



PA 11-236—sHB 6552
Human Services Committee
Public Health Committee

**AN ACT CONCERNING THE TRANSFER AND DISCHARGE OF
NURSING FACILITY RESIDENTS AND AUDITS OF CERTAIN LONG-
TERM CARE FACILITIES**

SUMMARY: This act changes the process that the Department of Social Services (DSS), nursing homes, and their residents or representatives must follow when nursing homes transfer or discharge residents, or hold beds for residents who are hospitalized (i.e., a “bed-hold”).

With respect to transfers and discharges, the act:

1. grants residents an explicit right to appeal these moves and shortens the deadline for the DSS commissioner to issue appeal hearing decisions for moves, and requires the home to readmit the resident when DSS determines that the move violates the law;
2. establishes the circumstances in which DSS must stay a move;
3. explicitly allows residents to request hearings when informed that they no longer need nursing home care, including residents with mental disabilities in homes that transfer or discharge them when the homes cannot provide needed services;
4. refines the definition of “self-pay” residents for purposes of applying the law to them; and
5. requires nursing homes in receivership to comply with its transfer and discharge notice requirements.

Regarding bed-holds, the act sets up a consultation process for homes and residents when the home is concerned about readmitting a resident because it cannot meet the resident’s needs or the resident may be a danger to himself, herself, or others. It requires the home to (1) meet one of three criteria in order to be able to refuse to readmit a resident and (2) provide notice when it decides not to readmit. The notice must include the resident’s right to a hearing to appeal the refusal. The act requires DSS to hold hearings on possible bed-hold law violations and changes how homes are assessed penalties for violations.

The act requires hospitals to provide nursing homes with patient records and access to the patients when they refer patients to nursing homes or when patients request the referral.

The act also exempts certain long-term care facilities from the general DSS audit provisions and sets up a similar statutory process (which apparently mirrors current practice) for auditing long-term care providers that receive DSS payments.

Lastly, the act makes technical changes.

EFFECTIVE DATE: Upon passage

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§ 1 — RESIDENT TRANSFERS AND DISCHARGES

Notice and Appeal Rights

By law, nursing homes must notify residents or a responsible party when they intend to transfer the residents to another facility or discharge them to a noninstitutional setting. Under the act, the transfer can include one made to a facility or institution that either admits or provides care to the resident for more than 24 hours. The facility or institution can include a hospital emergency room.

By law, the notice must include (1) the reasons for the move; (2) the date the move is effective; (3) where the resident will be going; (4) the resident's right to appeal, procedures for initiating an appeal, and the date by which the appeal must be initiated in order to stay the transfer or discharge (under prior law, 10 days from the notice date); (5) the resident's right to representation at an appeal hearing; and (6) the home's bed-hold and readmission policies, when appropriate.

The act explicitly grants residents the right to appeal these moves and gives them a 60 calendar-day deadline for doing so. To have the discharge or transfer stayed, the act requires an appeal to be initiated within 20 days from the date the resident receives the notice but allows this deadline to be extended if the resident demonstrates good cause for not meeting it. The act requires the notice to include both deadlines and the possibility of an extension of the 20-day deadline.

The act also specifies that the notice's bed-hold and readmission information must be provided whenever a resident is transferred to a hospital, instead of "when appropriate."

Hearing Decision — Shorter Time for DSS Commissioner to Issue Decision

When transfers and discharges are appealed, the DSS commissioner must hold a hearing between 10 and 30 days from the date he receives the request. Under prior law, he had to issue a decision within 60 days from the end of the hearing or 90 days from the date the hearing was requested, whichever occurred sooner. The act reduces these time frames to 30 days and 60 days, respectively.

Stays For Insufficient Notice

Except for an emergency or when the resident is not physically present in the nursing home, the act requires the commissioner, when he receives a transfer or discharge hearing request and the home's notice does not comply with the law as amended by the act, to order a stay of the transfer or discharge within 10 days "after the date of receipt of the notice" (presumably, the date DSS receives the notice) and return the notice to the home. Once the home receives the notice, it must issue a revised notice that complies with the amended law. (Presumably, once it does, the stay is lifted.)

Emergency Transfers and Discharges

By law, the transfer and discharge requirements are different when a home has to make an emergency transfer or discharge. For example, the home must provide the notice as soon as practicable, rather than 30 to 60 days before the move.

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Residents transferred or discharged on an emergency basis or who receive notice of such transfers or discharges can request a hearing to appeal the transfer or discharge. Previously, they had to request the hearing within 10 days of the notice or action. Under the act, they have 20 days. The act also permits the appeal to be considered after the deadline if the residents can demonstrate that they failed to meet the deadline for good cause.

The act also increases, from seven to 15, the number of business days the commissioner has from the date he receives the hearing request to hold the hearing. And it requires the commissioner, or his designee, to issue a decision within 30 days from the date the hearing record is closed.

When a Home Moves a Resident in Violation of Law

Under the act, if the DSS commissioner or his designee determines, after a hearing, that a home has transferred or discharged a resident in violation of the law, he can require the home to readmit the resident to a bed in a semi-private room, or if medically necessary, a private room. This can be done regardless of whether the resident (1) has already accepted placement in another home pending the hearing decision or (2) is awaiting a bed in the home that transferred or discharged him or her.

Decisions

By law, the commissioner or his designee must send the nursing home a copy of its hearing decision. Under the act, he must also send a copy to the resident; the resident's guardian or conservator, if any; legally liable relative; or other responsible party, if known.

By law, the nursing home is deemed to have received the notice within five days from when it was mailed unless the resident or his or her guardian, conservator, legally liable relative, or other responsible party proves otherwise by a preponderance of the evidence. The act permits the facility to rebut this presumption by the same level of evidence.

Notice When Resident No Longer Needs Nursing Home Care

Under the act, residents who receive notice from DSS or its agent stating that they no longer need the level of care that the nursing home provides (medical necessity determination) and as a result, the resident's coverage for facility care (presumably Medicaid) will stop, can request a hearing before the date Medicaid coverage is to end. Coverage must continue pending the hearing's outcome.

If the resident receives a separate notice of Medicaid denial for lack of medical necessity and of discharge from the home and requests a hearing to contest both actions, DSS can schedule one hearing for the resident to contest both.

Exemption When a Resident Has Mental Illness or a Developmental Disability

The act also explicitly exempts from the general ban on transferring and discharging residents those nursing homes that by law must move residents with a

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diagnosis of mental illness or developmental disability who may require specialized services that the home cannot provide. Consequently, the act applies all of the law's notice and hearing protections to these residents.

By law, nursing homes must notify the departments of Mental Health and Addiction Services or Developmental Services when a resident who is mentally ill or has a developmental disability, respectively, undergoes a change in condition that may require specialized services. When the home cannot provide those services, the law generally requires that the resident be (1) transferred to a facility that can provide him or her with the services or (2) discharged when the resident does not require the services.

Self-Pay Residents

The act refines the definition of "self-pay" residents for purposes of the transfer and discharge law. By law, they are defined as residents who are not receiving state or municipal assistance to pay for their care. The act excludes from this definition a resident who has (1) applied for Medicaid, (2) responded in a timely fashion to DSS requests for information that it needs to determine the resident's eligibility, and (3) not been determined eligible for benefits.

The law generally allows nursing homes to discharge self-pay residents for nonpayment of the home's daily rate or an arrearage of more than 15 days.

§ 3 — When A Home is in Receivership

By law, a nursing home receiver may not transfer all of a home's residents and close the home without a court order and without preparing a discharge plan for its residents. The act also requires the receiver to comply with its notice provisions before taking these actions.

It requires the receiver to notify each resident and resident's guardian or conservator, if any, legally liable relative, or other responsible party, if known, when a home is placed in receivership, regardless of whether it is medically contraindicated. Under prior law, the receiver had to notify the residents and family, except where medically contraindicated.

§ 2 — BED-HOLDS WHEN NURSING HOME RESIDENT IS HOSPITALIZED

By law, nursing homes generally must reserve the bed of a nursing home resident when he or she must be hospitalized or goes home for a visit and expects to return to the nursing home. The law establishes deadlines for notice when this occurs and requires Medicaid to pay the homes that reserve the beds.

Bed Type for Residents Whose Hospitalization Period Exceeds Bed-Hold Period

By law, if a nursing home resident's hospitalization exceeds the period of time the home must hold his or her bed (generally, 15 days), or the home otherwise is not required to hold the same bed for the resident, the home must take certain actions. Under prior law, the home had to provide the resident with the first bed available when it received notice that the hospital was discharging the resident.

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The act instead requires the home to provide the resident with the first bed available in a semi-private or, if medically necessary, a private room. The home must do this once it receives notice from the hospital that the resident is “medically ready” for discharge.

The law, unchanged by the act, also requires the home to grant the resident priority admission over a new applicant.

When a Home Refuses Readmission

The act provides that, if the DSS commissioner or his designee finds that a resident has been refused readmission in violation of the bed-hold law, the resident has the right to be readmitted, as described above, regardless of whether the resident has accepted placement in another facility while awaiting readmission.

Consultation. If a home is concerned about a readmission because it is unable to meet the resident’s care needs or the resident presents a danger to himself, herself, or others, the act requires it to request a consultation with the hospital and the resident or the resident’s representative within 24 hours of receiving the hospital’s notice that the resident is medically ready to leave. The purpose of the consultation is to develop an appropriate care plan to safely meet the resident’s nursing home care needs, including determining a readmission date that best meets these needs.

The consultation must begin as soon as practicable after the home requests it. The hospital must participate, grant the nursing home access to the resident in the hospital, and permit the home to review the resident’s hospital records. The resident’s wishes and the hospital’s recommendations must be considered as part of the process. The consultation must be completed within three business days after the home requests it and the home must reserve the bed until the process is complete.

When a Home May Refuse to Readmit. The act provides that a nursing home may refuse to readmit a resident only if (1) it cannot meet the resident’s needs, (2) the resident no longer needs the home’s services due to improved health, or (3) readmitting the resident would endanger other residents’ health and safety.

If a nursing home decides not to readmit a resident either without requesting or following a consultation, it must notify the hospital; resident; and resident’s guardian, conservator, legally liable relative, or other responsible party within 24 hours of making the decision. The notice must be written and indicate:

1. the refusal and reasons for it;
2. the resident’s right to appeal and procedures for initiating the appeal (as the DSS commissioner determines);
3. that the resident has 20 days from the date he or she receives the notice to initiate an appeal, which can be extended for good cause;
4. contact information, including the name, mailing address, and telephone number for the long-term care ombudsman; and
5. the resident’s right to represent himself or herself or be represented by counsel, a relative, a friend, or other spokesperson.

If the resident is, or the nursing home alleges a resident is, mentally ill or

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developmentally disabled, the notice must include the contact information, including the name, mailing address, and telephone number of the Office of Protection and Advocacy for Persons with Disabilities.

Right to Hearing for Violation of Bed-Hold Law

The act requires the commissioner or his designee to hold a hearing to determine whether the home has violated the bed-hold law. The commissioner or his designee must (1) convene the hearing within 15 days from the date the request is received and (2) issue a decision within 30 days of the date the hearing record is closed.

The act authorizes the commissioner or his designee (presumably only after a hearing is held) to require the home to readmit the resident to a semi-private room or, when medically necessary, a private one.

By law, these types of hearing decisions can be appealed to Superior Court. The act requires the court to consider these appeals as privileged in order to dispose of them with the least possible delay. (The court must already do this with appeals of transfers and discharges.)

If a home does not readmit a resident after a consultation, the act permits the resident to file a complaint with the DSS commissioner. If the resident has already requested a hearing under the act, the commissioner must stay an investigation of the complaint until he issues a decision following the hearing.

Penalties

Under the act, each day a nursing home fails to readmit a resident in violation of the bed-hold law is considered a separate violation for purposes of determining a penalty. When a resident who has been through a consultation requests a hearing, no penalty can accrue from the date the consultation is requested until the hearing decision is issued, if DSS finds that the nursing home acted in good faith in refusing to readmit the resident.

If a resident files a complaint but does not request a hearing, no penalty can accrue while DSS conducts an investigation, provided the commissioner finds the home's refusal to readmit was done in good faith.

The current maximum penalty DSS may impose is \$8,500 per violation.

§ 4 — HOSPITAL REFERRALS TO NURSING HOMES

The act requires a hospital to make copies of a patient's hospital record available to a nursing home whenever it refers the patient to a home as part of its discharge planning process or when the patient requests such a referral. The hospital must also give the home access to the patient for care planning and consultation purposes.

§§ 5 & 6 — AUDITS OF LONG-TERM CARE INSTITUTIONAL PROVIDERS

The act requires the DSS commissioner to audit nursing homes, residential care homes (RCHs), and intermediate care facilities for people with mental

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retardation (ICF-MRs) that receive Medicaid or other state payments. It establishes an audit process for these institutions that is similar to the audit process for other health care providers that receive DSS payments. (This process apparently codifies existing practice.)

Audit Scope and Notice

The act requires the commissioner to give at least 30 days written notice of the audit to the institution. This notice is not required if he or the audit agency makes a good faith determination that (1) a service recipient's health or safety is at risk or (2) the provider is engaging in vendor fraud.

Clerical Errors

Under the act, a clerical error discovered in a record or document produced for the audit by itself does not constitute a willful violation of DSS medical assistance program rules unless proof of an intent to commit fraud or otherwise violate program rules is established. (It is not clear whether State Supplement payments, which is what RCHs receive, fall into this category.) Under the act, a "clerical error" includes recordkeeping, typographical, writer's, or computer error.

Extrapolation

The act prohibits DSS from finding that an overpayment or underpayment was made to a facility based on extrapolated projections, unless (1) the facility has a sustained or high level of payment error, (2) documented educational intervention has failed to correct the error levels, or (3) the aggregate claims' value exceeds \$150,000 on an annual basis.

Extrapolation is the practice of (1) dividing the total number of payment errors found in a sample of documents by the sample size to arrive at average errors per sample and (2) multiplying this by the total number of claims to arrive at a presumed, extrapolated number of payment errors for all payments to the provider during the audited period. The facility must make repayments to DSS based on these extrapolated errors.

Provider's Right to Provide Documents Addressing Discrepancies

The act gives a facility at least 30 days to provide documentation related to a discrepancy discovered and brought to its attention during an audit.

Preliminary Report and Exit Conference

The act requires the commissioner to produce a preliminary written audit report and give it to the facility within 60 days after the audit's conclusion. The commissioner must hold an exit conference with the facility to discuss the preliminary report once it is issued.

Final Report

The commissioner or audit agency must produce a final written report and give it to the facility within 60 days after the exit conference unless the

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commissioner and the facility agree to a later date or there are other pending referrals or investigations concerning the provider.

Appeals

Under the act, a facility aggrieved by a final report can request a rehearing and the commissioner, or his designee, must hold the hearing provided the facility provides a detailed written description of all items of aggrievement in the final report within 90 days of the date of the commissioner's decision (presumably one related to the audit). The hearing must be held within 30 days after the filing date of the detailed written description of each specific item of aggrievement.

Binding Arbitration

The commissioner must issue a final decision by the later of 60 days after the close of evidence or the date on which final briefs are filed. Items not resolved at the rehearing to either party's satisfaction must be submitted to binding arbitration by an arbitration board consisting of three members—one appointed by the facility, one by the DSS commissioner, and one by the chief court administrator from among the Superior Court's retired judges. A judge must be compensated for serving on the board in the same manner as a state referee.

The arbitration board's proceedings and any decisions it renders must be conducted in accordance with the federal Medicaid Act and the Uniform Administrative Procedure Act.

Penalties for False Information

The act provides that submitting false or misleading fiscal information or data to the DSS commissioner is grounds for suspending payments to facilities (including those not subject to the act's audits, such as hospitals) in accordance with regulations the commissioner adopts. Any person, including a corporation, that knowingly (1) makes or causes to make false or misleading statements or (2) submits false or misleading fiscal information or data on forms DSS approves is guilty of a Class D felony (see Table on Penalties).

Authority for DSS Commissioner When Conducting Investigations and Hearings

The act grants the commissioner, or any agent he authorizes to conduct an inquiry, investigation, or hearing under the audit provisions, the power to administer oaths and take testimony under oath in the inquiry or investigation. At any such hearing, the commissioner or his agent, if the agent has the legal authority to issue process, can subpoena witnesses and require the production of records, papers, and documents pertaining to the inquiry.

If anyone disobeys the process or refuses to (1) answer pertinent questions the commissioner or his agent asks him or her or (2) produce records and papers related to the inquiry, the act allows the commissioner or his agent to apply to the Hartford Superior Court or the court in the judicial district where the person lives or his or her business is located (or to a judge if the court is not in session) and explain the disobedience to process or refusal to answer. The court or judge must

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cite the person to appear to answer questions or produce the records and papers.

BACKGROUND

Preadmission Screening and Resident Reviews

Federal law prohibits a Medicaid-certified nursing home from admitting applicants with serious mental illness or mental retardation (developmental disability) or a related condition unless they are properly screened, thoroughly evaluated, found to be appropriate for a nursing home placement, and will receive all specialized services necessary to meet their unique needs. Once admitted, these residents must be reviewed when there is a significant change in their physical or mental condition to determine if the home is still the most appropriate placement. Ascend Management Innovations, LLC contracts with DSS to perform these reviews.

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