HCFA Rulings

Department of Health and Human Services

Health Care Financing Administration

Ruling No. 92-1 Date: August 1992

HCFA Rulings are decisions of the Administrator that serve as precedent final opinions and orders and statements of policy and interpretation. They provide clarification and interpretation of complex or ambiguous statutory or regulatory provisions relating to Medicare, Medicaid, Utilization and Quality Control Peer Review, and related matters.

HCFA Rulings are binding on all HCFA components, the Provider Reimbursement Review Board and Administrative Law Judges who hear Medicare appeals. These decisions promote consistency in interpretation of policy and adjudication of disputes.

This Ruling announces the Health Care Financing Administration's determination that current regulations based on time limited agreements for providers of nursing services, under the Medicare and Medicaid programs, are inconsistent with the survey, certification, and enforcement provisions of sections 1819 and 1919 of the Social Security Act. Accordingly, those provisions of program regulations that are based on such time limited agreements are determined to be superseded by and inconsistent with sections 1819 and 1919 of the Act and will no longer be followed.

HCFAR 92-1-1

MEDICARE AND MEDICAID PROGRAMS

Hospital Insurance Benefits (Part A) and Medical Assistance Programs

Skilled Nursing Facility and Nursing Facility Provider Agreements

Purpose: This ruling provides notice of the Health Care Financing Administration's (HCFA) determination that time limited agreements for providers of nursing services under the Medicare and Medicaid programs are inconsistent with the implementation of the nursing home reform provisions of sections 1819 and 1919 of the Social Security Act (the Act). Accordingly, those provisions of program regulations that are based on such time limited agreements are determined to be superseded by and inconsistent with sections 1819 and 1919 of the Act and will no longer be followed.

Citations: Sections 1819 and 1919 of the Social Security Act (42 U.S.C. 1395i-3 and 1396r); 42 CFR §§442.15, 442.16, 442.109, 442.110, 488.50, 489.15 and 489.16.

Pertinent history: As part of the Social Security Amendments of 1972 (Pub. L. 92-603), the Congress amended section 1866 of the Act to require that Medicare provider agreements with skilled

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nursing facilities (SNFs) not exceed 12 months in duration. Although the Congress removed this requirement in its enactment of section 2153 of the Omnibus Budget Reconciliation Act of 1981 (Pub. L. 97-35), HCFA regulations retained the provisions governing time limited agreements and they have remained in force to the present.

In December 1987, the Congress enacted the nursing home reform provisions of the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100-203), which significantly rewrote the rules that govern the survey, certification, and enforcement responsibilities of the Secretary and the States for both the Medicare and Medicaid programs. These provisions in large measure reflected the conclusions reached by the National Academy of Science's Institute of Medicine (IOM) in its 1986 review of nursing home regulations. The survey, certification, and enforcement measures of this legislation reconfigured the way in the way in which HCFA and the States would track nursing home compliance with Federal requirements and approach enforcement strategies. While we believed at first that we could continue to implement the regulations' time limited agreement requirements until they could be replaced by new survey, certification, and enforcement regulations, we now believe that the continued implementation of these provisions frustrates many aspects of nursing home reform and, in a practical way, has rendered them inoperable.

Sections 1819(g)(2) and 1919(g)(2) of the Act require the Secretary and States to implement a flexible survey cycle for Medicare SNFs and Medicaid nursing facilities so that surveys are conducted at intervals not later than 15 months after the date of the previous survey with an annual State-wide average of 12 months. The legislative history and the IOM study are plain in their stated reasons for this change from the rigid system of having surveys for all facilities follow a 12-month cycle. First, a flexible survey cycle provides less predictability to the scheduling of surveys, thus reducing the opportunities for certain providers, by anticipating the survey, to achieve only temporary compliance for the short term period around the time of survey. To further establish the necessity for unpredictability, these sections of the statute expressly provide for civil money penalties for those persons who notify a facility of the time or date of standard surveys. Second, flexible survey cycles allow survey agencies to better allocate their limited resources by increasing the frequency of surveys for problem facilities while allowing other facilities with a better record of compliance to be less rigorously monitored. Additionally, because time limited agreements have automatic cancellation clauses, a significant paperwork and recordkeeping burden results from the frequent need to conduct resurveys as a means of avoiding provider agreement expirations.

The 12-month provider agreement limitation and the other HCFA regulations that contemplate fixed expiration dates for such agreements do not allow for the full implementation of these stated legislative goals. The scheduling of surveys is almost entirely predictable; there is no discrimination between problem and non-problem facilities that would allow for the better allocation of survey resources; and there is the continued paperwork and recordkeeping burden of time limited agreements. Even the House Budget Committee expressed its view that the continuation of fixed 12-month provider agreements would "conflict" with the new provisions of the statute. (H.R. Budget Comm. Rep. No. 391, 100th Cong., 1st sess. 467 (1987).)

Further, the enforcement provisions of nursing home reform, set forth at sections 1819(h) and 1919(h) of the Act, are designed to work in the context of provider agreements that do not have a fixed ending date. Specifically, sections 1819(h)(2)(C) and 1919(h)(3)(D) of the Act speak to the ability of the Secretary to continue payments for up to 6 months after the identification of deficiencies if certain criteria, described in those sections, are met. Sections 1819(h)(2)(D) and 1919(h)(2)(C) of the Act require the Secretary and States to impose a ban on the payment for new admissions should deficient facilities fail to achieve full compliance within 3 months after they have been determined

not to comply with Federal requirements. In both cases, these remedies make sense only where a facility's provider agreement has no set expiration date.

We reach this conclusion because under the current survey system where surveys are typically conducted shortly before the expiration of provider agreements, facilities would have only the shortest period of time to correct deficiencies if they are to be entitled to renewed agreements. The statutory remedies described above, however, contemplate periods of time that far exceed what would be available under the current system for providers to achieve compliance. For HCFA and the States to attempt to fit the current survey system into the procedures described in sections 1819(h) and 1919(h) of the Act would require the wholesale revamping of surveys so that they occur no later than mid-way through the term of the 12-month provider agreement. Such a radical departure from more than twenty years of practice would require the kind of massive reallocation of survey resources that is not possible under the current system and would likely cause many facilities to go unsurveyed by the time their time limited agreements are scheduled to expire. Of equal significance, we do not believe that the Congress would approve of a survey system in which decisions about the renewal of a provider agreement are made as far as 6 months prior to the expiration of that agreement, since there is very little

likelihood that determinations of compliance made so far in advance would have any relevance to the degree of facility compliance at the time the agreement is set to expire. None of these difficulties would present themselves if, as the Congress intended, there were no time limited provider agreements.

The resulting poor fit between current practice under time limited agreements and the enforcement provisions of sections 1819 and 1919 of the Act has forced HCFA and the States to rely almost exclusively on the termination of provider agreements in order to have a dispositive solution to provider non-compliance at the time the agreements expire. This is precisely a consequence the Congress wished to avoid. (H.R. Budget Comm. Rep. No. 391, 100th Cong., 1st Sess. 471 (1987).) The broad array of alternative sanctions that the Congress has given the Secretary and the states is rendered meaningless by the imperative to assure that some final action is taken with respect to each provider every 12 months. To this extent, we believe that the current regulations governing time limited agreements prevent HCFA and the States from implementing nursing home reform in the manner intended by the Congress.

RULING: Current regulations for the Medicare and Medicaid programs that govern time limited agreements are inconsistent with the survey, certification, and enforcement provisions of

sections 1819 and 1919 of the Act. Accordingly, we consider these sections of the statute to have superseded all those regulations (specified above) that speak to time limited agreements for both programs.

EFFECTIVE DATE

This Ruling is effective August 26, 1992

DATED: Aug. 26 1992

William Toby, Jr.
Acting Deputy Administrator,
Health Care Financing
Administration