filed with Court 6-1-90

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION

MILDRED LEA LINTON, by her next friend KATHY ARNOLD, on her own behalf and on behalf of all other persons similarly situated, Plaintiff, BELLE CARNEY, by her next friend MARY KIMBLE, on her own behalf and on behalf of all other persons similarly situated, Plaintiff-Intervenor, v. COMMISSIONER OF HEALTH AND ENVIRONMENT, STATE OF TENNESSEE Defendant.	)	CIVIL ACTION NO. 3-87-0941 JUDGE NIXON

STATE SUBMISSION PURSUANT TO ORDER

I. INTRODUCTION

By memorandum and order entered on April 23, 1990, this Court determined that Tennessee's policy of allowing Medicaid participating nursing homes to certify less than all available beds for Medicaid participation was contrary to federal law, created a disparate impact upon minority Medicaid patients, and violated federal statutory Medicaid requirements. This Court

ordered a hearing to be held on June 4, 1990, to determine an appropriate remedy and further ordered the defendant to submit a plan for Court approval to redress the disparate impact upon minority Medicaid patients' access to qualified nursing home care.

While the state defendant denies that state officials have intentionally administered the Tennessee Medicaid program in a manner that discriminates against minorities, this submission contains plans to redress all aspects of the Court's findings. In view of the findings of unintentional rather than intentional discrimination, the defendant has reviewed and modified facially neutral procedures related to distinct part certification and formulated rules and policies intended to prevent further unintentional disparate impact upon minorities or Medicaid recipients. Counsel for plaintiffs has authorized the defendant to state that this plan is the product of the parties' negotiations and that plaintiffs' counsel concludes the plan is reasonably calculated to respond to the Court's findings and to ensure the Department's future compliance as to the issues of this lawsuit. The parties agree that immediate

implementation of the plan is in the best interest of both parties.[1]

This submission contains a two part compliance plan, set forth at III and IV; reservation of future modification of the plan, at II; and exhibits containing draft rules and procedures, notices, letters and enforcement strategies.[2] See Collective Exhibits A, B, C and D. It is the intent of the parties to continue to discuss the state's management of implementation and to provide the state flexibility in that process so long as it remains consistent with this plan.

Section III addresses distinct part certification, including prophylactic measures to prevent or mitigate provider attrition. Section IV redresses the finding of disparate impact upon minority Medicaid patients' access to nursing home care.

---

[1] In the event this plan is not adopted in its entirety or is modified in any respect, the state reserves its right to appeal issues previously raised as well as remedies imposed.

[2] The proposed rules and regulations and notices are subject to modification so long as they remain consistent with this plan and federal and state law.

II. RESERVATION OF FUTURE MODIFICATION OF PLAN.

Subsequent Federal or State Law

The defendant reserves the right to modify the compliance plan as necessary to comply with federal and state law such as implementation of the federal Nursing Home Reform Act of 1987, Omnibus Budget Reconciliation Act of 1987 ("OBRA'87"), 42 U.S.C. § 1396r. Some relevant requirements of OBRA'87 will not become effective until October 1, 1990. In addition, specific guidance from the federal Health Care Financing Administration ("HCFA") to assist states in implementing OBRA'87 has not yet been promulgated and is not expected to be promulgated until September, 1990. OBRA'87 made numerous significant changes in requirements for Medicaid nursing facilities. The most significant change directly impacting upon this case is the elimination of distinctions between skilled and intermediate levels of care. After October 1, 1990, a person admitted to a nursing home is classified as a "resident" of the facility rather than being a patient in a skilled or intermediate portion of that facility. The new law permits facilities to retain a "distinct part" option, but "distinct part" is not defined therein. See 42 U.S.C. § 1396r(a).

Controlling law clearly establishes that prospective application of judgments must defer to a later change in the

governing law in the case. See, e.g., Pennsylvania v. Wheeling and Belmont Bridge Company, 18 How. 421, 15 L.Ed.2d 435 (1855) and System Federation No. 91, Railroad Employees Department v. Wright, 364 U.S. 642, 51 L.Ed.2d 349, 81 S.Ct. 368 (1961). Such change in law includes modification of controlling federal regulations, Class v. Norton, 507 F.2d 1058, 1062 (2nd Cir. 1974); Williams v. Atkins, 786 F.2d 457, 461-62 (1st Cir. 1986); Williams v. Butz, 843 F.2d 1335 (11th Cir. 1988). Regulations under the Medicaid Act have the force and effect of law. See, e.g., Smith v. Miller, 665 F.2d 172 (7th Cir. 1981); Planned Parenthood Affiliates v. Rhodes, 477 F. Supp. 529 (D.C. Ohio 1979); and Massachusetts General Hospital v. Sargent, 397 F. Supp. 1056 (D.C. Mass. 1975). Thus, the State may seek modification under Rule 60, Fed. R. Civ. P., to the extent necessary to accomodate subsequent law changes.

HCFA CONSULTATION

In accordance with this Court's order, the parties, by joint letter, have apprised the Regional Director of the U.S. Department of Health and Human Services ("H.H.S.") of the instant plan with reference to both the Medicaid and Title VI requirements. See Exhibit C. The defendant reserves the right to seek to to modify the plan in light of any directives HCFA

may provide.[3]

III. PLAN REGARDING DISTINCT PART CERTIFICATION.

A. Background

This Court's April 23rd memorandum and order required a further hearing to determine an appropriate remedy as to the distinct part certification findings and directed that prophylactic steps would be considered to prevent or mitigate provider attrition. See memorandum at 19, 25.

The state defendant has formulated the present plan regarding distinct part certification to address overall remedies, including system incentives and disincentives to prevent or reduce provider attrition. In summary, this plan:

1. requires certification of all available licensed nursing home beds in facilities that participate in Medicaid;

---

[3]This plan reflects the position of the State, which intends to implement it as written, upon judicial approval. In the event of unanticipated H.H.S. objections, the State will seek to implement this plan and reserves the right to seek joinder of responsible federal officials, which does not foreclose use of other necessary administrative or judicial remedies.

2. prohibits involuntary transfer or discharge based upon source of payment;

3. imposes admissions practices to regulate and enforce full certification and first come, first served requirements;

4. establishes procedures for orderly provider withdrawal from the program, including patient protection and incentives to reduce such attrition; and

5. includes draft policies, enforcement strategies and notification procedures.

As to provider attrition, the Department has recently substantially enhanced Medicaid nursing home reimbursement. While adequacy of reimbursement rates are not an issue in this case and the state believes its current rates are adequate, payment rates will soon be capped at the 65th percentile rather than the 50th percentile, and calculation methods have changed, raising rates by approximately $9.00 from an estimated $41.89 to approximately $51.00 per day, per patient. That financial incentive is coupled with procedural disincentives in the plan including:

1. notification requirements;

2. duty to retain patients and comply with Medicaid requirements under specified circumstances; and

3. exclusion from the Medicaid program for at least two years after withdrawal.

B. <u>Certification of All Beds</u>

1. Effective immediately upon judicial approval of this plan, the Department will certify all available licensed nursing home beds for Medicaid participation in all nursing homes participating in Medicaid (hereinafter "facilities").

a. Facilities which offer nursing home services only at the skilled level of care (SNF) will have all licensed beds certified for Medicaid participation at the SNF level.

b. Facilities which offer nursing home services only at the intermediate level of care (ICF) will have all licensed beds certified for Medicaid participation at the ICF level.

c. Facilities which offer nursing home services at both the SNF and ICF levels of care will have all SNF beds dually certified, that is, certified for both SNF and ICF participation. All other licensed nursing home beds will be certified as ICF only.

This plan does not preclude a distinct part which has been certified by the Department as meeting all regulatory requirements, including the <u>Linton</u> requirements, such as a distinct part SNF which is located in a hospital or an ICF distinct part in a residential home for the aged. It is recognized that OBRA'87 requirements will eliminate the distinctions between SNF and ICF care as of October, 1990.

C. <u>Transfer and Discharge</u>

1. Immediately upon judicial approval of this plan, no

resident will be involuntarily transferred or discharged from a Medicaid participating nursing facility because their source of payment is Medicaid.

a. Residents who are currently paying for nursing home care with non-Medicaid funds and who exhaust those resources shall be encouraged to and entitled to apply for Medicaid. No resident may be transferred or discharged involuntarily because their source of payment has changed to Medicaid.

b. Effective upon judicial approval of this plan, residents who are Medicaid eligible as of June 1, 1990, but who are in facilities that have not sought Medicaid reimbursement for that resident because a Medicaid certified bed had not been available will not be required to pay any more than the resident's liability as determined by the Department of Human Services (e.g., social security, VA, Champus benefits, etc.). The facility will be required to make residents aware that it cannot transfer the residents because their source of payment has changed to Medicaid and will be required to encourage and assist all residents to apply for Medicaid. A Medicaid eligible resident is one who has an approved Pre-Admission Evaluation ("PAE") and has been determined to be financially eligible by the Department of Human Services. A resident whose PAE has been denied shall be considered Medicaid eligible until the exhaustion of their Medicaid appeals consistent with Doe v. Word, No. 3-84-1260 (M.D. Tenn.).[4]

c. All residents who are determined to be financially eligible for Medicaid participation by the Department of Human Services as of June 1, 1990, but who have not submitted a PAE, or who have applied and not been finally denied, will also pay no more than the resident's liability as determined by DHS, until a PAE

---

[4] It is the parties' intent to incorporate the requirement of Doe v. Word, Id., that a nursing home may not discharge a resident who is appealing a denial of a PAE until there has been a final denial of the PAE and any appeal that is pursued has been exhausted. Compliance with Doe, however, is not the subject of this lawsuit.

is denied and their appeals have been exhausted under Doe v. Word, Id.

2. Immediately upon judicial approval of this plan, residents receiving SNF services in nursing facilities which offer both SNF and ICF nursing home services may not be discharged involuntarily because the level of care for the resident changes to ICF.

3. An involuntary transfer or discharge of a resident inconsistent with the requirements of this section shall be considered an unlawful involuntary discharge under state and federal laws and regulations prohibiting such discharge and subject to all penalties and disciplinary actions pursuant thereto.

4. Residents shall be notified by the nursing home of transfer and discharge policies upon admission to the nursing home by means of the Resident Rights and Responsibilities form required by OBRA'87. This form also includes a notice of the resident's right to appeal an involuntary transfer and shall be in compliance with the attached notice. All notices required in this plan shall be issued to the residents and their designated representative. See Collective Exhibit A.

D. <u>Admission Practices</u>

1. All nursing facilities participating in Medicaid must admit residents on a first come, first served basis in accordance with the terms of this plan and the Department's rules.

a. (i) Effective immediately upon judicial approval of this plan, each nursing facility shall maintain a single waiting list for applicants. Such list will contain sufficient information to identify the applicant and for the state to monitor compliance with the plan.

(ii) For the purposes of this plan, the term "applicant" means any person who seeks admission to nursing home care. The use of the term is not limited to those persons who have completed an official application or have complied with the nursing home's pre-admission requirements, but it includes all persons who have affirmatively expressed an intent to be considered for current or future admission to the nursing home or requested that their name be entered on any waiting list. "Applicant" does not include those persons who make only a casual inquiry concerning the nursing home or its admission practices, who request information on these subjects, and who do not express any intention that they wish to be actively considered for admission.

b. Any person contacting a nursing home to casually inquire concerning its services or admissions policies shall be informed by the facility of his or her right to apply and be considered on a non-discriminatory basis in accordance with the policies and procedures set out herein. Brochures, admission forms and similar written materials used by a facility to market its services or describe its admissions policies shall contain a similar notice of applicant rights as provided herein. Pursuant to T.C.A. § 68-11-910(a)(5), such notice shall also inform the inquirer or applicant of the complaint and advocacy services available to him in the event that he believes his rights have been violated. The same notice shall be incorporated into the notices required by T.C.A. § 68-11-910(b). (<u>See</u> Collective Exhibit A).

2. The nursing facility must admit applicants in the order in which the referral or request was received by the facility. Deviations from this principle shall be documented and may only be based upon the following exceptions:

a. medical need, including but not limited to, the expedited admission of patients being discharged from hospitals, and patients who previously resided in a nursing home at a different level of care, but who, in either case, continue to require institutional medical services;

b. the applicant's sex, if the only available bed is in a room or a part of the nursing home that exclusively serves residents of the opposite sex;

c. as necessary to implement the provisions of a plan of affirmative action to admit racial minorities, if the plan has previously been approved by the Department;

d. emergency placements requested by the Department when evacuating another health care facility or by the Adult Protective Services of the Department of Human Services;

e. where a Medicaid-eligible resident's hospitalization or therapeutic leave exceeds the period paid for under the Tennessee Medicaid program for the holding of a bed in the facility for the resident and if the resident continues to require the services provided by the nursing home, then the resident must be readmitted to the facility immediately upon the first availability of a bed in the facility;

f. other reasons or policies, e.g., community-based waiver or care approved in advance in writing by the Medical Director of the Department's Bureau of Manpower and Facilities; provided, however, that no such approval shall be granted if to do so would in any way impair the Department's or the facility's ability to comply with its obligations under federal and state civil rights laws, regulations or conditions of licensure or participation; or

g. where, with the participation and approval of the Department, expedited admission is approved for

residents who are being displaced from another facility or its waiting list as a result of that facility's withdrawal from the Medicaid program.

3. If an applicant, whether on his or her own behalf or acting through another, requests admission or to be placed on a list of applicants awaiting admission, the information on the waiting list must be recorded and preserved.

E. <u>Facilities Requesting Voluntary Termination of Provider Agreements</u>

1. Facilities who choose to voluntarily terminate their provider agreement may do so by notifying the Department in writing of such intent. The effective date of the termination will be determined by the Department consistent with this plan. The facility's notice to the Department will provide the following information:

a. the reasons for voluntary termination;

b. the names and Medicaid identification number of all Medicaid-eligible residents;

c. a copy of a letter which shall conform with Collective Exhibit A and which will be sent to all residents explaining the facility's voluntary termination, and a copy of a letter to be sent to all Medicaid-eligible residents explaining the facility's voluntary termination;

d. a copy of a letter which shall conform with Collective Exhibit A and which will be sent to all persons on the waiting list explaining the voluntary termination; and

e. other information determined by the Department as necessary to process the request for termination.

2. The termination of the provider's involvement in Medicaid must be done in such a manner so as to minimize the harm to current residents.

a. Residents who are currently Medicaid-eligible shall be informed, in a notice to be provided by the facility and approved by the Department, that the facility has elected to withdraw from the Medicaid program. The notice shall inform the resident of her right to remain in the facility as a Medicaid patient as long as she wishes to do so and remains otherwise eligible under the rules of the Medicaid program. The notice shall also inform the resident that, if she wishes to transfer to another facility, under the supervision of the Department, the nursing home where she now resides will assist in locating a new placement and providing orientation and preparation for the transfer, in accordance with 42 U.S.C. § 1396r(c)(2)(C), and any implementing regulations and guidelines.

b. All other residents of the facility shall receive a separate notice informing them of the facility's intention to withdraw from the Medicaid program. The notice will be provided by the facility after having been first reviewed and approved by the Department. The notice shall inform such residents that, should they become eligible for Medicaid coverage, they will be able to convert to Medicaid from their current source of payment and remain in the facility only during a period that ends June 30, 1991. They will not be eligible for Medicaid coverage of their care in the facility thereafter.

   The same notice will caution these residents that, if they require care as Medicaid patients beyond June 30, 1991, they will have to transfer to another facility. The notice will also inform the residents that, when their present facility is no longer participating in the Medicaid program, certain legal rights and protections that apply to all residents (regardless of source of payment) in Medicaid facilities will no longer be available to those who remain in the nursing

home.[5] Readers of the notice will be informed that, if they wish to transfer, or to have their names placed on waiting lists at other facilities, the nursing home that is withdrawing from the program will assist them by providing preparation and orientation, under the supervision of the Department, as required by 42 U.S.C. § 1396r(c)(2)(C), and any implementing regulations and guidelines.

c. Applicants whose names are on the facility's waiting list will be notified by the facility, on a form that has been reviewed and approved by the Department, that the facility intends to withdraw from the Medicaid program. They will be cautioned that they will not be able to obtain Medicaid coverage for any care that they receive in the facility. The notice shall also inform them that certain legal rights and protections that apply to all residents (regardless of source of payment) in Medicaid-participating facilities will not be available in the nursing home to which they have applied, once that facility has withdrawn from the Medicaid program.[6]

Applicants will be informed in the notice that, if they wish to make application at other facilities, the withdrawing facility, under the supervision of the Department, shall assist them in seeking placement elsewhere.

3. As long as a nursing home has a Medicaid-eligible resident, it must comply with all requirements for Medicaid participation. The facility will not, however, be entitled to payment for any additional or newly admitted Medicaid eligible residents under any circumstances.

---

[5] Licensed only nursing homes must continue to comply with all federal and state laws and rules and regulations applicable to licensed only facilities.

[6] See footnote 5 above.

4. After June 30, 1991, or the date on which the last resident who was Medicaid-eligible as of June 30, 1990, under ¶ III (E)(2)(a) is lawfully and appropriately transferred or discharged, whichever event occurs later, the nursing facility will be decertified and its Medicaid provider agreement terminated. Such transfers shall be considered an involuntary transfer and shall comply with Department rules and regulations governing involuntary transfers or discharges.

5. Facilities which terminate their provider agreements shall not be permitted to participate in Medicaid for a period of at least two years from the date the provider agreement is terminated.

6. Unless the facility notifies the Department within 30 days after giving a notice of termination, the facility may not stop the termination procedure consistent with this order without written approval from the Department.

F. Policies and Procedures

All nursing homes will be required to establish policies and procedures addressing admission, transfer and discharge, consistent with this plan and rules of the Department. See Collective Exhibit B.

G. Enforcement Strategy

1. A nursing home which violates this plan or facility policies and procedures adopted pursuant thereto shall be subject to civil monetary penalties as provided by state law, suspension of admissions or other licensure disciplinary action, imposition of temporary management, imposition of a monitor (which may include a monitor of the admission process), and/or involuntary termination from Medicaid, and/or any other remedy available under the law.

2. Involuntary Termination -- a facility which is involuntarily decertified because of its failure to comply with the provisions of the Court Order and plans submitted thereto, shall not be permitted to participate in Medicaid for a period of five years.

H. Notification

1. All facilities shall post in a conspicuous location a poster notification prepared by the Department which describes applicants' and residents' rights consistent with this plan. (See Collective Exhibit A).

2. Any nursing home which, from June 1, 1988, through June 1, 1990, discharged or transferred residents because a

Medicaid certified bed was not available or offered must notify such persons or their representative that the facility no longer has such a policy and that it admits persons on a first come, first served basis regardless of the source of payment. See Collective Exhibit A.

3. The Department shall prepare a press release for distribution to the wire services concerning this plan and rights of applicants and residents pursuant thereto.

IV. DEFENDANT'S PLAN TO REDRESS THE FINDING OF UNINTENDED DISPARATE IMPACT ON MINORITIES' ACCESS TO NURSING HOMES.

A. Background

Since the original filing of this lawsuit, the Department of Health and Environment ("DHE") has made numerous administrative enhancements to increase enforcement of Title VI compliance. Those enhancements include:

1. The Office of Civil Rights Compliance ("OCRC"), which is part of the Bureau of Manpower and Facilities of the Department, developed draft rules for Title VI civil rights compliance and enforcement which are expected to improve elderly minority residents' access to nursing home services. A copy of the draft regulations, Chapter 1200-8-16, is attached as Collective Exhibit B.

2. In July, 1988, the DHE initiated and funded a local community referral project in Shelby County, known as the Minority Applicant Pool System ("MAPS"), to identify and place elderly minority individuals in appropriate nursing home facilities. The MAPS project is administered by the Delta Commission on Aging in cooperation with the Memphis Regional Health Center ("the Med").

3. In December, 1988, four staff positions were added to the Office of Civil Rights Compliance, including three Regional Coordinators (Health Facilities Surveyors) and one office clerk. The staff, as mandated by state law, is responsible for conducting periodic compliance reviews and investigating complaints on the 1,040 health care facilities licensed under the authority of the Board for Licensing Health Care Facilities. It is the Department's policy to conduct annual reviews on all nursing homes. All (approximately 290) nursing homes were reviewed by OCRC in 1989 either through a desk or on-site review.

B. Compliance Plan and Remedies

Consistent with prior United States Supreme Court holdings, this Title VI plan involves initial use of racially neutral practices, i.e. full certification of all nursing home

facilities and enforcement of a neutral policy of a first come, first-served single waiting list. In view of this Court's finding of disparate impact on minorities' access to nursing home care as a result of admission practices, and in order to remedy such disparate impact, however, subsequent steps, if they become necessary, involve race conscious remedies. The first such remedies are premised upon the state's Method of Administration Plan, approved by the Office of Civil Rights Compliance of the Department of Health and Human Services as part of the Title VI compliance regulations under 45 C.F.R. Part 80. Those intermediate steps focus upon voluntary procedures to enhance minorities' access to nursing home care. They include, _inter alia_, creation of an identified pool of minorities eligible to be placed on the racially neutral first come, first served waiting lists; enhancement of such referrals through community outreach; development of and implementation of Title VI public service announcements and conducting education programs for nursing home staff.

Only after non-compliance of long duration will race preferential procedures, _i.e._ preferential admissions, be used. Thus, only a limited portion of the plan, narrowly tailored to deal with non-compliance of long duration, authorizes use of race preferential procedures, consistent with the dictates of _Wygant v. Jackson Board of Education_, 106 S.Ct. 1842, 1847, 1850, 476 U.S. 275, 274, 90 L.Ed.2d 260 (1986), and

cases cited therein; Hazelwood School District v. United States, 433 U.S. 299, 97 S.Ct. 2736, 53 L.Ed.2d 768 (1977); Fullilove v. Klutznick, 448 U.S. 448, 491, 100 S.Ct. 2758, 2781, 65 L.Ed.2d 902 (1980). See also, Local 28 of Sheet Metal Workers International Association v. Equal Employment Opportunity Commission, 106 S.Ct. 3019, 478 U.S. 421, 92 S.Ct. 344 (1986). Consistent with Supreme Court rulings, it is intended such remedies will be of temporary duration until compliance is achieved.

1. Full certification ("first come, first serve)"

Section III's requirement of full certification is expected to increase utilization of beds by Medicaid recipients and, as a result, to increase utilization by Medicaid minorities.

2. Execution of Assurances of Compliance by Organizations with Multiple Facilities.

Any entity with two or more nursing home facilities in Tennessee will be required to execute an Assurance of Compliance with Title VI and comply with Title VI federal and state rules and regulations as to all of its Tennessee nursing homes if any of its nursing homes receive Medicaid funds.

3. Expansion of MAPS

The Department is committed to expanding the Minority Applicant Pool System ("MAPS") concept, currently in operation in Shelby County, to provide a MAPS approach in each of the four metropolitan areas. See ¶ 2, p. 5, infra. Development of MAPS in Shelby County required approximately three years. It is anticipated MAPS can be in place in the other three metropolitan areas within approximately three years. That system is designed to identify and refer for placement elderly minority individuals in appropriate nursing home facilities.

The Department will explore the feasibility of expanding the MAPS concept statewide through development of specific local service delivery areas. Because rural areas lack the service network available in metropolitan areas, feasibility studies are required.

4. Monitoring of Minority Utilization

(a) Consistent with the Methods of Administration Plan of the Department, approved by the Department of Health and Human Services Office for Civil Rights, each year every Tennessee nursing home is required to complete a questionnaire reporting minority utilization in the facility, among other items pertaining to civil rights compliance. The percentage of

minority residents in the nursing home will be compared to the percentage of minority citizens who are age 65 or older in the county in which the home is located by calculating the difference between the two factors. This computation is illustrated in the following example:

> X Health Care Center, which has 100 licensed beds, reports that it had 12 black residents on the date of its report, a day when all beds were occupied. Thus, black residents constitute 12% of its census. X Health Care Center is located in Y county, Tennessee, for which the Department's Center for Health Statistics projects a 1988 population of 10,000 residents age 65 or older, of whom 1,500 are black. Thus, Y county has a 15% black population, age 65 or older. The difference between these two factors is minus 3% (12% in nursing homes contrasted to 15% in the county), identifying a slight under-representation of black residents in X Health Care Center (3 out of 100 patients under representation).

(b) A finding that a nursing home whose reported census of black residents is 10 percentage points (10%) or more below the percentage of black citizens age 65 or older in the county or service area in which the facility is located, according to the above calculation, will raise an inference of non-compliance with this plan. Such finding will trigger an evaluation and follow-up by the Office of Civil Right's Compliance according to the Department's Method of Administration Plan, as approved by the Office of Civil Rights of the United States Department of Health and Human Services. The facility will then be required to develop and implement affirmative action plans to improve access of racial minorities to the facility's services.

5. <u>Affirmative Action Plans</u>

(a) A nursing home may be found to be out of civil rights compliance through application of the above statistical standard coupled with an evaluation according to the Method of Administration Plan, through the resolution of a complaint investigation, based upon provisions of a judicial decree, based upon an evaluation, through findings of an administrative agency with jurisdiction over such matters other than the Department, or through other procedures authorized by law. Whenever such non-compliance is found, the nursing home will be required to prepare and submit for the Department's approval a plan of affirmative action, consistent with the Department's Methods of Administration Plan. Once approved, such plan shall be implemented by the nursing home under the supervision of the Department. A finding of compliance by the Department's Office of Civil Rights Compliance may include but is not limited to reliance upon absence of statistical disparity as set forth herein.

(b) In developing the required affirmative action plans, non-compliant nursing homes will be encouraged to develop innovative plans individualized to the facility and its particular service area. The scope and duration of such plans will be determined by the Department's Office of Civil Rights

Compliance director, and may include the following actions which are intended to improve access by racial minorities:

(i) enhancement of referrals through community interaction such as outreach to social services agencies, churches, civic groups, elderly apartments, hospital discharge planners, and similar entities,

(ii) development and implementation of Title VI public service announcements for local media,

(iii) conducting on-site Title VI training for that facility's key staff, including the administrator, as determined by the Department and with the supervision and technical assistance of the Title VI staff; and/or

(iv) coordination or development of MAPS resources in counties in which no MAPS is available.

Subject to no objection being raised by HCFA, an additional affirmative action requirement may be imposed for entities with two or more nursing facilities in Tennessee where one of the facilities does not participate in Medicaid and it has been found to not comply with Title VI. After a period of one year of operating under an approved affirmative action plan, if non-compliance continues, the Director of Civil Rights

Compliance shall impose a requirement of deviating from the first come, first served waiting list to increase minority participation. Such requirement may include alternating admissions by race with a limitation upon admissions if no minority applicant is available. In lieu of that requirement, the non-compliant facility may opt to enroll in the Medicaid program, to be accomplished within three months of exercising that option.

(c) Other activities may be mandatory under the Methods of Administration Plan. Participation in MAPS is mandatory if a non-compliant facility is located within a MAPS service area.

C. Enforcement

In the event a facility fails to develop or implement an affirmative action plan or non-compliance continues after corrective action plans have been attempted, the matter will be referred to the Office of General Counsel for enforcement action. This Compliance Plan shall not, however, preclude enforcement by the Department or protected persons through other procedures authorized by law or rule. Enforcement may include seeking denial, suspension or revocation of a facility's license pursuant to T.C.A. § 68-1-218, Chapter 1200-8-16-.02, Rules of the Department of Health and Environment; imposition of civil penalties where applicable

pursuant to T.C.A. §§ 68-1-218, 68-11-801, et seq.; requirement of temporary management; termination of a provider agreement; or any other sanction authorized by law, including termination of federal financial participation under the procedures set forth at 42 C.F.R. § 80.8(c).

D. Reports to the Court

On October 1, 1990, and on a quarterly basis for two years thereafter, the defendant shall file with the Court and serve on plaintiffs' counsel a report on the implementation of this plan. For one year thereafter, the same information shall continue to be compiled and provided upon request to plaintiffs' counsel, but need not be routinely filed with the Court. The reports required by this paragraph shall include the following information:

a. the name, address and Medicaid provider number of each facility that is licensed to provide nursing home care in the state, but which is not participating in the Medicaid program;

b. the identity of the owners of each such non-participating facility;

c. the number of licensed beds in each such facility, broken down (if applicable) by the type of care provided;

d. if the facility has given notice after June 1, 1990, of an intent to withdraw from the Medicaid program, the date on which such notice was received by the Department;

e. if a facility has given notice since June 1, 1990, of an intent to withdraw from the Medicaid program, the report shall state the number of Medicaid patients remaining in the facility as of the date the report is prepared; and

f. if the Department has any information regarding the facility's receipt of federal funds (either directly, or as part of a larger entity) the report shall identify the source of each different type of such federal funds.

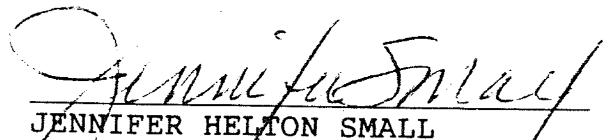
After the initial report due to be filed by October 1, 1990, subsequent reports need only update the initial report as necessary to reflect intervening changes. It is not necessary for subsequent reports to reiterate information contained in the original report regarding circumstances which remain unchanged.

E. Court Approval

Upon judicial approval, this submission shall become a final order.

Respectfully submitted,

CHARLES W. BURSON
Attorney General and Reporter

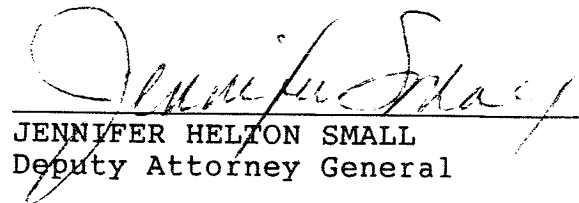


JENNIFER HELTON SMALL
Deputy Attorney General
450 James Robertson Parkway
Nashville, Tennessee 37243-0485
(615) 741-2640

Attorney for State Defendant

CERTIFICATE OF SERVICE

I hereby certify that a true and exact copy of the foregoing document has been forwarded by first-class U.S. Mail, postage prepaid, to Mr. Gordon Bonnyman, Attorney for Plaintiffs, Legal Services of Middle Tennessee, 800 Stahlman Building, 211 Union Street, Nashville, Tennessee 37201, on this 1st day of June, 1990.



JENNIFER HELTON SMALL
Deputy Attorney General

STATE OF TENNESSEE
DEPARTMENT OF HEALTH AND ENVIRONMENT
CORDELL HULL BUILDING
NASHVILLE, TENNESSEE 37219-5402

NED McWHERTER
GOVERNOR

J. W. LUNA
COMMISSIONER

MEMORANDUM

DATE: June 4, 1990

TO: All Nursing Home Administrators

FROM: J. W. Luna, Commissioner

SUBJECT: Implementation of Linton v. Commissioner

On April 22, 1990, the U.S. District Court for the Middle District of Tennessee ruled that Tennessee's practice of permitting nursing homes to certify less than all available beds was in violation of federal law and regulations. On June 4, 1990, the Court accepted the Department's plan, a copy of which is included as Attachment 1. Most of the aspects of the plan must be implemented immediately. The following are the most significant aspects of the plan with which nursing homes participating in Medicaid must comply:

1. All licensed beds in a Medicaid participating facility must be certified for Medicaid. The State will submit the appropriate information to the Bureau of Medicaid to certify all beds. No specific request by the facility will be necessary.

    a. Facilities which offer nursing home services only at the skilled level of care (SNF) will have all licensed beds certified for Medicaid participation at the SNF level.

    b. Facilities which offer nursing home services only at the intermediate level of care (ICF) will have all licensed beds certified for Medicaid participation at the ICF level.

    c. Facilities which offer nursing home services at both the SNF and ICF levels of care will have all SNF beds dually certified, that is, certified for both SNF and ICF participation. All other licensed nursing home beds will be certified as ICF only.

2. Each facility must maintain a single waiting list of applicants and admit residents on a first come first served basis with no private pay preference. The State will permit skipping applicants on the waiting list only for the reasons specified in the rules. The applicant must be given written confirmation that they are on the waiting list and the date and time of entry.

3. No facility will be permitted to transfer or discharge a resident because the resident's source of payment is Medicaid.

4. Residents who are currently paying for nursing home care with non-Medicaid funds and who exhaust those resources shall be encouraged to and entitled to apply for Medicaid. No resident may be transferred or discharged involuntarily because their source of payment has changed to Medicaid.

5. Effective upon judicial approval of this plan, residents who are Medicaid eligible as of June 1, 1990, but who are in facilities that have not sought Medicaid reimbursement for that resident because a Medicaid certified bed had not been available will not be required to pay any more than the resident's liability as determined by the Department of Human Services (e.g., social security, VA, Champus benefits, etc.). The facility will be required to make residents aware that it cannot transfer the residents because their source of payment has changed to Medicaid and will be required to encourage and assist all residents to apply for Medicaid. A Medicaid eligible resident is one who has an approved Pre-Admission Evaluation and has been determined to be financially eligible by the Department of Human Services. A resident whose PAE has been denied shall be considered Medicaid eligible until the exhaustion of their Medicaid appeals consistent with Doe v. Word, No. 3-84-1260 (M.D. Tenn.).

6. All residents who are determined to be financially eligible for Medicaid participation by the Department of Human Services as of June 1, 1990, but who have not submitted a PAE, or who have applied and not been finally denied, will also pay no more than the resident's liability as determined by DHS, until a PAE is denied and their appeals have been exhausted under Doe v. Word, Id.

7. The facility will also be required to place the attached poster notice at the facility prepared by the Department which provides notification concerning applicant's and resident's rights under the plan. You must provide on the

notice, the address and telephone number for the regional Ombudsman, Legal Services Office, and Department of Health and Environment.

8. All participating facilities must also comply with the Title VI requirements as described in the plan. This requirement applies to all Medicaid participating facilities and all licensed only facilities which are owned by an entity or organization which participates in Medicaid. All nursing homes whose reported census of black residents is 10 percentage points (10%) or more below the percentage of black citizens age 65 or older in the county or service area in which the facility is located, will be presumed to be out of compliance with the plan. Such findings will trigger an evaluation of the facility and it will be required to plan affirmative action steps to improve access of racial minorities to the facility's services.

9. A facility which decides to voluntarily withdraw from Medicaid participation will not be permitted to reenroll in the program for a period of two years after the provider agreement is terminated. If the facility is involuntarily terminated from Medicaid, the facility cannot reenroll in the program for a period of at least five (5) years after the provider agreement is terminated.

10. Facilities that wish to voluntarily withdraw from Medicaid participation will not be permitted to involuntarily transfer or discharge current residents except as provided in the plan. As long as such current residents remain in the facility, the facility must comply with all Medicaid requirements.

To assist you in understanding the requirements the Court has ordered, I am enclosing a copy of the relevant portions of the State's plan, Medicaid rules for implementation, and Commissioner's rules for civil rights enforcement, and required notices. The items listed above are highlighted for your information; however, you should read and be familiar with this plan and all rules and regulations.

Please direct all questions or inquiries concerning implementation of the Linton plan to Leslie A. Brown, Director of Health Care Facilities, 283 Plus Park Boulevard, Nashville, Tennessee 37247, (615) 367-6303.

JWL/A7200150

IMPORTANT NOTICE OF YOUR RIGHTS

This nursing home gets Medicaid funds. No person can be kept from making application or being admitted to this nursing home on a first-come, first-served basis because their source of payment is Medicaid.

If you apply for admission to this nursing home, your name is put on a wait list. You can see the wait list and copy it if you choose. You can also call us and we will tell you by phone where you stand on the wait list.

If you are eligible for Medicaid, this nursing home must seek Medicaid payment for your care. We cannot transfer or discharge you if your source of payment changes to Medicaid.

It is unlawful for this nursing home to charge you private pay rates after you have applied for Medicaid, and while Medicaid is deciding whether it will pay for your care. If Medicaid turns you down, you do not have to pay if you appeal, unless you lose your appeal. If you apply for Medicaid and are finally turned down, you may have to pay the nursing home for the care you have received.

You do not have to sell your home, if you own one, in order to get Medicaid. The nursing home cannot ask you to sell your home or to pay private rates for a certain amount of time before you apply for Medicaid. The nursing home must help you in applying for Medicaid if you need help.

This nursing home shall not deny admission to any person on the basis of race, color, national origin or handicapping condition, or method of payment.

If you have questions about your rights or need assistance, free services are available from:

Your Local Long Term Care Ombudsman:
Name: ______________________
Address: ______________________________
Phone: __________

Your Local Legal Services program:
Name: ______________________
Address: ______________________________
Phone: __________

Nearest Office of the Dept. of Health & Environment
Name: ______________________
Address: ______________________________
Phone: __________

DATE:

TO: Medicaid Eligible Residents

FROM: Administrator

RE: Voluntary Termination as a Medicaid Provider

Effective ______________________, this facility has elected to withdraw from the Medicaid program as a payment source for your nursing home care. Since you have been a resident here prior to our termination decision, you will be allowed to remain here as long as you wish and Medicaid will continue to pay.

If you choose to transfer to another nursing facility, we will give you all the information that you will need to make the right choice as well as help you make the transfer in a safe and orderly manner. We want you to feel comfortable about your move and will not force you to move until you are ready to do so. Because we have requested to withdraw from the Medicaid program, the Department of Health and Environment will monitor your transfer and continued stay in our facility.

If you have questions or need assistance regarding your rights as a nursing home resident, you may contact the Ombudsman, Legal Services, or the Tennessee Department of Health and Environment. Their addresses and phone numbers are listed on the back of this page. Their services are free.

DATE:
TO: Residents Who Are Not Now Covered by Medicaid
FROM: Administrator
RE: Voluntary Termination as a Medicaid Provider

Effective ____________________________, this facility has elected to withdraw from the Medicaid program as a payment source for nursing home care. Should your present payment source end you will be able to apply for and convert to Medicaid to pay for your care up to June 30, 1991. After June 30, 1991, Medicaid will no longer pay for your care.

If you choose to remain in this nursing home, it will still have a license, and will have to comply with state laws and rules. However, there are additional rights and protections for all residents of nursing homes that get Medicaid funds. After this nursing home withdraws from the Medicaid program those additional rights and protections will no longer apply to residents who remain here.

If you choose to transfer, we will provide you with a list of nursing facilities who do participate in the Medicaid program and help you make the best choice to suit your care needs. Our staff will be available to answer questions and prepare you for a transfer once you are ready to do so.

If you choose to stay with us until the June 30, 1991 date, we will place your name on the waiting lists of all nursing facilities that you choose. At the time you are ready to transfer, we will be available to assist you with the entire process and make this as easy a change as possible.

Since we have chosen to withdraw from the Medicaid program, the Department of Health and Environment will be supervising and monitoring all transfers and continued stays until transferred.

If you have questions or need assistance regarding your rights as a nursing home resident, you may contact the Ombudsman, Legal Services, or the Tennessee Department of Health and Environment. Their addresses and phone numbers are listed on the back of this page. Their services are free.

DATE:

TO: Current Applicants on Wait List

FROM: Administrator

RE: Voluntary Termination as a Medicaid Provider

Effective ___________________________, this facility has elected to withdraw from the Medicaid program as a payment source for nursing home care. Current legal rights and protections that apply to all residents will no longer be in effect once the Medicaid program is terminated.

Since you have placed your name on our list prior to this decision, we will assist you, under the supervision of the Department of Health and Environment, in seeking placement in another nursing facility.

Someone from our staff will be contacting you in the near future to assist with this process.

If you have questions or need assistance regarding your rights as a nursing home resident, you may contact the Ombudsman, Legal Services, or the Tennessee Department of Health and Environment. Their addresses and phone numbers are listed on the back of this page. Their services are free.

IMPORTANT NOTICE OF YOUR RIGHTS

This nursing home gets Medicaid funds. No person can be kept from making application or being admitted to this nursing home on a first-come, first-served basis because their source of payment is Medicaid.

If you apply for admission to this nursing home, your name is put on a wait list. You can see the wait list and copy it if you choose. You can also call us and we will tell you by phone where you stand on the wait list.

If you are eligible for Medicaid, this nursing home must seek Medicaid payment for your care. We cannot transfer or discharge you if your source of payment changes to Medicaid.

It is unlawful for this nursing home to charge you private pay rates after you have applied for Medicaid, and while Medicaid is deciding whether it will pay for your care. If Medicaid turns you down, you do not have to pay if you appeal, unless you lose your appeal. If you apply for Medicaid and are finally turned down, you may have to pay the nursing home for the care you have received.

You do not have to sell your home, if you own one, in order to get Medicaid. The nursing home cannot ask you to sell you home or to pay private rates for a certain amount of time before you apply for Medicaid. The nursing home must help you in applying for Medicaid if you need help.

This nursing home shall not deny admission to any person on the basis of race, color, national origin or handicapping condition, or method of payment.

If you feel your admission or continued stay rights as a Medicaid recipient have been violated, you are urged to contact your local Long-Term Care Ombudsman, Legal Services, or the Department of Health and Environment. Their addresses and phone numbers are on the back of this page. Their services are free.

Date

Dear ______________________:

This letter will serve as notice to you that we no longer have the policy to transfer a Medicaid recipient because a Medicaid certified bed was not available. We now have all of our beds certified to accept Medicaid as a source of payment and will accept any person that applies on a first come first serve basis regardless of the payment source.

We apologize for any inconvenience this may have caused you.

Sincerely,

____

WLP/A7260151

cc: Patient Care Advocate
Department of Health & Environment

PUBLIC NECESSITY RULES
OF
THE TENNESSEE DEPARTMENT OF HEALTH AND ENVIRONMENT

DIVISION OF MEDICAID

CHAPTER 1200-13-1
GENERAL RULES

AMENDMENTS

Rule 1200-13-1-.01 DEFINITIONS is amended by addition of new paragraphs (15) through (18) which shall read as follows:

(15) Applicant shall mean any person who seeks admission to nursing home care and is not limited to those persons who have completed an official application or have complied with the nursing home's preadmission requirements. The term shall include all persons who have affirmatively expressed an intent to be considered for current or future admission to the nursing home or requested that their name be entered on any "wait list". Persons who only make casual inquiry concerning the nursing home or its admission practices, who request information on these subjects, or who do not express any intention that they wish to be actively considered for admission shall not be considered applicants. All persons, whether applicants or non-applicants, who contact a nursing facility to casually inquire about the facility's services or admissions policies shall be informed by the facility of that person's right to apply for admission and be considered for admission on a non-discriminatory basis and in conformance with Rule 1200-13-1-.08 and Tennessee Code Annotated 68-11-910(b).

(16) Medicaid-eligible resident shall mean any person who has been determined financially eligible for medical assistance by the Tennessee Department of Human Services and who has an approved PAE.

(17) Involuntary transfer or discharge shall mean any transfer or discharge that is opposed by the resident or a representative of the resident. For purposes of compliance with the requirements of Rule 1200-13-1-.05(18), a discharge or transfer is involuntary when the nursing home initiates the action to transfer or discharge.

(18) Notice, when used in regulations pertaining to nursing facilities, shall mean notification that must be provided by the nursing facility to "residents" or "applicants", and shall also include notification to the person identified in a PAE application as the resident's or applicant's designated representative and any other individual who is authorized by law to act on the resident's or applicant's behalf or who is in fact

acting on the resident's or applicant's behalf in dealing with the nursing facility.

Rule 1200-13-1-.08 ADMISSIONS TO INTERMEDIATE CARE FACILITIES AND SKILLED NURSING FACILITIES is amended by deleting paragraphs (1) through (4) in their entirety, replacing them with new paragraphs (1) through (8) and renumbering existing paragraph (5) as paragraph (9). New paragraphs (1) through (8) shall read as follows:

(1) Each nursing facility participating in the medical assistance program must develop and consistently implement policies and procedures regarding its admissions, including the development and maintenance of a single wait list of persons requesting admission to those facilities. This list must at a minimum contain the following information pertaining to each request for admission:

   (a) The name of the applicant.
   (b) The name of the contact person or designated representative other than the applicant (if any).
   (c) The address of the applicant and the contact person or designated representative (if any).
   (d) The telephone number of the applicant and the contact person or designated representative (if any).
   (e) The name of the person or agency referring the applicant to the nursing facility.
   (f) The sex and race of the applicant.
   (g) The date and time of the request for admission.
   (h) Reason(s) for refusal/non-acceptance/other-action-taken pertaining to the request for admission.
   (i) The name and title of the nursing facility staff person taking the application for admission.
   (j) A notation stating whether the applicant is anticipated to be Medicaid eligible at time ofadmission or within one year of admission.

(2) The wait list should be updated and revised at least once each quarter to remove the names of previous applicants who are no longer interested n admission to the nursing home. Following three (3) contacts each separated by a period of at least ten (10) days, the nursing home shall, consistent with the written notice required in this section move an applicant to the end of the single admission list whenever an available bed is not accepted at the time of the vacancy, but the applicant wishes to remain on the admissions list. Applicants shall be advised of these policies at the time of their inquiry, and must be notified in writing, in a format approved by the Department, when their name is removed from the list or moved to the end of the list. Such contacts shall be documented in the facility log containing the wait list. The date, time and method of each contact shall be recorded along with the name of the facility staff person making the contact, and the identity of the applicant or contact person contacted. The log of such contacts shall

JUN 1 '90 14:10 FROM BUREAU OF MEDICAID PAGE.003

also summarize the communication between the facility staff person and the applicant or contact person.

(3) Each facility shall send written confirmation that an applicant's name has been entered on the wait list, their position on the wait list, and a notification of their right of access to the wait list s provided n paragraph (8) of these rules. This confirmation shall include at a minimum the date and time of entry on the wait list and shall be mailed by first class postage to the applicant and their designated representative (if any) identified pursuant to the requirements in paragraph (1) above.

(4) Each nursing facility participating in the medical assistance program shall admit applicants in the chronological order in which the referral or request for admission was received by the facility, except as permitted in paragraph (5) of this rule.

(5) Documentation justifying deviation from the order of the wait list must be maintained for inspection by the Department. Inspection shall include the right to review and/or make copies of these records. Deviation may be based upon:

(a) Medical need, including, but not necessarily limited to, the expedited admission of patients being discharged from hospitals and patients who previously resided in a nursing home at a different level of care, but who, in both cases, continue to require institutional medical services;

(b) The applicant's sex, if the available bed is in a room or a part of the nursing home that exclusively serves residents of the opposite sex;

(c) Necessity to implement the provisions of a plan of affirmative action to admit racial minorities, if the plan has previously been approved by the Department;

(d) Emergency placements requested by the Department when evacuating another health care facility or by the Adult Protective Service of the Tennessee Department of Human Services;

(e) Other reasons or policies, e.g., previous participation in a community based waiver or other alternative care program, when approved by the Medical Director of the Department's Bureau of Manpower and Facilities; provided, however, that no such approval shall be granted if to do so would in any way impair the Department's or the facility's ability to comply with its obligations under federal and state civil rights laws, regulations or conditions of licensure or participation.

(f) If a Medicaid-eligible recipient's hospitalization or therapeutic leave exceeds the period paid for under The Tennessee Medicaid

JUN 1 '90 14:10 FROM BUREAU OF MEDICAID PAGE.004

program for the holding of a bed in the facility for the resident and if the resident continues to require the services provided by the nursing home, then the resident must be readmitted to the facility immediately upon the first availability of a bed in the facility, consistent with paragraph (5)(b);

(g) Where, with the participation and approval of the Department, expedited admission is approved for residents who are being displaced from another facility or its waiting list as a result of that facility's withdrawal from the Medicaid program.

(6) Telephone requests to be placed on the wait list shall be accepted. The information required in paragraph (1) shall be documented.

(7) If an applicant, whether on his or her own behalf or acting through another, requests admission or to be placed on a list of applicants awaiting admission, the information on the waiting list must be recorded and preserved.

(8) Applicants (or their representative), Ombudsmen and appropriate State and Federal personnel shall have access to the wait list when requested. Such access shall include the right to review and/or copy the wait list, and to be informed by telephone of their position on the wait list.

Rule 1200-13-1-.05 PROVIDERS is amended by addition of new paragraphs (15) through (18) which shall read as follows:

(15) Nursing facilities who choose to voluntarily terminate their provider agreement may do so by notifying the Department in writing of such intent.

(a) The effective date of the termination will be determined by the Department. The notification must provide the following information:

1. The reason(s) for voluntary termination;

2. The names and Medicaid identification number of all Medicaid-eligible residents;

3. The name of the resident and name of the contact person for the resident (if any) for residents with an application for Medicaid eligibility pending;

4. A copy of the letter the facility will send to each resident informing them of the voluntary termination, and a copy of the letter to be sent to all Medicaid-eligible residents regarding this action;

5. A copy of the letter sent to all applicants on the wait list informing them of the facilities voluntary termination; and

6. Other information determined by the Department as necessary to process the request for termination.

(b) The termination of the provider's involvement in Medicaid must be done in such a manner as to minimize the harm to current residents.

1. Residents who are currently Medicaid-eligible shall be informed, in a notice to be provided by the facility and approved by the Department, that the facility has elected to withdraw from the Medicaid program. The notice shall inform the resident of the right to remain in the facility as a Medicaid patient as long as they wish to do so and remains otherwise eligible under the rules of the Medicaid Program. The notice shall also inform the resident that, if they wish to transfer to another facility, under the supervision of the Department, the nursing home where they now reside will assist in locating a new placement and providing orientation and preparation for the transfer, in accordance with 42 U.S.C. S 1396r(c) (2) (C) and implementing regulations and guidelines, if any.

2. All other residents of the facility shall receive a separate notice informing them of the facility's intention to withdraw from the Medicaid program. The notice will be provided by the facility after having been first reviewed and approved by the Department. The notice shall inform such residents that, should they become eligible for Medicaid coverage, they will be able to convert to Medicaid from their current source of payment and remain in the facility only during a period that ends June 30, 1991. They will not be eligible for Medicaid coverage of their care in the facility thereafter. Transfer of these residents shall be considered an involuntary transfer and shall comply with Department regulations governing involuntary transfer or discharges.

   The same notice will caution these residents that, if they require care as Medicaid patients beyond June 30, 1991, they will have to transfer to another facility. The notice will also inform the residents that, when their present facility is no longer participating in the Medicaid program, certain legal rights and protections that apply to all residents (regardless of source of payment) in Medicaid facilities will no longer be available to those who remain in the nursing home. Readers of the notice will be informed that, if they wish to transfer, or to have their names placed on wait lists at other facilities, the nursing home that is withdrawing from the program will assist them by providing preparation and orientation, under the supervision of the Department, as required by 42 U.S.C. S 1396r

(c) (2) (C) and implementing regulations and guidelines, if any.

3. Applicants whose names are on the facility's wait list will be notified by the facility, on a form that has been reviewed and approved by the Department, that the facility intends to withdraw from the Medicaid program. They will be cautioned that they will not be able to obtain Medicaid coverage for any care that they receive in the facility. The notice shall also inform them that certain legal rights and protections that apply to all residents (regardless of source of payment) in Medicaid-participating facilities will not be available in the nursing home to which they have applied, once that facility has withdrawn from the Medicaid program.

   Applicants will be informed in the notice that, if they wish to make application at other facilities, the withdrawing facility, under the supervision of the Department, shall assist them in seeking placement elsewhere.

4. After June 30, 1991, or the date on which the last Medicaid-eligible resident is lawfully and appropriately transferred or discharged, whichever event occurs later, the nursing facility will be decertified and its Medicaid provider agreement terminated.

(c) Facilities who notify the Department of their intent to voluntarily terminate Medicaid participation may rescind such notification within fifteen (15) days of receipt of the notification by the Department. Notices of voluntary termination shall automatically become irrevocable after fifteen (15) days unless Department approval is obtained to waive this provision. Facilities which voluntary terminate their provider participation agreements shall not be permitted to participate in the Medicaid program for a minimum of two (2) years from the date of the termination.

(16) Nursing facilities may be involuntarily decertified by the Department because of their failure to comply with the provisions of Medicaid General Rule, Chapter 1200-13-1. Facilities that are involuntarily decertified shall not be permitted to participate in the Medicaid program for a minimum of five (5) years from the date of decertification.

(17) Nursing facilities participating in the Medicaid Program shall not:

(a) Involuntarily transfer or discharge a Medicaid-eligible resident because Medicaid has been or becomes the resident's source of payment for nursing home care.

(b) Seek payment of an amount from a Medicaid-eligible resident in excess of the amount of patient liability determined by the Tennessee Department of Human Services.

(c) Seek payment in excess of the amount of patient liability determined by the Tennessee Department of Human Services from any resident who is financially eligible for medical assistance but who has not submitted a PAE for consideration or whose appeal rights for a denied PAE have not been exhausted.

(18) Nursing facilities participating in the Medicaid Program must comply with the following guidelines regarding transfers, discharges and/or readmissions.

(a) Transfer and Discharge Rights - A nursing facility must permit each resident to remain in the facility and must not transfer or discharge the resident from the facility unless:

1. The transfer or discharge is necessary to meet the resident's welfare which cannot be met in the facility;

2. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

3. The safety of individuals in the facility is endangered;

4. The health of individuals in the facility would otherwise be endangered;

5. The resident has failed, after reasonable and appropriate notice, to pay (or to have paid under Title XIX or Title XVIII on the resident's behalf) for a stay at the facility; or

6. The facility ceases to operate.

In each of the cases described above, no patient shall be discharged or transferred without a written order from the attending physician or through other legal processes and timely notification of next of kin and/or sponsor or authorized representative, if any. Each nursing home shall establish a policy for handling patients who wish to leave the home against medical advice. The basis for the transfer or discharge must be documented in the resident's clinical record. In the cases described in the clauses (a) 1. and (a) 2., the documentation must be made by the resident's physician, and in the case described in clause (a) 4. the documentation must be made by a physician. For purposes of clause (a) 5., in the case of a resident who becomes eligible for assistance under Title XIX after admission to the facility, only charges which may be imposed under Title XIX shall be considered to be allowable.

When a patient is transferred, a summary of treatment given at the nursing home, condition of patient at time of transfer and date and place to which transferred shall be entered in the record. If transfer is due to an emergency, this information will be recorded

within forty-eight (48) hours; otherwise, it will precede the transfer of the patient.

When a patient is transferred, a copy of the clinical summary should, with consent of the patient, be sent to the nursing home that will continue the care of the patient.

Where an involuntary transfer is proposed, in addition to any other relevant factors, the following factors shall be taken into account:

1. The traumatic effect on the patient.

2. The proximity of the proposed nursing home to the present nursing home and to the family and friends of the patient.

3. The availability of necessary medical and social services at the proposed nursing home.

4. Compliance by the proposed nursing home with all applicable Federal and State regulations.

(b) Pre-Transfer and Pre-Discharge Notice - Before effecting a transfer or discharge of a resident, a nursing facility must:

1. Notify the resident (and, if known, a family member of the resident or legal representative) of the transfer or discharge and the reasons therefore.

2. Record the reasons in the resident's clinical record (including any documentation required pursuant to (a) above and include in the notice the items described in (d) below.

3. Notify the Department and the long-term care Ombudsman.

4. Not transfer or discharge a resident until the above agencies have designated their intention to intervene and until any appeal process is complete, should the resident request a fair hearing.

(c) Timing of Notice - The notice under (b) must be made at least 30 days in advance of the resident's transfer or discharge except:

1. In a case described in (a) 3. or (a) 4. above.

2. In a case described in (a) 2. where the resident's health improves sufficiently to allow a more immediate transfer or discharge.

3. In a case described in (a) 1. where a more immediate transfer or discharge is necessitated by the resident's urgent medical needs.

4. In a case where a resident has not resided in the facility for 30 days.

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

(d) Items included in notice - Each pre-transfer and pre-discharge notice under (b) must include:

1. For transfers or discharges effected on or after October 1, 1989, notice of the resident's right to appeal the transfer or discharge.

2. The name, mailing address, and telephone number of the State long-term care ombudsman.

3. In the case of residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy system for developmentally disabled individuals.

4. In the case of mentally ill residents, the mailing address and telephone number of the agency responsible for the protection and advocacy system for mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.

(e) Orientation - A nursing facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

(f) Notice of Bed-Hold Policy and Readmission - Before a resident of a nursing facility is transferred for hospitalization or therapeutic leave, a nursing facility must provide written information to the resident and a family member or legal representative concerning:

1. The provisions of the State plan under this Title XIX regarding the period (if any) during which the resident will be permitted under the State plan to return and resume residence in the facility, and

2. The policies of the facility consistent with (g) below, regarding such a period.

(g) Notice Upon Transfer - At the time of transfer of a resident to a hospital or for therapeutic leave, a nursing facility must provide written notice to the resident and a family member or legal representative of the duration of any period under the State plan allowed for the resumption of residence in the facility.

Paragraph (9) of Rule 1200-13-1-.05 PROVIDERS is amended by addition of a new subparagraph (g) which shall read as follows:

(g) All nursing facilities shall establish written policies and procedures addressing admission, transfer and discharge, consistent with Medicaid General Rule, Chapter 1200-13-1. These policies and procedures shall be available for inspection by the Department.

** TOTAL PAGE.012 **

Signature of the agency officer or officers directly responsible for proposing and/or drafting these rules:

____
Manuel Martins
Assistant Commissioner
for Medicaid Administration
Tennessee Department of Health
and Environment

I certify that this is an accurate complete representation of the intent and scope of rulemaking proposed by the Tennessee Department of Health and Environment.

____
J. W. Luna
Commissioner

Subscribed and sworn to before me this the ____ day of ____________________, 19 ___.

____
Notary Public

My commission expires on the ______ day of ____________________, 19 ___.

All Pulic necessity Rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

____
Charles W. Burson
Attorney General and Reporter

The Public Necessity Rules set out herein were properly filed in the Department of State on the ______ day of __________________, 19______ and will be effective from the date of filing for a period of _______ days. The Public Necessity Rules will remain in effect through the _________ day of ___________, 19____.

____
Bryant Millsaps
Secretary of State

By: ______________________

PUBLIC NECESSITY RULES
OF
TENNESSEE DEPARTMENT OF HEALTH AND ENVIRONMENT
OFFICE ON CIVIL RIGHTS COMPLIANCE

CHAPTER 1200-24-3
CIVIL RIGHTS COMPLIANCE PENALTY PROGRAM
RULES AND REGULATIONS

NEW RULES
TABLE OF CONTENTS

1200-24-3-.01 PURPOSE
1200-24-3-.02 DEFINITIONS
1200-24-3-.03 SANCTIONS
1200-24-3-.04 TYPES OF CIVIL PENALTIES
1200-24-3-.05 REPEATED AND MAXIMUM PENALTIES

1200-24-3-.01 PURPOSE

The purpose of these rules is to provide regulatory guidance for assessing civil penalties pursuant to T.C.A. §68-1-113. The rules apply only to nursing homes as defined at T.C.A. §68-11-201 and licensed by the department for the purpose of assisting in enforcing compliance with Title VI of the Civil Rights Act of 1964, as amended and requirements of Linton v. Commissioner, M.D. Tenn, No. 3-87-0941.

1200-24-3-.02 DEFINITIONS.

(1) "HEALTH CARE FACILITY": Any facility licensed under the authority of the Board for Licensing Health Care Facilities as defined in T.C.A. §68-11-201.

(2) "CIVIL RIGHTS": Personal and individual rights guaranteed by the federal or state constitution and/or any federal or state statute.

(3) "COMMISSIONER": The Commissioner of the Tennessee Department of Health and Environment or his designated representative.

(4) "DEPARTMENT": Tennessee Department of Health and Environment

(5) "TITLE VI": Title VI of the Civil Rights Act of 1964, as amended (42 USC §2000d)

(6) "MINORITY": Persons who fall within the following categories: Black, not of Hispanic origin; Hispanic; American Indian; Alaskan Native; Asian or Pacific Islander.

(7) "DISCRIMINATION": Any act, policy, practice, or procedure which results in different treatment based on race, color, national origin or method of payment that impacts adversely upon minorities and others protected under Title VI of the Civil Rights Act of 1964.

(8) "OFFICE ON CIVIL RIGHTS COMPLIANCE (OCRC)": The administrative, regulatory and enforcement unit established within the Department of Health and Environment charged with the responsibility of monitoring and investigating complaints related to civil rights compliance of facilities regulated by the Board.

Statutory Authority: T.C.A. §§4-3-1803(1), 68-1-103(b), and 68-1-113, 4-5-209.

1200-24-3-.03 SANCTIONS

Pursuant to T.C.A. §68-1-113, the Commissioner of the Department of Health and Environment shall have the authority to impose civil penalties upon deficient health care facilities licensed as nursing homes. Based upon the investigation of the Office on Civil Rights Compliance and the severity of the discriminatory practice, the Commissioner may impose civil penalties as provided in this section. Civil penalties may be assessed in minimum and maximum amounts as follows:

(a) Type I civil penalties may be assessed in the amount of not less than three thousand five hundred dollars ($3,500) and not more than five thousand dollars ($5,000);

(b) Type II civil penalties may be assessed in the amount of not less than one thousand five hundred dollars ($1,500) and no more than three thousand five hundred dollars ($3,500);

(c) Type III civil penalties may be assessed in the amount of not less than five hundred dollars ($500) and no

more than one thousand five hundred dollars ($1,500).

Statutory Authority: T.C.A. §§4-3-1803(1), 68-1-103(b), 68-1-113, and 4-5-209.

1200-24-3-.04 TYPES OF CIVIL PENALTIES

(1) A Type I civil penalty may be assessed if the health care facility engages in discrimination which impacts negatively on the health, safety and welfare of multiple minority patients. Examples of practices which may lead to the imposition of a Type I civil penalty are:

(a) Denying persons admission to the facility on the basis of race, color, creed and national origin, or method of payment as provided by state or federal law, rules or regulations;

(b) Transferring multiple patients from one room to another on the basis of racial or source of payment considerations (except for affirmative action remedies which pose no risk to patients).

(c) Clustering patients on the basis of race, color, creed or national origin or source of payment on specific floors, sections, or wings of the facility.

(d) Not admitting applicants to a facility on a first come first serve basis as required by State or federal laws rules or regulations.

(e) Retaliating against residents or staff because of complaints made to the Department.

(2) A Type II Civil penalty may be assessed if the Health Care Facility utilizes a policy or procedure that is likely to be detrimental to a patient and the facility refuses to correct the violation. Examples of practices which may lead to the imposition of a Type II Civil Penalty are:

(a) Denial of admission of a single individual on the basis of race, creed, color or national origin or method of payment as provided by state or federal law or rules or regulations;

(b) Assigning a room or transferring a single individual on the basis of race, creed, color or national origin or method of payment contrary to state or federal law, rules or regulations.

(c) Providing segregated services, e.g., beauty and barber shops, dining rooms, lounges.

(d) Denial of an individual the opportunity to participate on a planning or advisory board on the basis of race, color, national origin, or method of payment as required by state or federal law, rules or regulations.

(e) Retaliating against an individual resident or staff member because of complaints made in good faith to the Department.

(3) A Type III civil penalty may be assessed for deficiencies that do not directly involve a specific individual but violate state and federal law, rules or regulations. Examples which may lead to a Type III civil penalty may include:

(a) Failure to develop an acceptable plan of correction within the time required.

(b) Failure to make available all data and pertinent information requested by OCRC.

(c) Failure to notify referral sources and the minority community that services are provided in a non-discriminatory manner as required by state or federal law, rules or regulations.

(d) Failure to display in prominent places the required compliance statements as required by state or federal law, rules or regulations.

(e) Failure to make adequate or appropriate notification of the facility's commitment to providing services in a non-discriminatory manner as required by state or federal law, rules or regulations.

(f) Failure to include a non-discriminatory statement in all vendor contracts and brochures and other information distributed to the public as required by state or federal law, rules or regulations.

Statutory Authority: T.C.A. §§4-3-1803 (1), 68-1-103(b), and 68-1-113, 4-5-209

1200-24-3-.05 REPEATED AND MAXIMUM PENALTIES.

(1) Penalties may be imposed simultaneously for multiple and distinct civil rights violations.

(2) If corrective action is not accomplished within a time period approved by OCRC a civil penalty with the initial amount may be imposed.

Statutory Authority: T.C.A. §§4-3-1803(1), 68-1-103(b), and 68-1-113, 4-5-209.

Signature of the agency or officers directly responsible for proposing and/or drafting these rules:

____
Beverly Bass, Director
Office on Civil Rights Compliance

I certify that this is an accurate and complete copy of Public Necessity Rules lawfully promulgated and adopted by the Department of Health and Environment on ______________, 1990.

____
J. W. Luna
Commissioner

Subscribed and sworn to before me this the ________ day of ____ ______________, 1990.

____
Notary Public

My commission expires on the ________ day of ______________, 1990.

All Public Necessity Rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

____
Charles W. Burson
Attorney General and Reporter

The Public Necessity Rules set out herein were properly filed in the Department of State on the _______ day of ___________, 1990, and will be effective from the date of filing for a period of _______ days. The Public Necessity Rules will remain in effect through the _________ day of _________________, 1990.

____

Bryant Millsaps
Secretary of State

WLP/A7210150

RULES
OF
TENNESSEE DEPARTMENT OF HEALTH AND ENVIRONMENT
BOARD FOR LICENSING HEALTH CARE FACILITIES

CHAPTER 1200-8-16
CIVIL RIGHTS COMPLIANCE
RULES AND REGULATIONS

NEW RULES

TABLE OF CONTENTS

1200-8-16-.01 Definitions
1200-8-16-.02 Requirements for Civil Rights Compliance
1200-8-16-.03 Monitoring Procedures
1200-8-16-.04 Corrective Action

1200-8-16-.01 DEFINITIONS

(1) "HEALTH CARE FACILITY (FACILITY)": Any facility licensed under the authority of the Board for Licensing Health Care Facilities as defined in T.C.A. 68-11-~~102.~~

(2) "CIVIL RIGHTS": Personal and individual rights guaranteed by the federal or state constitution and/or any federal or state statute.

(3) "COMMISSIONER": The Commissioner of the Tennessee Department of Health and Environment or his designated representative.

(4) "DEPARTMENT": Tennessee Department of Health and Environment

(5) "BOARD": Board for Licensing Health Care Facilities

(6) "TITLE VI": Title VI of the Civil Rights Act of 1964, 42 U.S.C. §2000d.

(7) "SECTION 504": Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. §794.

(8) "HANDICAPPED PERSON": means any person who (a) has a physical or mental impairment which substantially limits one or more major life activities, (b) has a record of such an impairment, or (c) is regarded as having such an impairment.

(9) "QUALIFIED HANDICAPPED PERSON": (a) With respect to receiving services, means a handicapped person who meets the eligibility requirements for receiving services offered by the facility; (b) With respect to employment, means a handicapped person who, with reasonable accommodations, can perform the essential functions of the job in question without undue hardship to the facility. Reasonable accommodations may include: Making facilities readily accessible to and

usable by handicapped persons; providing part-time or modified work schedules; and, providing readers or interpreters. In determining whether an accommodation would result in an undue hardship on the facility, factors to be considered may include: The overall size of the facility with respect to number of employees, number and type of facilities, and size of budget; the type of facility, including the composition and structure of the facility's workforce; and, the nature and cost of the accommodation needed.

(10) "PHYSICAL OR MENTAL IMPAIRMENT": means (a) Any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskelatal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin; and endocrine; or (b) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

(11) "DISCRIMINATION": Any act, policy, practice, or procedure which result in different treatment based on race, color, national origin or handicapping condition that impacts negatively upon qualified handicapped individuals and others protected under Title VI of the Civil Rights Act of 1964.

(12) "OFFICE ON CIVIL RIGHTS COMPLIANCE (OCRC)": The administrative, unit established within the Tennessee Department of Health and Environment charged with the responsibility of monitoring and investigating complaints related to civil rights compliance of facilities regulated by the Board.

(13) "MINORITY": Persons who fall within the following categories: Black, not of Hispanic origin; Hispanic; American Indian; Asian or Pacific Islander.

Statutory Authority: T.C.A. §§68-1-113, 68-11-102, 68-11-203, 4-5-202, U.S.C. 45 Part 80 and U.S.C. 45 Part 84.

1200-8-16-.02 REQUIREMENTS FOR CIVIL RIGHTS COMPLIANCE

The Board for Licensing Health Care Facilities may deny, suspend, or revoke a facility's license, or otherwise discipline the facility, for violations of the following requirements pursuant to T.C.A. 68-11-207 and 68-1-113. Licensed health care facilities must comply with the following:

(1) Shall not directly or through licensing, contractual or other arrangements, utilize criteria or methods of administering services which have the effect of subjecting individuals to discrimination on the basis of race, color, national origin or handicapping condition.

(2) Admission policies and procedures shall include measures to admit patients/residents to the facility without regard to race, color, national origin or handicapping condition.

(3) Shall include in their operational policies and procedures manuals measures to provide all services in a non-discriminatory manner (i.e. medical, dental, nursing, laboratory, pharmacy, skilled rehabilitative, social, volunteer, dietary and housekeeping).

(4) Physical facilities including lounges, dining facilities, beauty and barber shops shall not be used in a segregated or discriminatory manner.

(5) Shall include in their operational policies and procedures manuals that patients/residents are assigned to rooms, wards, floors, sections, buildings, and other areas without regard to race; color; national origin; or handicapping conditions, unless medically indicated.

(6) Shall include in their operational policies and procedures manuals that all aspects of all their training programs -- those operated by the facility, and those operated by other institutions within their facility for which the facility provides clinical training--are conducted without discrimination, on the basis of race, color, national origin or handicapping condition.

(7) Shall use all reasonable efforts to recruit minority and handicapped persons to training programs offered by the facility.

(8) Shall inform all patients/residents, potential patients/residents, and the general public that admissions and services are provided on a non-discriminatory basis. This shall be accomplished by:

(a) If a facility publishes or uses brochures, pamphlets and newsletters which are designed to acquaint potential patients/residents and members of the general public with the facility's programs and services, a statement of the facility's commitment and compliance to Title VI and Section 504 must be included. All efforts to communicate to the public should convey the message that services are provided in a non-discriminatory manner.

(b) Including a statement of the facility's commitment and compliance to Title VI and Section 504 on all application forms for admission and employment.

(c) Notifying all customary referral sources and the minority community within the service area that the facility's services and benefits are provided in a non-discriminatory manner.

(d) Displaying in prominent places in the facility notices indicating the Title VI and Section 504 compliance and commitment.

(9) Shall be responsible for conveying to all staff their non-discriminatory policy and how to file a complaint under Title VI or Section 504. This shall be accomplished by providing, as part of new employee's orientation and periodic retraining of permanent employees, information regarding the obligation, intent, and meaning of Title VI and Section 504 compliance.

(10) Those facilities with fifteen or more employees shall designate a responsible employee (Section 504 Coordinator) to coordinate its efforts to comply with Section 504 regulations.

(11) Shall establish and adhere to an internal procedure for handling patient/resident and employee grievances. The grievance procedure shall include:

(a) Complainant's right to due process.

(b) Time frames for the review, resolution and/or findings process.

(12) Shall ensure that the opportunity to participate as members of planning, advisory, and policy boards whose membership is opened to the public, is available in a non-discriminatory manner.

(13) Shall develop procedures for monitoring all aspects of its operation to ensure that no policy or practice is, or has the effect of discriminating against applicants, patients/residents, employees or other participants on the basis of race, color, national origin, or handicapping condition. Each facility shall establish a system to review annually all new and existing policies to determine compliance of such policies with Title VI and Section 504.

(14) Shall maintain and make available to the OCRC for the purpose of demonstrating compliance and upon request, all data and information necessary to determine the facility's compliance with Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973. Such statistical data shall include racial and ethnic data showing the extent to which minority and handicapped individuals participate in the facility's services and programs.

(15) All recruitment and employment practices shall not discriminate on the basis of race, color, national origin, handicapping condition, or have an adverse effect on the provision of services, privileges, or advantages offered to the facility's patients/residents.

(16) Shall include in their operational policies and procedures manuals a procedure for effective communication with handicapped persons and persons with limited English proficiency for the purpose of giving notice concerning benefits, services, waiver of rights, and consent to treatment, including emergency treatment.

(17) Shall provide appropriate auxiliary aids to persons with impaired sensory, manual, or speaking skills, where necessary to afford such persons an equal opportunity to benefit from services provided by the facility. Auxiliary aids may include information in braille, taped material and interpreters.

(18) Shall include an assurance of compliance with Title VI and Section 504 in all contracts with service agencies, health care providers and other health care facilities, e.g. services will be provided in a non-discriminatory manner without regard to race, color, national origin or handicapping condition.

Statutory Authority: T.C.A. §§68-11-209, 68-11-210, 4-5-202, 45 U.S.C., Part 80 and 45 U.S.C., Part 84.

1200-8-16-03 **MONITORING PROCEDURES.**

(1) Periodic compliance reviews.

The Office on Civil Rights Compliance shall have the authority to periodically review the practices of facilities to determine compliance with these regulations. Whenever a deficiency in compliance is cited by OCRC, a deficiency report shall be submitted to the facility. The facility shall develop and implement an acceptable plan of correction, specifying steps to correct the deficiencies and the time frame in which corrective measures will be taken. An acceptable plan of correction must be returned to OCRC no later than ten (10) days after receipt of the deficiency report, unless an extension is granted by the Director of OCRC or his/her designee. Documentation of already corrected deficiencies may be submitted with the plan of correction. The plan must be approved by the Director of OCRC, or his/her designee.

(2) Non-Compliance Investigations.

The Office on Civil Rights Compliance shall have the authority to conduct an investigation whenever a compliance review, report, complaint, or any other information indicates a possible failure to comply with State and federal law, and these regulations.

(3) Complaints.

Complaints involving discrimination prohibited by State and federal law may be filed with the Office on Civil Rights Compliance by the complainant or his or her representative. The identity of complainants shall be kept confidential to the extent the law permits.

(4) Intimidatory or Retaliatory Acts Prohibited.

No health care facility shall retaliate against or, in any manner, discriminate against any person because of a complaint made in good faith and without malice to the Board or the Department, or other agency having jurisdiction in the matter. A health care facility shall neither retaliate, nor discriminate against the complainant because of information provided to these authorities.

Statutory Authority: T.C.A. §§68-11-209, 4-5-202, 45 U.S.C., Part 80, and 45 U.S.C., Part 84.

1200-8-16-.04 CORRECTIVE ACTION.

If the facility has discriminated, or policies and procedures have resulted in discrimination against persons on the ground of race, color, national origin or handicapping condition, the facility must take action that will result in correcting the deficiency or the discriminatory act.

Statutory Authority: T.C.A. §§68-11-209, 4-5-202, 45 U.S.C., Part 80 and 45 U.S.C., Part 84.

BGB/G6139286

Appendix C

STATE OF TENNESSEE
DEPARTMENT OF HEALTH AND ENVIRONMENT
CORDELL HULL BUILDING
NASHVILLE, TENNESSEE 37219-5402

NED McWHERTER
GOVERNOR

J. W. LUNA
COMMISSIONER

May 31, 1990

Mr. Thomas T. Williams
Regional Director, HHS
101 Marietta Tower
Atlanta, Georgia 30323

Dear Mr. Williams:

On April 23, 1990, the United States District Court, Middle District, Tennessee, issued a memorandum decision in the case of Linton v. Commissioner, M.D. Tenn. No. 3-87-0941. See Attachment 1. The Court, in effect, ruled that Tennessee's practice of allowing Medicaid participating facilities to certify less than all beds for Medicaid violated federal law, created a disparate impact on minorities and violated numerous federal regulations. At page 22 and 25 of the Memorandum, the Court ordered the State to develop a plan to redress the disparate impact on minorities in consultation with HCFA.

The parties to the lawsuit have agreed that the attached plan adequately complies with federal requirements and the Court's Order. See Attachment 2.

This plan is submitted to you for your information and advice. If you believe the plan does not adequately address Medicaid and Title VI requirements, we would appreciate your prompt reply.

If you have questions, please let us know.

Sincerely,

J.W. Luna
Commissioner

Gordon Bonnyman
Attorney for the Plaintiff

WLP/A7270151

ENFORCEMENT STRATEGY

The Department will monitor facility compliance with regard to admission practices, during annual surveys as well as for on-site visits and complaint investigations. The monitoring strategy will be based upon each specific situation, but will include as part of the survey, visit or complaint investigation making blind telephone calls to the facility inquiring about admission policies, wait list and Medicaid acceptance. In addition, applicants, residents and/or families or referral sources of applicants or residents may be interviewed. Staff surveyors will inspect and review documentation on admission denials, reasons for by-passing a resident on the wait list, patient transfer, facility census data, operational policies and procedures manuals, and facility advertisements. When the Departments finds the facility has violated a requirement of this plan, it will be considered a violation of the facility's policies and procedures. As such a pending Type C penalty notification pursuant to TCA §68-11-80, will be issued along with a deficiency notice. If a facility is again found out of compliance within a twelve month period a Type C civil monetary penalty of $250 will be issued in accordance with TCA §68-11-8. Where noncompliance continues or where the noncompliance is

pervasive, the Department will consider additional civil monetary penalties, denial, supervision, or revocation of the facility's license, involuntary termination from Medicaid; and any other types disciplinary action available to the Commissioner and the Board.

The Department will evaluate as part of its annual facility survey a sample of transfers and discharges to assure that residents have not been transferred in constravention of the plan. In addition the Patient Care Advocacy Program (PCAP) monitors complaints regarding involuntary transfers. Upon determination that a facility transferred or discharged a resident in contravention of this Order, a Type B Civil Monetary Penalty will be issued pursuant to TCA §68-11-80 of up to $1,500. Where the noncompliance continues or where the noncompliance is pervasive, the Department will consider additional civil monetary penalties, denial, suspension, or revocation of the facility's license, involuntary termination from Medicaid, and any other type disciplinary action available to the Commissioner and the Board.

WLP/A7030144

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF TENNESSEE

OFFICE OF THE CLERK
800 UNITED STATES COURTHOUSE
NASHVILLE, TENNESSEE 37203

JULIET GRIFFIN
CLERK

615/736-5498

DATE: 4-23-90

RE: Mildred Lea Linton, et al. vs. Commissioner of Health & Environment, State of TN 3:87-0941
JUDGE NIXON

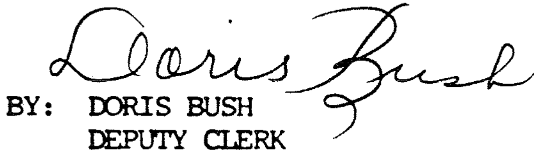
ENCLOSED IS A COPY OF THE FOLLOWING:

MEMORANDUM AND ORDER OF THE COURT

ENTERED ON THE DOCKET BY THE CLERK IN COMPLIANCE WITH RULE 58 AND/OR RULE 79(a) OF THE FEDERAL RULES OF CIVIL PROCEDURE ON:

4-23-90

CLERK, U.S. DISTRICT COURT



BY: DORIS BUSH
DEPUTY CLERK

COPIES SENT TO:

Pam Ford Wright
Gordon Bonnyman, Jr.
Napoleon B. William, Jr.
Jennifer Small
Richard F. LaRoche, Jr.