104TH CONGRESS
1ST SESSION

S. 1177

To amend the Social Security Act and the Internal Revenue Code of 1986 to provide improved access to quality long-term care services, to obtain cost savings through provider incentives and removal of regulatory and legislative barriers, to encourage greater private sector participation and personal responsibility in financing such services, and for other purposes.

IN THE SENATE OF THE UNITED STATES

AUGUST 10 (legislative day, JULY 10), 1995

Mr. HATCH introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To amend the Social Security Act and the Internal Revenue Code of 1986 to provide improved access to quality long-term care services, to obtain cost savings through provider incentives and removal of regulatory and legislative barriers, to encourage greater private sector participation and personal responsibility in financing such services, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Quality Care For Life Act of 1995''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

SEC. 2. FINDINGS; PURPOSES.

(a) FINDINGS.—The Congress finds the following:

(1) The Federal Government currently bears excessive costs in providing subacute care to patients for whom inpatient hospital services are not medically necessary, in part because of difficulties in placing such patients in nursing facilities.

(2) Nursing facilities are currently disadvantaged in providing subacute care services because of the significant cash flow burdens resulting from delays by the Health Care Financing Administration in approving exceptions from the medicare routine cost limits.

(3) Physicians are discouraged from facilitating the placement of subacute care patients into skilled nursing facilities because of the absence of equal reimbursement for equivalent medically necessary physician visits, regardless of setting.

(4) Current restrictions on payment for respiratory therapy provided in skilled nursing facilities discourage the admission of subacute care patients who will require such therapy services.

(5) The provision of subacute care by skilled nursing facilities and nursing facilities can result in increased efficiency and substantial cost savings to the medicare and medicaid programs.

(b) PURPOSES.—The purposes of this Act are to—

(1) amend the Internal Revenue Code of 1986 to clarify the Federal tax treatment of long-term care insurance policies to promote the purchase of such policies;

(2) amend the Internal Revenue Code of 1986 to develop reasonable Federal standards for long-term care insurance that promote consumer protection;

(3) modify financial eligibility standards under the medicaid program to ensure an inclusive ac-

counting of individual assets and promote personal responsibility for long-term care expenses;

(4) revise the transfer of asset prohibitions under the Medicaid Program to make the 60-month look-back period in the case of trusts applicable to all transfers of assets, to require ''income cap trusts'' and ''nonprofit association trusts'' to be irrevocable, to include the conversion of personal or real property into annuities as an unlawful transfer, and to direct the Secretary, by regulation, to close such other loopholes not covered by the Omnibus Budget Reconciliation Act of 1993 (Public Law 103–66);

(5) encourage the use of cost-effective subacute care in nursing facilities by providing equitable reimbursement under all appropriate Federal health care programs and by eliminating regulatory and legislative barriers to providing such care;

(6) remove existing and potential statutory and regulatory barriers to the provision of quality, cost-effective subacute care by skilled nursing facilities and nursing facilities under titles XVIII and XIX of the Social Security Act, and to alleviate the present cash flow burdens for skilled nursing facilities that provide such care;

(7) establish a program for home and community-based services for individuals with disabilities under the medicaid program to provide beneficiaries, whose needs would be determined by functional eligibility standards, with expanded choice of services within a continuum of care, and contain costs by encouraging the use of appropriate levels of care; and

(8) enact a prospective payment system for nursing facility services under all Federal health care programs that promotes quality care, assures equal access for all residents regardless of level of service needed, maintains adequate capital formation, provides for efficiency incentives for providers, and contains costs.

TITLE I—LONG-TERM CARE TAX CLARIFICATION

SEC. 101. SHORT TITLE.

This title may be cited as the ''Private Long-Term Care Insurance Incentive Amendments of 1995''.

SEC. 102. TREATMENT OF LONG-TERM CARE INSURANCE OR PLANS.

(a) IN GENERAL.—Chapter 79 of the Internal Revenue Code of 1986 (relating to definitions) is amended by inserting after section 7702A the following new section:

"SEC. 7702B. TREATMENT OF LONG-TERM CARE INSURANCE OR PLANS.

''(a) GENERAL RULE.—For purposes of this title—

''(1) a qualified long-term care insurance contract shall be treated as an accident or health insurance contract,

''(2) any plan of an employer providing coverage of qualified long-term care services shall be treated as an accident or health plan with respect to such services,

''(3) amounts received under such a contract or plan with respect to qualified long-term care services, including payments described in subsection (b)(2)(A), shall be treated—

''(A) as amounts received for personal injuries or sickness, and

''(B) for purposes of section 105(c), as amounts received for the permanent loss of a function of the body, and as amounts computed with reference to the nature of the injury, and

''(4) payments described in subsection (b)(2)(A) shall be treated as payments made with respect to qualified long-term care services.

Paragraph (3)(B) shall not apply in the case of amounts attributable to (and not in excess of) deductions allowed under section 213 (relating to medical etc., expenses) for

any prior taxable year and also shall not apply for purposes of section 105(f).

''(b) QUALIFIED LONG-TERM CARE INSURANCE CONTRACT.—

''(1) IN GENERAL.—For purposes of this title, the term 'qualified long-term care insurance contract' means any insurance contract if—

''(A) the only insurance protection provided under such contract is coverage of qualified long-term care services and benefits incidental to such coverage,

''(B) such contract or coverage is guaranteed renewable, or in the case of a group certificate, provides the insured individual with a basis for continuation or conversion of coverage,

''(C) such contract does not have any cash surrender value, and

''(D) all refunds of premiums, and all policyholder dividends or similar amounts, under such contract are to be applied as a reduction in future premiums or to increase future benefits.

''(2) SPECIAL RULES.—

''(A) PER DIEM, ETC. PAYMENTS PERMITTED.—A contract shall not fail to be treated

as described in paragraph (1)(A) by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.

''(B) REFUNDS OF PREMIUMS.—Paragraph (1)(D) shall not apply to any refund of premiums on surrender, cancellation of the contract, or death of the policyholder.

''(3) TREATMENT OF COVERAGE PROVIDED AS PART OF A LIFE INSURANCE CONTRACT.—Except as provided in regulations, in the case of coverage of qualified long-term care services provided as part of a life insurance contract—

''(A) APPLICATION OF GENERAL REQUIREMENTS.—The requirements of this section shall apply as if the portion of the contract providing such coverage was a separate contract.

''(B) PREMIUMS AND CHARGES FOR QUALIFIED LONG-TERM CARE COVERAGE.—Premiums for coverage of qualified long-term care services and charges against the life insurance contract's cash surrender value (within the meaning of section 7702(f)(2)(A)) for such cov-

erage shall be treated as premiums for the qualified long-term care insurance contract.

''(C) APPLICATION OF SECTION 7702.—Subsection (c)(2) of section 7702 (relating to the guideline premium limitation) shall be applied by increasing the guideline premium limitation with respect to the life insurance contract, as of any date—

''(i) by the sum of any charges (but not premiums) described in subparagraph (B) made to that date under the contract, less

''(ii) any such charges the imposition of which reduces the premiums paid for the contract (within the meaning of section 7702(f)(1)).

''(D) APPLICATION OF SECTION 72(e)(4)(B).—Subsection (e)(4)(B) of section 72 (relating to certain amounts retained by the insurer) shall be applied as including charges described in subparagraph (B).

''(E) APPLICANT.—No deduction shall be allowed under subsection (a) of section 213 for premiums and charges described in subparagraph (B).

For purposes of this paragraph, the term 'portion' means only the terms and benefits under a life insurance contract (whether provided by a rider or addendum on, or other provision of, such contract) that are in addition to the terms and benefits under the contract without regard to the coverage of qualified long-term care services and benefits incidental to such coverage.

''(c) QUALIFIED LONG-TERM CARE SERVICES.—For purposes of this section—

''(1) IN GENERAL.—The term 'qualified long-term care services' means necessary diagnostic, preventive, therapeutic, and rehabilitative services, and maintenance or personal care services, which—

''(A)(i) are required by a chronically ill individual in a qualified facility, and

''(ii) are provided pursuant to a plan of care prescribed by a licensed health care practitioner, or

''(B) are required by law or regulation.

''(2) CHRONICALLY ILL INDIVIDUAL.—

''(A) IN GENERAL.—The term 'chronically ill individual' means any individual who has been certified by a licensed health care practitioner as—

''(i)(I) being unable to perform (without substantial assistance from another individual) at least two activities of daily living (as defined in subparagraph (B)), due to a loss of functional capacity, or

''(II) having a level of disability similar (as determined by the Secretary) to the level of disability described in subclause (I), or

''(ii) having a similar level of disability due to cognitive impairment.

''(B) ACTIVITIES OF DAILY LIVING.—For purposes of subparagraph (A), each of the following is an activity of daily living:

''(i) BATHING.—The overall complex behavior of getting water and cleansing the whole body, including turning on the water for a bath, shower, or sponge bath, getting to, in, and out of a tub or shower, and washing and drying oneself.

''(ii) DRESSING.—The overall complex behavior of getting clothes from closets and drawers and then getting dressed.

''(iii) TOILETING.—The act of going to the toilet room for bowel and bladder

function, transferring on and off the toilet, cleaning after elimination, and arranging clothes.

''(iv) TRANSFER.—The process of getting in and out of bed or in and out of a chair or wheelchair.

''(v) EATING.—The process of getting food from a plate or its equivalent into the mouth.

''(vi) CONTINENCE.—The ability to voluntarily control bowel and bladder function and to maintain a reasonable level of personal hygiene.

''(vii) DETERMINED BY THE SECRETARY.—Any other activity determined by the Secretary to be an activity of daily living under subparagraph (D).

''(viii) STATE REQUIRED.—Any other activity required to be taken into account by State law or regulation which is not otherwise preempted by Federal law or regulation.

''(C) NUMBER OF ACTIVITIES OF DAILY LIVING.—A qualified long-term care insurance contract may, at its option, deem an individual

to be a chronically ill individual under subparagraph (A) if the individual is unable to perform (without substantial assistance from another individual) 1 activity of daily living (as defined in subparagraph (B)), due to a loss of functional capacity.

''(D) DETERMINATION OF ADDITIONAL ACTIVITIES OF DAILY LIVING.—For purposes of subparagraph (A), the Secretary, in consultation with the Secretary of Health and Human Services, may determine by regulation that additional activities constitute activities of daily living.

''(3) QUALIFIED FACILITY.—The term 'qualified facility' means—

''(A) a nursing, rehabilitative, hospice service, or adult day care facility (including a hospital, retirement home, nursing home, skilled nursing facility, intermediate care facility, or similar institution)—

''(i) which is licensed under State law, or

''(ii) which is a certified facility for purposes of title XVIII or XIX of the Social Security Act, or

''(B) an individual's home or other facility under a plan of treatment developed by a licensed health care practitioner.

''(4) MAINTENANCE OF PERSONAL CARE SERVICES.—The term 'maintenance or personal care services' means any care the primary purpose of which is to provide needed assistance with any of the activities of daily living described in paragraph (2)(B). Such term may include such services as adult day care, homemaker and chore services, hospice services, respite care, and services required by law or regulation.

''(5) LICENSED HEALTH CARE PRACTITIONER.—The term 'licensed health care practitioner' means any physician (as defined in section 1861(r) of the Social Security Act) and any registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary.

''(d) SPECIAL RULES.—

''(1) CONTINUATION RULES NOT TO APPLY.—The health care continuation rules contained in section 4980B (and contained in part 6 of subtitle B of title I of the Employee Retirement Income Secu-

rity Act of 1974 and in title II of the Public Health Service Act) shall not apply to—

''(A) qualified long-term care insurance contracts, or

''(B) plans described in subsection (a)(2).

''(2) EMPLOYER PLANS NOT TREATED AS DEFERRED COMPENSATION PLANS.—For purposes of this title, a plan of an employer providing coverage of qualified long-term care services shall not be treated as a plan which provides for deferred compensation by reason of providing such coverage.

''(3) CONTRACTS COVERING PARENTS AND GRANDPARENTS.—For purposes of this title, if a qualified long-term care insurance contract purchased by or provided to a taxpayer provides coverage with respect to one or more of the taxpayer's parents or grandparents (or, in the case of a joint return, of either spouse), such coverage and all payments made pursuant to such coverage shall be treated in the same manner as if the parents or grandparents were dependents (as defined in section 152) of the taxpayer. For purposes of this paragraph, the term 'parent' includes any stepmother or stepfather, the term 'grandparent' includes any stepgrandfather or stepgrandmother, and any rela-

tionship that exists by virtue of a legal adoption shall be recognized to the same extent as relationships by blood.

''(4) WELFARE BENEFIT RULES NOT TO APPLY.—For purposes of subpart D of part I of subchapter D of chapter 1 (relating to treatment of welfare benefit funds), qualified long-term care services shall not be treated as a welfare benefit or a medical benefit.

''(5) DEDUCTIBILITY.—For purposes of this title, no payment of a premium for a long-term care insurance contract shall fail to be deductible in whole or in part merely because the contract provides for level annual payments.

''(e) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the requirements of this section, including regulations to prevent the avoidance of this section by providing qualified long-term care services under a life insurance contract.''.

(b) CLERICAL AMENDMENT.—The table of sections for chapter 79 of such Code is amended by inserting after the item relating to section 7702A the following new item:

''Sec. 7702B. Treatment of long-term care insurance or plans.''.

SEC. 103. QUALIFIED LONG-TERM SERVICES TREATED AS MEDICAL CARE.

(a) IN GENERAL.—Paragraph (1) of section 213(d) of the Internal Revenue Code of 1986 (defining medical care) is amended by striking ''or'' at the end of subparagraph (B), by redesignating subparagraph (C) as subparagraph (D), and by inserting after subparagraph (B) the following new subparagraph:

''(C) for qualified long-term care services (as defined in section 7702B(c)), or''.

(b) CONFORMING AMENDMENTS.—

(1) Subparagraph (D) of section 213(d)(1) of such Code (as redesignated by subsection (a)) is amended by striking ''subparagraphs (A) and (B)'' and inserting ''subparagraphs (A), (B), and (C)''.

(2) Paragraph (6) of section 213(d) of such Code is amended—

(A) by striking ''subparagraphs (A) and (B)'' and inserting ''subparagraphs (A), (B), and (C)'', and

(B) in subparagraph (A), by striking ''paragraph (1)(C)'' and inserting ''paragraph (1)(D)''.

(3) Paragraph (7) of section 213(d) of such Code is amended by striking ''subparagraphs (A)

and (B)'' and inserting ''subparagraphs (A), (B), and (C)''.

SEC. 104. QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS PERMITTED TO BE OFFERED IN CAFETERIA PLANS.

Paragraph (2) of section 125(d) of the Internal Revenue Code of 1986 (relating to the exclusion of deferred compensation) is amended by adding at the end the following new subparagraph:

''(D) EXCEPTION FOR LONG-TERM CARE INSURANCE CONTRACTS.—For purposes of subparagraph (A), a plan shall not be treated as providing deferred compensation by reason of providing any long-term care insurance contract (as defined in section 7702B(b)) if—

''(i) the employee may elect to continue the insurance upon cessation of participation in the plan, and

''(ii) the amount paid or incurred during any taxable year for such insurance does not exceed the premium which would have been payable for such year under a level premium structure.''.

SEC. 105. INCLUSION IN INCOME OF EXCESSIVE LONG-TERM CARE BENEFITS.

(a) IN GENERAL.—Part II of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to items specifically included in gross income) is amended by adding at the end the following new section:

''SEC. 91. EXCESSIVE LONG-TERM CARE BENEFITS.

''(a) GENERAL RULE.—Gross income for the taxable year of any individual includes excessive long-term care benefits received by or for the benefit of such individual during the taxable year.

''(b) EXCESSIVE LONG-TERM CARE BENEFITS.—

''(1) IN GENERAL.—For purposes of this section, the term 'excessive long-term care benefits' means the excess (if any) of—

''(A) the aggregate amount from all policies which is not includible in the gross income of the individual for the taxable year by reason of the amendments made by the Private Long-Term Care Insurance Incentive Amendments of 1995 (determined without regard to this section), over

''(B) the aggregate of $250 for each day during the taxable year that such individual—

''(i) was a chronically ill individual (as defined in section 7702B(c)(2)), and

''(ii) was confined in a qualified facility (as defined in section 7702B(c)(3)).

''(2) INFLATION ADJUSTMENT.—In the case of any taxable year beginning after 1996, the $250 in paragraph (1)(B) shall be equal to the sum of—

''(A) the amount in effect under paragraph (1)(B) for the preceding calendar year (after application of this subparagraph), plus

''(B) the product of the amount referred to in subparagraph (A) multiplied by the cost-of-living adjustment for the calendar year of the amount under subparagraph (A).

''(3) COST-OF-LIVING ADJUSTMENT.—For purposes of paragraph (2), the cost-of-living adjustment for any calendar year is the percentage (if any) by which the cost index under paragraph (4) for the preceding calendar year exceeds such index for the second preceding calendar year.

''(4) COST INDEX.—The Secretary, in consultation with the Secretary of Health and Human Services, shall before January 1, 1997, establish a cost index to measure increases in the cost of nursing home and similar facilities. The Secretary may from time to time revise such index to the extent nec-

essary to accurately measure increase or decreases in such costs.

''(5) ROUNDING.—If any dollar amount determined under this paragraph is not a multiple of $10, such dollar amount shall be rounded to the nearest multiple of $10 (or, if such dollar amount is a multiple of $5, such dollar amount shall be increased to the next higher multiple of $10).

''(6) COMPUTATION OF DAILY AMOUNT.—For purposes of this section, the aggregate for each day may be determined by using an average daily amount for the month, computed by dividing the amount of benefits for the month by the number of days in the month.''.

(b) CLERICAL AMENDMENT.—The table of sections for part II of subchapter B of chapter 1 of such Code is amended by adding at the end the following new item:

''Sec. 91. Excessive long-term care benefits.''.

SEC. 106. TAX RESERVES FOR QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS.

(a) IN GENERAL.—Subparagraph (A) of section 807(d)(3) of the Internal Revenue Code of 1986 (relating to tax reserve methods) is amended by redesignating clause (iv) as clause (v) and by inserting after clause (iii) the following new clause:

''(iv) QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS.—In the case of any qualified long-term care insurance contract (as defined in section 7702B(c))—

''(I) the reserve method prescribed by the National Association of Insurance Commissioners which covers such contract (as of the date of issuance), or

''(II) if no reserve method has been prescribed by the National Association of Insurance Commissioners which covers such contract, a 1-year full preliminary term method.''.

(b) CONFORMING AMENDMENTS.—

(1) Clause (iii) of section 807(d)(3)(A) of such Code is amended by striking ''noncancellable accident and health insurance contract,'' and inserting ''noncancellable accident and health insurance contract (other than qualified long-term care insurance contracts (as defined in section 7702B(c)),''.

(2) Clause (v) of section 807(d)(3)(A) of such Code (as redesignated by subsection (a)) is amended by striking ''or (iii)'' and inserting ''(iii), or (iv)''.

SEC. 107. EFFECTIVE DATE.

(a) IN GENERAL.—Except as provided in subsection (b), the amendments made by this title shall apply to policies issued in taxable years beginning after the date of the enactment of this Act.

(b) EXCEPTION.—If a policy—

(1) was issued in a taxable year beginning on or before the date of the enactment of this Act; and

(2) met the requirements of the National Association of Insurance Commissioners' Model Long-Term Care Act and Regulations when the policy was issued,

such policy shall be considered qualified long-term care insurance and the services provided under such policy shall be considered qualified long-term care services.

TITLE II—LONG-TERM CARE INSURANCE STANDARDS

SEC. 200. SHORT TITLE.

This title may be cited as the ''Long-Term Care Insurance Standards Amendments of 1995''.

SEC. 201. NATIONAL LONG-TERM CARE INSURANCE ADVISORY COUNCIL.

(a) APPOINTMENT OF BOARD.—Congress shall appoint an advisory board to be known as the National Long-Term Care Insurance Advisory Council (hereafter in this section referred to as the ''Advisory Council'').

(b) MEMBERSHIP.—The Advisory Council shall consist of 5 members, each of whom has substantial expertise in matters relating to the provision and regulation of long-term care insurance or long-term care financing and delivery systems.

(c) DUTIES.—The Advisory Council shall—

(1) provide advice, recommendations, and assistance to Congress on matters relating to long-term care insurance as specified in this section and as otherwise required by the Secretary;

(2) collect, analyze, and disseminate information relating to long-term care insurance in order to increase the understanding of insurers, providers, consumers, and regulatory bodies of the issues relating to, and to facilitate improvements in, such insurance;

(3) develop for congressional consideration proposed models, standards, requirements, and procedures relating to long-term care insurance, as appropriate; and

(4) monitor the development of the long-term care insurance market and advise Congress concerning the need for statutory changes.

(d) POWERS.—In order to carry out its responsibilities under this section, the Advisory Council is authorized to—

(1) consult individuals and public and private entities with experience and expertise in matters relating to long-term care insurance;

(2) conduct meetings and hold hearings;

(3) conduct research (either directly or under grant or contract);

(4) collect, analyze, publish, and disseminate data and information (either directly or under grant or contract); and

(5) develop model formats and procedures for insurance products, and develop proposed standards, rules, and procedures for regulatory programs, as appropriate.

(e) AUTHORIZATION OF APPROPRIATION.—There are authorized to be appropriated for each fiscal year beginning after September 30, 1995, $1,500,000 to carry out the activities of the Advisory Council.

SEC. 202. POLICY REQUIREMENTS.

Section 7702B of the Internal Revenue Code of 1986 (as added by section 102) is amended by inserting after subsection (e) the following new subsection:

''(f) CONSUMER PROTECTION PROVISIONS.—

''(1) IN GENERAL.—The requirements of this subsection are met with respect to any contract if any long-term care insurance policy issued under the contract meets—

''(A) the requirements of the model regulation and model Act described in paragraph (2),

''(B) the disclosure requirement of paragraph (3),

''(C) the requirements relating to nonforfeitability under paragraph (4), and

''(D) the requirements relating to rate stabilization under the paragraph (5).

''(2) REQUIREMENTS OF MODEL REGULATION AND ACT.—

''(A) IN GENERAL.—The requirements of this paragraph are met with respect to any policy if such policy meets—

''(i) MODEL REGULATION.—The following requirements of the model regulation:

''(I) Section 7A (relating to guaranteed renewal or noncancellability), and the requirements of section 6B of the model Act relating to such section 7A.

''(II) Section 7B (relating to prohibitions on limitations and exclusions).

''(III) Section 7C (relating to extension of benefits).

''(IV) Section 7D (relating to continuation or conversion of coverage).

''(V) Section 7E (relating to discontinuance and replacement of policies).

''(VI) Section 8 (relating to unintentional lapse).

''(VII) Section 9 (relating to disclosure), other than section 9F thereof.

''(VIII) Section 10 (relating to prohibitions against post-claims underwriting).

''(IX) Section 11 (relating to minimum standards).

''(X) Section 12 (relating to requirement to offer inflation protection), except that any requirement for a signature on a rejection of inflation

protection shall permit the signature to be on an application or on a separate form.

''(XI) Section 23 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).

''(ii) MODEL ACT.—The following requirements of the model Act:

''(I) Section 6C (relating to preexisting conditions).

''(II) Section 6D (relating to prior hospitalization).

''(B) DEFINITIONS.—For purposes of this paragraph—

''(i) MODEL PROVISIONS.—The terms 'model regulation' and 'model Act' mean the long-term care insurance model regulation, and the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners (as adopted in January of 1993).

''(ii) COORDINATION.—Any provision of the model regulation or model Act listed

under clause (i) or (ii) of subparagraph (A) shall be treated as including any other provision of such regulation or Act necessary to implement the provision.

''(3) TAX DISCLOSURE REQUIREMENT.—The requirement of this paragraph is met with respect to any policy if such policy meets the requirements of section 4980D(d)(1).

''(4) NONFORFEITURE REQUIREMENTS.—

''(A) IN GENERAL.—The requirements of this paragraph are met with respect to any level premium long-term care insurance policy if the issuer of such policy offers to the policyholder, including any group policyholder, a nonforfeiture provision.

''(B) REQUIREMENTS OF PROVISION.—The nonforfeiture provision required under subparagraph (A) shall meet the following requirements:

''(i) The nonforfeiture provision shall be appropriately captioned.

''(ii) The nonforfeiture provision shall provide for a benefit available in the event of a default in the payment of any premiums and the amount of the benefit may

be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying policies approved by the Secretary for the same policy form.

''(iii) The nonforfeiture provision shall provide for a benefit based on an equitable schedule where benefits returned are equal to the asset share remaining in the policy and which assures that persisting policyholders are not required to subsidize the cost of insurance premiums for policyholders who terminate coverage. The criteria for determining the actuarial value of this benefit shall be developed by the National Long-Term Care Insurance Advisory Council in consultation with the American Society of Actuaries and the National Association of Insurance Commissioners and shall be approved by Congress.

''(5) RATE STABILIZATION.—

''(A) IN GENERAL.—The requirements of this paragraph are met with respect to any

long-term care insurance policy, including any group master policy, if—

''(i) such policy contains the minimum rate guarantees specified in subparagraph (B), and

''(ii) the issuer of such policy meets the requirements specified in subparagraph (C).

''(B) MINIMUM RATE GUARANTEES.—The minimum rate guarantees specified in this subparagraph are as follows:

''(i) Rates under the policy shall be guaranteed for a period of at least 3 years from the date of issue of the policy.

''(ii) After the expiration of the 3-year period required under clause (i), any rate increase shall be guaranteed for a period of at least 2 years from the effective date of such rate increase.

''(iii) In the case of any individual age 75 or older who has maintained coverage under a long-term care insurance policy for 10 years, any rate increase under such policy shall not exceed 10 percent in any 12-month period.

''(C) INCREASES IN PREMIUMS.—The requirements specified in this subparagraph are as follows:

''(i) IN GENERAL.—If an issuer of any long-term care insurance policy, including any group master policy, plans to increase the premium rates for a policy, such issuer shall, at least 90 days before the effective date of the rate increase, offer to each individual policyholder under such policy the option to remain insured under the policy at a reduced level of benefits which maintains the premium rate at the rate in effect on the day before the effective date of the rate increase.

''(ii) INCREASE OF MORE THAN 50 PERCENT.—

''(I) IN GENERAL.—If an issuer of any long-term care insurance policy, including any group master policy, increases premium rates for a policy by more than 50 percent in any 3-year period—

''(aa) in the case of a group master long-term care insurance

policy, the issuer shall discontinue issuing all group master long-term care insurance policies in any State in which the issuer issues such policy for a period of 2 years from the effective date of such premium increase; and

''(bb) in the case of an individual long-term care insurance policy, the issuer shall discontinue issuing all individual long-term care policies in any State in which the issuer issues such policy for a period of 2 years from the effective date of such premium increase.

''(II) APPLICABILITY.—Subclause (I) shall apply to any issuer of long-term care insurance policies or any other person that purchases or otherwise acquires any long-term care insurance policies from another issuer or person.

''(D) MODIFICATIONS OR WAIVERS OF REQUIREMENTS.—The Secretary may modify or

waive any of the requirements under this paragraph if—

''(i) such requirements will adversely affect an issuer's solvency;

''(ii) such modification or waiver is required for the issuer to meet other State or Federal requirements;

''(iii) medical developments, new disabling diseases, changes in long-term care delivery, or a new method of financing long-term care will result in changes to mortality and morbidity patterns or assumptions;

''(iv) judicial interpretations of a policy's benefit features results in unintended claim liabilities; or

''(v) in the case of a purchase or other acquisition of long-term care insurance policies of an issuer or other person, the continued sale of other long-term care insurance policies by the purchasing issuer or person is in the best interest of individual consumers.

''(6) LONG-TERM CARE INSURANCE POLICY DEFINED.—For purposes of this subsection, the term

'long-term care insurance policy' has the meaning given such term by section 4980C(e).''.

SEC. 203. ADDITIONAL REQUIREMENTS FOR ISSUERS OF LONG-TERM CARE INSURANCE POLICIES.

(a) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986 is amended by adding at the end the following new section:

"SEC. 4980C. FAILURE TO MEET REQUIREMENTS FOR LONG-TERM CARE INSURANCE POLICIES.

''(a) GENERAL RULE.—There is hereby imposed on any person failing to meet the requirements of subsection (c) or (d) a tax in the amount determined under subsection (b).

''(b) AMOUNT OF TAX.—

''(1) IN GENERAL.—For purposes of subsection (a), the amount of the tax shall not exceed the greater of—

''(A) 3 times the amount of any commissions paid for each policy involved in the violation, or

''(B) $10,000.

''(2) WAIVER.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed by subsection (a) to the extent that payment

of the tax would be excessive relative to the failure involved.

''(c) ADDITIONAL RESPONSIBILITIES.—The requirements of this subsection are as follows:

''(1) REQUIREMENTS OF MODEL PROVISIONS.—

''(A) MODEL REGULATION.—The following requirements of the model regulation must be met:

''(i) Section 13 (relating to application forms and replacement coverage).

''(ii) Section 14 (relating to reporting requirements), except that the issuer shall also report at least annually the number of claims denied during the reporting period for each class of business (expended as a percentage of claims denied), other than claims denied for failure to meet the waiving period or because of any applicable pre-existing condition.

''(iii) Section 20 (relating to filing requirements for marketing).

''(iv) Section 21 (relating to standards for marketing), including inaccurate completion of medical histories, other than sec-

tion 21C(1), 21(C)(3) and 21C(6) thereof, except that—

''(I) in addition to such requirements, no person shall in selling or offering to sell a long-term care insurance policy, misrepresent a material fact;

''(II) no such requirements shall include a requirement to inquire or identify whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance; and

''(III) the association shall disclose in any long-term care insurance solicitation the amount of compensation that the association receives from endorsement or sale of the policy or certificate to its members, expressed as a percentage of annual premium generated by such policies.

''(v) Section 22 (relating to appropriateness of recommended purchase).

''(vi) Section 24 (relating to standard format outline of coverage).

''(vii) Section 25 (relating to requirement to deliver shopper's guide).

''(B) MODEL ACT.—The following requirements of the model Act must be met:

''(i) Section 6F (relating to right to return), except that such section shall also apply to denials of applications and any refund shall be made within 30 days of the return or denial.

''(ii) Section 6G (relating to outline of coverage).

''(iii) Section 6H (relating to requirements for certificates under group plans).

''(iv) Section 6I (relating to policy summary).

''(v) Section 6J (relating to monthly reports on accelerated death benefits).

''(vi) Section 7 (relating to incontestability period).

''(C) DEFINITIONS.—For purposes of this paragraph, the terms 'model regulation' and 'model Act' have the meanings given such terms by section 7702B(f)(2)(B).

''(2) DELIVERY OF POLICY.—If an application for a long-term care insurance policy (or for a cer-

tificate under a group long-term care insurance policy) is approved, the issuer shall deliver to the applicant (or policyholder or certificate-holder) the policy (or certificate) of insurance not later than 30 days after the date of the approval.

''(3) INFORMATION ON DENIALS OF CLAIMS.—If a claim under a long-term care insurance policy is denied, the issuer shall, within 60 days of the date of a written request by the policyholder or certificate-holder (or representative)—

''(A) provide a written explanation of the reasons for the denial, and

''(B) make available all information directly relating to such denial except in cases where such issuer would be prohibited from providing information regarding claims denial under confidentiality statues or other state or Federal laws.

''(d) DISCLOSURE.—The requirements of this subsection are met if either of the following statements, whichever is applicable, is prominently displayed on the front page of any long-term care insurance policy and in the outline of coverage required under subsection (c)(1)(B)(ii):

''(1) A statement that: 'This policy is intended to be a qualified long-term care insurance contract under section 7702B(b) of the Internal Revenue Code of 1986.'.

''(2) A statement that: 'This policy is not intended to be a qualified long-term care insurance contract under section 7702B(b) of the Internal Revenue Code of 1986.'.

''(e) LONG-TERM CARE INSURANCE POLICY DEFINED.—For purposes of this section:

''(1) IN GENERAL.—The term 'long-term care insurance policy' means any insurance policy or rider advertised, marketed, offered, or designed to provide coverage for not less than 12 consecutive months for each covered person—

''(A) on an expense incurred, indemnity, prepaid or other basis, and

''(B) for one or more necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital.

''(2) CERTAIN POLICIES INCLUDED.—Such term includes—

''(A) group and individual annuities and life insurance policies or riders which provide coverage directly or which supplement long-term care insurance, and

''(B) a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity.

''(3) INSURANCE.—A long-term care insurance may be issued by insurers, fraternal benefit societies, nonprofit health, hospital and medical service corporations, prepaid health plans, health maintenance organizations, or any similar organization to the extent such organizations are otherwise authorized to issue life or health insurance.

''(4) EXCLUSIONS.—

''(A) IN GENERAL.—A long-term care insurance policy shall not include any insurance policy which is offered primarily to provide basic medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease

or specified accident coverage, or limited benefit health coverage.

''(B) LIFE INSURANCE.—A long-term care insurance policy shall not include coverage provided under a life insurance policy which accelerates the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement, and which provides the option of a lump-sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.''.

(b) CLERICAL AMENDMENT.—The table of sections for chapter 43 of such Code is amended by adding at the end the following new item:

''Sec. 4980C. Failure to meet requirements for long-term care insurance policies.''.

SEC. 204. RELATION TO STATE LAW.

Insurance policies which have been deemed in compliance with the requirements of this title and the Internal Revenue Code of 1986 (as amended by this title) by the State Insurance Commissioner in the State of domicile shall be deemed approved for sale in any other State. No State may prohibit an insurance carrier from selling out-

side the State of domicile long-term care insurance policies which have been approved in the State of domicile. A determination by a State Insurance Commissioner under this section shall not be binding on the Secretary of the Treasury.

SEC. 205. UNIFORM LANGUAGE AND DEFINITIONS.

(a) RECOMMENDATIONS.—The National Long-Term Care Insurance Advisory Council shall develop recommendations for the use of uniform language and definitions in long-term care insurance policies (as defined in section 4980C(e) of the Internal Revenue Code of 1986) for approval by Congress.

(b) USE OF NONUNIFORM LANGUAGE.—The recommendations developed under subsection (a) may permit the use of nonuniform language to the extent required to take into account differences among States in the licensing of nursing facilities and other providers of long-term care.

SEC. 206. EFFECTIVE DATES.

(a) IN GENERAL.—Except as provided in subsection (b), this title and the amendments made by this title shall take effect on the date of the enactment of this Act.

(b) SECTION 202.—The amendments made by section 202 shall apply—

(1) to contracts issued in taxable years beginning after the date of the enactment of this Act; and

(2) to actions taken in taxable years beginning after the date of the enactment of this Act.

TITLE III—FINANCIAL ELIGIBILITY STANDARDS

SEC. 301. REVISIONS TO FINANCIAL ELIGIBILITY PROVISIONS.

Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(1) in paragraph (17)(C), by inserting ''subject to subsection (z),'' before ''provide''; and

(2) by adding at the end the following new subsection:

''(z)(1) For purposes of subsection (a)(17)(C), notwithstanding any other provision of this title, the resources of an individual, and the spouse of such individual, which shall be used to determine financial eligibility for nursing facility services under this title shall include—

''(A) all of the real property owned by the individual, including but not limited to, the individual's primary residence;

''(B) all personal property of the individual, including but not limited to, any automobiles owned by the individual; and

''(C) all liquid assets held by the individual, including but not limited to, the asset value of any trust established by such individual.

''(2)(A) An individual shall not be eligible for nursing facility services under this title if the total value of the resources owned by the individual (individually or jointly with his or her spouse, if any) exceeds the value of the median price of a home in the geographic region in which such individual resides.

''(B) For purposes of subparagraph (A), the Secretary shall establish a valuation system for single family homes in appropriate geographic regions, taking appropriate account of the variation in values between urban and rural areas. The valuation system established by the Secretary shall be updated annually.

''(C) Subparagraph (A) shall apply for a couple in the same manner as such subparagraph applies for an individual where one member of the couple applies for nursing facility services under this title.

''(D) For purposes of determining the total value of resources in paragraph (A), the value of resources held jointly with the individual's spouse shall be considered available to the individual applying for medical assistance as determined under section 1924(d)(2).

''(3) No provision under this subsection shall affect the community spouse protections contained in section 1924.

''(4) The Secretary shall provide grants to States for demonstration projects to investigate the coordination of private long-term care insurance benefits and financial eligibility requirements under this title. Such demonstration projects shall include, but not be limited to, investigations of—

''(A) a State policy which subtracts the amounts paid by an individual for private long-term care insurance from the individual's resources which are counted to determine financial eligibility; and

''(B) a State policy which provides purchasers of private long-term care insurance with impoverishment protections by using medicaid as reinsurance.

''(5) Eligibility requirements under paragraphs (1) through (4) of this subsection shall not apply to services provided under this title other than nursing facility services.''.

SEC. 302. EFFECTIVE DATE.

The amendments made by this title shall be effective January 1, 1996.

TITLE IV—ASSET TRANSFERS

SEC. 401. TRANSFERS OF ASSETS.

Section 1917(c)(1)(B)(i) of the Social Security Act (42 U.S.C. 1396p(c)(1)(B)(i)) is amended to read as follows:

''(B)(i) The look-back date specified in this subparagraph is a date that is 60 months before the date specified in clause (ii).''.

SEC. 402. TREATMENT OF CERTAIN TRUSTS.

Section 1917(c)(2) of the Social Security Act (42 U.S.C. 1396p(c)(2)) is amended by adding at the end the following new flush sentences:

''In order for the income or assets of an income cap trust, nonprofit asset trust or other such trust arrangement to be exempt under this paragraph, the trust must be irrevocable and all amounts remaining in the beneficiary's account must be paid to the State upon the death of the beneficiary. For purposes of this section, the term 'trust' shall not include a personal service contract annuity for a family member within the 60-month period even if such transfer is for fair market value. The Secretary shall prohibit, by regulation, the use of family limited partnerships to convert available assets into an exempt status; purchases of interests in third-party assets for the purpose of rendering otherwise includable assets unavailable, and

not subject to liens; and purchase of care services agreements for past services by family members to reduce countable assets.''.

SEC. 403. EFFECTIVE DATE.

The amendments made by this title shall be effective January 1, 1996.

TITLE V—MISCELLANEOUS

Subtitle A—Subacute Care Continuum Amendments of 1995

SEC. 500. SHORT TITLE.

This subtitle may be cited as the ''Subacute Care Continuum Amendments of 1995''.

SEC. 501. CREATION OF A "LEVEL PLAYING FIELD" TO ENCOURAGE THE DEVELOPMENT OF SUBACUTE CARE PROVIDERS.

(a) SKILLED NURSING FACILITIES UNDER THE MEDICARE PROGRAM.—

(1) IN GENERAL.—Section 1819(a) of the Social Security Act (42 U.S.C. 1395i–3(a)) is amended by adding at the end the following new flush sentences:

''Nothing in this title shall be construed to prohibit, or otherwise limit, a skilled nursing facility from offering or providing subacute care services. Any requirements relating to the provision of such services as may be prescribed

by the Secretary or the States shall not include any term or condition forbidding, or otherwise limiting, such facility from so qualifying based on its status as a skilled nursing facility. As used in this subsection, a patient needing 'subacute care services' has had an acute event as a result of an illness, injury, or exacerbation of a disease process; has a determined course of treatment; does not require intensive diagnostic or invasive procedures; and has a severe condition requiring an outcome-focused, interdisciplinary approach utilizing a professional team to deliver complex clinical interventions (medical or rehabilitative or both) and a higher frequency of physical visits than traditional extended or skilled nursing care.''.

(2) CONFORMING AMENDMENTS.—

(A) Section 1861(v)(1)(E) of the Social Security Act (42 U.S.C. 1395x(v)(1)(E)) is amended by inserting '', including subacute care services furnished by such facilities'' in the first sentence after ''services'' the second place it appears.

(B) Section 1888(c) of the Social Security Act (42 U.S.C. 1395yy(c)) is amended by inserting ''(including the provision of subacute care services by such facility)'' after ''case mix''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall be effective on the date of the enactment of this Act.

(b) NURSING FACILITIES UNDER THE MEDICAID PROGRAM.—

(1) IN GENERAL.—Section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)) is amended by inserting after the last sentence the following new sentences: ''Nothing in this title shall be construed to prohibit, or otherwise limit, a skilled nursing facility from offering or providing subacute care services. Any requirements relating to the provision of such services as may be prescribed by the Secretary or the States shall not include any term or condition forbidding, or otherwise limiting, such facility from so qualifying based on its status as a skilled nursing facility. As used in this subsection, a patient needing 'subacute care services' has had an acute event as a result of an illness, injury, or exacerbation of a disease process; has a determined course of treatment; does not require intensive diagnostic or invasive procedures; and has a severe condition requiring an outcome-focused, interdisciplinary approach utilizing a professional team to deliver complex clinical interventions (medical or rehabilitative or both) and a

higher frequency of physical visits than traditional nursing facility care.''.

(2) CONFORMING AMENDMENTS.—Section 1902(a)(13)(A) of the Social Security Act (42 U.S.C. 1396a(a)(13(A)) is amended—

(A) by inserting '', subacute care services furnished by a nursing facility'' after ''nursing facility services'' ; and

(B) by inserting ''nursing facility furnishing subacute care services,'' after ''the filing of uniform cost reports by each hospital, nursing facility,''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall be effective on the date of the enactment of this Act.

SEC. 502. EXCEPTION PROCESS FROM MEDICARE ROUTINE COST LIMITS.

(a) INTERIM EXCEPTION.— Section 1888 of the Social Security Act (42 U.S.C. 1395yy) is amended by adding at the end the following new subsection:

''(e) Effective January 1, 1997, regardless of the issuance of final regulations, with respect to any limits on the reasonable costs of providing subacute care services, the Secretary shall grant any skilled nursing facility providing subacute care services an interim exception within

90 days of submission of a request for such exception, subject to such procedures and accompanied by such data and such documentation as the Secretary shall determine by regulation. The Secretary shall finalize such interim exception based upon settled data at the end of the applicable cost reporting period. Upon finalization of the exception request, the Secretary shall be responsible for reimbursement of any underpayment, and the skilled nursing facility shall be responsible for reimbursement of any overpayment within 30 days of such finalization, subject to such guarantees as the Secretary shall determine by regulation.''.

(b) PAYMENT OPTION.—Notwithstanding any other provision of, or amendment made by this title, a nursing facility that has obtained an exception from the routine cost limits for providing subacute care under section 1888(e) of the Social Security Act (as added by subsection (a)), before the effective date specified by section 507(b), shall have the option of continuing to receive payments in accordance with such exception for not more than 12 months after such date.

SEC. 503. PHYSICIAN VISITS AND CONSULTATIONS FOR MEDICARE PATIENTS IN SKILLED NURSING FACILITIES.

Section 1848(b) of the Social Security Act (42 U.S.C. 1395w–4(b)) is amended by—

(1) redesignating paragraphs (2) and (3) as paragraphs (3) and (4), respectively; and

(2) inserting after paragraph (1) the following new paragraph:

''(2) TREATMENT OF PHYSICIAN VISITS TO SUBACUTE CARE PATIENT IN A SKILLED NURSING FACILITY.—Not later than January 1 of each year (beginning in 1997 and regardless of the issuance of final regulations), the Secretary shall establish by regulation, fee schedules that establish amounts for physician visits to a subacute care patient in a skilled nursing facility that shall be the same as if the physician visited such subacute care patient in a hospital.''.

SEC. 504. COVERAGE OF RESPIRATORY THERAPY SERVICES IN SKILLED NURSING FACILITIES UNDER THE MEDICARE PROGRAM.

(a) EXTENDED CARE SERVICES.—Section 1861(h)(3) of the Social Security Act (42 U.S.C. 1395x(h)) is amended by striking ''or occupational'' and inserting ''occupational, or respiratory''.

(b) REASONABLE COST.—Section 1861(v)(5)(A) of the Social Security Act (42 U.S.C. 1395x(v)(5)(A)) is amended by inserting ''(other than respiratory therapy services)'' after ''other therapy services''.

SEC. 505. DRGS APPROPRIATE FOR SUBACUTE CARE IN SKILLED NURSING FACILITIES.

(a) REVIEW.—Not later than October 1, 1996, the Secretary shall review the provision of subacute care by skilled nursing facilities and determine which hospital diagnosis-related groups (hereafter in this section referred to as ''DRGs'') are appropriate for skilled nursing facilities that provide such care, and the appropriate hospitalizations and co-payments for such DRGs.

(b) PUBLICATION.—Not later than October 1, 1997, the Secretary shall publish a list of applicable DRGs with appropriate hospitalizations and co-payments, and rebase medicare payments for such groups to reflect the lower cost of such care provided in skilled nursing facilities.

SEC. 506. SUBACUTE CARE SERVICES UNDER TITLE XIX.

It is the sense of the Congress that—

(1) States are encouraged to develop payment methodologies under section 1902(a)(13) of the Social Security Act (42 U.S.C. 1396a(a)(13)), for nursing facilities which provide subacute care to medicaid patients; and

(2) Federal funding should be available for nursing facilities which provide subacute care to medicaid patients.

SEC. 507. EFFECTIVE DATE.

(a) IN GENERAL.—Except as otherwise provided in this title and subsection (b), the provisions of, and the amendments made by, this title shall be effective January 1, 1997.

(b) EXCEPTION.—Subacute classifications established under the provisions of, and amendments made by, this title shall be effective not later than October 1, 1997.

Subtitle B—Establishment of Program for Home and Community-based Services for Certain Individuals With Disabilities

SEC. 511. SHORT TITLE.

This subtitle may be cited as the ''Home and Community-Based Services for Individuals with Disabilities Program Amendments of 1995''.

SEC. 512. ESTABLISHMENT OF PROGRAM.

Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by redesignating section 1931 as section 1932 and by inserting after section 1931 the following new section:

''HOME AND COMMUNITY-BASED SERVICES FOR INDIVIDUALS WITH DISABILITIES

''SEC. 1932. (a) IN GENERAL.—There is hereby established a program under which States will be required to provide home and community-based services as described in this section on behalf of individuals with disabilities who meet the requirements described in this section. This program is established notwithstanding any other provisions of this title, and such services must be provided to all such individuals by a State that has an approved State plan under this title. The State shall not have responsibility to cover such services under this title to the extent that such services are provided to an individual under any other public programs. All provisions of this title shall be applicable to the program established under this section except to the extent such provisions are inconsistent with this section.

''(b) ELIGIBILITY.—

''(1) INDIVIDUALS WITH DISABILITIES DEFINED.—In this section, the term 'individual with disabilities' means any individual who falls within one or both of the following 2 categories of individuals:

''(A) INDIVIDUALS REQUIRING HELP WITH ACTIVITIES OF DAILY LIVING.—An individual of any age who—

''(i) requires hands-on or standby assistance, supervision, or cueing (as defined in regulations) to perform 3 or more activities of daily living (as defined in paragraph (2)), and

''(ii) is expected to require such assistance, supervision, or cueing over a period of at least 100 days.

''(B) INDIVIDUALS WITH MODERATE COGNITIVE OR MENTAL IMPAIRMENT.—An individual of any age—

''(i) whose score, on a standard mental status protocol (or protocols) appropriate for measuring the individual's particular condition specified by the Secretary, indicates either moderate cognitive impairment or moderate mental impairment, or both;

''(ii) who displays symptoms of one or more serious behavioral problems (that is on a list of such problems specified by the Secretary) which create a need for super-

vision to prevent harm to self or others; and

''(iii) who is expected to meet the conditions of clauses (i) or (ii) over a period of at least 100 days.

''(2) ACTIVITY OF DAILY LIVING DEFINED.—In this section, the term 'activity of daily living' means any of the following: eating, toileting (dressing and bathing), transferring, and mobility.

''(c) SCREENING.—

''(1) INITIAL SCREENING.—The State shall provide for an initial screening of all individuals who appear to have some reasonable likelihood of being an individual with disabilities. Such a screening may be conducted by a qualified case manager, or by any other person or entity designated by the State under criteria specified by the Secretary. Such assessment shall be conducted using a uniform protocol specified by the Secretary. A State may specify the collection of addition information, or an alternative protocol, if approved in advance by the Secretary. Such assessment shall include, at a minimum an assessment of the individual's—

''(A) ability or inability to perform any activities of daily living;

''(B) health status;

''(C) mental status;

''(D) current living arrangement; and

''(E) use of formal and informal long-term care support systems.

''(2) PERIODIC REASSESSMENT.—For any individual who receives services under this program, the State shall arrange for a reassessment of the individual's need for services under this section after a significant change in an individual's condition that may affect the individual's need for such services, within 6 months of the most recent assessment, or for a longer period in cases where the occurrence of a significant change in an individual's condition that may affect such determination is unlikely.

''(d) CARE PLAN DEVELOPMENT.—

''(1) IN GENERAL.—The State shall assign a qualified case manager to any individual who qualifies for coverage under this section. The qualified case manager shall arrange for the development of, or develop, an individualized written plan of care based upon the comprehensive assessment. The care plan shall be developed under any criteria that may

be specified by the State based upon any criteria that the Secretary may specify. At a minimum, such plan shall identify—

''(A) the long-term problems and needs of the individual;

''(B) the mix of formal and informal services and support systems that are available to meet the long-term care and service needs of the individual;

''(C) goals for the individual which shall be measurable to the extent practicable;

''(D) the appropriate services necessary to meet such needs; and

''(E) the manner in which covered services will be provided.

''(2) PROVISION OF SERVICES.—

''(A) COVERED SERVICES.—The qualified case manager, in consultation with the individual, the individual's family and the individual's primary medical care provider, shall arrange for, or provide, the appropriate covered services in a cost-effective manner, consistent with obtaining quality care. The qualified case manager also shall assist in making the necessary

arrangements for the delivery of such services and the implementation of the care plan.

''(B) NON-COVERED SERVICES.—The State may require the qualified case manager to assist the individual in obtaining non-covered services, at the individual's own expense, or through other programs that may be available. Nothing in this section shall be construed to make the State responsible for payment under this section for any services that are not covered services, as defined in subsection (f)(1), or from prohibiting the individual, or other individuals, from paying for non-covered services or services in excess of the amount or type approved by the case manager.

''(C) INDIVIDUAL CHOICE.—The acceptance of benefits under this provision is a voluntary choice of the individual or his or her representative. Nothing in this section shall be construed to require an individual to accept the services available under this section, or to accept benefits under this section instead of entering a nursing facility, skilled nursing facility, or intermediate care facility for the mentally retarded. An individual shall not be denied other

covered services under this section solely because he or she refuses to accept one such covered service, unless the failure to accept that one covered service would vitiate the effectiveness of the other covered services, and no cost-effective alternative acceptable to the individual is reasonably available. To the extent possible, the case manager shall follow the choice of an individual with disabilities regarding which covered services to receive and the providers who will provide such services.

''(3) COORDINATION.—The plan shall specify how the plan will integrate services provided under this section with services provided under titles V and XX of this Act and the Housing and Urban Development Act, programs under the Older Americans Act of 1965, and any other Federal or State programs that provide services or assistance targeted to the aged and individuals with disabilities.

''(4) INVOLVEMENT OF INDIVIDUALS.—The qualified case manager shall be responsible for arranging for the involvement of appropriate persons in the comprehensive assessment and development of the plan of care. In addition, the plan of care shall

be developed and implemented in close consultation with the individual and individual's family.

''(5) CARE PLAN MONITORING.—The qualified case manager shall monitor the delivery of services to the individual, the quality of care provided, and the status of individual. Periodic reassessments of the status and needs of the individual, and revisions of the care plan, shall be made by the qualified case manager as appropriate. Such reassessments shall be conducted not less than every 6 months. If the individual is no longer eligible for benefits as a result of improved health conditions or death, the qualified case manager, in consultation with the individual's primary medical care provider, shall discharge the case.

''(6) QUALIFIED CASE MANAGER.—In this section, the term 'qualified case manager' means a person or entity which—

''(A) provides case management services to an individual who is eligible for home and community-based services;

''(B) is not a relative of the individual receiving such case management services;

''(C) has experience in assessing individuals' functional and cognitive impairment;

''(D) has experience or has been trained in establishing, and in periodically reviewing and revising, individual community care plans, and in the provision of case management services to individuals who are eligible for home and community-based services under this section;

''(E) completes the individual care plan in a timely manner and reviews and discusses new and revised individual care plans with the individual or such individual's representative or both; and

''(F) meets such other standards established by the Secretary or the State which may include standards which assure—

''(i) the quality of the case management services; and

''(ii) that individuals whose home and community-based services such person or entity manages are not at risk of financial exploitation due to such a manager.

''(7) RELATIVE DEFINED.—In this section, the term 'relative' means an individual bearing a relationship to another individual which is described in paragraphs (1) through (8) of section 152(a) of the Internal Revenue Code of 1986.

''(e) TYPES OF PROVIDERS AND REQUIREMENTS FOR PARTICIPATION.—

''(1) IN GENERAL.—The State plan shall specify—

''(A) the types of services eligible to participate in the program under the plan; and

''(B) any requirements for participation applicable to each type of service provider.

''(2) SERVICE PROVIDER DEFINED.—In this section, the term 'service provider' means a provider who is licensed under State law or who meets other criteria as the Secretary or State may specify.

''(f) COVERED SERVICES.—

''(1) IN GENERAL.—In this section, the term 'covered services' includes—

''(A) case management;

''(B) adult day services;

''(C) habilitation and rehabilitation services;

''(D) home health care;

''(E) respite services; and

''(F) hospice services.

''(2) DELIVERY OF SERVICES.—Subject to the limits in subsection (g), covered services may be de-

livered in an individual's home, a range of community residential arrangements, or outside the home.

''(3) AMOUNT, SCOPE, AND DURATION.—In establishing the amount, scope, and duration of services required to be provided, covered services shall be treated as required services under this title.

''(g) EXCLUSIONS AND LIMITATIONS.—

''(1) IN GENERAL.—The following are specifically excluded from coverage under this section:

''(A) Room and board.

''(B) Items or services otherwise covered to the extent that such items or services are covered under an insurance plan or program other than a State health program.

''(C) Services provided to an individual who otherwise would be institutionalized in a nursing facility or intermediate care facility for the mentally retarded, unless the State, or if delegated, the qualified case manager reasonably estimates (under methods specified by the Secretary) that the cost of covered services under this section would be lower than if the individual were so institutionalized.

''(D) Services specified in the plan of care which are not specified as covered services under subsection (f)(1).

''(2) TAKING INTO ACCOUNT INFORMAL CARE.—A State plan may take into account, in determining the amount and array of services made available to covered individuals with disabilities, the availability of informal care.

''(h) MAINTENANCE OF EFFORT.—The State plan shall provide assurances that, in the case of an individual receiving medical assistance for home and community-based services under this title as of the date of the enactment of this section, the State will continue to make available (either under this title or otherwise) to such individual an appropriate level of assistance for home and community-based services, taking into account the level of assistance provided as of such date and the individual's need for home and community-based services.

''(i) QUALITY ASSURANCE AND SAFEGUARDS.—

''(1) QUALITY ASSURANCE.—The State shall ensure and monitor the quality of services, including—

''(A) safeguarding the health and safety of individuals with disabilities;

''(B) establishing minimum standards for care managers and providers and enforcing those standards;

''(C) establishing the minimum competency requirements for provider employees who provide direct services under this section and how the competency of such employees will be enforced;

''(D) obtaining meaningful consumer input, including consumer surveys that measure the extent to which participants receive the services described in the plan of care and participant satisfaction with such services;

''(E) participation in quality assurance activities; and

''(F) specifying the role of the long-term care ombudsman (under the Older Americans Act of 1965) and the Protection and Advocacy Agency (under the Developmental Disabilities Assistance and Bill of Rights Act) in assuring quality of services and protecting the rights of individuals with disabilities.

''(2) SAFEGUARDS.—

''(A) CONFIDENTIALITY.—The State shall provide safeguards which restrict the use or dis-

closure of information concerning applicants and beneficiaries to purposes directly connected with the administration of the program.

''(B) SAFEGUARDS AGAINST ABUSE.—The State shall provide safeguards against physical, emotional, or financial abuse or exploitation in the provision of care management and covered services.

''(j) PROVIDER REIMBURSEMENT.—

''(1) PAYMENT METHODS.—The State shall specify the payment methods to be used to reimburse providers and case managers for services furnished under the plan. Such methods may include reimbursement on a fee-for-service basis, prepayment on a capitation basis, or a combination of these methods. The State, if it chooses, may provide the case manager with authority to negotiate rates with individual providers.

''(2) PAYMENT RATES.—The State shall specify the methods and criteria to be used to set payment rates for services furnished under the plan. In addition to any other requirements, such payments must be sufficient to ensure that the requirements of 1902(a)(30)(A) are satisfied.

''(3) PAYMENT IN FULL.—Except as specified in subsection (d)(2)(B), the State shall restrict payment for covered services to those providers that agree to accept the payment under the plan (at rates established pursuant to subparagraph (2)) as payment in full for services furnished under this section.

''(k) APPROVAL OF STATE PLAN AMENDMENTS.—Each State shall take whatever action is necessary to have an amendment to its State plan under this title approved by October 1, 1997, that implements this section for that State not later than October 1, 1998, except that where an Act of the State legislature is necessary to effectuate such State plan amendment and said legislature is not in session as of the date of the enactment of this section, the State shall have said amendment approved not later than 6 months after the commencement of the session of its legislature that begins immediately subsequent to such date of enactment, if such date is later than October 1, 1997.''.

SEC. 513. INCREASED RESOURCE DISREGARDS FOR NURSING FACILITY RESIDENTS.

Section 1902(a)(10) of the Social Security Act (42 U.S.C. 1396a(a)(10)) is amended—

(1) by striking ''and'' at the end of subparagraph (E);

(2) by inserting ''and'' at the end of subparagraph (F); and

(3) by inserting after subparagraph (F) the following new subparagraph:

''(G) that, in determining the eligibility of any individual who is an inpatient in a nursing facility or intermediate care facility for the mentally retarded, in the case of an unmarried individual, the first $12,000 of resources shall be disregarded.''.

Subtitle C—Prospective Payment System for Nursing Facilities

SEC. 521. SHORT TITLE.

This subtitle may be cited as the ''Prospective Payment System for Nursing Facilities Amendments of 1995''.

SEC. 522. DEFINITIONS.

For purposes of this subtitle, the following definitions shall apply:

(1) ACUITY PAYMENT.—The term ''acuity payment'' means a fixed amount that will be added to the facility-specific prices for certain resident classes designated by the Secretary as requiring heavy care.

(2) AGGREGATED RESIDENT INVOICE.—The term ''aggregated resident invoice'' means a com-

pilation of the per resident invoices of a nursing facility which contain the number of resident days for each resident and the resident class of each resident at the nursing facility during a particular month.

(3) ALLOWABLE COSTS.—The term ''allowable costs'' means costs which HCFA has determined to be necessary for a nursing facility to incur according to the Provider Reimbursement Manual (hereafter in this subtitle referred to as ''HCFA–Pub. 15'').

(4) BASE YEAR.—The term ''base year'' means the most recent cost reporting period (consisting of a period which is 12 months in length, except for facilities with new owners, in which case the period is not less than 4 months nor more than 13 months) for which cost data of nursing facilities is available to be used for the determination of a prospective rate.

(5) CASE MIX WEIGHT.—The term ''case mix weight'' means the total case mix score of a facility calculated by multiplying the resident days in each resident class by the relative weight assigned to each resident class, and summing the resulting products across all resident classes.

(6) COMPLEX MEDICAL EQUIPMENT.—The term ''complex medical equipment'' means items such as

ventilators, intermittent positive pressure breathing (IPPB) machines, nebulizers, suction pumps, continuous positive airway pressure (CPAP) devices, and bead beds such as air fluidized beds.

(7) DISTINCT PART NURSING FACILITY.—The term ''distinct part nursing facility'' means an institution which has a distinct part that is certified under title XVIII of the Social Security Act and meets the requirements of section 201.1 of the Skilled Nursing Facility Manual published by HCFA (hereafter in this subtitle referred to as ''HCFA–Pub. 12'').

(8) EFFICIENCY INCENTIVE.—The term ''efficiency incentive'' means a payment made to a nursing facility in recognition of incurring costs below a prespecified level.

(9) FIXED EQUIPMENT.—The term ''fixed equipment'' means equipment which meets the definition of building equipment in section 104.3 of HCFA–Pub. 15, and includes attachments to buildings such as wiring, electrical fixtures, plumbing, elevators, heating systems, and air conditioning systems.

(10) GEOGRAPHIC CEILING.—The term ''geographic ceiling'' means a limitation on payments in

any given cost center for nursing facilities in 1 of not less than 8 geographic regions, further subdivided into rural and urban areas, as designated by the Secretary.

(11) HEAVY CARE.—The term ''heavy care'' means an exceptionally high level of care which the Secretary has determined is required for residents in certain resident classes.

(12) HCFA.—The term ''HCFA'' means the Health Care Financing Administration of the Department of Health and Human Services.

(13) INDEXED FORWARD.—The term ''indexed forward'' means an adjustment made to a per diem rate to account for cost increases due to inflation or other factors during an intervening period following the base year and projecting such cost increases for a future period in which the rate applies. Indexing forward under this subtitle shall be determined from the midpoint of the base year to the midpoint of the rate year.

(14) MARSHALL SWIFT SEGMENTED COST METHOD.—The term ''Marshall Swift segmented cost method'' means an appraisal method published by the Marshall Swift Valuation Service.

(15) MINIMUM DATA SET.—The term ''minimum data set'' (hereafter in this subtitle referred to as 'MDS') means a resident assessment instrument, currently recognized by HCFA, in addition to any extensions to MDS, such as MDSs, as well as any extensions to accommodate subacute care which contain an appropriate core of assessment items with definitions and coding categories needed to comprehensively assess a nursing facility resident.

(16) MAJOR MOVABLE EQUIPMENT.—The term ''major movable equipment'' means equipment which meets the definition of major movable equipment in section 104.4 of HCFA–Pub. 15, and includes accounting machines, beds, wheelchairs, desks, vehicles, and x-ray machines.

(17) NURSING FACILITY.—The term ''nursing facility'' means an institution which meets the requirements of a ''skilled nursing facility'' under section 1819(a) of the Social Security Act (42 U.S.C. 1395i–3(a)) and a ''nursing facility'' under section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(18) PER BED LIMIT.—The term ''per bed limit'' means a per bed ceiling on the fair asset

value of a nursing facility for one of the geographic regions designated by the Secretary.

(19) PER DIEM RATE.—The term ''per diem rate'' means a rate of payment for the costs of covered services for a resident day.

(20) RELATIVE WEIGHT.—The term ''relative weight'' means the index of the value of the resources required for a given resident class relative to the value of resources of either a base resident class or the average of all the resident classes.

(21) R. S. MEANS INDEX.—The term ''R. S. Means Index'' means the index of the R. S. Means Company, Inc., specific to commercial/industrial institutionalized nursing facilities, which is based upon a survey of prices of common building materials and wage rates for nursing facility construction.

(22) REBASE.—The term ''rebase'' means the process of updating nursing facility cost data for a subsequent rate year using a more recent base year.

(23) RENTAL RATE.—The term ''rental rate'' means a percentage that will be multiplied by the fair asset value of property to determine the total annual rental payment in lieu of property costs.

(24) RESIDENT CLASSIFICATION SYSTEM.—The term ''resident classification system'' means a sys-

tem which categorizes residents into different resident classes according to similarity of the assessed condition and required services of such residents.

(25) RESIDENT DAY.—The term ''resident day'' means the period of services for one resident, regardless of payment source, for one continuous 24 hours of services. The day of admission of the resident constitutes a resident day but the day of discharge does not constitute a resident day. Bed hold days are not to be considered resident days, and bed hold day revenues are not to be offset.

(26) RESOURCE UTILIZATION GROUPS, VERSION III.—The term ''Resource Utilization Groups, Version III (hereafter in this subtitle referred to as 'RUG–III')'' means a category-based resident classification system used to classify nursing facility residents into mutually exclusive RUG–III groups. Residents in each RUG–III group utilize similar quantities and patterns of resources.

(27) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

SEC. 523. PAYMENT OBJECTIVES.

Payment rates under the Prospective Payment System for Nursing Facilities shall reflect the following objectives:

(1) To maintain an equitable and fair balance between cost containment and quality of care in nursing facilities.

(2) To encourage nursing facilities to admit residents without regard to such residents' source of payment.

(3) To provide an incentive to nursing facilities to admit and provide care to persons in need of comparatively greater care.

(4) To maintain administrative simplicity for both nursing facilities and the Secretary.

(5) To encourage investment in buildings and improvements to nursing facilities (capital formation) as necessary to maintain quality and access.

SEC. 524. POWERS AND DUTIES OF THE SECRETARY.

(a) REGULATIONS.—The Secretary shall establish by regulation all rules and regulations necessary for the implementation of this subtitle. The rates determined under this subtitle shall reflect the objectives set forth in section 523.

(b) INFORMATION.—The Secretary may require that each nursing facility file such data, statistics, schedules,

or information as required to enable the Secretary to implement this subtitle.

SEC. 525. RELATIONSHIP TO TITLE XVIII OF THE SOCIAL SECURITY ACT.

(a) NO EFFECT ON MEDICARE SNF'S.—No provision in this subtitle shall replace, or otherwise affect, the skilled nursing facility benefit under title XVIII of the Social Security Act.

(b) HCFA–PUB. 15.—The provisions of HCFA–Pub. 15 shall apply to the determination of allowable costs under this subtitle except to the extent that such provisions conflict with any other provision in this subtitle.

SEC. 526. ESTABLISHMENT OF RESIDENT CLASSIFICATION SYSTEM.

(a) ESTABLISHMENT.—The Secretary shall establish a resident classification system which shall—

(1) group residents into classes according to similarity of the assessed condition and required services of such residents;

(2) be modeled after the RUG–III system and all updated versions of that system; and

(3) be reflective of the necessary professional and paraprofessional nursing staff time and costs required to address the care needs of nursing facility residents.

(b) RELATIVE WEIGHTS.—

(1) IN GENERAL.—The Secretary shall assign a relative weight for each resident class based on the relative value of the resources required for each resident class. The assignment of relative weights for resident classes shall be performed for each geographic region as determined in accordance with subsection (c).

(2) CONSIDERATION OF INFORMATION.—In assigning the relative weights of the resident classes in a geographic region, the Secretary shall utilize information derived from the most recent MDSs of all of the nursing facilities in a geographic region.

(3) RECALIBRATION.—The relative weights of the resident classes in each geographic region shall be recalibrated every 3 years based on any changes in the cost or amount of resources required for the care of a resident in the resident class.

(c) DESIGNATION OF GEOGRAPHIC REGIONS.—

(1) IN GENERAL.—The Secretary shall designate not less than 8 geographic regions for the total United States. Within each geographic region, the Secretary shall take appropriate account of variations in cost between urban and rural areas.

(2) NO PEER GROUPING.—There shall be no peer grouping of nursing facilities (based on whether the nursing facilities are hospital-based or not) other than peer-grouping by geographic region.

SEC. 527. COST CENTERS FOR NURSING FACILITY PAYMENT.

(a) DETERMINATION OF PAYMENT RATES.—Consistent with the objectives set forth in section 523, the Secretary shall determine payment rates for nursing facilities using the following cost-service groupings:

(1) The nursing service cost center shall include salaries and wages for the Director of Nursing, Quality Assurance Nurses, registered nurses, licensed practical nurses, nurse aides (including wages related to initial and on-going nurse aide training and other on-going or periodic training costs incurred by nursing personnel), contract nursing, fringe benefits and payroll taxes associated therewith, medical records, and nursing supplies.

(2) The administrative and general cost center shall include all expenses (including salaries, benefits, and other costs) related to administration, plant operation, maintenance and repair, housekeeping, dietary (excluding raw food), central services and sup-

ply (excluding medical supplies), laundry, and social services.

(3) Ancillary services to be paid on a fee-for-service basis shall include physical therapy, occupational therapy, speech therapy, respiratory therapy, hyperalimentation, and complex medical equipment (CME). These fee-for-service ancillary service payments under part A of title XVIII of the Social Security Act shall not affect the reimbursement of ancillary services under part B of title XVIII of the Social Security Act.

(4) The cost center for selected ancillary services and other costs shall include drugs, raw food, medical supplies, IV therapy, x-ray services, laboratory services, property tax, property insurance, minor equipment, and all other costs not included in the other 4 cost/service groupings.

(5) The property cost center shall include depreciation on the buildings and fixed equipment, major movable equipment, motor vehicles, land improvements, amortization of leasehold improvements, lease acquisition costs, and capital leases, interest on capital indebtedness, mortgage interest, lease costs, and equipment rental expense.

(b) PROSPECTIVE PAYMENT.—Nursing facilities shall be paid a prospective, facility-specific, per diem rate based on the sum of the per diem rates established for the nursing service, administrative and general, and property cost centers as determined in accordance with sections 529, 530, and 533.

(c) UNIT RATES.—Nursing facilities shall be paid a facility-specific prospective rate for each unit of the fee-for-service ancillary services as determined in accordance with section 531.

(d) REIMBURSEMENT.—Nursing facilities shall be reimbursed for selected ancillary services and other costs on a retrospective basis in accordance with section 532.

SEC. 528. RESIDENT ASSESSMENT.

(a) IN GENERAL.—The nursing facility shall perform a resident assessment in accordance with section 1819(b)(3) of the Social Security Act (42 U.S.C. 1395i–3(a)) not later than 14 days after the date the resident is admitted, and at such other times as required by such section.

(b) USE OF ASSESSMENT.—The resident assessment shall be used to determine the resident class of each resident in the nursing facility for purposes of determining the per diem rate for the nursing service cost center in accordance with section 529.

SEC. 529. THE PER DIEM RATE FOR NURSING SERVICE COSTS.

(a) CALCULATION OF RATE.—

(1) IN GENERAL.—The nursing service cost center rate shall be calculated using a prospective, facility-specific per diem rate based on the nursing facility's case-mix weight and nursing service costs during the base year.

(2) CASE-MIX WEIGHT.—The case-mix weight of a nursing facility shall be obtained by multiplying the number of resident days in each resident class at a nursing facility during the base year by the relative weight assigned to each resident class in the appropriate geographic region. Once this calculation is performed for each resident class in the nursing facility, the sum of these products shall constitute the case-mix weight for the nursing facility.

(3) FACILITY NURSING UNIT VALUE.—A facility nursing unit value for the nursing facility for the base year shall be obtained by dividing the nursing service costs for the base year, which shall be indexed forward from the midpoint of the base period to the midpoint of the rate period using the DRI McGraw-Hill HCFA Nursing Home Without Capital Market Basket, by the case-mix weight of the nursing facility for the base year.

(4) FACILITY-SPECIFIC NURSING SERVICES PRICE.—A facility-specific nursing services price for each resident class shall be obtained by multiplying the lower of the indexed facility unit value of the nursing facility during the base year or the geographic ceiling, as determined in accordance with subsection (b), by the relative weight of the resident class.

(5) DESIGNATION OF HEAVY CARE CLASSES.—The Secretary shall designate certain resident classes as requiring heavy care. An acuity payment of 3 percent of the facility-specific nursing services price shall be added on to the facility-specific price for each resident class which the Secretary has designated as requiring heavy care. The acuity payment is intended to provide an incentive to nursing facilities to admit residents requiring heavy care.

(6) PER DIEM RATE FOR NURSING SERVICE COST.—The per diem rate for the nursing service cost center for each resident in a resident class shall constitute the facility-specific price, plus the acuity payment where appropriate.

(7) ANNUAL REBASEMENT.—The per diem rate for the nursing service cost center, including the fa-

cility-specific price and the acuity payment, shall be rebased annually.

(8) DETERMINATION OF PAYMENT AMOUNT.—To determine the payment amount to a nursing facility for the nursing service cost center, the Secretary shall multiply the per diem rate (including the acuity payment) for a resident class by the number of resident days for each resident class based on aggregated resident invoices which each nursing facility shall submit on a monthly basis.

(b) GEOGRAPHIC CEILINGS.—

(1) IN GENERAL.—The facility nursing unit value identified in subsection (a)(3) shall be subjected to geographic ceilings established for the geographic regions designated by the Secretary in section 526(c).

(2) DETERMINATION OF CEILING.—

(A) FOR FISCAL YEAR 1997.—The geographic ceiling shall be determined by first creating an array of indexed facility unit values in a geographic region from lowest to highest. Based on this array, the Secretary shall identify a fixed proportion between the indexed facility unit value of the nursing facility which contained the medianth resident day in the array

(except as provided in subsection (b)(4)) and the indexed facility unit value of the nursing facility which contained the 95th percentile resident day in that array during the first year of operation of the Prospective Payment System For Nursing Facilities. The fixed proportion (e.g., 1.1 times the median or 110 percent of the median) shall remain the same in subsequent years.

(B) FOR SUBSEQUENT FISCAL YEARS.—To obtain the geographic ceiling on the indexed facility unit value for nursing facilities in a geographic region in each fiscal year after fiscal year 1997, the fixed proportion identified pursuant to subsection (b)(2) shall be multiplied by the indexed facility unit value of the nursing facility which contained the medianth resident day in the array of facility unit values for the geographic region during the base year.

(3) EXCLUSION OF LOW-VOLUME AND NEW FACILITIES.—The Secretary shall exclude low-volume and new nursing facilities, as defined in subsections (a) and (b) of section 534, respectively, for purposes of determining the geographic ceiling for the nursing service cost center.

(c) EXCEPTIONS.—The Secretary shall establish by regulation, procedures for allowing exceptions to the geographic ceiling imposed on the nursing service cost center. The procedure shall permit exceptions based on the following factors:

(1) Local supply and labor shortages which substantially increase costs to specific nursing facilities.

(2) Higher per resident day usage of contract nursing personnel, if utilization of contract nursing personnel is warranted by local circumstances, and the provider has taken all reasonable measures to minimize contract personnel expense.

(3) Extraordinarily low proportion of distinct part nursing facilities in a geographic region resulting in a geographic ceiling which unfairly restricts the reimbursement of distinct part facilities.

(4) Regulatory changes that increase costs to only a subset of the nursing facility industry.

(5) The offering of a new institutional health service or treatment program by a nursing facility (in order to account for initial startup costs).

(6) Disproportionate usage of part-time employees, where adequate numbers of full-time employees cannot reasonably be obtained.

(7) Other cost producing factors, to be specified by the Secretary in regulations that are specific to a subset of facilities in a geographic region (except case-mix variation).

SEC. 530. THE PER DIEM RATE FOR ADMINISTRATIVE AND GENERAL COSTS.

(a) DETERMINATION OF RATE.—

(1) IN GENERAL.—Payment relative to the administrative and general cost center shall be a facility-specific, prospective, per diem rate.

(2) ASSIGNMENT OF RATE.—The Secretary shall assign a per diem rate to a nursing facility by applying 2 standards which shall be calculated as follows:

(A) Standard A shall be derived for each geographic region by first creating an array of indexed nursing facility administrative and general per diem costs from lowest to highest. The Secretary shall then identify a fixed proportion by dividing the indexed administrative and general per diem costs of the nursing facility which contained the medianth resident day of the array (except as provided in subsection (a)(4)) into the indexed administrative and general per diem costs of the nursing facility which con-

tained the 75th percentile resident day in that array. Standard A for each base year shall constitute the product of this fixed proportion (e.g., 1.1 times the median or 110 percent of the median) and the administrative and general indexed per diem costs of the nursing facility which contained the medianth resident day in the array of such costs during the base year.

(B) Standard B shall be derived using the same calculation as in subparagraph (A) except that the fixed proportion shall use the indexed administrative and general costs of the nursing facility containing the 85th percentile, rather than the 75th percentile, resident day in the array of such costs.

(3) GEOGRAPHIC REGIONS.—The Secretary shall use the geographic regions identified in section 526(c) for purposes of determining Standard A and Standard B.

(4) EXCLUSION OF LOW-VOLUME AND NEW FACILITIES.—The Secretary shall exclude low-volume and new nursing facilities, as defined in subsections (a) and (b) of section 535, respectively, for purposes of determining Standard A and Standard B.

(5) DETERMINATION OF ADMINISTRATIVE AND GENERAL COSTS.—To determine a nursing facility's per diem rate for the administrative and general cost center, Standard A and Standard B shall be applied to a nursing facility's administrative and general per diem costs, indexed forward using the DRI McGraw-Hill HCFA Nursing Home Without Capital Market Basket, as follows:

(A) Each nursing facility having indexed costs which fall below the median shall be assigned a rate equal to such facility's individual indexed costs plus an ''efficiency incentive'' equal to one half of the difference between the median and Standard A.

(B) Each nursing facility having indexed costs which fall below Standard A but at or above the median shall be assigned a per diem rate equal to such facility's individual indexed costs plus an ''efficiency incentive'' equal to one-half of the difference between such facility's indexed costs and Standard A.

(C) Each nursing facility having indexed costs which fall between Standard A and Standard B shall be assigned a rate equal to Stand-

ard A plus one-half of the difference between such facility's indexed costs and Standard A.

(D) Each nursing facility having indexed costs which exceed Standard B shall be assigned a rate as if such facility's costs equaled Standard B. These nursing facilities shall be assigned a per diem rate equal to Standard A plus one-half of the difference between Standard A and Standard B.

(E) For purposes of subparagraphs (A) through (D), the median represents the indexed administrative and general per diem costs of the nursing facility which contained the medianth resident day in the array of such costs during the base year in the geographic region.

(b) REBASEMENT.—Rebasing of the payment rates for administrative and general costs shall occur not less than once a year.

SEC. 531. PAYMENT FOR FEE-FOR-SERVICE ANCILLARY SERVICES.

(a) PROSPECTIVE PAYMENT.—Payment for each ancillary service enumerated in section 106(a)(3), such as physical therapy, shall be calculated and paid on a prospective fee-for-service basis.

(b) DETERMINATION OF FEE.—The Secretary shall identify the fee for each of the fee-for-service ancillary services for a particular nursing facility by dividing the nursing facility's actual costs, including overhead allocated through the cost finding process, of providing each particular service, indexed forward using the DRI McGraw-Hill HCFA Nursing Home Without Capital Market Basket, by the units of the particular service provided by the nursing facility during the cost year.

(c) ANNUAL CALCULATION.—The fee for each of the fee-for-service ancillary services shall be calculated not less than once a year for each facility and ancillary service.

SEC. 532. REIMBURSEMENT OF SELECTED ANCILLARY SERVICES AND OTHER COSTS.

(a) RETROSPECTIVE REIMBURSEMENT.—Reimbursement of selected ancillary services and other costs identified in section 527(a)(4), such as drugs and medical supplies, shall be reimbursed on a retrospective basis as pass-through costs, including overhead allocated through the cost-finding process.

(b) INTERIM RATES.—The Secretary shall set charge-based interim rates for selected ancillary services and other costs for each nursing facility providing such services. Any overpayments or underpayments resulting from the difference between the interim and final settle-

ment rates shall be either refunded by the nursing facility or paid to the nursing facility following submission of a timely filed medicare cost report.

SEC. 533. THE PER DIEM RATE FOR PROPERTY COSTS.

(a) ESTABLISHMENT OF RATE.—

(1) IN GENERAL.—The basis for payment within the property cost center for nursing facilities shall be calculated and paid on a prospective (except as provided for newly constructed facilities in subsection (d)(2)), facility-specific, per resident day rate based on the fair asset value of the property.

(2) FAIR ASSET VALUE.—

(A) IN GENERAL.—The fair asset value of the property shall constitute the sum of the market value of the land (including site preparation costs), a reconstruction cost appraised value for the buildings and fixed equipment, and the product of the number of beds in the nursing facility and a per bed allowance for major movable equipment.

(B) LIMITATION.—The land, buildings, and fixed equipment which are included in determining the fair asset value must be used in connection with the care of residents.

(C) APPRAISALS.—Appraisals for the buildings and fixed equipment shall be performed using the Marshall-Swift segmented cost method. A nursing facility shall be appraised every 4 years.

(D) ANNUAL ALLOWANCE.—The Secretary shall utilize an annual allowance of $3,500 per bed for major movable equipment for a nursing facility. The Secretary shall review the annual allowance for major movable equipment every 5 years to determine its accuracy.

(E) RENOVATIONS.—If a nursing facility has commenced a renovation to a building and fixed equipment between appraisals the cost of which constitutes at least 5 percent of the total value of the existing building and the fixed equipment, such facility may submit documentation as to the cost of the renovation during the previous year. The Secretary shall add the reasonable costs of the major renovation for the previous year to the fair asset value of the facility. This new asset value is to be the base for indexing until the next full appraisal.

(F) SALES, REFINANCING, AND RECAPTURE OF DEPRECIATION.—The value of the as-

sets is determined through appraisals, indexing, and the application of allowances, and is, therefore, unaffected by sales transactions, refinancing, or other changes in financing. Accordingly, the concept of recapture of depreciation is inapplicable to facilities whose payment is established under this title.

(3) ANNUAL INDEX FOR LAND, BUILDINGS, AND FIXED EQUIPMENT.—The value of the land, buildings, and fixed equipment shall be indexed annually between reappraisals as follows:

(A) The land shall be indexed using Consumer Price Index Urban.

(B) The buildings and fixed equipment shall be indexed annually using the R. S. Means Index.

(4) ANNUAL INDEX FOR MAJOR MOVABLE EQUIPMENT.—The annual allowance for major movable equipment shall be indexed annually using the hospital equipment index of the Marshall Swift Valuation Service.

(5) ADJUSTMENT OF INDEXES.—The Secretary shall adjust the indexes used for the land, buildings and fixed equipment, and major movable equipment for the different geographic regions.

(b) ESTABLISHMENT OF PER BED LIMIT.—

(1) IN GENERAL.—The Secretary shall establish a per bed limit on the fair asset value of a nursing facility for each geographic region, as designated in section 105(c). The per bed limit shall be equal to the average indexed costs incurred by all recently constructed nursing facilities in the geographic region which have been designed and constructed in an efficient manner.

(2) ANNUAL INDEX.—The per bed limit on the fair asset value shall be indexed annually using the R. S. Means Index.

(3) RECALCULATION.—The per bed limit shall be recalculated every 5 years.

(c) DETERMINATION OF TOTAL ANNUAL RENTAL.—The total annual rental shall constitute the product of the lower of the indexed fair asset value or the indexed per bed limit and a rental rate which shall be based on the average yield for 20 year United States Treasury Bonds during the prior year plus a risk premium of 3 percentage points.

(d) DETERMINATION OF PER RESIDENT DAY RENTAL.—

(1) IN GENERAL.—The per resident day rental shall be obtained by dividing the total annual rental

by 90 percent of the annual licensed bed days. The per resident day rental shall constitute the per diem rate attributable to the property cost center.

(2) FOR NEWLY CONSTRUCTED FACILITIES.—The per resident day rental rate for a newly constructed facility during such facility's first year of operation shall be based on the total annual rental divided by the greater of 50 percent of available resident days or actual annualized resident days up to 90 percent of annual licensed bed days during such facility's first year of operation.

(e) EXISTING FACILITIES.—Facilities in operation prior to the effective date of this title shall receive the per resident day rental or actual costs, as determined in accordance with HCFA–Pub. 15, whichever is greater, except that a nursing facility shall be reimbursed the per resident day rental on and after the earlier of—

(1) the date upon which the nursing facility changes ownership;

(2) the date the nursing facility accepts the per resident day rental; or

(3) the date of the renegotiation of the lease for the land and buildings, not including the exercise of optional extensions specifically included in the original lease agreement or valid extensions thereof.

SEC. 534. MID-YEAR RATE ADJUSTMENTS.

(a) MID-YEAR RATE ADJUSTMENTS.—The Secretary shall establish by regulation, a procedure for granting mid-year rate adjustments for the nursing service, administrative and general, and fee-for-service ancillary services cost centers.

(b) REQUIREMENTS FOR GRANTING ADJUSTMENTS.—The mid-year rate adjustment procedure shall require the Secretary to grant adjustments on an industry-wide basis, without the need for nursing facilities to apply for such adjustments, based on the following circumstances:

(1) Statutory or regulatory changes affecting nursing facilities (e.g., new staffing standards or expanded services).

(2) Changes to the Federal minimum wage.

(3) General labor shortages with high regional wage impacts.

(c) REQUIREMENTS FOR ALLOWING APPLICATIONS BY SPECIFIC FACILITIES OR GROUPS.—The mid-year rate adjustment procedure shall permit specific facilities or groups of facilities to apply for an adjustment based on the following factors:

(1) Local labor shortages.

(2) Regulatory changes that apply to only a subset of the nursing facility industry.

(3) Economic conditions created by natural disasters or other events outside of the control of the provider.

(4) Other cost producing factors, except case-mix variation, to be specified by the Secretary by regulation.

(d) REQUIRED SUPPORTING DATA.—

(1) NECESSARY DEVIATION IN RATE.—A nursing facility which applies for a mid-year rate adjustment pursuant to subsection (c) shall be required to show that the adjustment will result in a greater than 2 percent deviation in the per diem rate for any individual cost service center or a deviation of greater than $5,000 in the total projected and indexed costs for the rate year, whichever is less.

(2) COST DATA OR BUDGET PROJECTIONS.—A nursing facility application for a mid-year rate adjustment must be accompanied by recent cost experience data or budget projections.

SEC. 535. EXCEPTION TO PAYMENT METHODS FOR NEW AND LOW-VOLUME NURSING FACILITIES.

(a) DEFINITION OF LOW-VOLUME NURSING FACILITY.—A low-volume nursing facility shall constitute a nursing facility having fewer than 2,500 medicare part A resident days per year.

(b) DEFINITION OF NEW NURSING FACILITY.—A new nursing facility shall constitute a newly constructed, licensed, and certified nursing facility, or a nursing facility that is in its first 3 years of operation as a medicare part A provider. A nursing facility that has operated for more than 3 years but has a change of ownership shall not constitute a new facility.

(c) OPTIONS FOR LOW-VOLUME FACILITIES.—Low-volume nursing facilities shall have the option of submitting a cost report to receive retrospective payment for all of the cost centers, other than the property cost center, or accepting a per diem rate which shall be based on the sum of—

(1) the median indexed resident day facility unit value for the appropriate geographic region for the nursing service cost center during the base year as identified in section 529(b)(2);

(2) the median indexed resident day administrative and general per diem costs of all nursing facilities in the appropriate geographic region as identified in section 530(a)(5)(E);

(3) the median indexed resident day costs per unit of service for fee-for-service ancillary services which shall be obtained using the cost information from the nursing facilities in the appropriate geo-

graphic region during the base year, excluding low-volume and new nursing facilities, and which shall be based on an array of such costs from lowest to highest; and

(4) the median indexed resident day per diem costs for selected ancillary services and other costs which shall be obtained using information from the nursing facilities in the appropriate geographic region during the base year, excluding low-volume and new nursing facilities, and which shall be based on an array of such costs from lowest to highest.

(d) OPTION FOR NEW FACILITIES.—New nursing facilities shall have the option of being paid on a retrospective cost pass-through basis for all cost centers, or in accordance with paragraphs (1) through (4) of subsection (c).

SEC. 536. APPEAL PROCEDURES.

(a) RIGHT OF APPEAL.—

(1) IN GENERAL.—Any person or legal entity aggrieved by a decision of the Secretary under this title, and which results in an amount in controversy of $10,000 or more, shall have the right to appeal such decision directly to the Provider Reimbursement Review Board (hereinafter referred to as the

''Board'') authorized under section 1878 of title XVIII of the Social Security Act.

(2) COMPUTATION OF AMOUNT IN CONTROVERSY.—The $10,000 amount in controversy shall be computed in accordance with 42 CFR 405.1839.

(b) PROCEDURE FOR HEARINGS.—Hearings before the Board under this title, and any appeals thereto, shall follow the procedures under section 1878 of title XVIII of the Social Security Act and the regulations contained in 42 CFR 405.1841–1889, except to the extent that such procedures conflict with, or are inapplicable on account of, any other provision of this title.

SEC. 537. EFFECTIVE DATE.

(a) IN GENERAL.—The provisions of this subtitle shall be effective October 1, 1996.

(b) INCONSISTENT PROVISIONS.—The provisions contained in this subtitle shall supersede any other provisions of title XVIII or title XIX of the Social Security Act which are inconsistent with such provisions.

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