

Legislative History for Connecticut Act

HB 7228 PA 348 1989

House 4235, 10831-10869 (40)

Senate 4105-4106, 4164A-4164B (4)

Human Services 698-700, 701-702, 749, 786-787,
827-830, 840-841, 862-863, 916-917, 941 (31)

1294-1299, 1301-1302, 1310-1313

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House of Representatives

Wednesday, April 26, 1989

Calendar 377, Substitute HB7228. AN ACT CONCERNING
ADMISSION TO CERTAIN NURSING FACILITIES AND A PATIENT'S
BILL OF RIGHTS.

Favorable Report of the Committee on HUMAN
SERVICES.

REP. FRANKEL: (121st)

Mr. Speaker?

SPEAKER BALDUCCI:

Representative Frankel.

REP. FRANKEL: (121st)

I move this bill be referred to the Committee on
Public Health.

SPEAKER BALDUCCI:

The question is on referral. Is there objection?

Seeing none, so ordered.

CLERK:

Calendar 394, on page 17, SB817. AN ACT CONCERNING
HISTORICALLY SIGNIFICANT BUILDINGS OWNED BY THE STATE.
(As amended by Senate Amendment Schedules "A" and "B").

Favorable Report of the Committee on GOVERNMENT
ADMINISTRATION AND ELECTIONS.

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Calendar.

CLERK:

Calendar 377, Substitute for HB7228. AN ACT
CONCERNING ADMISSION TO CERTAIN NURSING FACILITIES AND
PATIENT'S BILL OF RIGHTS.

Favorable Report of the Committee on
APPROPRIATIONS.

REP. COURTNEY: (56th)

Madam Speaker.

DEPUTY SPEAKER POLINSKY:

Representative Courtney.

REP. COURTNEY: (56th)

Mr. Speaker, I move acceptance of the Joint
Committee's Favorable Report and passage of the bill.

DEPUTY SPEAKER POLINSKY:

The motion is on acceptance and passage. Will you
remark? Representative Courtney, please do.

REP. COURTNEY: (56th)

Thank you, Madam Speaker. This legislation is
being proposed to implement federal requirements
concerning nursing homes in the Omnibus Reconciliation
Act, otherwise known as OBRA, of 1987. It contains
many, many sections. The first four sections,
basically concern the rights of patients in nursing
homes, homes to the aged and chronic hospitals. The

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bill covers rights concerning transfers and discharges. It concerns rights regarding treatment by the facilities and also rights concerning the use and handling of their patient funds, which is in Section 5 of the bill.

Section 6 of the bill concerns Medicaid regulations concerning the duties and the responsibilities of the Department of Health Services to investigate possible violations of different provisions in the Medicaid laws and the Department of Income Maintenance's powers concerning violations of those laws.

Section 7 is regarding the creation of a temporary manager who can be appointed in cases where violations have occurred.

Section 8 is regarding screening of mentally ill and mentally retarded patients. Again, this is a requirement which the federal government is now imposing on the state and that also is included in Section 9 of the bill.

Madam Speaker, we have an amendment, LC08134, which I would ask that the Clerk please call and I be allowed to summarize.

DEPUTY SPEAKER POLINSKY:

Will the Clerk please call LC08134, which shall be designated House Amendment "A".

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CLERK:

LCO8134, House "A", offered by Representative
Courtney.

REP. COURTNEY: (56th)

May I have permission to summarize.

DEPUTY SPEAKER POLINSKY:

The gentleman has asked leave of the Chamber to summarize. Is there objection? Seeing no objection, please proceed, Representative Courtney.

REP. COURTNEY: (56th)

Thank you, Madam Speaker. This amendment is largely technical. The largest portion of the amendment basically extends the appeal rights that are being created for patients in nursing homes and it's extending it also to patients who are in homes for the aged, who it was felt certainly need those appellate rights to protect their position in homes for the aged as well.

In addition, in lines 62 through lines 92 of the amendment it basically is to reinstate into our laws protection regarding intrafacility or bed-to-bed transfers. At the time that the bill was reported out of committee, it was realized by many of the advocates that in fact we had inadvertently removed protections which presently are utilized by the Department of Aging

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and Legal Services to protect patients from involuntary transfers within a facility and lines 93 through the end of the bill, line 102, are simply technical amendments which had been identified, or technical changes which were identified as being necessary by LCO after the bill came out of Appropriations.

It's a good amendment. It, I think, if it does anything, it bolsters the rights of patients and homes for the aged and also all patients regarding bed-to-bed transfers and I would move its adoption and ask the Chamber to support it.

DEPUTY SPEAKER POLINSKY:

The motion is on adoption of House "A". Will you remark further? Will you remark further? If not, let us try your minds. All in favor of House "A" please indicate by saying aye.

REPRESENTATIVES:

Aye.

DEPUTY SPEAKER POLINSKY:

Opposed nay.

The ayes have it.

The amendment is adopted and ruled technical.

House Amendment Schedule "A".

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In line 26, after "PATIENT" insert "FROM THE FACILITY"

In line 108, after "DISCHARGED" insert 'FROM THE FACILITY"

In line 172, before the period insert "and notice of the right of the resident to appeal a transfer or discharge by the facility pursuant to subsection (d) of this section. No resident shall be involuntarily transferred or discharged from a facility if such transfer or discharge presents imminent danger of death."

After line 177 insert subsection (d) as follows:

"(d) (1) For transfers or discharges effected on or after October 1, 1989, a resident or his legally liable relative, guardian or conservator who has been notified by a facility, pursuant to subsection (b) of this section, that he will be transferred or discharged from the facility may appeal such transfer or discharge to the commissioner of health services by filing a request for a hearing with the commissioner within ten days of receipt of such notice. Upon receipt of any such request, the commissioner or his designee shall hold a hearing to determine whether the transfer or discharge is being effected in accordance with this section. Such a hearing shall be held within seven business days of receipt of such request and a determination made by the commissioner or his designee within twenty days of the termination of the hearing. The hearing shall be conducted in accordance with chapter 54.

(2) In an emergency the facility may request that the commissioner make a determination as to the need for an immediate transfer or discharge of a resident. Before making such a determination, the commissioner shall notify the resident and, if known, his legally liable relative, guardian or conservator. The commissioner shall issue such a determination no later than seven days after receipt of the request for such determination. If, as a result of such a request, the commissioner or his designee determines that a failure to effect an immediate transfer or discharge would endanger the health, safety or welfare of the resident or other residents, the commissioner or his designee shall order the immediate transfer or discharge of the resident from the facility. A hearing shall be held in accordance with the requirements of subdivision (1) of this subsection within seven business days of the issuance of any determination issued pursuant to this subdivision.

(3) Any involuntary transfer or discharge shall be

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stayed pending a determination by the commissioner or his designee. Notwithstanding any provision of the general statutes, the determination of the commissioner or his designee after a hearing shall be final and binding upon all parties and not subject to any further appeal."

Delete lines 232 to 251, inclusive, and insert the following in lieu thereof, renumbering the remaining subdivisions accordingly: "in experimental research; (4) is transferred [or discharged] FROM ONE ROOM TO ANOTHER WITHIN THE FACILITY only for medical reasons, or for his welfare or that of other patients, as documented in his medical record [; or, in the case of a private patient, for his nonpayment or arrearage of more than fifteen days of either the per diem nursing home room rates established by the commissioner of income maintenance or the per diem chronic disease hospital room rates approved by the commission on hospitals and health care, whichever rate is applicable, for his stay, except as prohibited by the Social Security Act,] AND SUCH RECORD SHALL INCLUDE DOCUMENTATION OF ACTION TAKEN TO MINIMIZE ANY DISRUPTIVE EFFECTS OF SUCH TRANSFER, PROVIDED NO PATIENT MAY BE INVOLUNTARILY TRANSFERRED FROM ONE ROOM TO ANOTHER WITHIN THE FACILITY IF SUCH TRANSFER PRESENTS IMMINENT DANGER OF DEATH; and in the case of an involuntary transfer [or discharge] FROM ONE ROOM TO ANOTHER WITHIN THE FACILITY, the patient [or his guardian, relative or sponsoring agency and the patient's personal physician if the discharge plan is prepared by the medical director of the nursing home facility or chronic disease hospital] AND, IF KNOWN, HIS LEGALLY LIABLE RELATIVE, GUARDIAN OR CONSERVATOR, is given at least thirty days written notice to ensure orderly transfer [or discharge] FROM ONE ROOM TO ANOTHER WITHIN THE FACILITY, EXCEPT WHERE THE HEALTH, SAFETY OR WELFARE OR OTHER PATIENTS IS ENDANGERED OR WHERE IMMEDIATE TRANSFER FROM ONE ROOM TO ANOTHER WITHIN THE FACILITY IS NECESSITATED BY URGENT MEDICAL NEED OF THE PATIENT OR WHERE A PATIENT HAS RESIDED IN THE FACILITY FOR LESS THAN THIRTY DAYS, IN WHICH CASE NOTICE SHALL BE GIVEN AS MANY DAYS BEFORE THE TRANSFER AS PRACTICABLE; (5) is encouraged and assisted,"

In line 501, after the semicolon insert "imposition of civil monetary penalties;"

In line 735, after "developed" insert ", or in the case of out-of-state residents approved,"

In line 758, after "developed" insert ", or in the case of out-of-state residents approved,"

In line 847, after "developed" insert "or in the

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case of out-of-state residents approved,"
In line 876, after "developed" insert ", or in the
case of out-of-state residents approved,"

DEPUTY SPEAKER POLINSKY:

Will you remark further on the bill as amended?

REP. FARR: (19th)

Yes, Madam Speaker.

DEPUTY SPEAKER POLINSKY:

Representative Farr of the 19th.

REP. FARR: (19th)

Madam Speaker, the Clerk has an amendment. Will
the Clerk please call LC07522 and I be allowed to
summarize.

DEPUTY SPEAKER POLINSKY:

Will the Clerk please call LC07522, which shall be
designated House Amendment Schedule "B".

CLERK:

LC07522, House "B", offered by Representative Farr,
et al.

DEPUTY SPEAKER POLINSKY:

The gentlemen asks leave of the Chamber to
summarize. Is there objection? Seeing no objection,
please proceed, Representative Farr.

REP. FARR: (19th)

Yes, Mr. Speaker, Members of the Chamber, the

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amendment essentially says that the discharge is from -- shall not occur if an alternative resident placement is not available. What the amendment is attempting to get at is the issue of dumping.

The problem with the bill, may people believe, is that it will result in the dumping of mentally ill people from institutions when other facilities are not available for them. What the amendment attempts to do is to ensure that won't happen by stating that they do not transfer patients when other facilities are not available and I would move adoption of the amendment.

DEPUTY SPEAKER POLINSKY:

The question is on adoption of House "B". Will you remark further? Representative Farr.

REP. FARR: (19th)

Yes, Madam Speaker. As I indicated in summarizing the amendment, I think that this amendment addresses in a small way one of the major concerns I have with the bill. It is stamped "No Fiscal Impact." Fiscal Analysis does not think it will have a major impact. I'm hopeful that it will prevent dumping from occurring in this institutions and I would urge passage of the amendment.

DEPUTY SPEAKER POLINSKY:

Will you remark further on the amendment? Will you

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remark further on the amendment? If not, let's try our minds again. All those in favor of House "B", please indicate by saying aye.

REPRESENTATIVES:

Aye.

DEPUTY SPEAKER POLINSKY:

Opposed nay.

The ayes have it.

The amendment is adopted and ruled technical.

House Amendment Schedule "B".

In line 795, after the word "Services" add ", except if an alternate residential placement is not available, the resident shall not be transferred"

In line 914, after the word "Services" add ", except if an alternative residential facility is not available, the resident shall not be transferred"

DEPUTY SPEAKER POLINSKY:

Will you remark further on the bill as amended by "A" and "B"? Representative O'Neill.

REP. O'NEILL: (98th)

Thank you, Madam Speaker. A question to the proponent please.

DEPUTY SPEAKER POLINSKY:

Representative Courtney on your feet. Please frame your question, Representative O'Neill.

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REP. O'NEILL: (98th)

Representative Courtney, this bill is a lengthy bill. It has 40 some odd pages or 39 or 38 pages, many different sections, but from reading at length, I find that the most important thing or one of the more important things is the bill is that in cases where the welfare, the health or the safety of the patient is concerned, the documentation shall be by the patient's physician. It has to do with the health, the wealth and the safety of the person who is receiving the medical attention. Am I right in that or am I wrong?

DEPUTY SPEAKER POLINSKY:

Representative Courtney.

REP. COURTNEY: (56th)

Through you, Madam Speaker, could you pinpoint what particular lines you're looking at?

REP. O'NEILL: (98th)

21, 22, 23 and 24 of the file copy.

REP. COURTNEY: (56th)

Madam Speaker, I think you correctly read the criteria which are going to be utilized by the facilities and by the physician.

REP. O'NEILL: (98th)

Thank you very much. One of the many, many things affecting the health and welfare and the safety of the

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patients which this bill is primarily concerned with is the question of competency of doctors and the competency of doctors, naturally, from the time that they have served as interns and the time that they have served as residents.

There has been strong documentation in recent years, primarily from a case which was decided in New York City. It was called the Libby Zion case and this was a case where an individual was taken into a hospital and by incompetence of a physician the particular person died.

Now it wasn't that the physician didn't want to do a good job, it was a question of the physician being too tired to do the job. The physician had been up for over 24 straight hours and this was a question of residents and interns not having sufficient sleep and not having sufficient rest to perform their duties in a competent and professional manner.

So with that in mind I will ask the Clerk to call LC07538 and allow me to read the bill or to explain it.
DEPUTY SPEAKER POLINSKY:

I beg your pardon, Representative O'Neill, would you repeat that?

REP. O'NEILL: (98th)

I called LC07538.

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DEPUTY SPEAKER POLINSKY:

Will the Clerk please call LCO7538, which shall be designated House Amendment "C".

CLERK:

LCO7538, designated House Amendment "C", offered by Representative O'Neill, et al.

DEPUTY SPEAKER POLINSKY:

Representative O'Neill, did you wish to summarize. Excuse me, Representative O'Neill. The gentleman has asked leave of the Chamber to summarize. Is there objection? Seeing no objection, please proceed, Representative O'Neill.

REP. O'NEILL: (98th)

Thank you, Madam Speaker. Madam Speaker, this is a very simple amendment. It merely states that the hospitals conducting residency and intern programs shall comply with the standards set forth for working hours promulgated by the Association of American Medical Colleges and accreditation councils for graduates and medical education.

I move its adoption.

DEPUTY SPEAKER POLINSKY:

The motion is on adoption of House Amendment "C". Will you remark? Will you remark further? Representative O'Neill.

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REP. O'NEILL: (98th)

Yes, I certainly will. This is a bill, or this amendment, had been at one time a bill for two years in the Labor Committee. There was a lengthy, and I use the word lengthy study, conducted by the Labor Committee in the last 18 months. The Labor Committee interviewed medical individuals from Yale-New Haven, from the Connecticut School of Medicine, from St. Francis, from any other hospital that wanted to come to the committee and to testify.

As a result of that, we found out that the interns and the residents in the State of Connecticut had for a long period of time been working upwards to 24, 36 hours straight without any break off, in the emergency rooms taking care of patients. We've had testimony from medical students at Yale-New Haven and Yale-New Haven medical students, a large proportion of those who were interviewed state that there was no question whatsoever that the rules relative to the working hours of interns and of residents must be changed for the safety of the patients.

There have been cases of individuals being prescribed drugs that there was no reason for them to have prescribed for them. There were questions were nurses had to go back to the doctor to reiterate that

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this is not a drug which was prescribed. There were cases where nurses themselves had to take it upon themselves to caution doctors as to what they could or what they could not do because of the mistakes which were being made. There have been many, many studies done on the hours of medical individuals and I quote from a study done by Dr. Charles Krishler, Director of a center for circulation and sleep at hospitals in Birmingham and in Boston, Massachusetts and he stated that 25% of medical residents, doctors-in-training, often work 34-hour shifts and 24- to 36-hour shifts. They fall asleep during that period of time when on the telephone talking to other doctors, talking to patients, talking to individuals who can help them in diagnoses.

The head of Yale-New Haven Hospital, the Chief Administration, Dr. Fenn, admitted that he himself has fallen asleep while talking on the telephone after being up for long hours.

REP. MAZZOTTA: (32nd)

Mr. Speaker.

DEPUTY SPEAKER POLINSKY:

Excuse me, Representative O'Neill, for what purpose do you rise, Representative Mazzotta.

REP. MAZZOTTA: (32nd)

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Thank you, Madam Speaker. I rise for a Point of Order, Madam Speaker.

DEPUTY SPEAKER POLINSKY:

Please present your Point of Order.

REP. MAZZOTTA: (32nd)

Thank you, Madam Speaker. I fully respect Representative O'Neill. I know he's been working very hard on this particular issue. However, I must disagree with him. My Point of Order is that according to Mason's 402, I do not believe this amendment is properly before us as I don't think it's germane to the file copy as amended.

DEPUTY SPEAKER POLINSKY:

Representative Mazzotta has raised a Point of Order in regard to this amendment and the question of germaneness. When I was first handed a copy of this amendment I took a look at it and thought to myself, there is going to be a Point of Order. It has arrived. I have reviewed the file somewhat already in anticipation of that question and I am ready to rule.

DEPUTY SPEAKER POLINSKY:

The section of Mason's that the Point of Order was raised on presumably was Section 402, presumably more specifically 402, Subsection 2, which reads in part that the question, the amendment, that is, is one that

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has relevance, is appropriate and in a, and I quote, "natural and logical sequence to the subject matter of the original proposal."

I notice that when Representative O'Neill asked Representative Courtney a question as to lines 21, 22 and I think 23 and 24. I think particularly he was asking to make that silver thread a little thicker. The bill, as most of you who have read it know, deals with the treatment of patients, their care, bill of rights. It talks about changing reasons for a nursing facility to transfer or discharge patients.

Basically, the bill talks only of patient care and except for one reference in those lines I indicated, does not talk to doctors, nor their conditions of employment. Though a silver thread does exist, in my opinion, that thread is so slim, so thin as not to fall within the description the requirement of 402.2 and, therefore, sir, your Point of Order is well taken and this amendment is not appropriately before us.

REP. MAZZOTTA: (32nd)

Thank you, Madam Speaker.

DEPUTY SPEAKER POLINSKY:

Will you remark further on the bill as amended?
Will you remark further on the bill? Representative
Emmons.

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REP. EMMONS: (101st)

Madam Speaker, I have a couple of questions, through you, to the proponent of the bill.

DEPUTY SPEAKER POLINSKY:

Representative Courtney, prepare yourself.

DEPUTY SPEAKER POLINSKY:

Please frame your questions, Representative Emmons.

REP. EMMONS: (101st)

Thank you.

REP. EMMONS: (101st)

Representative Courtney, on line 225, as one of the inclusions of the bill or rights, it says that a patient is entitled to choose his own physician. Now my question to you is that in some nursing homes they have a house doctor, a house dentist, something of that sort. If you're on Medicaid and you choose not to use the house physician, how would this work if there are some physicians who will not handle Medicaid and Medicare individuals?

DEPUTY SPEAKER POLINSKY:

Representative Courtney.

REP. COURTNEY: (56th)

Through you, Madam Speaker, well, I think you've identified a problem which exists for all Medicaid patients, whether they're in facilities or not if you

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have doctors who don't want to accept them as patients. There's no law that requires doctors to accept Medicaid patients if they don't want to accept Medicaid patients, so if the hypothetical that you're asking is if the patient has requested a doctor who will not take Medicaid, I think then that choice is one that's not going to be required to be adhered to.

REP. EMMONS: (101st)

Thank you. Just to clarify, through you, Madam Speaker, then what you're saying is a resident of a nursing home has the right to choose the doctor, but if the doctor doesn't want to come, then the nursing home is not liable?

REP. COURTNEY: (56th)

Through you, Madam Speaker, that's correct.

DEPUTY SPEAKER POLINSKY:

Representative Emmons.

REP. EMMONS: (101st)

Thank you, and then, through you, Madam Speaker, should a patient choose their own doctor and not be able to pay the bill, the nursing home would not be liable for that cost?

REP. COURTNEY: (56th)

Through you, Madam Speaker, that's also correct.

DEPUTY SPEAKER POLINSKY:

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Representative Emmons.

REP. EMMONS: (101st)

Thank you, Madam Speaker. Another question, through you, Madam Speaker.

DEPUTY SPEAKER POLINSKY:

Please proceed, I'm sorry.

REP. EMMONS: (101st)

Thank you. It is easy to just daydream here isn't? Madam Speaker, through you, on line 299 there's a -- under the -- I presume it's another patient's bill of rights, but my questions is, and I can understand unopened mail, but to make and receive telephone calls privately, as most of the patients are in double-bedded rooms, how is this right just to make a receive a telephone call privately when needed or is it assumed to be something that is an ongoing situation?

REP. COURTNEY: (56th)

Through you, Madam Speaker.

DEPUTY SPEAKER POLINSKY:

Representative Courtney.

REP. COURTNEY: (56th)

I think the intent is to accommodate private calls when they're requested by patients within some realm of reasonableness. I think if, again, your hypothetical which that, you know, another person may be present in

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the room and that the patient requests that that call be allowed to be made alone in the room, again, I think the nursing homes will be given some latitude to inquire as to the length of the call, the nature of the call and to try to accommodate that without inconveniencing the other patient.

Again, I think there's an understanding here that reasonableness will be allowed. It's only, again, the calls that really the patient insists because of the nature of the call, the delicacy or whatever the content, that they be allowed to have complete privacy.

DEPUTY SPEAKER POLINSKY:

Representative Emmons.

REP. EMMONS: (101st)

Well, thank you, Madam Speaker. Through you, Madam Speaker, what you're then suggesting is that in order for a patient to have a private phone call, your solution is that the roommate will be asked to leave, rather than the nursing home providing a phone in, say, the director's office.

REP. COURTNEY: (56th)

Through you, Madam Speaker, I think either hypothetical could occur under this statute. Again, I think what's reasonableness and convenience would be what the nursing home would have to use as criteria in

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terms of what decision to make. Again, I think your suggesting of using an office phone would be entirely a good idea if that was felt to be the quickest and least inconvenient way to give a person a private call.

DEPUTY SPEAKER POLINSKY:

Representative Emmons.

REP. EMMONS: (101st)

Thank you, Madam Speaker. Madam Speaker, I'm not going to vote against this bill, I don't think, but I think that that particular line was not very well thought out. In one hand you're saying the patient will be reasonable, but there are some very unreasonable individuals in nursing homes and they can file their complaints and make life quite unattractive for the administrators.

It seems to me that if you wanted to have something like this, it should have been detailed a little bit better because I think that for some situations there are bedridden nursing home patients and they really don't ever move out of that room almost at all, so if you have two of them in one room, it's going to be very difficult to have a private phone call.

DEPUTY SPEAKER POLINSKY:

Thank you, Madam. Will you remark further on this

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bill as amended? Will you remark further?

Representative Belden.

REP. BELDEN: (113th)

Thank you, Madam Speaker. First, I'd like to thank Representative Courtney for all of the diligent effort he has put into this particular piece of very complicated legislation, and if I might, a question to the gentleman, through you, Madam Speaker.

DEPUTY SPEAKER POLINSKY:

Representative Courtney, on your feet. Please proceed, sir.

REP. BELDEN: (113th)

Representative Courtney, on line 301 in the file it talks about "receives adequate notice before the room, his room or his roommate in the facility is changed." Just for the record, could you kind of define what adequate notice might mean there? Is it a day or a half an hour or what, through you, Madam Speaker?

REP. COURTNEY: (56th)

Through you, Madam Speaker.

DEPUTY SPEAKER POLINSKY:

Please proceed, sir.

REP. COURTNEY: (56th)

The amendment which we just adopted in lines 232 to 251 refers to the question of transfers within a

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facility and as far as to answer your question regarding room changes, I think that portion of the amendment addresses that issues and after much negotiation between all the parties, the facilities and the advocates, what was agreed upon was a 30-day notice for room transfers where the room transfer was involuntary and where the health, safety or welfare of other patients was not endangered, which is in lines 85 through 87.

It goes on also to say if there is a urgent medical problem regarding the patient himself, an immediate transfer is allowable with notice as soon as practicable, and finally, if a patient has resided in the facility for less than 30 days, the 30-day notice is not required.

As far as roommates are concerned, which is also referred to in the line that you requested, I can only say maybe for purpose of legislative intent that the understanding of the parties was is that notice, unless otherwise specified, would be as soon as practicable to the patient or his representative.

DEPUTY SPEAKER POLINSKY:

Representative Belden.

REP. BELDEN: (113th)

Thank you, Representative Courtney. In addition to

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that, I have some amendments I would like to offer at this time. Would the Clerk please call LCO6798, may he call and read please.

DEPUTY SPEAKER POLINSKY:

Will the Clerk please call LCO6798, which shall be designated House Amendment Schedule "D" and will the Clerk please read.

CLERK:

LCO6798, House "D", offered by Representative Belden.

In line 454, after "PATIENT" insert "OR HIS LEGAL REPRESENTATIVE"

In line 459, after "PATIENT" insert "OR HIS LEGAL REPRESENTATIVE"

REP. BELDEN: (113th)

Madam Speaker, I move adoption.

DEPUTY SPEAKER POLINSKY:

The question is on adoption of House "D". Will you remark further?

DEPUTY SPEAKER POLINSKY:

Representative Belden.

REP. BELDEN: (113th)

Very briefly, this is just some clarifying language since we know that some of the patients in a nursing home may not be able to act on their own behalf. By

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adding the words "legal representative" I believe we've covered perhaps an option that should be in there.

DEPUTY SPEAKER POLINSKY:

Will you remark further on House Amendment "D"? Will you remark further? If not, let us try your minds. All those in favor of the amendment please signify by saying aye.

REPRESENTATIVES:

Aye.

DEPUTY SPEAKER POLINSKY:

Opposed nay.

The ayes have it.

The amendment is adopted and ruled technical.

Will you remark further on the bill as amended?

REP. BELDEN: (113th)

Yes.

DEPUTY SPEAKER POLINSKY:

Representative Belden.

REP. BELDEN: (113th)

Thank you, Madam Speaker, the Clerk has an amendment, LC05862. Would the Clerk please call and read.

DEPUTY SPEAKER POLINSKY:

Will the Clerk please call LC05682, which shall be designated House Amendment "E" and will the Clerk

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please read.

CLERK:

LCO --.

DEPUTY SPEAKER POLINSKY:

Hold it. Would you repeat the LCO number?

REP. BELDEN: (113th)

LCO5862.

DEPUTY SPEAKER POLINSKY:

We liked that other amendment back then so much we were going to try it again. Will the Clerk please call LCO5862, which shall be designated House "E" and will the Clerk please read.

CLERK:

LCO5862, designated House Amendment "E", offered by Representative Belden.

In line 342, after "FACILITY" insert "TO THE EXTENT THE FACILITY HAS EXISTING MEETING SPACE AVAILABLE WHICH MEETS APPLICABLE BUILDING AND FIRE CODES"

REP. BELDEN: (113th)

Madam Speaker, I move adoption.

DEPUTY SPEAKER POLINSKY:

The motion is on adoption of House "E". Will you remark? Representative Belden.

REP. BELDEN: (113th)

Very briefly, Madam Speaker, the file indicates

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that families are entitled to have meetings in the nursing home with other family and I think that clarifies the fact that to the extent that there is meeting room space available in the facility. Thank you.

DEPUTY SPEAKER POLINSKY:

Will you remark further on House "E"? If not, let us try your minds. We should be in good voice by now. All in favor please indicate by saying aye.

REPRESENTATIVES:

Aye.

DEPUTY SPEAKER POLINSKY:

Opposed nay.

The ayes have it.

The amendment is adopted and ruled technical.

Will you remark further on the bill as amended by all those amendments?

REP. BELDEN: (113th)

Madam Speaker.

DEPUTY SPEAKER POLINSKY:

Representative Belden.

REP. BELDEN: (113th)

One more amendment, Madam Speaker. This is not exactly a technical amendment. I would ask the Clerk to call and read LCO7525.

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DEPUTY SPEAKER POLINSKY:

Will the Clerk please call LCO7525, which shall be designated House Amendment "F".

CLERK:

LCO7525, House "F".

DEPUTY SPEAKER POLINSKY:

Representative Belden, did you wish to be read or summarized?

REP. BELDEN: (113th)

Read.

CLERK:

In line 442, strike the bracket

In line 446, strike the bracket and strike "DEPOSIT ANY AMOUNT IN EXCESS OF FIFTY"

Strike lines 447 to 452, inclusive, in their entirety

In line 453, strike "FUND."

REP. BELDEN: (113th)

Madam Speaker, I move adoption.

DEPUTY SPEAKER POLINSKY:

The motion is on adoption of House "F". Will you remark further? Representative Belden.

REP. BELDEN: (113th)

Thank you, Madam Speaker. The file, essentially in line 441 to 453 takes the old language and deletes it

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which essentially said that they had to maintain separate accounts for the patients or maintain an aggregate trust account for the patient's funds, prevent co-mingling with the nursing homes' funds.

This was legislation that was just passed within the last two or three years, to my recollection, and then we have new language in the file that mandates that for any patient who has more than \$50 in his account, that the nursing home will have to open an interesting bearing account for that particular patient for those funds over \$50, as I understand it.

The amendment deletes that new language and leaves the law the way it has been, that the nursing home has to keep the accounts, they have to keep records, but the old language did not mandate individual interest bearing accounts.

This will create, in my opinion, kind of a nightmare for a nursing home that has 150 or 200 patients and will now have to establish interest bearing bank accounts for potentially every one of those residents whose account happens to go over \$50 at any point in time and so it is, to me, somewhat of an accounting nightmare and perhaps in the discussion that'll follow, I'll perhaps find out some facts maybe I don't know, that make this new language that's in the

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file worthwhile, so I'll wait and see. Thank you,
Madam Speaker.

DEPUTY SPEAKER POLINSKY:

The question is on House "F". Will you remark?
Representative Thompson of the 13th.

REP. THOMPSON: (13th)

Madam Speaker, a question, through you, to
Representative Belden.

DEPUTY SPEAKER POLINSKY:

It's your turn, Representative Belden, prepare
yourself. Please proceed, Representative Thompson.

REP. THOMPSON: (13th)

The original language, Representative Belden, if I
can find it, would have in our judgment given greater
integrity to the individual patient's account. Would
it be your understanding, and for legislative intent,
that maintaining the old language and striking the new
would still permit the nursing home to maintain a
separate account, especially accounts that would be
greater than \$50 or perhaps a higher number, well,
having the option of co-mingling those funds, but at
the same time, setting up an accounting system which
would truly trace the funds of each individual patient
so that there would be no confusion?

As I understand the intent of the bill, the

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original bill, was to protect the interest of the individual patients and make it easier for them to understand exactly what was happening to their funds, through you, Madam Speaker.

DEPUTY SPEAKER POLINSKY:

Did you get that question, Representative Belden?

REP. BELDEN: (113th)

Yes, I did, Madam Speaker. It's so seldom that we get the question.

DEPUTY SPEAKER POLINSKY:

Would you care to answer it?

REP. BELDEN: (113th)

Yes, I would.

DEPUTY SPEAKER POLINSKY:

Good.

REP. BELDEN: (113th)

I'd be more than happy to. The old language which remains in the file in my amendment would have been the brackets would have been removed, on line 442 and 446, does indicate that there is an option of how the nursing home could keep track of the funds.

My amendment deletes the new language only on lines 446 through the word "fund" on 453. It leaves the balance of the new language that in fact indicates that the facility shall notify each patient receiving

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Medicaid. It says, "When the amount of the patient's account reaches \$200," etc. So they will in fact have to keep track of each individual patient's account, but I just felt that having the nursing home possibly having to open an interest bearing account individually for each member and to have to keep track of this week are they over or under \$50, etc., was quite a burden in terms of accounting and that's why the amendment is before us.

DEPUTY SPEAKER POLINSKY:

Representative Thompson.

REP. THOMPSON: (13th)

Through you, Madam Speaker. Thank you, Representative Belden. We don't believe there's any objection to the amendment.

DEPUTY SPEAKER POLINSKY:

That's lovely. Will you remark further on House Amendment Schedule "F". If not, let us try our voices. All those in favor of House "F" please indicate by saying aye.

REPRESENTATIVES:

Aye.

DEPUTY SPEAKER POLINSKY:

Opposed nay.

The ayes have it.

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The amendment is adopted and ruled technical.

Will you remark further on the bill as amended?

Will you remark further?

REP. FARR: (19th)

Madam Speaker.

DEPUTY SPEAKER POLINSKY:

Representative Farr.

REP. FARR: (19th)

Yes, Madam Speaker, just, through you, a few questions to Representative Courtney. One of my major concerns with the bill is Section 8 on the requirement that anybody admitted to a nursing home has to be evaluated and it's Page 16 of the bill, line 715 and it says that "Without regard to the source of the payment no person shall admitted to any person without a pre-admission screening process which the Department of Mental Health determines based upon an independent physical and mental evaluation performed under the department whether the person is mentally ill."

As I read that, an elderly woman in a hospital with a broken who has no place to go, discharged to the convalescent, can't be admitted until there's an evaluation for her mental illness.

Through you, to Representative Courtney, is that in fact what the process will require that even though

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somebody has an obvious physical infirmity which requires convalescent care, nursing home care, they will still have to be evaluated for mental illness, through you, Madam Speaker, to Representative Courtney.

DEPUTY SPEAKER POLINSKY:

Representative Courtney.

REP. COURTNEY: (56th)

Through you, Madam Speaker, I don't believe that would be the case. I think if the person is incapacitated, that alone would be grounds for admission.

DEPUTY SPEAKER POLINSKY:

Representative Farr.

REP. FARR: (19th)

Thank you. I hope that's the case. I just read the language and it seemed to me rather clear in the language that that was not the case and I just ask you, through you, Madam Speaker, to Representative Courtney, what would the evaluation that's contemplated in that language consist of? Are we talking about a simple letter from a doctor stating that the person is mentally ill or not mentally ill? Can you give us some idea of what is envisioned by that evaluation, through you, Madam Speaker, to Representative Courtney?

DEPUTY SPEAKER POLINSKY:

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Representative Courtney.

REP. COURTNEY: (56th)

Through you, Madam Speaker, I think the evaluation is basically to determine whether or not the person requires the services of a skilled nursing facility or even any active treatment whatsoever, which the terminology which I think you'll see later in the bill because those are the sort of key findings that determine whether or not a home and the state have to develop some kind of alternative, either placement or method of treatment outside of a skilled nursing facility.

Again, I think it's a question of whether or not it's overkill to have someone in the nursing home is the issue that's going to be determined.

REP. FARR: (19th)

Thank you, Madam Speaker. One more time, through you, Madam Speaker, to Representative Courtney. I wondered if you could point out somewhere in the bill where there's some language that might say that it's not necessary in every case to have this evaluation for mental illness. It seems to me that Subsection B states rather clearly that no facility shall admit any person who has not undergone a pre-admission screening based upon a process established by the Department of

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Mental Health, which includes a mental evaluation performed under the department to determine whether the person is mentally. It strike me quite clear in that language that even for those cases of people coming, being discharged from hospitals because of physical illness, that they would still have to be evaluated for mental illness.

If there's some other part of the bill that exempts them, I'd be pleased to see it, through you, Madam Speaker, to Representative Courtney.

REP. COURTNEY: (56th)

Through you, Madam Speaker, as I think a lot of the Members of the Chamber are aware, we have in place in Connecticut a Pre-admissions Screening Program which exists now for all patients going into facilities. Again, this legislation is in response to federal requirements and I feel that given the fact that we already have a program in place which evaluates all patients to determine that the need for skilled nursing facility services, that this is simply adding another component to that screening process that patients who are mentally ill, who are presently in homes are now going to be screened, as the file copy indicates, and also patients coming from wherever, who have problems, mental health problems, where it's been suggested that

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they go to nursing homes, will have to submit to the pre-admission screening process, just like every other patient.

REP. FARR: (19th)

Thank you, Madam Speaker. Just to comment on the bill itself, this is another of those bills that the federal government has imposed its mandates, but, frankly, we probably don't have any choice but to vote for that section of the bill, but I think the members ought to be aware of what it does say.

It says that any person being admitted to a convalescent home has to be evaluated for mental illness, so if you have a constituent who is an elderly constituent who does not have somebody available to care for him at home and he's injured and he's in the hospital and he's discharged to a convalescent home, they're going to find themselves being evaluated for mental illness.

I think that that's an outrageous thing to require. It does that without regard to the source of the funding, so even the person who is a private pay individual, they have to be evaluated for mental illness. I think that that's an absurd approach. I recognize that that decision was apparently made on the federal level, but it's still a bad decision. If we

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had the choice, I would obviously seek to change those provisions. I don't think we have any choice, but I think you may be getting some inquiries later on by people asking why they're being evaluated for mental illness when they're obviously being admitted to a convalescent home because of a physical infirmity.

DEPUTY SPEAKER POLINSKY:

Will you remark further on the bill as amended? Will you remark further? If not, will all members please take their seats. Staff and guests to the well of the House. The machine will be opened.

CLERK:

The House of Representatives is voting by roll call. All members report to the Chamber. The House is voting by roll call. Members to the Chamber please.

DEPUTY SPEAKER POLINSKY:

Have all members voted and is your vote properly recorded? Have all members voted? If all members have voted, the machine will be locked and the Clerk will take a tally.

The Clerk will announce the tally.

CLERK:

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HB7228, as amended by House Amendment
Schedules "A", "B", "D", "E" and "F".

Total Number Voting	145
Necessary for Passage	73
Those voting Yea	145
Those voting Nay	0
Those absent and not Voting	6

DEPUTY SPEAKER POLINSKY:

The bill as amended is passed.

Are there any announcements or Points of Personal
Privilege?

REP. FRANKEL: (121st)

Madam Speaker.

DEPUTY SPEAKER POLINSKY:

Representative Frankel.

REP. FRANKEL: (121st)

Ladies and Gentlemen, Members of the House, it's
our intention to recess the Chamber momentarily for a
Democratic House Caucus. It will be one hour in
length. We will be in Room 2C at the LOC, Democratic
House Caucus, 2C, LOB for one hour.

I would ask the members to please move as rapidly
as they can from the Chamber to the LOB. We intend on
commencing the caucus in precisely ten minutes. We
would ask all members to move along rapidly so we don't

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CONNECTICUT
GEN. ASSEMBLY
SENATE

PROCEEDINGS
1989

VOL. 52
PART 12
8947-4317

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Without objection, so ordered.

THE CLERK:

Calendar Page 3, Calendar 580 and File 465 and 738,
Substitute HB7228, AN ACT CONCERNING ADMISSION TO
CERTAIN NURSING FACILITIES AND PATIENT'S BILL OF
RIGHTS. As amended by House Amendment Schedules "A",
"B", "D", "E" and "F". Favorable Report of the
Committee on APPROPRIATIONS.

SENATOR PRZYBYSZ:

Mr. President.

THE CHAIR:

Senator Przybysz.

SENATOR PRZYBYSZ:

Thank you, Mr. President. I move acceptance of the
Joint Committee's Favorable Report and passage of the
bill in concurrence with the House.

THE CHAIR:

Will you remark?

SENATOR PRZYBYSZ:

Thank you, Mr. President. This bill makes numerous
changes in the law relating to, number one, enforcing
Medicaid standards in nursing facilities, skilled
nursing facilities and intermediate care facilities.
It requires facilities to screen mentally ill and
mentally retarded patients before admitting them and

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annually thereafter.

The bill also expands the patient's bill of rights to make our statute in compliance with Federal law. It requires nursing facilities, chronic disease hospitals and boarding homes for the aged to manage patient accounts.

The bill also changes the allowable reasons under which a nursing facility may transfer or discharge a patient. And it also limits when a chronic disease hospital or boarding home may discharge a patient.

I may add that this bill accomplishes a number of things that we must do to comply with Federal law. And I would wish that the Chamber would adopt it as so described.

THE CHAIR:

Further remarks on the bill? Senator Przybysz.

SENATOR PRZYBYSZ:

If there are no objections, I would move that it be placed on the Consent Calendar.

THE CHAIR:

Without objection, so ordered.

THE CLERK:

Calendar 584, File 652, Substitute HB5739, AN ACT IMPLEMENTING DATA COLLECTION AND DATA REPORTING BY THE COMMISSIONER OF REVENUE SERVICES AS RECOMMENDED BY THE

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amendment by House Amendment Schedules "A" and "D".

The machine is open, please record your vote.

Senator Smith, Senator Avallone, Senator Hale,
Senator Larson. Senator Avallone, Senator Hale.

The machine is closed.

Clerk, please tally the vote.

The result of the vote:

28 Yea

7 Nay

The bill is adopted.

Clerk, please make an announcement for an immediate
roll call on the Consent Calendar.

THE CLERK:

Immediate roll call has been ordered in the Senate
on the Consent Calendar. Will all Senators please
return to the Chamber. Immediate roll call has been
ordered in the Senate on the Consent Calendar. Will
all Senators please return to the Chamber.

THE CHAIR:

Please give your attention to the Clerk who will
read the items that have been referred to the Consent
Calendar. Mr. Clerk.

THE CLERK:

Consent Calendar #1 begins on Calendar Page 1,
Calendar #21, Substitute HB5693. Calendar Page 3,

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Calendar #580, Substitute HB7228. Calendar Page 4,
Calendar #586, Substitute HB7239. Calendar #587,
Substitute 7571. Calendar #589, Substitute HB7445.
Calendar Page 6, Calendar #422, Substitute HB7201.
Calendar Page 10, Calendar #22, Substitute HB5694.
Calendar Page 11, Calendar #243, Substitute SB156.

Mr. President, that completes the First Consent
Calendar.

THE CHAIR:

Are there any changes or omissions?

The machine is open, please record your vote.

Senator Benvenuto. Has everyone voted?

The machine is closed.

Clerk, please tally the vote.

The result of the vote:

36 Yea

0 Nay

The First Consent Calendar is adopted.

Senator O'Leary.

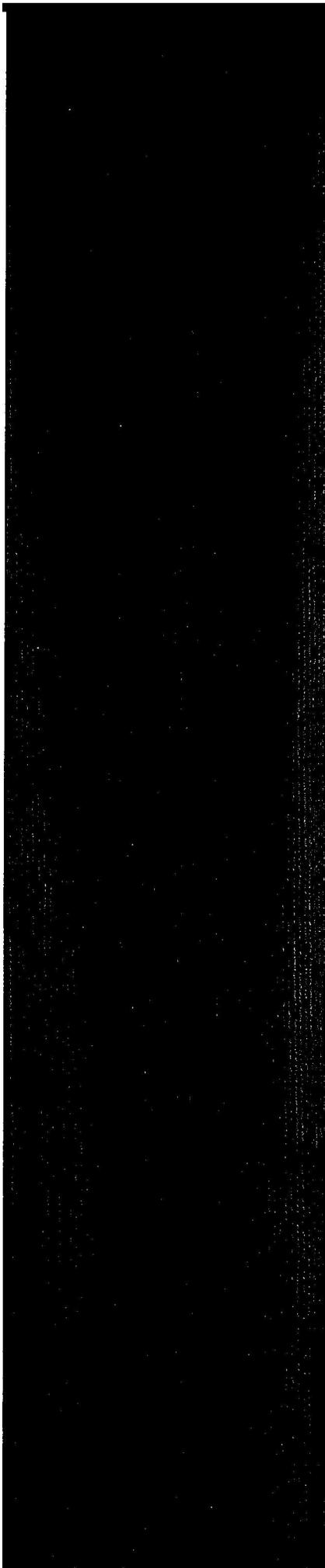
SENATOR O'LEARY:

Mr. President, I move for immediate transmittal of
those items that are going to the House.

THE CHAIR:

Without objection, so ordered.

SENATOR O'LEARY:



recovering from illness or accident injuries. Total care for some of these patients can be required for many years.

The Governor's Task Force recommended increasing funding for nursing staff salaries to address the critical need to provide adequate nursing care. This budget cut could reduce patient care staff by as much as 30%. I believe we have made great strides in improving long-term care for our citizens and there is still room for further improvements.

The bill before you will take a step in the wrong direction. We need to make reductions in the budget before us, but this is not one of the areas that should be cut. Thank you very much.

REP. COURTNEY: Thank you, Representative Conway. Are there any questions? Thank you. Our next speaker is Judy Greiman from the Office of Policy and Management.

JUDY GREIMAN: Senator Przybysz, Representative Courtney, and members of the Committee. My name is Judy Greiman. I'm counsel for the Office of Policy and Management and I'm here today to speak in support of HB7228, AN ACT CONCERNING ADMISSION TO CERTAIN NURSING FACILITIES AND A PATIENT BILL OF RIGHTS.

This bill is part of the Governor's legislative proposals to implement the budget. Funding for Fiscal Year 90, totaling nearly \$3.2 million has been recommended to implement the federal mandates addressed in this bill.

REP. COURTNEY: Excuse me, Judy. Can you maybe move the microphone a little closer. They can't hear you in the back.

JUDY GREIMAN: Failure to implement, is that better? Failure to implement the requirement of the Federal Nursing Home Reform Act could result in the loss of significant Medicaid revenue.

In 1987, Congress passed sweeping legislation to assure the quality of the nation's nursing homes. This legislation requires the states to establish

programs to prescreen admissions to nursing homes, as to determine whether placement is appropriate and to assure that persons with mental illness, mental retardation or relation conditions are not inappropriately placed in them.

In addition, the Federal Nursing Home Reform Act requires the states to establish programs to assure that training and certification of competency of nurses' aids, to protect the rights of nursing home patients, to strengthen procedures to assure the quality of nursing home care and to establish a range of penalties to enforce these provisions.

The State and its nursing home industry can be proud that we've already taken so many steps to insure the quality of nursing home care, and in fact, have served as a model for other states and for this federal act.

The bill before you today makes changes in State statute which are necessary to conform to these new federal requirements. Implementation of these mandates is already well underway. The Departments of Income Maintenance, Mental Health and Mental Retardation have jointly developed the procedures which enabled us to implement preadmission screening of new nursing home admissions as mandated as of January 1, 1989.

These agencies will continue to work together to develop a plan to insure annual review of nursing home residents. The Departments of Mental Health and Mental Retardation have each developed an alternative disposition plan which has been submitted by the Department of Income Maintenance to the health care financing administration to permit the State to delay discharges from nursing homes until suitable alternative placements may be assured.

The Department of Health Services has been developing the procedures necessary to implement various quality assurance provisions for both Medicare and Medicaid and to develop and implement the systems necessary to approve programs for nurse-aide training and certification.

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HUMAN SERVICES

March 14, 1989

In light of the fiscal constraints we face, we have sought to implement nursing home reform in the most cost-effective manner possible. We do have several technical changes to the bill which will strengthen and clarify the language, and I will leave the changes for you and urge your adoption of them. Thank you for your consideration of this bill, and while I am, I'd be pleased to answer questions. Some of the agency representatives could probably answer some of the specific areas of the bill.

REP. COURTNEY: Thank you, Judy. Senator Robertson.

SEN. ROBERTSON: Judy, thank you very, very much. You began your testimony on HB7228 is that you were here representing the Office of Policy and Management, specifically HB7228. It was a bill to implement the Governor's budget.

I don't know if there are other speakers from the Office of Policy and Management, but seeing that you're here to speak on behalf of the bill, on behalf of the Governor, could you possibly respond to HB7227. Is the lack of your response representing OPM not to speak on HB7227 indication that the Governor has decided to withdraw the bill?

JUDY GREIMAN: No, it is not an indication.

SEN. ROBERTSON: Are you prepared to speak on HB7227 representing the Governor's office?

JUDY GREIMAN: I am not.

SEN. ROBERTSON: Thank you.

REP. COURTNEY: Are there any other questions. Thank you, Judy. The next speaker is Lorraine Aronson, Commissioner of the Department of Income Maintenance.

HB7227

COMM. LORRAINE ARONSON: The Committee have the testimony? The Committee should have the testimony. Do you have it? Well, it would be a big help, because there are some numbers that I want to go through with you that are in the testimony. Where is it? Okay.

Good afternoon, Senator Przybysz, Representative Courtney and members of the Committee. I'm Lorraine Aronson, Commissioner of the Department of Income Maintenance. I'm here today to testify in support of HB7227.

I also strongly urge your approval of HB7228. My written testimony, which you will have shortly, addresses this and several of the other bills that are before you today, but I would like to spend my allotted time addressing the Governor's proposal for controlling the increase in long-term care costs.

To fully appreciate the gravity of the choices the Governor faced in proposing this bill, I think it's important to place the bill and the issues related to it in the context of the overall budget of the Department of Income Maintenance.

As a newcomer to the Department, I have to tell you that I am struck when I look at our budget by one thing above all else, and that is, that while we are thought of as a welfare agency, most of our money is not spent on poor families. Less than 18% of our budget goes for cash benefits to the typical welfare mother with children. Less than 4% of our expenditure goes to reimburse towns and cities for local welfare benefits to poor single men and women.

Medical assistance - Costs

If such a small proportion of our budget goes to the traditional welfare recipient, where does most of our money go? The answer is, our medical assistance program. Medical assistance makes up more than 61% of our entire budget, and if you'll look at the chart on page 2 of the testimony, you will also see that nearly 61% of our medical assistance budget goes to pay for the care provided to the elderly or disabled who are living in nursing homes or chronic disease hospitals.

In short, medical assistance is the lion's share of our budget and long-term care is the lion's share of our medical assistance budget.

Not only do most of the dollars go for the care of a relatively small proportion of our client caseload, but the rate of increase in the cost of

that care has grown tremendously. While nursing home expenditures represented 29% of our 1984 overall budget, we expect that they will make up nearly 39% of our expenditures in 1990, and that is even with the cost-containment measures proposed by the Governor.

Long-term care expenses are the fastest growing component of medical assistance. And if you will look at the chart on the bottom of page 3, you will see the picture of how those long-term care expenditures has grown since 1985.

Some of this growth is accounted for by sheer demographics. Our elderly population is increasing. However, much of the expenditure growth is attributable to cost increases that outstrip both the standard consumer price index and the CPI for medical care. That is depicted on the chart on page 4.

The average Medicaid payment for a nursing home resident has jumped from about \$40 a day in 1984 to about \$71 a day currently, an increase of 75% over five years. Currently, we are spending \$491 million on nursing home care. That's more than 50% increase since 1986.

I also want to mention to you that when we will be speaking to the Appropriations Committee shortly about our deficiency budget, this overall trend is a significant contributor to the deficiency that we will have to bring to this Body to cover costs for the current year.

When you analyze these trends, I think it's clear why we felt we had no choice but to seek to control the cost growth in this area. This has been a difficult decision to make, but to try to contain costs statewide while overlooking such a large cost item is simply not appropriate.

The proposed cost containment system has three components: adjustment to certain rate setting elements, a special fund for hardship relief and controls on the growth rate of nursing pool costs.

RACHEL DONOVAN: I -- speaking for myself and some people I know, I can't speak for pool nurses in general, I don't think, but the wages are higher, although there aren't benefits, but those of us who are lucky enough to have a spouse who has benefits can afford to do that. Many people cannot afford to work for a pool for that reason. The wages are better. It's very flexible. You can work more hours one week, less the next, so it does meet those needs.

SEN. MORTON: Thank you. I just wanted that on the record.

REP. COURTNEY: Thank you, Senator, and thank you, Rachel. Our next speaker is Dick Goodman, who I think has a friend with him. Five minutes, guys.

ATTY. RICHARD GOODMAN: We'll sure try. Senator Przybysz, Representative Courtney, Members of the Human Services Committee, I'm Attorney Richard Goodman, registered Lobbyist for the Connecticut Association of Health Care Facilities, which represents 182 of the 300 nursing homes, primarily propriety homes in the state. It's about two-thirds of the skilled and intermediate care beds in the state.

With me is Michael Lipnicki. Mike is CPA with Anquillare, Saas, and Lipnicki in West Haven. They represent a large portion of the both profits and non-profits in the state. I think he can answer a lot of the questions that you might have.

I'm here basically to speak in opposition to HB7227 and to try and set out, as quick as I can, and I'll try and beat the five minutes, the industry position and give you some facts and figures. Later on you're going to hear from some individual nursing home owners as to the specific effects on their homes.

Before I get on to HB7227, just very briefly. We are in opposition to HB7228. You will hear a couple of speakers later. I know one, Martha Meng. Basically part of it is mandated, but as usual, the State of Connecticut wants to be early to do the mandates as soon as possible before the federal

ROBERT SHEPARD: Well, we went from approximately one patient, one Medicare patient a day to an average of maybe 14 or 15 Medicare patients a day now.

REP. MAZZOTTA: You went from --?

ROBERT SHEPARD: One, that's going back like a year and a half because these changes, you started in the middle of 1988, but the real cost changes did not begin until January 1 of this year.

REP. MAZZOTTA: Okay, thank you.

SEN. PRZYBYSZ: Thank you, Mr. Shepard. The next person is Lauchlin McLean followed by Carroll Huges and Joan Achille.

LAUHLIN MCLEAN: Mr. Chairman and Members of the Committee, I am Lauchlin McLean from West Hartford and I'm speaking as a volunteer representative AARP in Connecticut in support of HB7228. The bill, as you list it, to deal with admissions and discharges from certain nursing facilities and a patients' bill of rights.

We right up front want to say that we acknowledge that there are many, many fine nursing homes and operators in the State of Connecticut. Nevertheless, it is clear that there are problems that need to be addressed and corrected which affect the care of patients and residents of some of our nursing homes.

The existence of these problems in Connecticut is substantiated by a number of federal reports and by reference to the annual report of the Connecticut State Ombudsman. Responding to these conditions, not only in Connecticut, but nationwide, federal legislation was passed in 1987 which in turn requires Connecticut state legislation to strengthen nursing home licensing and regulatory laws and particularly to enact sanctions which are alternative and intermediate to Medicaid decertification.

HB7228 was introduced by the Senate and House leadership. It is designed to safeguard nursing home patients and residents on admission and

discharge, to strengthen the existing statutory bill of rights for them and to provide the Department of Income Maintenance with strengthened intermediate remedies in case of non-compliance with Medicaid requirements.

I won't go into detail about the provisions of the bill because the Office of Policy and Management representative has already reviewed it for you. I would like, if I might be indulged, to also ask the Committee Members, as individuals, to support Raised HB7239, which is now pending in the Public Health Committee. It relates to the licensing functions of the Department of Health Services. It improves the licensing process for nursing homes and is a necessary part of a package to fully implement the 1987 federal legislative mandates designed to safeguard the health, safety and quality of life of nursing home patients. Without it, as well as HB7228, there will still be recognized gaps in the network of regulation and safeguards.

In summary, the American Association of Retired Persons in Connecticut ask the committee to approve HB7228, which is before you and asks you as individual members of the legislature, to support Raised HB7238, which is before the Public Health Committee. The enactment of these two bills into law not only is required by federal legislation, but more importantly, will go a long way toward securing the health, safety and quality of life for nursing home patients and residents in Connecticut.

REP. COURTNEY: Thank you, Mr. McLean. Are there any questions? Thank you. Our next speaker is Carroll Hughes followed by Joan Achille.

CARROLL HUGHES: Thank you, Chairman Courtney and Chairman Przybysz and Members of the Human Services Committee. My name is Carroll Hughes. I represent the Connecticut Home Health Services and Staffing Association. I would like to speak in regard to HB7227, particularly Section 4 of that bill, which purports to regulate the nurse pools in the State of Connecticut.

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When that individual runs out of their Medicare days, now, then we have to restart back on the Medicaid program. That may take "x" number of days, weeks or months once again.

It's conceivable that we could carry some of these people almost a year now, on the way this game is being played with deliberate balance sheet manipulation by the federal and state agencies and we, the providers, cannot carry this kind of money without adding dramatically to the cost of our care. It makes no sense and we cannot do it.

REP. BOLSTER: Once you get a patient on to Medicaid, I mean, you know, you've gone through this and the state has acknowledged another person is going to be -- or you're going to be reimbursed through Medicaid, how long does it take you to get your reimbursements? Do you have any idea?

ED KILBY: From --?

REP. BOLSTER: Medicaid?

ED KILBY: Medicaid. It depends -- it runs literally from a relatively short period of time to months and months and months and months and I would be happy to research it and provide the committee with that information. I don't have the detail. I would be happy to try and dig out what I could.

REP. BOLSTER: Thank you.

REP. COURTNEY: Any other questions from the committee? Thank you, Mr. Kilby. Our next speaker is Joe Sands followed by August Love.

ATTY. JEFF SANDS: Good evening, Members of the Committee. My name is Jeff Sands, not Joe Sands, that's okay. At this time of the night I really don't know what my name is, but bear with me. My name is Jeff Sands. I'm an attorney with the firm of Wiggin & Dana. I also happen to be the counsel for the Connecticut Association of non-profit facilities for the aged.

HB 7228

HB 7227

I wanted to speak very briefly to you on two bills, HB7228 and HB7227. First, with respect to HB7228. I think it's interest to look at this bill. First, to my knowledge, and I think I'd know, the industry wasn't consulted at all in connection with the drafting of HB7228 and it's a bill which is supposed to concern admission to certain nursing facilities and increase the patient's bill or rights.

The purported purpose of the bill is to implement under state law certain provisions that were passed under the Medicare law, OBRA, back in 1987. I have written testimony and I won't go into all the details, but you'll find two things, I think, when you look at HB7228. First, a number of the provisions that are included in this bill are not mandated by federal law to go into effect until October 1990. Now there's a good reason for waiting to implement those in the state law, which is, number one, HCFA has said that they will put out regulations explaining their legislation a little clearer, number one, and number two, there are changes to certain areas that have been proposed.

For example, last year we struggled in Connecticut with a bill concerning nursing homes having responsible parties or relatives for residents guaranteeing the payment and after a long struggle Connecticut passed a law that said you can't do that except in two circumstances, one, where there's been fraud, or, two, where the relative has deliberately transferred the assets away and you really should go after them.

The federal law makes no such exception, although Congress -- there has been a bill introduced to make such an exemption under federal law. If HB7228 goes through as it is, it negates all the work we did last year on that responsible party contract. I could have pointed that out in one second. Again, I hear an echoing theme through here which is why don't we work together on some of these things. So that's one example of why we ought to wait on some of this stuff that doesn't have to go into effect until 1990.

The other thing that makes a point that Ed Kilby made just one minute ago, and I'll just talk to you about one section of the bill because there are some things that need to be in place by October 1989 and one of them is a hearing process for involuntary transfer of nursing home patients. It's a little different than all the money things we've been talking about before. Basically, what has happened in other states is patients, there were no protections as we have in Connecticut and patients were transferred in the middle of the night if they turned from private pay to Medicaid. That's the story anyhow.

Well, in Connecticut we have very specific laws on when you can transfer a patient and for an involuntary transfer, you can only do it really in three circumstances. One, is if they're a danger to themselves or others. Two, is if you can no longer through a medical, you have to document this, but you can no longer provide the level of care that the patient requires, or, three, if it's a private pay patient, they haven't paid the bill for 15 days, but any of those three cases, unless it's an emergency, you have to give the patient 30 days notice, involve his family and involve his physician.

What this bills does is sets up what's called a hearing process over and above what we already have here, a hearing process for involuntary transfers and provides that in the case of an involuntary transfer, remember, it's only for those three reasons and you've already had to give 30 days notice, the patient can request a hearing from the Department of Health Services. There are absolutely no time limits on that hearing. It doesn't say when you have to ask for the hearing. It doesn't say how long the department has to decide it. It doesn't say what the appeal mechanisms are, but it does say clearly that during the dependency of that process, whatever it is, and we don't know, the nursing home has to keep the patient, no exceptions, it doesn't make much sense if you can't give them the level of care they require or they're a danger to themselves or others and if it's a 15 day non-payment, you've already

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had to give them 30 days so they've had a free ride for 45fd and under the hearing process, why not a little longer. It just doesn't make sense.

We have talked to OPM. Martha Meng, who's an attorney for the for-profit association and I managed to catch them in the hallway. They've agreed to sit down with us and work on some of these sections, but it shows what kind of inane regulation can come out, well meaning, but can have a drastic impact on facilities that aren't able to transfer patients who either don't pay the bills, or even in a worse situation, can't be cared for because of the level of care restrictions in the facility. I have written testimony on that bill. We will work it out and they've agreed to meet within the next seven days to do that. We know you're under a tight time frame.

(cass 4)

Turning to HB7227, what else can you say? I think a lot of things have been said already and in some respects I kind of think I am sitting in Alice in Wonderland's world because things get curiouser and curiouser. I have heard today, that despite all the numbers you have seen, and I think they are mostly verifiable to use a Government term, we are only going through a dislocation here.

I don't know exactly what a dislocation is, but to me it's a serious situation. It's not a dislocation. I also heard that this isn't a cut. This HB7227 doesn't represent a cut. And if you look at DIM's own budget you will see that their predicted increase in costs for nursing homes, costs for nursing homes are between 12% and 13% for SNIF and ICF. You heard Marvin Freed and others testify that their experiences, their costs went up last year about 16% and what we are seeing is a budget that only proposes an increase of 2%, 2.5% to nursing homes. I think you call that a cut. I don't think you can call that anything but a cut. If your expenses have gone up to that extent and you are only getting 2% I think it's a cut.

I want to take one second and this will sum up my testimony. Not many people have talked about the 6 provisions in any exclusive detail and I just want to tell you that I was involved as well as one of

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will not allow state checks to be attached which also inhibits the normal legal channels available to creditors.

I hope this testimony will shed further light on the charges of excessive profits realized by supplemental staffing agencies. And I thank you for the opportunity to speak to you.

SEN. PRZYBYSZ: Thank you. Any questions? Thank you. Is Martin Sbriglio here please? Followed by Kim Czeipga followed by Herbert Ausubel from Smith House.

MARTIN SBRIGLIO: Hi, I am Martin Sbriglio. I will make it simple. I am opposed to the HB7227 and HB7228. But I am also here because Reverend Benson, who was supposed to speak today had to leave early. He wanted me to submit a petition that was done by the Methodist Home in Shelton, neighbors of mine and the petition was drafted and circulated throughout Fairfield County to many of the Methodist organizations, churches, the Baldwin Center in Stratford, mostly non-profits, of course, church organizations are non-profit.

So this bill basically stipulates that we are against HB7227, HB7228 and that we not only are against it, but we certainly need more dollars to strengthen the disallowances we have experienced. There were some comments made before, though, that I want to clarify. One of the comments was that maybe the nursing homes are playing games with the money when we don't pay nursing pools for 4 or 5 months. Well, when you hear about nursing homes losing money, we have to slow down paying our bills otherwise we don't meet payroll. Obviously we have to delay payment. I mean, you can't experience a few hundred thousand, in some case a few million dollars in losses and pay your bill everyday.

You have to wait til your fiscal year ends or wait until you have a little extra cash and your bills trickle out. It's very basic. It's very easy to understand.

As far as other comments made about nursing pools. Why we don't send out bids out to nursing pools. Well, you sign a contract with a nursing pool it's

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not like signing a contract with an oil company. You sign a contract with an oil company they guarantee you oil for all of your needs for the whole year. You sign a contract with a nursing pool, are they going to guarantee to fill every slot, every vacancy you have? Impossible. We have 8 nursing pools we contact and we go down the list. There is a vacancy we call one, they say no, we can't fill it, we go to the next, and we go to the next and we go to the next. And if we don't fill the slot, well, if you read HB7228, we may be subject to \$10,000 a day penalties, HB7239, Public Health Committee heard two weeks ago, we may be subject to \$100,000 penalty. We are looking at very serious penalties for not filling these slots.

So, no, sending out to bid to a nursing pool is not always the solution. But I do want to clarify that we are doing that. Continuum Organization in Wallingford is getting all the nursing pools around the State and they have sent me a form and it is a bid system, so yes, we are doing that.

But, on how to save money? It was discussed. Donald Trump could go on Medicaid in this State. Donald Trump lives in Greenwich, so it's not too farfetched. He could transfer all his billions of dollars below market value and within two years and four months go on Medicaid assistance. I mean, you want to save money, let's open our eyes and look around. The options are there. Why DIM didn't propose that? Good question. Why didn't the OPM propose it? I don't know.

But if you are going to expand the give away program. If you are actually going to give millions of dollars to people that don't need it, how can you complain about the cost? I don't know. Well, anyway, you got my message and thank you for those of you who lasted this long, thank you.

SEN. PRZYBYSZ: We thank you Martin.

REP. BOLSTER: Just one question. (Inaudible) Senator, he stayed just as long as we have and it gets very tiresome standing outside a public hearing. It's nice to see you again. I don't understand this. I

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As I said these kinds of units are operating in other states. They appear to be doing well. We think there is a great need in Connecticut and Miss Kennedy has devoted a great deal of time to attempting to getting a demonstration project in this State off the ground. We would really like to see it happen. I would be happy to try and answer any questions, or Catherine can answer them later if you would like.

REP. COURTNEY: Thank you Miss Meng. Are there any questions from the Committee? Thank you.

ATTY. MARTHA EVERETT MENG: I have another client on HB7228.

REP. COURTNEY: I actually read your...I got a copy of this this morning and I have had a chance to read it through and I would just ask that you please summarize.

ATTY. MARTHA EVERETT MENG: I will be very, very brief.

REP. COURTNEY: It sounds like it is off Attorney Sands' comments.

ATTY. MARTHA EVERETT MENG: It will be similar. There is only one provision, Section 1H of the entire sections 1 through 5 that needs to be implemented this year. 7 through 9, 10 and 11, I have given you our redraft of the bill. I have redrafted what we would like to see and it is attached to the written testimony that has been given to you. We will be meeting with Income Maintenance and with Counsel to try to resolve this, but I don't want to indicate that we don't take it very, very seriously.

Some reference was made earlier to intermediate sanctions on this bill. They are not intermediate sanctions. The kinds of sanctions we are talking about are the kind that put people out of business. They are per diem fines at a level that will result in a facility closing, limitation on admission, receiverships, all the things that force discharges, all the things that generally result in a facilities' going under. So these are serious matters that we are talking about. We take them

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seriously and we hope that we can work something out with the Department.

Very briefly, on HB7485, which the industry has not had a chance to respond to, Mr. Wells from 1199, testified that somehow this is just implementing something that has already been on the books, if I understood his testimony correctly. That's not correct. Lines 41 through 43, excuse me, 43 through 45 of that bill, would require a lifting of the cap only for labor costs imposed by collective bargaining agreements, that's what it says. The Connecticut Association of Health Care Facilities feels that that is very discriminatory and unfair to have that kind of a pass through only for those facilities where there is union representation and not a lifting of the cap, generally. Which of course we would support.

REP. COURTNEY: Thank you. Attorney Sands indicated that they will be meeting with OPM as well as,

ATTY. MARTHA EVERETT MENG: Yes, we will all be meeting and we will try very hard to work this out. It's difficult because the federal government has not given clear guidelines as to how this should be implemented. But we are very, very concerned about many of the provisions.

REP. COURTNEY: Get back to us. Okay. Robert Jones.

ROBERT JONES: Thank you. Mr. Chairman and members of the Committee, my name is Robert Jones, I'm a Certified Public Accountant. At the moment I represent approximately 35 to 40 facilities. I've had 12 years of experience in the health care field and have been a consultant to facilities for a major period of that time. Prior to that I was with Ernst and Whinney, and was responsible for about 160 nursing home wards. I am intimately familiar with the reimbursement system. Based on my reading of bill HB7227, the bill would be an unmitigated disaster for the entire industry just based on pure mathematics.

Forget about the savings of a hundred million dollars, the system itself is totally mathematically flawed as it exists today. HB7227 will make the mathematical flaws in the system so

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WIGGIN & DANA

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TESTIMONY OF JEFFREY SANDS ON BEHALF OF
THE CONNECTICUT ASSOCIATION FOR NON-PROFIT FACILITIES
FOR THE AGED REGARDING BILL NUMBER 7228

AN ACT CONCERNING ADMISSION TO CERTAIN NURSING
FACILITIES AND A PATIENTS' BILL OF RIGHTS

We at the Connecticut Association for Non-Profit Facilities for the Aged ("CANPFA") urge the Committee to reject Bill Number 7228 in its present form since, in our view, it is premature, unworkable and imposes burdens on nursing facilities which are unjustifiable.

The Department of Income Maintenance has indicated that this Bill is necessary to implement recent changes in federal Medicare Law created by the Omnibus Budget Reconciliation Act of 1987 ("OBRA"). The statement of purpose attached to the Bill indicates that the purpose is to implement the Governor's budget. Neither of these purposes is met in this legislation.

Most of the provisions of OBRA which relate to patient care do not have to be implemented by the State of Connecticut until October 1, 1990. We believe it is premature to act on these provisions in this legislative session. We understand that the federal government will be promulgating regulations which will clarify the various provisions of OBRA and, in some cases, changes to some of these requirements have been proposed in Congress. It seems to us better to wait until these situations are clarified before moving forward on these provisions.

We do recognize that there are three areas which need to be acted on immediately since OBRA requires the State to implement certain provisions by October 1, 1989. These provisions are discussed below:

1. Hearing Process for Involuntary Transfers. Under OBRA the State must implement an appeals process for patients subject to involuntary transfer or discharge from a nursing home.

The appeals process set forth in Section 1(h) of Bill 7228 provides only that a patient being involuntarily transferred or discharged has a right to appeal such decision to the Department of Health Services and that a UAPA type hearing must be held in such regard. The proposed bill also provides that a nursing home can take no action to transfer or discharge the patient pending the outcome of such hearing.

Under present Connecticut law, involuntary transfers of nursing home patients can only be made in situations where the resident either 1) no longer requires the level of care being provided by the facility; 2) continued residency in the facility poses a danger to the patient or to others; or 3) in the case of a private pay patient, failure to pay for 15 days. Connecticut law also currently requires that 30 day notice be given to a patient, the patient's family and physician in the case of any such involuntary transfer.

The hearing process being proposed in Bill 7227 provides no time limits with respect to the appeal and specifically requires that the nursing facility not transfer or discharge a patient during the pendency of the hearing process. Obviously, in any of the three circumstances described above where involuntary transfers are permitted, the result of a lengthy hearing process could be disastrous. In a situation where the health of the patient or the health or safety of other patients is endangered, there clearly should be an ability on the part of the nursing home to immediately discharge the patient subject to readmission if it is ultimately determined that the decision to transfer was inappropriate. In the case of a patient who no longer requires the level of care being provided, the facility will be at risk in terms of collecting Medicare or Medicaid payment for the patient if it is subsequently determined that the patient, while the hearing was pending, did not require the level of care provided at the facility.

Finally, in the case of private pay patient, since the 15 day non-payment must take place prior to the 30 day notice, a patient in this position has already spent 45 days in the facility without payment and presumably, would be smart enough to request a hearing and extend the period of occupancy without payment even longer.

Accordingly, we recommend that the bill be amended to provide an exemption from the provision that requires a facility to keep a patient pending a hearing where the reason for discharge is the health of the patient or the health and safety of other patients.

We also suggest that a very short time frame be established for the appeals process and that it be clarified that the resident need only be maintained at the facility until the original decision is made by the Health Department not pending any subsequent appeals.



STATE OF CONNECTICUT

OFFICE OF POLICY AND MANAGEMENT

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MEMORANDUM

March 14, 1989

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TO: Senator Kenneth L. Przybysz
Representative Joseph Courtney
C-24-1
Human Services Committee

FROM: Judith B. Greiman, Counsel/Executive Advisor *JBG*

SUBJECT: HB 7228 - An Act Concerning Admission to Certain
Nursing Facilities and A Patient's Bill of Rights

Attached is an amendment to the above referenced bill for your consideration. It is mostly technical in nature but also addresses some of the concerns that the industry has with this bill. In addition to the changes listed, please change all references to "patient" to "resident" and all references to "mentally retarded" to "who has mental retardation". These changes will make the language consistent with the federal statute and other state statutes.

Attachment

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FREDERICK A. THOMAS
GAYLE M. WATTERWORTH

RE: BILL NO. 7228

WRITTEN TESTIMONY OF MARTHA EVERETT MENG, ESQ., MURTHA, CULLINA, RICHTER AND PINNEY, ON BEHALF OF THE CONNECTICUT ASSOCIATION OF HEALTH CARE FACILITIES, INC.

My name is Martha Everett Meng. I am an attorney with Murtha, Cullina, Richter and Pinney, counsel to the Connecticut Association of Health Care Facilities, Inc. ("CAHCF").

CAHCF opposes Bill No. 7228 in its present form. This Bill in general incorporates as state law or implements the requirements of the federal nursing home reform provisions of the 1987 Omnibus Budget Reconciliation Act, P.L. 100-203 (the "1987 OBRA"). This law, enacted by Congress in December, 1987, constitutes the most far-reaching changes in federal law governing the nursing home industry since the Social Security Amendments of 1965. Its requirements are phased in beginning during the period from January 1, 1989 through October 1, 1990.

Bill No. 7228 is acceptable insofar as it accurately implements federal OBRA requirements. However, in many respects the Bill's provisions exceed these requirements or implement them inaccurately or inappropriately.

1. Changes in the Patients' Bill of Rights.

The only part of Sections 1 through 5 of the Bill that the State must enact prior to October 1, 1989 is section 1(h). Sections 1, 4, and 5 of the Bill generally incorporate as state law the expanded patients' rights provisions of the 1987 OBRA. Under OBRA, these changes are not effective until October 1, 1990. Bill No. 7228, however, would make these provisions effective in Connecticut as of October 1, 1989. We anticipate that many of these provisions will be clarified by federal regulation during

the next 18 months and that some may be amended by Congress during that time. In addition, there are costs to nursing homes attached to implementation of these expanded rights. In this time of severe budgetary constraints, we can perceive no justification for the premature implementation of these provisions.

Sections 2 and 3 of Bill No. 7228 apply some of the OBRA patients' rights provisions to homes for the aged and chronic disease hospitals. Under federal law, these provisions do not apply to homes for the aged or chronic disease hospitals. Again, in this time of rate-cutting, we see no reason why such institutions should be required to incur the additional cost of implementing these changes when they are not required by federal law.

2. Appeals Process for Involuntary Transfers and Discharges.

The only part of sections 1 through 5 of the Bill that the State must have in place by October 1, 1989 is an appeals process for involuntary transfers and discharges from nursing homes, which appears in section 1(h) of the Bill. Connecticut law already specifies the limited circumstances under which such transfers or discharges can occur; in general, they are permissible only when the health, safety or welfare of the patient or other patients is endangered, or for non-payment. As proposed, section 1(h) of the Bill is severely flawed and its requirements are unclear. For example, even though such transfers and discharges are usually of an urgent nature, the Bill as proposed fails to set a timetable for the appeal process, which could delay the transfer or discharge indefinitely. In addition, the Bill appears to require the nursing home, but not the patient, to abide by the decision of the department of health services, i.e., the patient could take a further appeal but the nursing home could not.

Finally, the Bill as proposed makes no provision for exceptions to the hearing process when the transfer or discharge is immediately required. For example, in a recent case, a nursing home needed to effect an involuntary transfer of a male patient who was attempting to sexually molest elderly, confused female patients (ripping off clothing, fondling breasts and genitals). The patient could have been transferred to a nursing home in another town that had an all-male wing available; however, the family objected to the transfer. Under section 1(h) of the Bill as proposed, if the family had appealed, the transfer could have been delayed indefinitely, at grave risk to female patients in the facility.

Although involuntary transfers and discharges are rare, when they do occur they usually are urgently required. We believe that any appeals process should be brief, clear and unambiguous and that the decision of the Department of Health Services should be final with respect to all parties. Proposed wording is set forth in the suggested substitute Bill attached hereto.

3. Department of Income Maintenance Enforcement Remedies.

Sections 6 through 9 of the Bill implement State enforcement remedies for failure to comply with federal regulations governing nursing home operations that must be in place by October 1, 1989. Bill No. 7228 goes beyond the federal requirements in several respects; in addition, the appeals process as proposed is defective.

a. Civil Penalties. Under OBRA, the State must have in place a variety of enforcement remedies, including termination of the facility's Medicaid provider agreement, limitations on new admissions, the appointment of a temporary manager, *i.e.*, a receiver, and civil penalties. Bill No. 7228 proposes civil penalties ranging from \$3,250 to \$10,000 per day for failure to comply with a "Condition of Participation." ("Conditions" are broadly stated federal standards governing nursing home operations.)

These penalties could be imposed in addition to other remedies and in addition to existing civil penalties that maybe enforced under state law by the Department of Health Services. The imposition of penalties in the amounts proposed in the Bill will virtually ensure the closing of any facility against which they are levied. Federal law does not specify the amount of the penalty and we believe that the amounts proposed in Bill No. 7228 far exceed any amounts that have been suggested as appropriate by the federal government. Suggested substitute Bill No. 7228 sets forth amounts we believe would be in accordance with federal guidelines.

b. Temporary Managers. OBRA requires the State to have in place authority to appoint a temporary manager, *i.e.*, a receiver. The Department of Health Services already has this authority pursuant to general statutes §19a-541 et seq. CAHCF believes that these existing provisions meet OBRA requirements. However, if additional authority is to be given to the Department of Income Maintenance, the statute as a minimum must specify that any temporary manager must operate under the supervision and direction of the Department and in accordance with the limitations on the powers of a receiver already set forth under Connecticut law. Bill No. 7228 imposes no such restraints and may therefore be subject to constitutional challenge. Alternative wording is set forth in the attached suggested substitute Bill.

c. Hearings and Appeals. The enforcement remedies set forth in Sections 6 through 9 of the Bill, if imposed, will in most instances lead to the closing of the facility. Therefore, due process must be accorded any nursing home subject to any such remedy. The process set forth in Section 9 of the Bill is constitutionally inadequate. Except in extreme emergency, no penalty should be imposed prior to a hearing. An opportunity for further appeal must be given. By law, whether a penalty could be

imposed pending further appeal would be decided by the court. Finally, fairness requires that an independent hearing officer who is not an employee of any state agency hear such cases. The Department of Health Services already uses independent hearing officers in cases involving suspension or revocation of a license. Because of the similarly severe consequences of action by the Department of Income Maintenance in these cases, comparable neutrality on the part of the administrative official is essential. Substitute Bill No. 7228 sets forth a revised appeals process. CAHCF further recommends that, because of the nature of these provisions, Sections 6 through 9 of the Bill should be referred to the Judiciary Committee.

4. Preadmission Screening and Annual Review of Mentally Ill and Mentally Retarded Applicants and Residents.

Section 10 and 11 of Bill No. 7228 implement OBRA requirements regarding preadmission screening and annual review of mentally ill and mentally retarded applicants and residents. The purpose of the federal requirements is to ensure that persons with these conditions who need active treatment receive such treatment and are not simply "warehoused" in nursing homes.

a. Transfer and Discharge. Sections 10 and 11 are defective and do not meet federal requirements because they delegate to nursing homes matters that, by federal law, are the responsibility of the State. OBRA requires that, if the placement is inappropriate, the State must arrange for a safe and orderly transfer or discharge of the resident and must "prepare and orient" the resident. Bill No. 7228 requires the nursing home to arrange for transfer or discharge. This is an improper delegation by the State; moreover, as a practical matter, the nursing homes by themselves will not be able to make suitable arrangements in such cases. Federal law requires the appropriate state agency to make such arrangements and the agencies are best suited to do so.

b. Active Treatment. Pursuant to OBRA provisions, under certain circumstances, mentally ill and mentally retarded patients who need active treatment may remain in nursing homes. However, OBRA requires the State to arrange and pay for such treatment. "Active treatment," as defined in federal regulations, is both difficult to provide and expensive. It is not available in most nursing homes. Bill No. 7228 is unclear as to how such treatment will be provided or who will pay for it. Again, requiring nursing homes to arrange for and absorb the cost of such treatment is inconsistent Federal law. Proposed substitute Bill No. 7228 clarifies the duties of state agencies in this regard.

c. Screening Forms. Bill No. 7228 implements an "identification screening" process that must be completed for all nursing home applicants and residents to identify applicants and residents who are mentally ill or mentally retarded. If any applicant or resident is diagnosed as mentally ill or mentally retarded as a

result of the "identification screening," further screening is required. As part of the "identification screening" process, the personal physician of the applicant or resident must complete a diagnostic form. It is not clear whether this extensive "identification screening" is required under OBRA. However, it is clear that Bill No. 7228 exceeds OBRA requirements by mandating that nursing homes "ensure" that personal physicians complete the forms. The forms, already in use with respect to applicants, are lengthy, and physicians are not paid for completing them. As a practical matter, nursing homes cannot ensure that personal physicians complete these forms. If this State wishes to require them, it should also directly require physicians to complete them.

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Statement by Lauchlin H. McLean on Behalf of the AARP in Connecticut
Presented to the Human Services Committee of the General Assembly
March 14, 1989

THE NEED TO STRENGTHEN NURSING HOME REGULATION & OMBUDSMAN PROGRAM

Even though there are many fine nursing homes and operators in Connecticut, it is clear there are problems that need to be addressed and corrected which affect the care of patients and residents of some of our nursing homes. The problems generally relate to:

- ° Abuse, neglect, and quality of life of patients and residents,
- ° Financial abuse of patients and residents,
- ° Qualification and financial stability of operators,
- ° Compliance with public health and safety codes,
- ° Levels, quality and training of staff.

The existence of these problems in Connecticut is substantiated by:

- ° A report of surveys of such facilities made in 1987 and 1988 by the federal Health Care Financing Administration (See Exhibit 1 attached),
- ° A federal General Accounting Office Report in 1987,
- ° Conclusions reached in an information paper prepared by the staff of the Committee On Aging of the United States Senate in 1986,
- ° Annual reports of the Connecticut State Ombudsman,

Responding to these conditions nationwide, federal legislation was passed in 1987 which in turn requires Connecticut State legislation to strengthen nursing home licensing and regulatory laws and particularly to enact sanctions which are alternative and intermediate to Medicaid decertification.

THE CONNECTICUT AARP SUPPORTS BILL NO. 7228
AND URGES COMMITTEE APPROVAL

Bill No. 7228 was introduced by Senate and House leadership. It is designed to safeguard nursing home patients and residents on admission and discharge, to strengthen the existing statutory Bill of Rights for them, and to provide the Department Of Income Maintenance with strengthened intermediate remedies in case of non-compliance with Medicaid requirements.

Bill No. 7228 covers the following matters:

- ° It keys standards for admission and discharge to the patient's welfare and calls attention to the availability of State Ombudsman aid,
- ° It substantially expands upon the patient's bill of rights presently found in our statutes: choice of physician, grievance procedures, freedom from corporal punishment, right to file complaints with the Departments of Aging and Health Services, rights concerning the management of personal funds etc.,
- ° It provides that the Department of Income Maintenance may appoint temporary managers and may impose other intermediate

TESTIMONY ON HB 7228

AN ACT CONCERNING ADMISSION TO CERTAIN
NURSING FACILITIES AND A PATIENT'S BILL OF RIGHTS 1301

by

Judith Greiman
Office of Policy and Management

Members of the Human Services Committee:

My name is Judith Greiman, Counsel for the Office of Policy and Management, and I am here today to speak in support of HB 7228, An Act Concerning Admission to Certain Nursing Facilities and a Patient's Bill of Rights.

This bill is part of the Governor's legislative proposals necessary to implement the Budget. Funding for FY90 totalling nearly \$3.2 million has been recommended to implement the federal mandates addressed in this bill. Failure to implement the requirements of the federal Nursing Home Reform Act could result in the loss of significant Medicaid revenue.

In 1987, Congress passed sweeping legislation to assure the quality of the nation's nursing homes. This legislation requires states to establish programs to prescreen admissions to nursing homes to determine whether placement is appropriate and to assure that persons with mental illness, mental retardation, or related conditions are not inappropriately placed in them. In addition, the federal Nursing Home Reform Act requires states to establish programs to assure the training and certification of competency of nurse aides, to protect the rights of nursing home patients, to strengthen procedures to assure the quality of nursing home care, and to establish a range of penalties to enforce these provisions.

The state and its nursing home industry can be proud that we have already taken so many steps to insure the quality of nursing home care and, in fact, have served as a model for other states and this federal act. The bill before you today makes changes in state statute which are necessary to conform to these new federal requirements. Implementation of these mandates is already well under way. The Departments of Income Maintenance, Mental Health and Mental Retardation have jointly developed the procedures which enabled us to implement preadmission screening of new nursing home admissions as mandated on January 1, 1989. These agencies will continue to work together to develop a plan to assure annual review of nursing home residents. The Departments of Mental Health and Mental Retardation have each developed an alternative disposition plan which has been submitted by the Department of Income Maintenance to the Health Care Financing Administration to permit the state to delay discharges from nursing homes until suitable alternative placements may be assured. The Department of Health Services

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has been developing the procedures necessary to implement various quality assurance provisions for both Medicare and Medicaid and to develop and implement the systems necessary to approve programs for nurse aide training and certification.

In light of the fiscal constraints we face, we have sought to implement Nursing Home Reform in the most cost effective manner possible. We do have several technical changes to the bill which will strengthen and clarify the language. I will leave these changes with you and urge your adoption of them.

Thank you for your consideration of this bill.

MARCH 2, 1989

TESTIMONY GIVEN BY MARIA GOSSELIN, RN
ATTN: PUBLIC HEALTH COMMITTEE
RE: PROPOSED LEGISLATION TO CAP NURSING POOLS

HB 7228

My name is Maria Gosselin. I am an RN who has been active in the field of nursing for the past forty years, as a head nurse, supervisor, Associate Director, Director of a Hospital Department of Nursing and on the faculty of a hospital based School of Nursing and Director of Professional Education for the Lung Association of New York. Upon moving to Connecticut, I was employed as an Associate Director in the Department of Nursing in a Connecticut Hospital, Director of Community Relations in that same hospital and for the past nine years Director of Professional Services for Staff Mates, Inc., a supplemental staffing company owned and operated by me and my son Roy Besmond.

We are proud of our agency and our association with hospitals, nursing homes, schools and clinics throughout the state where we place our personnel to fill their staffing needs.

We share many of the same personnel; we have nurses working for us who are on staff at hospitals, nursing homes, doctors' offices, faculty members from schools of nursing, students from LPN and RN programs and undergraduate and graduate programs both in nursing and in other fields. Additionally, we have on our staff directors of nursing services from long term care facilities and an administrator from a Connecticut long term care facility. It is a dynamic group; the majority of whom are women. It is also a group whose numbers are decreasing. We are losing many of our nurses to other careers; to real estate, photography, computer science, business, self employment such as landscaping, writing, the candy and cake industry and one who will be entering medical school this year. Although we will miss her as an employee, one of our RN's, who in fact we recommended for the position, will be assuming the role of Director of Nursing Services in a 120 bed nursing home on March 6, 1989.

While one may hear from the nursing home industry that pool nurses are not providing continuity of care or even so called quality care, many of our staff members work both in

hospitals and nursing homes, choosing to alternate between the acute care and long term care settings. We have two nurses on long term assignments of eight months to date at a leading Hartford hospital. In most instances our nurses will select places they prefer working at which are neighborhood hospitals and facilities.

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Unfortunately we have our failures but this does not make us unique. I know we deal swiftly and decisively in ridding ourselves of undesirable nursing personnel who, in some instances, have taken staff positions at long term care facilities.

We are faced with the same problems of recruitment and retention that all other users of nursing personnel are facing. As an example of the difficulty there is in recruiting RN's, the U.S. Department of Navy has contracted with a private firm based in Florida to provide physicians and RNs to staff their hospitals. The people here from Florida, who are used to recruiting nation-wide, stated they have not seen anything to equal the poor response they have had to their recruitment efforts in Connecticut.

In the 1930's and early 40's nurses were listed in Washington Labor statistics as non-professionals and were found grouped under housekeeping. Those of us entering the field in the late 40's and early 50's went through traditional hospital based three year programs. Many of us went on to earn undergraduate and graduate degrees, at a time in fact when few universities in New York City offered programs in nursing education.

In 1940 the nation was faced with a critical shortage of nurses and the government funded a program to attract young people into the field. It was intended as a panacea - to introduce the exciting and rewarding world of nursing to young people - again mainly oriented to women.

In the 50's nurses began to speak out about poor salaries and working conditions and the lack of professional recognition amongst other health professionals and with the public in general. We endured Victorian work ethics.

In the 60's nurses continued to speak out - statements began surfacing - about poor conditions in the work place, low salaries and the lack of autonomy.

In the 70's there was an on-going cry about shortages in the work place, lack of professional status, and poor salaries. However while the complaints were getting more visibility, there were far fewer voices; many nurses began leaving the field; fewer were entering schools of nursing. Administration was beginning to hear the expression "Burn-out".

In the '80's the shortage was recognized as a nation-wide **1312** problem and one of critical proportion. Nurses began to seriously turn to unions as their bargaining agents; many turned away from the field all together. We began to see foreign nurses brought to this country to replenish the diminishing ranks. Many of these nurses from countries such as Korea, India, the Phillipines and China, had serious language and cultural barriers when they first arrived.

We still hear the cries about low salaries, severe restrictive schedules, lack of professional autonomy, and a poor public image of the nurse.

And as we approach the end of the 20th century and we hear the public out cry about the shortage of nursing personnel and the impact this has on health care, we have this legislative body, here today, debating over whether or not to regulate what a nurse can earn in the State of Connecticut.

Make no mistake about this, regulation of a nurse's salary in any sector of care will directly affect all practicing nurses in all settings. Supply and demand should be the factors negotiating the economic conditions.

Thirty states, Connecticut included, have authorized task forces to review the problems, identify areas of concern, and to look at possible solutions; short and long term. My understanding is that all of the reports indicate that salary, understaffing, over-work and expanding career options have created the crisis we are facing today. Today's crisis still means the end effect; floors closed down, services curtailed and staff stretched to the limit. Welcome to the real world of nursing!

While the profession has endured whichever regimen is current in the nurse's place of employment, increasingly, individuals are making simple statements ... they leave!

It may well be too late to correct the problems as entry levels into schools plummet and the exodus increases. To continue the situation of educating nurses to practice, only to lose them is a costly and time consuming process. Retention of nurses is a major responsibility of all employers. We should be exploring every opportunity to keep the nurse in the work force, not advocate ways to alienate them. The nurses' role must become more attractive and their terms and conditons as competitive as in all other fields. This must become a priority if a long term solution to the crisis is be found.

And finally, the profession itself must address the problems equally if we are to acheive the advances we so desperately need for nursing in the future.

I urge each of you here today to see the other side of the crisis - what it will mean to the nurse if salaries are to be regulated. I trust that when you make your decision you will do so as enlightened individuals. **1313**