House of Representatives

General Assembly

File No. 146

February Session, 2024

House Bill No. 5046

House of Representatives, March 27, 2024

The Committee on Aging reported through REP. GARIBAY of the 60th Dist., Chairperson of the Committee on the part of the House, that the bill ought to pass.

AN ACT PROMOTING NURSING HOME RESIDENT QUALITY OF LIFE.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 19a-521b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Each licensed chronic and convalescent nursing home, chronic disease hospital associated with a chronic and convalescent nursing home, rest home with nursing supervision and residential care home shall position beds in a manner that promotes resident care and that provides at least a three-foot clearance at the sides and foot of each bed. Such bed position shall (1) not act as a restraint to the resident, (2) not create a hazardous situation, including, but not limited to, an entrapment possibility, or obstacle to evacuation or being close to or blocking a heat source, and (3) allow for infection control.

(b) On and after July 1, 2025, no licensed chronic and convalescent nursing home or rest home with nursing supervision shall place a newly

admitted resident in a room containing more than two beds. On and after July 1, 2026, no resident room in a licensed chronic and convalescent nursing home or rest home with nursing supervision shall contain more than two beds. A violation of the requirements of this subsection shall constitute a Class B violation under section 19a-527. Each day a licensed chronic and convalescent nursing home or rest home with nursing supervision fails to comply with the requirements of this subsection may be considered a separate violation for the purpose of imposing a penalty pursuant to section 19a-528.

Sec. 2. (NEW) (*Effective July 1, 2024*) (a) As used in this section: (1) "Center of Excellence" means a nursing home licensed under section 19a-491 of the general statutes that provides services that are consistent with evidence-based best practices for the delivery of person-centered care; (2) "Centers of Excellence Program" means a program that sets the standards for a nursing home to be designated as a Center of Excellence; and (3) "nursing home" has the same meaning as provided in section 19a-490 of the general statutes.

(b) The Commissioner of Public Health shall design a state-wide Centers of Excellence Program to provide incentives to licensed nursing homes that provide services consistent with evidence-based best practices for the delivery of person-centered care.

(c) When designing the program, the Commissioner of Public Health shall:

(1) Study the extent to which a Centers of Excellence Program may improve the quality of care provided at nursing homes and what the best practices are in other similar programs nation-wide; and

(2) Consult with (A) nursing home owners and operators; (B) hospitals; (C) nursing home residents and their advocates; (D) the Office of the Long-Term Care Ombudsman; (E) the Commissioner of Social Services, or the commissioner's designee; (F) the Secretary of the Office of Policy and Management, or the secretary's designee; and (G) other relevant stakeholders as deemed necessary by the Commissioner of

Public Health.

(d) The design of the program shall, at a minimum, (1) identify evidence-based qualitative and quantitative standards for delivery of person-centered care a nursing home must meet to be designated as a Center of Excellence; (2) identify for each standard the measure or measures nursing homes must meet to qualify as a Center of Excellence; (3) identify a pathway through application, inspection or other means by which a nursing home may be designated as a Center of Excellence; (4) create a mechanism to designate nursing homes that meet or exceed the standards and qualify as a Center of Excellence; (5) determine potential incentives to nursing homes that meet the standards set for the Centers of Excellence Program; and (6) identify ways to maximize the use of available federal funding to support the Centers of Excellence Program.

(e) The Centers of Excellence Program shall be designed as a voluntary program. No nursing home shall be required to participate in said program, and nursing homes that choose not to participate shall not be penalized by the state.

(f) When developing the program, the Commissioner of Public Health may, within available appropriations, engage a consultant to identify best practices and design the Centers of Excellence Program.

(g) Upon completion of designing the Centers of Excellence Program, or not later than January 1, 2026, the Commissioner of Public Health shall report to the Secretary of the Office of Policy and Management on the plan developed.

(h) The Commissioner of Social Services may seek approval of an amendment to the state Medicaid plan or a waiver from federal law to provide incentives for the Centers of Excellence Program designees. The commissioner shall develop the incentives in a time frame and manner to ensure that such incentives do not duplicate other applicable federal or state funding.

Sec. 3. (NEW) (*Effective July 1, 2024*) The Department of Public Health, in consultation with the Office of the Long-Term Care Ombudsman and the Long-Term Care Advisory Council, shall establish an online nursing home consumer report card, within available appropriations, that provides: (1) Comprehensive information concerning quality of care for people in need of nursing home care and their families; and (2) showcases industry leading practices. The department shall include a link to the report in a prominent place on the department's Internet web site.

Sec. 4. Section 19a-533 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2024*):

(a) As used in this section, "nursing home" means any chronic and convalescent facility or any rest home with nursing supervision, as defined in section 19a-521, which has a provider agreement with the state to provide services to recipients of funds obtained through Title XIX of the Social Security Amendments of 1965; and "indigent person" means any person who is eligible for or who is receiving medical assistance benefits from the state.

(b) A nursing home which receives payment from the state for rendering care to indigent persons shall:

(1) Be prohibited from discriminating against indigent persons who apply for admission to such facility on the basis of source of payment. Except as otherwise provided by law, all applicants for admission to such facility shall be admitted in the order in which such applicants apply for admission. Each nursing home shall (A) provide a receipt to each applicant for admission to its facility who requests placement on a waiting list stating the date and time of such request, and (B) maintain a dated list of such applications which shall be available at all times to any applicant, his bona fide representative, authorized personnel from the Departments of Public Health and Social Services and such other state agencies or other bodies established by state statute whose statutory duties necessitate access to such lists. If a nursing home desires to remove the name of an applicant who is unresponsive to facility

telephone calls and letters from its waiting list, the nursing home may, no sooner than ninety days after initial placement of the person's name on the waiting list, inquire by letter to such applicant and any one person if designated by such applicant whether the applicant desires continuation of his name on the waiting list. If the applicant does not respond and an additional thirty days pass, the facility may remove such applicant's name from its waiting list. A nursing home may annually send a waiting list placement continuation letter to all persons on the waiting list for at least ninety days to inquire as to whether such person desires continuation of his name on the waiting list, provided such letter shall also be sent to any one person if designated by such applicant. If such person does not respond and at least thirty days pass, the facility may remove the person's name from its waiting list. Indigent persons shall be placed on any waiting list for admission to a facility and shall be admitted to the facility as vacancies become available, in the same manner as self-pay applicants, except as provided in subsections (f) and (g) of this section;

(2) Post in a conspicuous place a notice informing applicants for admission that the facility is prohibited by statute from discriminating against indigent applicants for admission on the basis of source of payment. Such notice shall advise applicants for admission of the remedies available under this section and shall list the name, address and telephone number of the ombudsman who serves the region in which the facility is located;

(3) Be prohibited from requiring that an indigent person pay any sum of money or furnish any other consideration, including but not limited to the furnishing of an agreement by the relative, conservator or other responsible party of an indigent person which obligates such party to pay for care rendered to an indigent person as a condition for admission of such indigent person;

(4) Record in the patient roster, maintained pursuant to the Public Health Code, or in a separate roster maintained for this purpose, the number of patients who are Medicare, Medicaid and private pay

patients on each day. Such numbers shall be recorded daily and made available, upon request, to the state or regional ombudsman.

(c) Upon the receipt of a complaint concerning a violation of this section, the Department of Social Services shall conduct an investigation into such complaint.

(d) The Department of Social Services is authorized to decrease the daily reimbursement rate to a nursing home for one year for a violation of this section which occurred during the twelve-month period covered by the cost report upon which the per diem rate is calculated. The per diem rate shall be reduced by one-quarter of one per cent for an initial violation of this section and one per cent for each additional violation.

(e) Prior to imposing any sanction, the Department of Social Services shall notify the nursing home of the alleged violation and the accompanying sanction, and shall permit such facility to request an administrative hearing, in accordance with sections 4-176e to 4-181a, inclusive. A facility shall request such hearing within fifteen days of receipt of the notice of violation from the Department of Social Services. The department shall stay the imposition of any sanction pending the outcome of the administrative hearing.

(f) A nursing home with a number of self-pay residents equal to or less than thirty per cent of its total number of residents shall not be required to admit an indigent person on a waiting list for admission when a vacancy becomes available during the subsequent six months, provided (1) no bed may be held open for more than thirty days, [. Each such nursing home meeting the conditions for such waiver shall on a quarterly basis notify] and (2) the nursing home notifies the Commissioner of Social Services and the regional nursing home ombudsman office [of] on the date on which such six-month period of [waiver began] waiting list exemption began and thereafter on a quarterly basis if the conditions for exemption still apply.

(g) A nursing home shall not be required to admit an indigent person on a waiting list for admission when a vacancy becomes available if the

vacancy is in a private room.

(h) Notwithstanding the provisions of this section, a nursing home [may] shall, without regard to the order of its waiting list, admit an applicant who (1) seeks to transfer from a nursing home that is closing, or (2) seeks to transfer from a nursing home in which the applicant was placed following the closure of the nursing home where such applicant previously resided or, in the case of a nursing home placed in receivership, the anticipated closure of the nursing home where such applicant previously resided, provided (A) the transfer occurs not later than sixty days following the date that such applicant was transferred from the nursing home where he or she previously resided, and (B) except when the nursing home that is closing transferred the resident due to an emergency, the applicant submitted an application to the nursing home to which he or she seeks admission at the time of the applicant's transfer from the nursing home where he or she previously resided. A nursing home that qualifies for a waiting list exemption pursuant to subsection (f) of this section shall not be required to admit an indigent person under this subsection except when the resident is being transferred from a nursing home that is closing due to an emergency.

Sec. 5. (NEW) (*Effective from passage*) The Commissioner of Public Health shall not grant any new license to establish, conduct or operate a rest home with nursing supervision on and after the effective date of this section. Notwithstanding the provisions of this section, the commissioner may, upon application by a rest home with nursing supervision, approve a one-time renewal for not more than one year of a license that expires on or after the effective date of this section, provided the rest home is in compliance with the requirements for such renewal. The denial of such a renewal shall not be subject to an appeal under section 19a-501 of the general statutes.

Sec. 6. Section 17b-357 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) For purposes of this section and sections 17b-358 to 17b-360,

inclusive, a "nursing facility" means a chronic and convalescent home or a rest home with nursing supervision as defined in section 19a-521, which participates in the Medicaid program through a provider agreement with the Department of Social Services.

(b) If the Department of Public Health finds, through the results of a survey, that a nursing facility is not in compliance with one or more of the requirements of Subsections (b), (c) and (d) of 42 USC 1396r, or the requirements of applicable state statutes or regulations, and that such noncompliance poses an immediate and serious threat to patient health or safety, the Department of Public Health shall issue a statement of charges to the facility and shall file a copy of the charges with the Department of Social Services with a request for a summary order from the Department of Social Services. The summary order which the Department of Social Services may issue shall include termination of the facility's participation in Medicaid or appointment of a temporary manager to oversee the operation of the facility and may include transfer of patients to other participating facilities; denial of payment under Medicaid for new admissions; imposition of a directed plan of correction of the facility's deficiencies; imposition of civil monetary penalties; or imposition of other remedies authorized by regulations adopted by the Department of Social Services in accordance with chapter 54.

(c) If the Department of Public Health finds, through the results of a survey, that a nursing facility is not in compliance with one or more of the requirements of Subsections (b), (c) and (d) of 42 USC 1396r, or the requirements of applicable state statutes or regulations, but that such noncompliance does not pose an immediate and obvious threat to patient health or safety, the Department of Public Health shall issue a statement of charges to the facility and shall file a copy of the charges with the Department of Social Services with a request for an order imposing one or more alternative remedies under this subsection. If the Department of Social Services finds, based on a statement of charges filed by the Department of Public Health, that a nursing facility is not in compliance with one or more of the requirements of Subsections (b), (c)

and (d) of 42 USC 1396r, or the requirements of applicable state statutes or regulations, but does not issue a summary order, it may impose one or more of the following alternative remedies: Termination of the facility's participation in Medicaid; appointment of a temporary manager to oversee the operation of the facility; transfer of patients to other participating facilities; denial of payment under Medicaid for new admissions; imposition of a directed plan of correction of the facility's deficiencies; imposition of civil monetary penalties; or imposition of other remedies authorized by regulations adopted by the Department of Social Services in accordance with chapter 54. The civil monetary penalties imposed may be in the range of three thousand two hundred fifty dollars to ten thousand dollars per day for each day the facility is found to be out of compliance with one or more requirements of Subsections (b), (c) and (d) of 42 USC 1396r if the failure to comply with such requirements is found to constitute an immediate and serious threat to resident health or safety, or in the range of two hundred dollars to three thousand dollars per day for each day the facility is found to be out of compliance with a requirement of Subsections (b), (c) and (d) of 42 USC 1396r that is found not to constitute an immediate and serious threat to resident health or safety. The exact civil monetary penalty will be set depending on such factors as the existence of repeat deficiencies or uncorrected deficiencies and the overall compliance history of the provider. The remedies available to the Department of Social Services for violations of the requirements of Subsections (b), (c) and (d) of 42 USC 1396r are cumulative and are in addition to the remedies available to the Department of Public Health under chapter 368v for violations of state licensure requirements. Any penalties collected by the Department of Social Services pursuant to this section shall be deposited in a special fund under the control of the Department of Social Services, which fund shall be utilized, in the discretion of the department, for the protection of the health or property of residents of nursing facilities found to be deficient, including payment for the costs of relocating residents, payment for the maintenance of operation of a facility pending correction of deficiencies or closure, and reimbursement of residents for personal funds lost. The deficient nursing facility shall be obligated to

reimburse the Department of Social Services for any moneys expended by the department at the facility from the fund established pursuant to this section.

(d) The facility may request a hearing in accordance with the provisions of chapter 54 from the Department of Social Services within ten days of the issuance of the statement of charges or the summary order, as the case may be. If the facility does not request a hearing within ten days and no summary order has been issued, the Department of Social Services shall automatically adopt the Department of Public Health's findings and shall issue an order incorporating one or more of the remedies authorized by subsection (c) of this section. If the facility timely requests a hearing or the Department of Social Services issues a summary order, the Department of Social Services shall issue a notice of hearing. At such hearing the facility shall be given the opportunity to present evidence and cross-examine witnesses. The Department of Social Services shall issue a decision based on the administrative record and may, if it finds the facility not in compliance with one or more of the requirements of Subsections (b), (c) and (d) of 42 USC 1396r, or the requirements of applicable state statutes or regulations, order any of the remedies specified in this section. The Department of Social Services may impose any of the alternative remedies, except for a civil monetary penalty, during the pendency of any proceedings conducted pursuant to this subsection. In such cases, the Department of Social Services must provide the facility the opportunity to discuss the Department of Public Health's findings at an informal conference prior to the imposition of any remedy. The requirement of an informal conference does not apply to summary order proceedings.

Sec. 7. Subsection (b) of section 19a-496 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) The department may inspect an institution to determine compliance with applicable state statutes and regulations. Upon a finding of noncompliance with such statutes or regulations, the

department shall issue a written notice of noncompliance to the institution. Not later than ten business days after such institution receives a notice of noncompliance, the institution shall submit a plan of correction to the department in response to the items of noncompliance identified in such notice. The plan of correction shall include: (1) The measures that the institution intends to implement or systemic changes that the institution intends to make to prevent a recurrence of each identified issue of noncompliance; (2) the date each such corrective measure or change by the institution is effective; (3) the institution's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure or systemic change is sustained; and (4) the title of the institution's staff member that is responsible for ensuring the institution's compliance with its plan of correction. The plan of correction shall be deemed to be the institution's representation of compliance with the identified state statutes or regulations identified in the department's notice of noncompliance. The failure of the institution to comply with a plan of correction accepted by the department may be the subject of disciplinary action against the institution pursuant to section 19a-494. Any institution that fails to submit a plan of correction that meets the requirements of this section may be subject to disciplinary action.

Sec. 8. Section 19a-700 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

A managed residential community shall enter into a written residency agreement with each resident that clearly sets forth the rights and responsibilities of the resident and the managed residential community, including the duties set forth in section 19a-562. The residency agreement shall be set forth in plain language and printed in not less than fourteen-point type. The residency agreement shall be signed by the managed residential community's authorized agent and by the resident, or the resident's legal representative, prior to the resident taking possession of a private residential unit and shall include, at a minimum:

(1) An itemization of assisted living services, transportation services, recreation services and any other services and goods, lodging and meals to be provided on behalf of the resident by the managed residential community;

(2) A full and fair disclosure of all charges, fees, expenses and costs to be borne by the resident including, for written residency agreements entered into on and after July 1, 2024, nonrefundable charges, fees, expenses and costs;

(3) A schedule of payments and disclosure of all late fees or potential penalties;

(4) For written residency agreements entered into on and after July 1, 2024, the manner in which the managed residential community may adjust monthly fees or other recurring fees, including, but not limited to, (A) how often fee increases may occur, (B) the schedule or specific dates of such increases, and (C) the history of fee increases over the past three calendar years;

[(4)**]** (5) The grievance procedure with respect to enforcement of the terms of the residency agreement;

[(5)**]** (6) The managed residential community's covenant to comply with all municipal, state and federal laws and regulations regarding consumer protection and protection from financial exploitation;

[(6)**]** (7) The managed residential community's covenant to afford residents all rights and privileges afforded under title 47a;

[(7)**]** (8) The conditions under which the agreement can be terminated by either party;

[(8)**]** (9) Full disclosure of the rights and responsibilities of the resident and the managed residential community in situations involving serious deterioration in the health of the resident, hospitalization of the resident or death of the resident, including a provision that specifies that in the event that a resident of the

community dies, the estate or family of such resident shall only be responsible for further payment to the community for a period of time not to exceed fifteen days following the date of death of such resident as long as the private residential unit formerly occupied by the resident has been vacated; and

[(9)**]** (10) Any adopted rules of the managed residential community reasonably designed to promote the health, safety and welfare of residents.

Sec. 9. Section 19a-694 of the 2024 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2024*):

(a) All managed residential communities operating in the state shall;

(1) Provide a written residency agreement to each resident in accordance with section 19a-700, as amended by this act;

(2) Provide residents or residents' representatives advance notice of ninety days of any increase to monthly or reoccurring fees and disclose in writing any nonrefundable charges;

(3) Provide residents prorated or full reimbursements of certain charges if the managed residential community determines it can no longer meet the resident's needs during the first forty-five days after occupancy by the resident of the managed residential community unit, including, but not limited to, prorated first month's rent, prorated community fee, full last month's rent and full security deposit;

[(2)**]** (4) Afford residents the ability to access services provided by an assisted living services agency. Such services shall be provided in accordance with a service plan developed in accordance with section 19a-699;

[(3)**]** (5) Upon the request of a resident, arrange, in conjunction with the assisted living services agency, for the provision of ancillary medical services on behalf of a resident, including physician and dental services,

pharmacy services, restorative physical therapies, podiatry services, hospice care and home health agency services, provided the ancillary medical services are not administered by employees of the managed residential community, unless the resident chooses to receive such services;

[(4)**]** (6) Provide a formally established security program for the protection and safety of residents that is designed to protect residents from intruders;

[(5)**]** (7) Afford residents the rights and privileges guaranteed under title 47a;

[(6)**]** (8) Comply with the provisions of subsection (c) of section 19-13-D105 of the regulations of Connecticut state agencies;

[(7)**]** (9) Assist a resident who has a long-term care insurance policy with preparing and submitting claims for benefits to the insurer, provided such resident has executed a written authorization requesting and directing the insurer to (A) disclose information to the managed residential community relevant to such resident's eligibility for an insurance benefit or payment, and (B) provide a copy of the acceptance or declination of a claim for benefits to the managed residential community at the same time such acceptance or declination is made to such resident; and

[(8) On or before January 1, 2024, encourage**]** (10) Encourage and assist in the establishment of a family council in managed residential communities offering assisted living services. Such family council shall not allow a family member or friend of a resident who is not a resident of a dementia special care unit to participate in the family council without the consent of such resident.

(b) No managed residential community shall control or manage the financial affairs or personal property of any resident, except as provided for in subdivision (7) of subsection (a) of this section.

Sec. 10. Subsection (e) of section 19a-564 of the 2024 supplement to

the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2024*):

(e) An assisted living services agency shall: **[**ensure that**]** (1) Ensure that all services being provided on an individual basis to clients are fully understood and agreed upon between either the client or the client's representative; **[**, and**]** (2) ensure that the client or the client's representative are made aware of the cost of any such services; (3) disclose fee increases to a resident or a resident's representative not later than sixty days prior to such fees taking effect; and (4) provide, upon request, to a resident and a resident's representative the history of fee increases over the past three calendar years. Nothing in this subsection shall be construed to limit an assisted living services agency from immediately adjusting fees to the extent such adjustments are directly related to a change in the level of care or services necessary to meet individual resident safety needs at the time of a scheduled resident care meeting or if a resident's change of condition requires a change in services.

Sec. 11. Section 17b-99a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) (1) For purposes of this section, (A) "extrapolation" means the determination of an unknown value by projecting the results of the review of a sample to the universe from which the sample was drawn, (B) "facility" means any facility described in this subsection and for which rates are established pursuant to section 17b-340 or 17b-340d, **[**and**]** (C) "universe" means a defined population of claims submitted by a facility during a specific time period, and (D) "forensic audit" means an examination of financial records for information or evidence that may be used in a legal proceeding.

(2) The Commissioner of Social Services shall conduct any audit, including a forensic audit, of a licensed chronic and convalescent nursing home, chronic disease hospital associated with a chronic and convalescent nursing home, a rest home with nursing supervision, a licensed residential care home, as defined in section 19a-490, and a

residential facility for persons with intellectual disability which is licensed pursuant to section 17a-227 and certified to participate in the Medicaid program as an intermediate care facility for individuals with intellectual disabilities in accordance with the provisions of this section.

(b) Not less than thirty days prior to the commencement of any such audit, the commissioner shall provide written notification of the audit to such facility, unless the commissioner makes a good-faith determination that (1) the health or safety of a recipient of services is at risk; or (2) the facility is engaging in vendor fraud under sections 53a-290 to 53a-296, inclusive.

(c) Any clerical error, including, but not limited to, recordkeeping, typographical, scrivener's or computer error, discovered in a record or document produced for any such audit, shall not of itself constitute a wilful violation of the rules of a medical assistance program administered by the Department of Social Services unless proof of intent to commit fraud or otherwise violate program rules is established. In determining which facilities shall be subject to audits, the Commissioner of Social Services may give consideration to the history of a facility's compliance in addition to other criteria used to select a facility for an audit.

(d) A finding of overpayment or underpayment to such facility shall not be based on extrapolation unless (1) there is a determination of sustained or high level of payment error involving the facility, (2) documented educational intervention has failed to correct the level of payment error, or (3) the value of the claims in aggregate exceeds two hundred thousand dollars on an annual basis.

(e) A facility, in complying with the requirements of any such audit, shall be allowed not less than thirty days to provide documentation in connection with any discrepancy discovered and brought to the attention of such facility in the course of any such audit.

(f) The commissioner shall produce a preliminary written report concerning any audit conducted pursuant to this section and such

preliminary report shall be provided to the facility that was the subject of the audit not later than sixty days after the conclusion of such audit.

(g) The commissioner shall, following the issuance of the preliminary report pursuant to subsection (f) of this section, hold an exit conference with any facility that was the subject of any audit pursuant to this subsection for the purpose of discussing the preliminary report. Such facility may present evidence at such exit conference refuting findings in the preliminary report.

(h) The commissioner shall produce a final written report concerning any audit conducted pursuant to this subsection. Such final written report shall be provided to the facility that was the subject of the audit not later than sixty days after the date of the exit conference conducted pursuant to subsection (g) of this section, unless the commissioner and the facility agree to a later date or there are other referrals or investigations pending concerning the facility.

(i) Any facility aggrieved by a final report issued pursuant to subsection (h) of this section may request a rehearing. A rehearing shall be held by the commissioner or the commissioner's designee, provided a detailed written description of all items of aggrievement in the final report is filed by the facility not later than ninety days following the date of written notice of the commissioner's decision. The rehearing shall be held not later than thirty days following the date of filing of the detailed written description of each specific item of aggrievement. The commissioner shall issue a final decision not later than sixty days following the close of evidence or the date on which final briefs are filed, whichever occurs later. Any items not resolved at such rehearing to the satisfaction of the facility or the commissioner shall be submitted to binding arbitration by an arbitration board consisting of one member appointed by the facility, one member appointed by the commissioner and one member appointed by the Chief Court Administrator from among the retired judges of the Superior Court, which retired judge shall be compensated for his services on such board in the same manner as a state referee is compensated for his services under section 52-434.

The proceedings of the arbitration board and any decisions rendered by such board shall be conducted in accordance with the provisions of the Social Security Act, 42 USC 1396, as amended from time to time, and chapter 54.

(j) The submission of any false or misleading fiscal information or data to the commissioner shall be grounds for suspension of payments by the state under sections 17b-239 to 17b-246, inclusive, and sections 17b-340, and 17b-343, in accordance with regulations adopted by the commissioner. In addition, any person, including any corporation, who knowingly makes or causes to be made any false or misleading statement or who knowingly submits false or misleading fiscal information or data on the forms approved by the commissioner shall be guilty of a class D felony.

(k) The commissioner, or any agent authorized by the commissioner to conduct any inquiry, investigation or hearing under the provisions of this section, shall have power to administer oaths and take testimony under oath relative to the matter of inquiry or investigation. At any hearing ordered by the commissioner, the commissioner or such agent having authority by law to issue such process may subpoena witnesses and require the production of records, papers and documents pertinent to such inquiry. If any person disobeys such process or, having appeared in obedience thereto, refuses to answer any pertinent question put to the person by the commissioner or the commissioner's authorized agent or to produce any records and papers pursuant thereto, the commissioner or the commissioner's agent may apply to the superior court for the judicial district of Hartford or for the judicial district wherein the person resides or wherein the business has been conducted, or to any judge of such court if the same is not in session, setting forth such disobedience to process or refusal to answer, and such court or judge shall cite such person to appear before such court or judge to answer such question or to produce such records and papers.

(l) The commissioner shall provide free training to facilities on the preparation of cost reports to avoid clerical errors and shall post

information on the department's Internet web site concerning the auditing process and methods to avoid clerical errors. Not later than April 1, 2015, the commissioner shall establish audit protocols to assist facilities subject to audit pursuant to this section in developing programs to improve compliance with Medicaid requirements under state and federal laws and regulations, provided audit protocols may not be relied upon to create a substantive or procedural right or benefit enforceable at law or in equity by any person, including a corporation. The commissioner shall establish and publish on the department's Internet web site audit protocols for: (1) Licensed chronic and convalescent nursing homes, (2) chronic disease hospitals associated with chronic and convalescent nursing homes, (3) rest homes with nursing supervision, (4) licensed residential care homes, as defined in section 19a-490, and (5) residential facilities for persons with intellectual disability that are licensed pursuant to section 17a-227 and certified to participate in the Medicaid program as intermediate care facilities for individuals with intellectual disabilities. The commissioner shall ensure that the Department of Social Services, or any entity with which the commissioner contracts to conduct an audit pursuant to this section, has on staff or consults with, as needed, licensed health professionals with experience in treatment, billing and coding procedures used by the facilities being audited pursuant to this section.

(m) A facility shall be liable to the Department of Social Services for the costs of any forensic audit of a facility identified by the department as potentially experiencing a serious financial loss, including, but not limited to, any reports or subsequent testimony related thereto. A facility shall cooperate and assist with a forensic audit as requested by the department and shall ensure that all facility personnel, financial consultants and accountants fully cooperate and assist with a forensic audit as may be necessary. A facility shall be subject to a civil monetary penalty not to exceed three thousand two hundred fifty dollars per day for each day that the facility fails to comply with a written request by the department to cooperate and assist with a forensic audit. A facility may request a fair hearing on the assessment of any such civil monetary penalty as an aggrieved person pursuant to section 17b-60. The

department may recover the costs of any such forensic audit or civil monetary penalties assessed in accordance with this subsection through recoupment of such amounts against the funds that would otherwise be paid to such facility for services rendered to recipients of assistance under the Medicaid program.

Sec. 12. Section 19a-543 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

The court shall grant an application for the appointment of a receiver for a nursing home facility or residential care home upon a finding of any of the following: (1) Such facility or home is operating without a license issued pursuant to this chapter or such facility's or home's license has been suspended or revoked pursuant to section 19a-494; (2) such facility or home intends to close and adequate arrangements for relocation of its residents have not been made at least thirty days prior to closing; (3) such facility or home has sustained a serious financial loss or failure **[**which jeopardizes the health, safety and welfare of the patients**]** or there is a reasonable likelihood of such loss or failure; or (4) there exists in such facility a condition in substantial violation of the Public Health Code, or any other applicable state statutes, or Title XVIII or XIX of the federal Social Security Act, 42 USC 301, as amended, or any regulation adopted pursuant to such state or federal laws.

Sec. 13. Section 19a-547 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The court may appoint any responsible individual whose name is proposed by the Commissioner of Public Health and the Commissioner of Social Services to act as a receiver. **[**For a nursing home facility, such individual shall be a nursing home facility administrator licensed in the state of Connecticut with substantial experience in operating Connecticut nursing homes. For a residential care home, such individual shall have experience as a residential care home administrator or, if there is no such individual, such individual shall have experience in the state similar to that of a residential care home administrator. The Commissioner of Social Services shall adopt

regulations governing qualifications for proposed receivers consistent with this subsection.] Such individual shall have substantial experience in the delivery of high-quality health care services and successful management or operation of long-term care facilities, and have achieved an educational level or have such licensure as customarily is held by persons managing or operating health care facilities similar to the facility or facilities subject to receivership. No state employee or owner, administrator or other person with a financial interest in the nursing home facility or residential care home may serve as a receiver for that nursing home facility or residential care home. No person appointed to act as a receiver shall be permitted to have a current financial interest in the nursing home facility or residential care home; nor shall such person appointed as a receiver be permitted to have a financial interest in the nursing home facility or residential care home for a period of five years from the date the receivership ceases.

(b) The court may remove such receiver in accordance with section 52-513. A nursing home facility or residential care home receiver appointed pursuant to this section shall be entitled to a reasonable receiver's fee as determined by the court. The receiver shall be liable only in the receiver's official capacity for injury to person and property by reason of the conditions of the nursing home facility or residential care home. The receiver shall not be personally liable, except for acts or omissions constituting gross, wilful or wanton negligence.

(c) The court, in its discretion, may require a bond of such receiver in accordance with section 52-506.

(d) The court may require the Commissioner of Public Health to provide for the payment of any receiver's fees authorized in subsection (a) of this section upon a showing by such receiver to the satisfaction of the court that (1) the assets of the nursing home facility or residential care home are not sufficient to make such payment, and (2) no other source of payment is available, including the submission of claims in a bankruptcy proceeding. The state shall have a claim for any court-ordered fees and expenses of the receiver that shall have priority over

all other claims of secured and unsecured creditors and other persons whether or not such nursing home facility or residential care home is in bankruptcy, to the extent allowed under state or federal law.

Sec. 14. Section 19a-561 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) As used in this section, (1) "nursing facility management services" means services provided in a nursing facility to manage the operations of such facility, including the provision of care and services, **[**and**]** (2) "nursing facility management services certificate holder" means a person or entity certified by the Department of Public Health to provide nursing facility management services, and (3) "managed facility" means a nursing facility that receives nursing facility management services from a nursing facility management services certificate holder.

(b) No person or entity shall provide nursing facility management services in this state without obtaining a certificate from the Department of Public Health.

(c) Any person or entity seeking a certificate to provide nursing facility management services shall apply to the department, in writing, on a form and in the manner prescribed by the department. Such application shall include the following:

(1) (A) The name and business address of the applicant and whether the applicant is an individual, partnership, corporation or other legal entity; (B) if the applicant is a partnership, corporation or other legal entity, the names of the officers, directors, trustees, managing and general partners of the applicant, the names of the persons who have a **[**ten**]** five per cent or greater beneficial ownership interest in the partnership, corporation or other legal entity, and a description of each such person's relationship to the applicant; (C) if the applicant is a corporation incorporated in another state, a certificate of good standing from the state agency with jurisdiction over corporations in such state; and (D) if the applicant currently provides nursing facility management services in another state, a certificate of good standing from the licensing

agency with jurisdiction over public health for each state in which such services are provided;

(2) A description of the applicant's nursing facility management experience;

(3) An affidavit signed by the applicant and any of the persons described in subparagraph (B) of subdivision (1) of this subsection disclosing any matter in which the applicant or such person (A) has been convicted of an offense classified as a felony under section 53a-25 or pleaded nolo contendere to a felony charge, or (B) has been held liable or enjoined in a civil action by final judgment, if the felony or civil action involved fraud, embezzlement, fraudulent conversion or misappropriation of property, or (C) is subject to a currently effective injunction or restrictive or remedial order of a court of record at the time of application, or (D) within the past five years has had any state or federal license or permit suspended or revoked as a result of an action brought by a governmental agency or department, arising out of or relating to business activity or health care, including, but not limited to, actions affecting the operation of a nursing facility, residential care home or any facility subject to sections 17b-520 to 17b-535, inclusive, or a similar statute in another state or country; and

(4) The location and description of any nursing facility in this state or another state in which the applicant or a beneficial owner of the applicant currently provides management services or has provided such services or is currently or has been the owner, operator or administrator within the past five years and whether any such facility has been subject to:

(A) Three or more civil penalties imposed through final order of the commissioner in accordance with the provisions of sections 19a-524 to 19a-528, inclusive, or civil penalties imposed pursuant to the laws or regulations of another state during the two-year period preceding the date on which such application is submitted;

(B) Sanctions, other than civil penalties less than or equal to twenty

thousand dollars, imposed in any state through final adjudication under the Medicare or Medicaid program pursuant to Title XVIII or XIX of the federal Social Security Act, 42 USC 301, as amended from time to time; or

(C) Termination or nonrenewal of a Medicare or Medicaid provider agreement.

(d) In addition to the information provided pursuant to subsection (c) of this section, the department may reasonably request to review the applicant's audited and certified financial statements, which shall remain the property of the applicant when used for either initial or renewal certification under this section.

(e) Each application for a certificate to provide nursing facility management services shall be accompanied by an application fee of three hundred dollars. The certificate shall list each location at which nursing facility management services may be provided by the holder of the certificate. The nursing facility management services certificate holder shall request the approval of the Department of Public Health to provide nursing facility management services not later than thirty days in advance of providing services to a nursing facility not listed on its certificate. The department may grant said approval subject to conditions or deny such approval based upon the compliance with state and federal regulatory requirements by the nursing facilities managed by the holder of the certificate.

(f) The department shall base its decision on whether to issue or renew a certificate on the information presented and otherwise available to the department and on the compliance status of the managed **[**entities**]** facilities. The department may deny certification to any applicant for the provision of nursing facility management services (1) **[**at any specific facility or facilities where there has been a substantial failure to comply with the Public Health Code, or (2)**]** if the applicant fails to provide the information required under **[**subdivision (1) of**]** subsection (c) of this section, or (2) if the department determines that the applicant or a beneficial owner of the applicant has an unacceptable

history of past and current compliance with state licensure requirements, applicable federal requirements and state regulatory requirements for each licensed health care facility owned, operated or managed by the applicant or a beneficial owner of the applicant in the United States or any territory of the United States during the five years preceding the date on which such application is submitted, as evidenced by:

(A) Any such licensed health care facility being subject to any adverse action described in subdivision (4) of subsection (c) of this section;

(B) Any such licensed health care facility having continuing violations or a pattern of violations of state licensure standards or federal certification standards; or

(C) Criminal conviction of, or a guilty plea by, an applicant or beneficial owner of an applicant on or to a charge of fraud, patient or resident abuse or neglect or a crime of violence or moral turpitude.

(g) Renewal applications shall be made biennially after (1) submission of the information required by subsection (c) of this section and any other information required by the department, **[**pursuant to subsection (d) of this section,**]** and (2) submission of evidence satisfactory to the department that any nursing facility at which the applicant provides nursing facility management services has been and currently is in substantial compliance with federal regulatory requirements, the provisions of this chapter, the Public Health Code and licensing regulations, and (3) payment of a three-hundred-dollar fee.

(h) In any case in which the Commissioner of Public Health finds that there has been a substantial failure by one or more managed facilities to comply with state licensure requirements, applicable federal requirements and state regulatory requirements or a substantial failure by a nursing facility management services certificate holder managing such facilities to comply with the requirements for such certificate holder established under this section, the commissioner may initiate and impose disciplinary action against a nursing facility management

services certificate holder pursuant to section 19a-494. If three or more facilities managed by a nursing facility management services certificate holder are subject to civil penalties imposed through final order of the commissioner in accordance with the provisions of sections 19a-524 to 19a-528, inclusive, during a twelve-month period, the commissioner may impose a civil penalty on the nursing facility management services certificate holder of not more than twenty thousand dollars. The procedure for imposition of said penalty shall be in accordance with subsection (b) of section 19a-494.

(i) The department may limit or restrict the provision of management services by any nursing facility management services certificate holder against whom disciplinary action has been initiated under subsection (h) of this section.

(j) The department, in implementing the provisions of this section, may conduct any inquiry or investigation, in accordance with the provisions of section 19a-498, regarding an applicant or certificate holder.

(k) In any case in which the commissioner finds that there has been a substantial failure to comply with the requirements established under this chapter, or regulations adopted thereunder, the commissioner may require the nursing facility licensee and the nursing facility management service certificate holder to jointly submit a plan of correction as described in section 19a-496, as amended by this act. A plan of correction accepted by the department shall constitute an order of the department. Violation of such order may be the subject of disciplinary action against a nursing facility management services certificate holder pursuant to section 19a-494.

(l) Any person or entity providing nursing facility management services without the certificate required under this section shall be subject to a civil penalty of not more than one thousand dollars for each day that the services are provided without such certificate.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	19a-521b
Sec. 2	*July 1, 2024*	New section
Sec. 3	*July 1, 2024*	New section
Sec. 4	*July 1, 2024*	19a-533
Sec. 5	*from passage*	New section
Sec. 6	*from passage*	17b-357
Sec. 7	*from passage*	19a-496(b)
Sec. 8	*from passage*	19a-700
Sec. 9	*July 1, 2024*	19a-694
Sec. 10	*July 1, 2024*	19a-564(e)
Sec. 11	*from passage*	17b-99a
Sec. 12	*from passage*	19a-543
Sec. 13	*from passage*	19a-547
Sec. 14	*from passage*	19a-561

AGE *Joint Favorable*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 25 $	FY 26 $
Public Health, Dept.	GF - Cost	750,000	None
Resources of the General Fund	GF - Potential Revenue Gain	Minimal	Minimal
Social Services, Dept.	GF - See Below	See Below	See Below

Note: GF=General Fund

Municipal Impact: None

Explanation

Section 1 establishes a Class B violation under CGA Sec. 19a-527, which results in a potential minimal General Fund revenue gain starting 7/1/26 to the extent that violations occur, nursing homes are issued civil penalties by the Department of Public Health (DPH), and associated fines are collected. For each violation, a civil penalty of not more than $10,000 may be imposed. A new violation occurs each day that a nursing home fails to comply.

Section 2, which requires DPH to design a statewide Centers of Excellence Program to provide incentives to licensed nursing homes that deliver services consistent with evidence-based best practices, is anticipated to cost $250,000 in FY 25.

Section 3, which requires DPH to establish an online nursing home consumer report card dashboard, is anticipated to cost $500,000 in FY 25.

Section 11 may result in a fiscal impact to the Department of Social

Services (DSS) associated with forensic audits and related potential civil monetary penalties on certain facilities. The bill specifies that forensic audits may be conducted by DSS, the costs for which the audited facility would be liable. The bill also subjects facilities to civil penalties of up to $3,250 per day until the facility cooperates. DSS may recover such costs and penalties through reduced Medicaid payments otherwise due to impacted facilities.

The Out Years

The costs to DPH in sections 2 and 3 are anticipated to be one-time in nature. The annualized ongoing fiscal impact associated with civil penalties would continue subject to the incidence of related violations and the amount of the penalties imposed.

OLR Bill Analysis

HB 5046

AN ACT PROMOTING NURSING HOME RESIDENT QUALITY OF LIFE.

TABLE OF CONTENTS:

§ 7 — PENALTIES FOR HEALTHCARE INSTITUTIONS FAILING TO COMPLY WITH CORRECTIVE ACTION PLANS

Subjects DPH-licensed healthcare institutions to potential disciplinary action for failing to comply with an accepted plan of corrective action

§§ 8 & 9 — MANAGED RESIDENTIAL COMMUNITY RESIDENCY AGREEMENTS AND FEES

Requires MRCs to (1) include information in written residency agreements on the way they may adjust monthly or other recurring fees; (2) give residents, or their representatives, 90 days' notice of any fee increases; and (3) give residents prorated or full refunds of certain fees if the facility cannot meet the resident's needs within the first 45 days of occupancy

§ 10 — ALSA FEES

Requires ALSAs to (1) disclose fee increases to residents or their representatives at least 60 days before they take effect and (2) upon request, give them the history of fee increases over the past three years

§ 11 — FORENSIC AUDITS OF LONG-TERM CARE FACILITIES

Requires long-term care facilities potentially experiencing serious financial losses to be liable for the costs of any forensic audit by DSS, and subjects them to civil penalties for failure to cooperate

§§ 12 & 13 — APPOINTMENT OF RECEIVERS OF NURSING HOMES OR RESIDENTIAL CARE HOMES

Requires nursing home or residential care home receiver applications be granted if the facility sustains any type of serious financial loss or failure and updates the criteria for who may be appointed as a receiver of these facilities

§ 14 — NURSING FACILITY MANAGEMENT SERVICES

Requires each entity seeking a nursing facility management certificate to disclose additional information in its application, revises the criteria upon which DPH can base its certificate issuance decisions, and expands the penalties and grounds upon which DPH can impose disciplinary action against these certificate holders

SUMMARY

This bill makes changes related to the management and oversight of long-term care and similar licensed facilities. For example, it:

1. prohibits nursing homes from placing residents in a room

containing more than two beds, for newly admitted residents starting July 1, 2025, and for all residents one year after that (§ 1);

2. requires the design of a Center of Excellence Program for nursing homes (§ 2);

3. requires the establishment of an online nursing home consumer report card, within available appropriations (§ 3);

4. phases out the license category of rest homes with nursing supervision (§ 5);

5. authorizes the Department of Public Health (DPH) to impose disciplinary action on licensed health care institutions that fail to comply with a plan of correction accepted by the department (§ 7); and

6. explicitly authorizes the Department of Social Services (DSS) to conduct forensic audits and makes facilities liable for the cost of forensic audits (§ 11).

The bill also makes various minor, technical, and conforming changes.

EFFECTIVE DATE: Upon passage, unless otherwise specified below.

§ 1 — NURSING HOME ROOM CAPACITY LIMITATIONS

Prohibits each licensed chronic and convalescent nursing home and rest home with nursing supervision from placing residents in a room containing more than two beds

The bill prohibits each licensed chronic and convalescent nursing home and rest home with nursing supervision (nursing home) from placing newly admitted residents in a room containing more than two beds beginning on July 1, 2025. It also prohibits any resident room at a nursing home from containing more than two beds beginning on July 1, 2026.

A violation is a Class B violation and may result in a civil penalty of up to $10,000. A new violation occurs each day that a nursing home fails

to comply with this section and an additional penalty may be assessed.

§ 2 — NURSING HOME CENTER OF EXCELLENCE PROGRAM

Requires the public health commissioner to design a Center of Excellence Program for licensed nursing homes to provide incentive for those that meet certain criteria

The bill requires the DPH commissioner to design a Center of Excellence Program to provide incentives for qualifying nursing homes. A "Center of Excellence" is a nursing home that serves residents in a manner consistent with evidence-based best practices for person-centered care.

While designing the program, the commissioner must study (1) how much a Center of Excellence Program could improve the quality of care at nursing homes, and (2) what other states with similar programs consider to be best practices for nursing homes.

The commissioner is also required to consult:

1. nursing home owners and operators,
2. hospitals,
3. nursing home residents and their advocates,
4. the Office of the Long-Term Care Ombudsman,
5. the DSS commissioner or her designee,
6. the Office of Policy and Management (OPM) secretary or his designee, and
7. other relevant stakeholders as the DPH commissioner considers necessary.

The program's design must at least do the following:

1. identify evidence-based qualitative and quantitative standards for care delivery that a nursing home must meet to be designated as a Center of Excellence, and the measures that must be met for

each standard;

2. identify a pathway for nursing homes to achieve this designation (by applying, an inspection, or other means), and create a way to designate them;

3. determine potential incentives for nursing homes that meet these standards; and

4. identify ways to maximize the use of available federal funding to support the program.

The program is voluntary, and nursing homes will not be penalized if they do not participate.

The commissioner can engage with a consultant, within available appropriations, to identify best practices and design the program.

Upon completing the program's design or no later than January 1, 2026, the commissioner is required to report to the OPM secretary on the plan developed.

The DSS commissioner is authorized to seek an amendment to the state Medicaid plan, or a waiver from federal law, to provide incentives for the program participants. The commissioner must develop incentives that do not duplicate other federal or state funding.

EFFECTIVE DATE: July 1, 2024

§ 3 — ONLINE NURSING HOME CONSUMER REPORT CARD

Requires DPH to establish an online nursing home consumer report card, within available appropriations

The bill requires DPH, in consultation with the Office of the Long-Term Care Ombudsman and the Long-Term Care Advisory Council, to establish an online nursing home consumer report card, within available appropriations, that includes:

1. comprehensive information on the quality of care for people in need of nursing home care and their families, and

2. industry leading practices.

DPH is required to include a link to the report in a prominent place on the department's website.

EFFECTIVE DATE: July 1, 2024

§ 4 — NURSING HOME WAITING LIST AND TRANSFERS

Requires nursing homes, without regard for the waiting list, to admit transferring residents from a nursing home that is closing; generally exempts from this requirement homes with no more than 30% self-pay patients if the transferring patient is indigent

Under existing law and subject to certain exceptions, nursing homes receiving state funds for providing care for the indigent must admit applicants on a first-come, first-served basis and cannot discriminate against indigent applicants based on their source of payment.

Under one existing exception, a nursing home with 30% or fewer self-pay residents is not required to admit an indigent person on a waiting list when a bed becomes available in the following six months, provided that a bed cannot be held open for more than 30 days. A home taking advantage of this waiver must notify DSS and the regional long-term care ombudsman on a quarterly basis. The bill specifically requires the home to notify these entities on the date the exemption began, and quarterly thereafter.

Under current law, nursing homes are authorized to admit transferring residents from a nursing home that was closing without regard for the waiting list. The bill makes this mandatory, with one exception (see below). This specifically applies to applicants wishing to transfer from a nursing home (1) that is closing or (2) in which they were placed after the nursing home where they previously resided closed (or for homes in receivership, was anticipated to close).

Under the bill, nursing homes that qualify for the waiting list exemption described above (i.e., homes with no more than 30% self-pay patients) are not required to admit indigent persons who are transferring under these provisions except when they are being transferred from a nursing home that is closing due to an emergency.

EFFECTIVE DATE: July 1, 2024

§ 5 — DISCONTINUATION OF REST HOME WITH NURSING SUPERVISION LICENSES

Prohibits the DPH commissioner from granting new rest home with nursing supervision licenses

The bill prohibits the DPH commissioner from granting new licenses to establish or operate a rest home with nursing supervision. A rest home with nursing supervision is a residential facility that provides intermediate care services to residents. (In practice, nursing homes generally have been phasing out these beds or converting them to chronic and convalescent nursing home beds.)

The DPH commissioner is authorized to approve a one-time license renewal for a duration of one year or less if the applicant follows the existing criteria for renewal. Applicants seeking a one-year license renewal are prohibited from appealing a decision to deny the renewal.

§ 6 — NURSING FACILITIES AND STATE ENFORCEMENT AUTHORITY

Extends certain existing procedures and penalties for nursing home violations of federal law to violations of state laws or regulations

Under the bill, if a Medicaid-participating nursing facility is found to be noncompliant with applicable state statutes or regulations during a DPH survey, it is treated the same as being noncompliant with specified federal law under existing procedures.

Under this law, among other things:

1. if DPH finds that this noncompliance poses an imminently serious threat to patient well-being, it must state the charges and request a summary order from DSS, which (if issued) must include termination of Medicaid participation or appointment of a temporary manager and may include other penalties (e.g., having patients transferred to other facilities or civil penalties);

2. if DPH finds that this noncompliance does not pose an immediate threat, it must state the charges and request that DSS impose any

of a range of similar remedies as for imminently serious charges (but none are mandatory); and

3. the facility may request a hearing with DSS within 10 days of the statement of charges or summary order.

Other existing laws, under specified procedures, authorize DPH to impose a range of sanctions on nursing homes that violate applicable state laws or regulations.

§ 7 — PENALTIES FOR HEALTHCARE INSTITUTIONS FAILING TO COMPLY WITH CORRECTIVE ACTION PLANS

Subjects DPH-licensed healthcare institutions to potential disciplinary action for failing to comply with an accepted plan of corrective action

By law, a DPH-licensed health care institution (such as a hospital or nursing home) must submit a correction plan to DPH if the department, after an inspection, issues a notice that the institution was out of compliance with applicable state laws or regulations. DPH may impose disciplinary action on these institutions if they fail to submit a plan of correction meeting the law's requirements.

The bill additionally authorizes DPH to impose disciplinary action on these institutions if they fail to comply with a plan of correction accepted by the department. These actions may only be imposed after a hearing and may include, among other things:

1. revocation or suspension of a license;

2. censure of a licensee;

3. placement of a licensee on probationary status, and the requirement to report regularly to the department on the matters which are the basis of the probation;

4. restricting the acquisition of other facilities for a period set by the commissioner; or

5. issuing an order compelling compliance with applicable laws or regulations of the department.

§§ 8 & 9 — MANAGED RESIDENTIAL COMMUNITY RESIDENCY AGREEMENTS AND FEES

Requires MRCs to (1) include information in written residency agreements on the way they may adjust monthly or other recurring fees; (2) give residents, or their representatives, 90 days' notice of any fee increases; and (3) give residents prorated or full refunds of certain fees if the facility cannot meet the resident's needs within the first 45 days of occupancy

Existing law requires managed residential communities (MRC) to give each resident a written residency agreement that clearly sets forth the resident's and the MRC's rights and responsibilities. The bill modifies the contents of the agreement and establishes notification and reimbursement requirements for certain resident fees.

EFFECTIVE DATE: July 1, 2024, except the provisions on the residency agreements are effective upon passage.

Written Residency Agreement

The bill adds to the required contents of the agreement the way in which MRCs may adjust monthly or other recurring fees, including (1) how often fees may increase, (2) the schedule or specific dates of these increases, and (3) the history of fee increases over the past three calendar years.

Under current law, written residency agreements must include, among other things, a full and fair disclosure of all charges, fees, expenses, and costs to be borne by the resident. The bill specifies that this includes nonrefundable charges, fees, expenses, and costs.

The bill's provisions apply to written residency agreements entered into on and after July 1, 2024.

Fee Notifications and Reimbursements

The bill requires MRCs to give residents, or their representatives, 90 days' advance notice of any increase in monthly or recurring fees and written disclosure of any nonrefundable charges.

It also requires MRCs to give residents prorated or full reimbursements of certain charges if the MRC determines it can no

longer meet the resident's needs during the first 45 days of the resident's occupancy (e.g., prorated first month's rent, prorated community fee, full last month's rent, and full security deposit).

Background — Related Bill

sHB 5001, §§ 23 & 24, favorably reported by the Aging Committee, modifies the contents of MRC residency agreements and related notification and reimbursement requirements in a similar manner, on and after October 1, 2024, instead of July 1, 2024.

§ 10 — ALSA FEES

Requires ALSAs to (1) disclose fee increases to residents or their representatives at least 60 days before they take effect and (2) upon request, give them the history of fee increases over the past three years

Existing law requires an assisted living services agency (ALSA) to ensure all services provided individually to clients are fully understood by the client or the client's representative, and that the client or representative is made aware of their cost.

The bill also requires an ALSA to (1) disclose fee increases to the client or representative at least 60 days before they take effect and (2) upon request, give the resident or representative the history of fee increases over the past three calendar years.

The bill specifies that this requirement does not limit an ALSA from immediately adjusting fees if (1) they are directly related to a change in the level of care or services necessary to meet the resident's safety needs at the time of a scheduled resident care meeting or (2) the resident's condition changes, resulting in a required change in services.

EFFECTIVE DATE: July 1, 2024

Background — Related Bill

sHB 5001, § 25, favorably reported by the Aging Committee, requires ALSAs to disclose fee increases to residents or their representatives at least 90 days before they take effect and, upon request, to give them the history of fee increases over the past three years, effective October 1, 2024.

§ 11 — FORENSIC AUDITS OF LONG-TERM CARE FACILITIES

Requires long-term care facilities potentially experiencing serious financial losses to be liable for the costs of any forensic audit by DSS, and subjects them to civil penalties for failure to cooperate

Existing law sets procedures and requirements related to DSS audits of long-term care facilities that receive Medicaid or other state payments (including chronic and convalescent nursing homes, chronic disease hospitals associated with them, rest homes with nursing supervision, residential care homes, and certain residential facilities for persons with intellectual disabilities).

The bill explicitly extends these provisions to forensic audits. A "forensic audit" is an examination of financial records for information or evidence which may be used in legal proceedings.

The bill also requires facilities identified by DSS as potentially experiencing a serious financial loss to be liable for the costs of a forensic audit (such as reports or subsequent testimony) if DSS requires them to undergo one. It requires the facilities to fully cooperate with forensic audits and to ensure that their personnel, financial consultants, and accountants also cooperate as necessary. If a facility does not comply with DSS's written request to cooperate, the facility is subject to a maximum civil penalty of $3,250 per day until it cooperates. Facilities are permitted to appeal any civil penalties under this section in accordance with DSS's administrative appeals process.

The bill authorizes DSS to recover the costs of conducting a forensic audit, or these civil penalties, through deducting the amount from Medicaid payments due to be made to the facility.

§§ 12 & 13 — APPOINTMENT OF RECEIVERS OF NURSING HOMES OR RESIDENTIAL CARE HOMES

Requires nursing home or residential care home receiver applications be granted if the facility sustains any type of serious financial loss or failure and updates the criteria for who may be appointed as a receiver of these facilities

By law, DSS or DPH, or in some cases a facility resident or a resident's representative, may apply to Superior Court seeking the appointment of a receiver for a nursing home or residential care home under certain

circumstances. The bill requires the court to grant the application for a receiver if the facility experiences a serious financial loss or failure. Under current law, this applies only if that financial loss or failure jeopardizes the health, safety, and well-being of patients. Generally, a receiver is a neutral party the court appoints to operate the facility until conditions improve or, in some cases, the facility is ready to be closed.

The bill removes the requirement for a receiver to be a licensed nursing home facility administrator or have experience as a residential care home administrator or something similar, as applicable. It requires candidates to have substantial experience in the delivery of high-quality health care services and management of long-term care facilities; current law does not specifically reference the quality of services. The bill also requires candidates to have a level of education or licensure that is customarily commensurate with people who manage facilities like the one under receivership.

The bill also removes the requirement for DSS to adopt regulations on receiver qualifications.

§ 14 — NURSING FACILITY MANAGEMENT SERVICES

Requires each entity seeking a nursing facility management certificate to disclose additional information in its application, revises the criteria upon which DPH can base its certificate issuance decisions, and expands the penalties and grounds upon which DPH can impose disciplinary action against these certificate holders

The bill requires nursing facility management services certificate applicants who have beneficial owners to include the names of all persons who have a 5% or greater ownership interest in the applying entity and a description of their relationship to the applicant. Under current law, the threshold to disclose a beneficial owner is 10%.

Under existing law, people listed on the application must sign an affidavit disclosing certain information about their criminal history, civil cases, or health care business-related disciplinary actions.

The bill requires applicants to also disclose:

1. the location and description of any nursing facility (in any state)

to which a beneficial owner provides, or has provided within the last five years, management services, and

2. if a beneficial owner or applicant owns, operates, or administers a nursing facility, or has within the last five years.

Additionally, the bill requires applicants to disclose if any such nursing facility associated with the applicant or beneficial owner has been subject to any of the following:

1. three or more civil penalties imposed through DPH final orders or by other states within the last two years;

2. Medicare or Medicaid sanctions in any state, other than civil penalties of $20,000 or less; and

3. nonrenewal or termination of a Medicare or Medicaid provider agreement.

Providing Nursing Facility Management Services to Facilities not Listed on the Original Certificate

The bill requires nursing facility management certificate holders to request the approval of DPH to provide management services to a facility not listed on their certificate at least 30 days before doing so. The department has the discretion to approve the request subject to conditions or deny the request based on the certificate holder's compliance history with state and federal regulatory requirements at the facilities it manages.

Adjudication of Applications

The bill requires DPH to base its decision to renew or issue a certificate on information otherwise available to DPH, in addition to the information submitted to DPH by the applicant and the managed facilities' compliance status as under current law.

The bill expands the conditions under which DPH may deny a nursing facility management certificate. Current law allows DPH to do so based on the substantial failure to comply with the Public Health

Code. The bill instead allows DPH to deny issuing a certificate if the applicant or a beneficial owner has an evidentially demonstrable unacceptable history of compliance with (1) state licensure requirements; (2) federal requirements; and (3) state regulatory requirements for each licensed health care facility owned, operated, or managed by the applicant or beneficial owner in the United States in the five years before the application.

The bill states that an unacceptable history of compliance can be evidenced by:

1. licensed health care facilities being subject to the adverse actions described above that must be listed on the application (e.g., three or more civil penalties);

2. licensed health care facilities having continuing violations, or a pattern of violations, of state licensure standards or federal certification standards; or

3. the criminal conviction or guilty pleas by an applicant or beneficial owner to charges of fraud, patient or resident abuse or neglect, or a crime of violence or moral turpitude.

Under existing law, unchanged by the bill, DPH can also deny an application based on the facility's failure to provide required information.

The bill requires renewal applicants to submit satisfactory evidence that any nursing facilities that the applicant provides management services to is in substantial compliance with federal regulatory requirements. As under existing law, the applicant must also submit evidence that they are in substantial compliance with existing state law, the Public Health Code, and licensing regulations, in addition to any other information DPH requires. The bill also specifies that the applicant must show a history of past compliance.

Disciplinary Action for Failing to Comply With State and Federal Requirements

Existing law authorizes DPH to impose disciplinary action (e.g., suspension or revocation of the certificate) on a nursing facility management services certificate holder for substantial failure to comply with statutory requirements. The bill specifically authorizes DPH to also impose discipline on them if, at any of the facilities they manage, there is a substantial failure to comply with state licensure requirements, state regulatory requirements, or federal requirements.

The bill also authorizes DPH, after a hearing, to impose a civil penalty on a nursing home facility management certificate holder of $20,000 or less if three or more facilities managed by the certificate holder are subject to civil penalties imposed by DPH during a 12-month period.

Under existing law, DPH may require a certificate holder and the nursing facility licensee to submit a plan of corrective action to DPH when the commissioner finds there has been a substantial failure to comply with requirements applicable to nursing home facility management certificate holders. Under the bill, a plan of correction accepted by DPH is an order of the department, and violations of these orders can result in disciplinary action against the certificate holder. Disciplinary actions can include, among other things, the suspension or revocation of the certificate.

COMMITTEE ACTION

Aging Committee

Joint Favorable
Yea 15 Nay 0 (03/12/2024)