape), neglect (withholding or failure to provide adequate food, shelter and health care) and financial exploitation (theft, predatory lending and other illegal misuse or taking of funds, property or assets).

In addition, because the demand for home-based care is expected to grow rapidly in the coming decades, policy to prevent and address elder abuse in home-based care settings is needed.[4] A recent investigation published in the Wall Street Journal examined cases of abuse and neglect by home health aides, noting that "in tiny Lake County, California [population <66,000 in 2006], 80 percent of the 74 prosecutions of elder abuse in the past year involved home health aides."[5]

Most States now have significant gaps and loopholes in the procedures they use to check applicants. For example, registries and databases established for different sectors of the workforce are often poorly coordinated, causing lengthy clearance times. While nursing homes are required under Federal law to conduct registry checks on all Certified Nurse Aides (CNAs), they may not conduct State and Federal criminal history checks on all employees who have direct access to residents. And in many states, requirements for pre-employment checks do not extend to workers in other long-term care settings. This allows individuals with a history of substantiated abuse or a serious criminal history to avoid detection, frequently by crossing State lines.

A 2002 Government Accountability Office (GAO) report requested by members of the Senate Special Committee on Aging (Committee) recommended that individuals applying to work in all long-term care settings also undergo background checks because the elderly, like children, are a highly vulnerable population.[6] The Department of Health and Human Services Office of Inspector General has made similar recommendations in several reports.

To date, without broad-based Federal requirements and funding, only a few States have moved to incorporate these efficiency-improving system changes. Instead, many states continue to use slower, less accurate paper-based systems that can result in long processing times for providers. In turn, slow processing times increase the risk of abuse by allowing employees with disqualifying crimes to work for several months before background checks are completed. In turn, this contributes to a practice of "job-hopping," in

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[2] Payne, Brian and Gainey, Randy. "The Criminal Justice Response to Elder Abuse in Nursing Homes: A Routine Activities Perspective." Western Criminology Review. 7(3). 67–81 (2006).

[3] Ibid.

[4] Goldberg, Lee. "Everything You Wanted to Know About Long Term Care . . . But Were Afraid to Ask." Presentation to the National Academy of Social Insurance. July 22, 2008.

[5] Shishkin, Philip. "Cases of Abuse by Home Aides Draw Scrutiny." The Wall Street Journal. 15 July 2008.

[6] U.S. Government Accountability Office, "Nursing Homes: More Can Be Done to Protect Residents from Abuse." GAO–02–312. March 2002.

which workers switch jobs frequently, before their criminal history checks can be processed.

SCREENING OF LONG-TERM CARE WORKFORCE INVOLVES MULTIPLE TYPES OF CHECKS

Three different types of databases are typically used to conduct background checks:

- Registry checks cross-reference an individual's name with public databases, such as the National Sex Offender Registry, or with lists of workers found to have a record of substantiated abuse in a particular field, such as the state CNA registries;
- State name-based and fingerprint criminal checks are searches of state police records using a person's name and other identifying information, or their fingerprints;
- Federal criminal history checks are conducted by the FBI through its all-state biometric repository, the Integrated Automated Fingerprint Identification System (IAFIS), which uses fingerprints to identify whether an individual has been arrested or convicted.

Because no single database is complete, a comprehensive background check process that uses many different databases promises to be most effective.

Recent technological improvements are helping to streamline the different types and levels of background check processes. For example, "Livescan" fingerprint technology, which records an electronic copy of a fingerprint, is less prone to error and is faster to process than paper-based inked fingerprints. Another innovation is the "rap-back" system, which ensures that any new disqualifying crimes an individual commits after an initial clearance are flagged in a state's database and can be reported back to the current employer—so that the individual can be terminated. The FBI is now working to create a parallel federal rap-back capability as part of the agency's "Next Generation Identification" (NGI) System initiative.[7] Rap-back systems also have the potential to reduce costs by avoiding the need for duplicative checks.

Absent focused state initiatives to refine, improve and expand existing background check procedures and implementation of other innovations, such as abuse prevention training and related measures to prevent and detect elder abuse, experts warn that mistreatment and exploitation of frail elders will rise further during the first half of the 21st century as the number of older adults grows. Today, conservative estimates are that elder abuse affects hundreds of thousands of seniors each year.[8]

To address this, for States electing to participate, the Patient Safety and Abuse Prevention Act will:

- Provide the opportunity to improve their existing background check infrastructure for employees who work one-on-one with frail elders and individuals with disabilities in long-term care facilities and other settings. To accomplish this, the bill makes available up to $3 million in grant funding to each participating state, provided over three years, contingent on a 25 percent state match.

[7] U.S. Department of Justice. "The Attorney General's Report on Criminal History Background Checks." June 2006.

[8] Colello, Kirsten. "Background on Elder Abuse Legislation and Issues." Congressional Research Service. 25 January 2007.

• Enable recipient states to create a comprehensive background check system for long-term care job applicants by making needed investments in their databases, creating workforce background check units, updating applicable laws and regulations, and offering additional training to long-term care providers.

• Establish mechanisms for workers who are denied employment to dispute the results through an independent external process, and develop procedures aimed at reducing unnecessary repeat fingerprint checks for workers who change jobs frequently.

• Significantly improve the ability of states across the country to design cost-effective and efficient background check systems that would reduce the risk of elder abuse in the thousands of facilities and other settings where many of the frailest Americans receive health and long-term care.

II. LEGISLATIVE HISTORY

One of the first major congressional actions taken to combat elder abuse was the creation of the Long-Term Care Ombudsman Program (LTCOP) in order to investigate and resolve complaints in nursing homes and other residential care settings. This program was created in 1972 as a Public Health Service demonstration project in five states. As a result of the pilot program's success, the LTCOP was expanded to all states and included as an amendment to the Older Americans Act (OAA) in 1978.[9] In 1992, the program become incorporated into a new title VII of the OAA that authorized elder rights protection activities and required the Administration on Aging (AoA) to create a permanent National Ombudsman Resource Center.

Other federal resources aimed at preventing elder abuse include the Social Services Block Grant (SSBG) program authorized by title XX of the Social Security Act, which includes Adult Protective Services (APS), and some programs of the Violence Against Women Act.

Although Congress has passed several laws that address child abuse and domestic violence, less attention has been paid to combating elder abuse at the Federal level. However, in addition to the Elder Justice Act, there have been several legislative proposals introduced in the Senate during the last several Congresses to combat elder abuse.

During the 105th Congress, Senator Herb Kohl (D–WI) introduced the Patient Abuse Prevention Act, S. 1122, on July 31, 1997, and the Long-Term Care Patient Protection Act of 1998, S. 2570, on October 7, 1998. Both bills were referred to the Senate Finance Committee.

Senator Kohl introduced the Patient Abuse Prevention Act, S. 1445, again on July 27, 1999, in the 106th Congress, and the bill was referred to the Senate Finance Committee.

Also during the 106th Congress, Senator Charles E. Grassley (R–IA) introduced the Home Health Integrity Preservation Act, S. 255, on January 20, 1999, and Senator John Ashcroft (R–MO) introduced the Senior Care Safety Act of 2000, S. 3066, on September 19, 2000. Both bills were referred to the Senate Finance Committee.

[9] P.L. 95–478.

Senator Kohl introduced the Patient Abuse Prevention Act, S. 3091, again on October 10, 2002, in the 107th Congress, and the bill was referred to the Senate Finance Committee.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, H.R. 1, was introduced by Representative Dennis Hastert (R–IL) on June 25, 2003, during the 108th Congress. The bill became Public Law 108–173 on December 8, 2003. This law established a pilot program for national and state background checks on direct patient access employees of long-term care (LTC) facilities and providers. The Secretary of Health and Human Services, 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.

Also in the 108th Congress, on April 30, 2003, Senator Kohl introduced the Patient Abuse Prevention Act, S. 958, and the bill was referred to the Senate Finance Committee.

During the 110th Congress, Senator Kohl introduced the Patient Safety and Abuse Prevention Act of 2007, S. 1577, on June 7, 2007, and the bill was referred to the Senate Finance Committee. Under the leadership of Chairman Max Baucus (D–MT), the Senate Finance Committee considered the bill in Executive Session on September 10, 2008, after postponement of an Executive Session scheduled for August 1, 2008. On September 10, 2008, the Senate Finance Committee unanimously reported the bill as an amendment in the nature of a substitute.

III. SECTION-BY-SECTION ANALYSIS

SHORT TITLE (SECTION 1 OF THE COMMITTEE BILL)

Present law

No provision.

Committee bill

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

FINDINGS (SECTION 2(a) OF THE COMMITTEE BILL)

Present law

No provision.

Committee bill

The Committee Bill 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 COMMITTEE BILL)

Present law

No provision.

Committee bill

The Committee Bill 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 COMMITTEE BILL)

Present 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 agreed to participate in the pilot project were 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 established 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 was 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 the participating states were 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 included 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 were permitted to establish procedures for facilitating background checks through employment agencies. States could also impose penalties to enforce the requirements of the pilot program conducted in that state.

LTC providers were not permitted to knowingly employ any direct patient access employee who has any disqualifying information; however, participating states could 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 were designed to 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 could only be used for the purpose of determining the suitability of the applicant for employment. States were required to ensure that providers were protected from liability for denying employment based on reasonable reliance on information from the background checks.

The Secretary, in consultation with the Attorney General, was 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 was required to pay participating states out of funds in the Treasury for the costs of conducting the pilot program (reserving 4 percent 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.

Committee bill

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 COMMITTEE BILL)

Present 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 percent, but certain functions receive a higher amount. Section 1903(a)(3) of the Social Security Act authorizes a 90 percent 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 percent match for the operation of MMISs that are approved by the Secretary of Health and Human Services (HHS). A 50 percent 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.

Committee bill

The Committee Bill 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 COMMITTEE BILL)

Present 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.

Committee bill

The Committee Bill 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 Committee Bill.

IV. REGULATORY IMPACT AND OTHER MATTERS

A. REGULATORY IMPACT

Pursuant to paragraph 11(b) of rule XXVI of the Standing Rules of the Senate, the Committee makes the following statement concerning the regulatory impact that might be incurred in carrying out the provisions of the bill as amended.

Impact on individuals and businesses

The provisions of the bill are not expected to impose additional administrative requirements or regulatory burdens on individuals or businesses.

Impact on personal privacy and paperwork

The provisions of the bill do not reduce personal privacy.

This information is provided in accordance with section 423 of the Unfunded Mandates Reform Act of 1995 (P.L. 104–4).

The Committee has determined that the provisions of the bill contain no Federal private sector mandates.

The Committee has determined that the provisions of the bill do not impose a Federal intergovernmental mandate on State, local, or tribal governments.

V. COST ESTIMATE

SEPTEMBER 17, 2008.

Hon. MAX BAUCUS,
Chairman, Committee on Finance,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for S. 1577, the Patient Safety and Abuse Prevention Act.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Mindy Cohen.

Sincerely,

PETER R. ORSZAG.

Enclosure.

S. 1577—Patient Safety and Abuse Prevention Act

Summary: S. 1577 would direct the Secretary of Health and Human Services (HHS) to provide funding to States that participate in a program to enforce a requirement that long-term care facilities and providers conduct criminal background checks on employees who have direct access to patients. The bill also would require that state Medicaid programs adopt systems to identify, and deny payment for, claims for inappropriate services and claims that are incorrectly coded. In addition, S. 1577 would provide funding for the Secretary to make improvements in Medicare part A and part B benefits during fiscal years 2014 through 2017.

In total, CBO estimates that the net impact on direct spending of enacting S. 1577 would be negligible over both the 2009–2013 and 2009–2018 periods. Enacting the bill would not affect federal revenues or spending subject to appropriation.

S. 1577 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA). The bill would place new requirements on state Medicaid programs that would reduce state spending for the program by about $80 million over the 2009–2013 period.

The estimated budgetary impact of S. 1577 is shown in the following table. The costs of this legislation fall within budget functions 550 (health) and 570 (Medicare).

	Outlays, by fiscal year, in millions of dollars—											
	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2009–2013	2009–2018
CHANGES IN DIRECT SPENDING												
Background Checks on Employees of Long-Term Care Facilities:												
Estimated Budget Authority	0	50	45	5	0	0	0	0	0	0	100	100
Estimated Outlays	0	50	45	5	0	0	0	0	0	0	100	100
National Correct Coding Initiative:												
Estimated Budget Authority	0	−10	−20	−30	−40	−50	−60	−75	−85	−90	−100	−460
Estimated Outlays	0	−10	−20	−30	−40	−50	−60	−75	−85	−90	−100	−460
Medicare Improvement Fund:												
Estimated Budget Authority	0	0	0	0	0	90	90	90	90	0	0	360
Estimated Outlays	0	0	0	0	0	90	90	90	90	0	0	360
Total Changes:												
Estimated Budget Authority	0	40	25	−25	−40	40	30	15	5	−90	0	0
Estimated Outlays	0	40	25	−25	−40	40	30	15	5	−90	0	0

Basis of estimate: The bill contains provisions that would both increase and decrease direct spending. CBO estimates the net budgetary impact of the legislation would be negligible over both the 2009–2013 and 2009–2018 periods.

Background checks on employees of long-term care facilities

S. 1577 would expand a pilot program created by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Public Law 108–173) for background checks on certain employees of long-term care facilities or providers. The expanded pilot program would be available to any state that did not implement a Statewide program under the previous authority. In the states that decide to participate under the expanded pilot program, long-term care providers that participate in Medicare or Medicaid would be required to obtain state and national criminal histories on all prospective employees. Participating states also would be required to monitor compliance with these requirements. Newly participating states would be eligible to receive up to $3 million for these activities; previously participating states would be eligible to receive $1.5 million. S. 1577 would appropriate the amount necessary to operate this program during fiscal years 2009 through 2011, up to a limit of $160 million over those three years. Based on spending under the original pilot program, CBO estimates that provision would increase direct spending by $100 million over the 2009–2013 and 2009–2018 periods.

National Correct Coding Initiative

The National Correct Coding Initiative (NCCI) consists of automated procedures to identify Medicare claims that are inaccurately coded or seek payment for inappropriate services. Although the use of NCCI procedures to check claims is mandatory in the Medicare program, State Medicaid agencies are not required to use those edits in processing Medicaid claims. S. 1577 would require that state Medicaid programs adopt certain NCCI procedures by October 1, 2009. CBO estimates that use of the NCCI checks would lead to the denial of certain Medicaid claims and therefore save Medicaid $100 million over the 2009–2013 period and $460 million over the 2009–2018 period.

Medicare Improvement Fund

The Medicare Improvement Fund was created by the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275). The fund is available to the Secretary of HHS to make improvements in Part A and Part B benefits. S. 1577 would increase the amounts available in the fund for the 2014–2017 period. CBO estimates that those changes in funding would increase outlays by $360 million over that period.

Estimated impact on state, local, and tribal governments: S. 1577 contains no intergovernmental mandates as defined in UMRA. To reduce inappropriate payments in the Medicaid program, the bill would require states to incorporate the National Correct Coding Initiative when processing provider claims. The requirement to comply with the initiative, however, would not impose an intergovernmental mandate as defined in UMRA because the Medicaid program provides states with significant flexibility to make pro-

grammatic adjustments to accommodate the changes. Incorporating the initiative would ultimately reduce state spending in the program by about $80 million over the 2009–2013 period. States also would benefit from funding provided by the bill for background checks of prospective employees of long-term care facilities or providers. Any costs states incur, including matching funds, would be incurred voluntarily.

Estimated impact on the private sector: S. 1577 contains no private-sector mandates as defined in UMRA.

Estimate prepared by: Federal Costs: Mindy Cohen and Rob Stewart; Impact on State, Local and Tribal Governments: Lisa Ramirez-Branum; Impact on the Private Sector: Patrick Bernhardt.

Estimate approved by: Keith J. Fontenot, Deputy Assistant Director for Health and Human Resources, Budget Analysis Division.

VI. VOTE OF THE COMMITTEE

In compliance with paragraph 7(b) of rule XXVI of the Standing Rules of the Senate, the following statements are made concerning the vote in the Committee's consideration of the bill.

Motion to report the bill

The bill was ordered favorably reported by a unanimous voice vote on September 10, 2008. A quorum was present. No amendments were voted upon.

VII. CHANGES IN EXISTING LAW

In compliance with paragraph 12 of rule XXVI of the Standing Rules of the Senate, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

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TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

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PART E—MISCELLANEOUS PROVISIONS

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MEDICARE IMPROVEMENT FUND

SEC. 1898. (a) ESTABLISHMENT.—The Secretary shall establish under this title a Medicare Improvement Fund (in this section referred to as the "Fund") which shall be available to the Secretary to make improvements under the original fee-for-service program under parts A and B for individuals entitled to, or enrolled for, benefits under part A or enrolled under part B.

(b) FUNDING.—

[(1) IN GENERAL.—There shall be available to the Fund, for expenditures from the Fund for services furnished during fiscal year 2014, $2,220,000,000 and, in addition for services furnished during fiscal years 2014 through 2017, $19,900,000,000.]

(1) IN GENERAL.—There shall be available to the Fund, for expenditures from the Fund for services furnished during—

(A) fiscal year 2014, $2,220,000,000; and

(B) fiscal years 2014 through 2017, $20,200,000,000.

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TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

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PAYMENT TO STATES

SEC. 1903. (a) From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing January 1, 1966—

* * * * * * *

(r)(1) In order to receive payments under subsection (a) for use of automated data systems in administration of the State plan under this title, a State must have in operation mechanized claims processing and information retrieval systems that meet the requirements of this subsection and that the Secretary has found—

(A) are adequate to provide efficient, economical, and effective administration of such State plan;

(B) are compatible with the claims processing and information retrieval systems used in the administration of title XVIII, and for this purpose—

(i) have a uniform identification coding system for providers, other payees, and beneficiaries under this title or title XVIII;

(ii) provide liaison between States and carriers and intermediaries with agreements under title XVIII to facilitate timely exchange of appropriate data; [and]

(iii) provide for exchange of data between the States and the Secretary with respect to persons sanctioned under this title or title XVIII; *and*

(iv) effective for claims filed on or after October 1, 2009, incorporate compatible methodologies of the National Correct Coding Initiative administered by the Secretary (or any successor initiative to promote correct coding and to control improper coding leading to inappropriate payment) and such other methodologies of that Initiative (or such other national correct coding methodologies) as the Secretary identifies in accordance with paragraph (3);

* * * * * * *

(3) Not later than September 1, 2009, the Secretary shall do the following:

(A) Identify those methodologies of the National Correct Coding Initiative administered by the Secretary (or any successor initiative to promote correct coding and to control improper coding leading to inappropriate payment) which are compatible to claims filed under this title.

(B) Identify those methodologies of such Initiative (or such other national correct coding methodologies) that should be incorporated into claims filed under this title with respect to items or services for which States provide medical assistance under this title and no national correct coding methodologies have been established under such Initiative with respect to title XVIII.

(C) Notify States of—

(i) the methodologies identified under subparagraphs (A) and (B) (and of any other national correct coding methodologies identified under subparagraph (B)); and

(ii) how States are to incorporate such methodologies into claims filed under this title.

(D) Submit a report to Congress that includes the notice to States under subparagraph (C) and an analysis supporting the identification of the methodologies made under subparagraphs (A) and (B).

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