https://www.cga.ct.gov/PS98/rpt%5Colr%5Chtm/98-R-0277.htm

Topic:
NURSING HOMES; STATE BOARDS AND COMMISSIONS;
Location:
NURSING HOMES;

OLR RESEARCH REPORT

Final Report of the

Nursing Home Working Group

Representative Peter Villano, Chairman

February, 1998

98-R-0277

TABLE OF CONTENTS

EXECUTIVE SUMMARY

In 1996 a legislative task force was established by public act. It studied a number of issues concerning nursing homes and made recommendations in January of 1997. To follow up on the work of that task force, in 1997 the Human Services Committee formed an informal Nursing Home Working Group, chaired by Representative Peter Villano.

The working group was charged with studying a number of nursing home issues, including but not limited to:

1. The financial viability of the nursing home industry

2. Nursing home access and utilization

3. Rates and reimbursement

4. Information and data collection

5. Levels of care provided by nursing home facilities, including, but not limited to, intermediate care, skilled nursing care, chronic and convalescent care, and rest home with nursing home supervision care

6. Quality assurance

7. The impact of Medicaid managed care on nursing home care and services

8. Which department should regulate the continuing care retirement community industry and whether additional regulations are needed to protect residents or prospective residents from financial loss

Given its overall charge, the working group agreed to form a number of subcommittees. These included subcommittees on (1) nursing home finance, which would be responsible for examining the industry's financial viability, nursing home rates and rates of reimbursement; (2) nursing home access and utilization, including long-term care; (3) quality and care levels, focusing on

quality assurance and the levels of care provided by nursing home facilities, including intermediate care, skilled nursing care, chronic and convalescent care, and rest home with nursing supervision care; (4) Medicaid managed care, studying the impact of Medicaid managed care on nursing home care and service; and (5) continuing care retirement communities, to study the question of which department should regulate that industry and whether additional regulations are needed.

The full working group met six times. The individual subcommittees met a total of 18 times over the course of several months and made recommendations to the full working group in late January and early February 1998. The number of meetings for each was as follows:

No. of Meetings

1. Full working group 6

2. Finance 5

3. Access and Utilization 3

4. Quality Care 3

5. Medicaid Managed Care 2

6. Continuing Care Retirement Communities 5

The working group reviewed all of the recommendations and adopted most of them with some revisions.

The focus of this year's working group was to provide for an ongoing constructive dialogue among parties interested in the nursing home industry and long-term care as it relates to financial stability and quality of care issues; to continue last year's task force work such as the call for better data collection on nursing home access, demand, and bed availability; to provide for further support and review of certain areas of long-term care, including home and community care and continuing care retirement communities; to call again for the study and articulation of a State of Connecticut long-term care policy; and to consider the impact of the 1115 waiver proposal and other cost control options on Medicaid managed care as it relates to nursing home care and services.

The working group agreed that there were several areas that required ongoing study and participation by the interested and affected parties in order to achieve maximum and continuing benefit. The working group's major recommendations include a nursing home financial advisory committee adjunct to the departments of Social Services and Public Health for the purpose of early identification of nursing homes in distress; a study of case mix with quality indicators as an alternative form of reimbursement; creation of a Long-term Care Commission to study and articulate a state long-term care policy; a study of long-term care bed supply and demand; and

strengthening of preconstruction and reporting requirements for continuing care retirement communities.

The working group affirms that nursing homes and other health care providers should be regulated in a way that promotes quality of care. The end result should be oversight and reimbursement that rewards and promotes quality of care as well as cost control and solvency.

RECOMMENDATIONS

The working group approved the following recommendations. The attached subcommittee reports provide a more detailed analysis of the issues involved and the rationales for the recommendations (Appendices I – IV).

Finance

1. The working group recommends establishing an early warning system for nursing homes in financial distress. Specifically, DSS, in conjunction with DPH, should work with a *Nursing Home Financial Advisory Committee* to (a) examine, on an ongoing basis, the financial solvency of nursing homes and (b) support those departments in their regulatory mission to provide industry oversight that promotes financial solvency and quality care.

2. The working group recommends that the DSS commissioner may, on the advice of the Nursing Home Finance Advisory Committee, allow minimum fair rent as the base upon which property reimbursement associated with property improvements is added.

3. The working group recommends the study of a Case-Mix Adjusted Payment System.

Access and Utilization

1. The working group recommends establishing a long-term care commission to develop a state-wide long-term care plan that covers the full spectrum of options such as nursing home care, home and community-based services, supportive housing arrangements, adult day care, and assisted living. In addition, the working group recommends that the state fund a study, perhaps conducted by the long-term care commission to determine if there are access problems **(a) in certain geographic areas, (b) for those with certain payment sources, (c) for people with certain diagnoses, (d) for people who only require long-term care, and (e) as a result of the designation of special care or subacute units.**

2. The working group recommends that Medicaid-covered nursing home residents be allowed to utilize their Medicaid home leave days with hospital bed hold days when they require extensive, inpatient psychiatric hospitalization, provided that the nursing facility receives payment for such home leave days.

3. The working group recommends that training for assisting long-term care providers who care for people with behavioral symptoms be coordinated and intensified by creating a partnership of provider groups and relevant state agencies.

4. The working group recommends that this partnership develop interdisciplinary mobile teams to assist long-term care providers in caring for individuals experiencing behavioral symptoms in the settings where they reside.

5. The working group recommends that training for assisting long-term care providers who care for people with behavioral symptoms be coordinated and intensified by creating a partnership of provider groups and relevant state agencies.

6. The working group recommends that this partnership develop interdisciplinary mobile teams to assist long-term care providers in caring for individuals experiencing behavioral symptoms in the settings where they reside.

7. The working group recommends that the state build further upon the existing home- and community-based care system in order to effectively identify, target, and provide care management for clients. The Connecticut Home Care Program for Elders funding should be increased substantially. The working group further recommends changing one of the eligibility criteria, namely, including medically needy as well as categorically needy.

8. The working group recommends that the state explore additional community-based service options, such as assisted living services and adult day care centers, including federal waivers, when appropriate.

Quality Care

1. The working group recommends adoption and implementation of the proposed changes in the new Public Health Code regulations of the Department of Public Health and specifically the new Section 19a-X-III on quality of life, care and services.

2. The working group recommends that additional training in different types of care be given to ensure the quality of care at nursing homes.

Medicaid Managed Care

This subcommittee was to study the impact of Medicaid Managed Care on nursing home care and service. However, in view of the status of the proposed 1115 Waiver plan, which DSS has decided not to go forward with at this time, this subcommittee's meetings remaining scheduled meetings were cancelled and the subcommittee was disbanded. A copy of the DSS commissioner's letter is attached. *

Continuing Care Retirement Communities

1. The working group recommends that the supervision of CCRCs remain with the Department of Social Services (DSS).

2. The working group recommends shifting certain CCRC requirements from statute to regulation.

3. The working group recommends giving the DSS commissioner authority to strengthen preconstruction and reporting requirements for CCRCs.

4. The working group recommends requiring prospective CCRC residents to sign a notice document.

5. The subcommittee discussed the issue of whether all CCRCs should have a requirement that fire insurance proceeds should go to a trustee for the purpose of rebuilding the complex.

6. The working group recommends that a CCRC be required to promptly notify the DSS Commissioner whenever it taps into its reserves.

7. The working group recommends that the legislature should budget an amount at least equivalent to the fees CCRCs pay DSS to hire staff or outside consultants with specific expertise to review feasibility studies, disclosure statements, annual filings and changes in corporate structure.

8. The working group recommends that DSS be empowered to charge back to the affected CCRC its costs in "extraordinary" situations (e.g., cost of corporate restructuring, remedial action for financially troubled CCRCs, and potential bankruptcies and receiverships).

Attachment:

*DSS Commissioner's letter about 1115 waiver.

APPENDIX I

NURSING HOME FINANCE SUBCOMMITTEE REPORT

TO: Nursing Home Working Group

FROM: Representative Peter Villano, Subcommittee Chair

RE: Recommendations on Financial Viability of Nursing Homes

DATE: January 20, 1998

SCOPE OF REVIEW

The subcommittee was asked to review and evaluate the financial viability of nursing homes and, if there are problems, determine what can be done to improve their financial viability.

BACKGROUND

Under current statutes and regulations, the Department of Social Services (DSS) is responsible for administration of the Medicaid program including rate setting for nursing facilities. Nursing facility rates in Connecticut are set on a cost-based prospective system in accordance with CGS Section 17b-340. Cost reports are due from facilities by December 31st of each year for the cost report period of October 1 of the prior year through September 30. The cost report filings include balance sheet information as of September 30. DSS does not routinely analyze the financial strength of facilities.

There are 270 nursing facilities in Connecticut with a total of 32,000 beds. In state fiscal year (SFY) 1997, Medicaid payments for nursing facility services were $838.1 million. There were an average of 21,500 Medicaid recipients in nursing facilities during this period. The average Medicaid rate was $130 per day. In SFY 1998, the average Medicaid rate is $133 per day.

The Department of Public Health (DPH) is responsible for the licensure and Medicare/Medicaid certification of nursing facilities. Under CGS Section 19a-543, the DPH may seek the appointment of a receiver if a nursing facility "has sustained a serious financial loss or failure which jeopardizes the health, safety and welfare of the patients." DSS worked with and assisted DPH with situations that required nursing facility receivership actions due to financial problems.

Six facilities were placed in receivership in the past twelve months. Five of the six were operated by the same non-profit organization (AHF Connecticut, Inc.). Debt service associated with borrowing for the purchase and renovation of the facilities greatly exceeded costs allowed under Medicaid reimbursement and two of the facilities experienced high vacancy rates. The six facilities are still operating. Five of them are currently in receivership and one was taken over by another company.

The subcommittee is concerned that there is presently no formal monitoring of the financial viability of nursing facilities. DSS prepared sample financial viability analysis reports for the Finance Subcommittee of the Nursing Home Work Group. These materials included 1996 reported profits and losses and profits and losses adjusted for unallowable Medicaid costs (e.g. "excess" rent, management fees, and owner compensation). In addition, DSS compiled lists and rankings of facilities with high levels of accounts payable and "adjusted" losses. One analysis identified 33 facilities that had potential financial viability issues. Of those, 20 were either being addressed or had already been addressed through Medicaid rate adjustment sought by operators. The other facilities require further review.

FINDING OF PUBLIC POLICY

It is in the interest of the state to promote the financial viability of nursing homes. Nursing homes must provide a safe and stable environment for residents as well as achieve quality health care. Given the fact that the state has placed a moratorium on new nursing home beds and that the state has significant financial interest as both payer and backer of nursing homes, it is in the state's interest to promote financial viability in the industry. In addition, the state has an interest in assuring a smooth transition from an insolvent facility to a financially sound one. The best way to ensure a stable environment for nursing home residents is to identify financial and/or care problems and take steps early to avert a disruption in care.

RECOMMENDATIONS

1) The subcommittee recommends establishing an early warning system for nursing homes in financial distress. Specifically, DSS, in conjunction with DPH, should work with a *Nursing Home Financial Advisory Committee* to (a) examine, on an ongoing basis, the financial solvency of nursing homes and (b) support those departments in their regulatory mission to provide industry oversight that promotes financial solvency and quality care.

The ***Nursing Home Financial Advisory Committee*** shall be composed of 12 members. The following six appointments shall be made by the legislative leaders: 1) an advocate for nursing home clients, 2) a labor representative, 3) two representatives from the non-profit sector of the nursing home industry, and 4) two representatives from the for-profit sector of the nursing home industry. The Governor shall appoint two at-large members. The commissioners of the Department of Social Services, or her designee, and Department of Public Health, or his designee, shall serve on the committee and be its co-chairmen. The secretary of the Office of Policy and Management, or his designee, as well as the nursing home ombudsman, shall also serve on the committee.

The Department of Social Services and the Department of Public Health shall develop a system to provide financial and quality reports that gauge the health of nursing homes in the state. The system shall identify homes that appear to be heading towards financial distress and examine the underlying reasons for the financial difficulty. The information shall be reported to the advisory committee, which shall recommend appropriate action for improving the financial condition of the nursing home to the commissioner of social services.

The advisory committee shall report annually on its activities to the legislature's committees of cognizance. The departments, in conjunction with the advisory committee, shall establish the criteria used to determine financial stability and the format for reporting such information. The subcommittee recommends that additional financial resources be allocated for the advisory committee's functions.

2) The subcommittee recommends that the DSS commissioner may, on the advice of the Nursing Home Finance Advisory Committee, allow minimum fair rent as the base upon which property reimbursement associated with property improvements is added. One of a number of factors used in calculating nursing homes' allowable costs for the formula that sets their Medicaid reimbursement is a "fair rent allowance." This factor is calculated to yield a constant amount each year in place of mortgage interest and depreciation costs on property. But a facility that has allowable fair rent less than the 25th percentile of the statewide allowable fair rent is reimbursed as though it had fair rent equal to the 25th percentile (known as the "minimum fair rent").

There are concerns that if an older facility that has been receiving the minimum fair rent allowance needs to make renovations, the actual cost of making the renovations will not be reflected in its Medicaid reimbursement. Particularly for facilities that are over 30 years old and have their original mortgage paid off, making renovations does not necessarily result in a corresponding increase in the Medicaid rate it receives. This could be a disincentive to do those renovations because, if the cost is less than the minimum fair rent, that factor stays the same. If the cost is more than minimum fair rent, replacing the minimum by the actual cost means the

home's new rate reflects only part of the renovation costs. Suppose a facility's actual fair rent costs are $2 but it already gets the minimum fair rent of, for example, $5 per patient day. If it then makes improvements whose annualized cost is $2, that would result in an actual cost of $4, which continues to entitle the facility only to the $5 minimum fair rent. If, on the other hand, that $5 is instead used *as a base* and the $2 for the renovations is added on top of it, that would give the facility a higher reimbursement factor of $7, which could provide more incentive for older homes to make renovations.

The subcommittee discussed setting conditions on this option, but decided to leave that area to the advisory committee to decide when it is warranted. The advisory committee could recommend using this method of calculation when a facility has costs in excess of caps or when it needs this adjustment to obtain financing for facility improvements or applying other specific criteria.

3) The subcommittee recommends the study of a Case-Mix Adjusted Payment System. The Long Term Care Commission (to be established by the legislature pursuant to the task force recommendations) shall coordinate a study concerning the application of a case-mix adjusted Medicaid payment system with quality indicators for nursing facility services. The commission shall coordinate the study with the assistance of the legislative and executive branches, and shall review the advisability of implementing a case-mix payment system in Connecticut. Among the areas to be considered in this study are the effect of a case-mix system upon access; administrative complexity and cost; quality of care; levels of care, including physical, medical, and mental status of the resident; and cost equity for nursing facilities. This study shall include a complete review of systems operating in other states, an identification of the success and failures of those systems, and the effect of case-mix adjusted payment systems on wages and benefits.

Since case-mix payment system design can range from basic to complex, the study shall include a range of options for consideration, each having an assessment of the potential fiscal impact on the Medicaid program and its administration. Such report shall be submitted to the committees of cognizance by September 30, 1999. Funds to complete the study shall be appropriated by the legislature.

*Note: On Recommendation No. 2, Leslie Frane cast a dissenting vote and Bill Eddy abstained.

FINANCE SUBCOMMITTEE MEMBERS

Representative Peter Villano, Chair

William Eddy Gary Richter

Rick Wallace Sara Johnson-McDuffie

Michael Lipnicki Cynthia Denne

Irving Kronenberg Theresa Cusano

Leslie Frane Marvin Fried

Lawrence Santilli

Attachments:

1. Fair Rent Allowance Discussion by Lawrence Santilli

2. Leslie Frane's Dissenting Statement on Fair Rent Allowance

APPENDIX II

NURSING HOME ACCESS AND UTILIZATION SUBCOMMITTEE REPORT

TO: Nursing Home Working Group

FROM: Representative Christel Truglia, Subcommittee Chair

RE: Recommendations on Nursing Home Access and Utilization

DATE: January 28, 1998

SCOPE OF REVIEW

The subcommittee was asked to review access and utilization issues affecting both present and future nursing home residents.

BACKGROUND

The access and utilization subcommittee represented a broad base of interests drawn from the nursing home and community care industry, agency representatives, and advocates. Access issues affect the whole spectrum of long-term care. If people need to be in a nursing home and cannot be admitted to one in a timely manner, they need to make other arrangements for their care at home or in the community. On the other hand, additional opportunities for home and community care, such as home health care and homemaker services, adult day care, and assisted living services in elderly housing complexes, may reduce or delay nursing home admissions. Issues the subcommittee discussed include the need for a comprehensive long-term care plan, a broadening of seniors' options, problems associated with special care and subacute units, and the multiple challenges regarding the care of nursing home residents who have mental health or severe behavioral symptoms.

The subcommittee drew heavily on the extensive work of its predecessor subcommittee of last year's nursing home task force.

RECOMMENDATIONS

1) The subcommittee recommends establishing a long-term care commission to develop a state-wide long-term care plan that covers the full spectrum of options such as nursing home care, home and community-based services, supportive housing arrangements, adult day care, and assisted living. The subcommittee generally supports the interagency long-term care committee in the Program Review proposal and its proposed functions, but recommends that it be expanded to include advocates, consumers of services, and industry representatives. The subcommittee envisions the long-term care ***commission's*** composition as made up of 20 members. These would include the commissioners of the departments of Social Services (DSS) and Public Health or their designees (who should be its co-chairmen), a representative from the Office of Policy and Management, a representative from the DSS alternate care division, a representative from the Department of Economic and Community Development, the executive director of the Commission on Aging or her designee, the state long-term care ombudsman or her designee, and the president of the Coalition of Presidents of Resident Councils or his or her designee. In addition, the following members should be appointed by legislative leaders: one consumer of long-term care services; one member of an advocacy group; one long-term care employee representative; two nonprofit nursing home representatives; two for-profit nursing home representatives; two representatives of the homecare industry, one of which must be a representative of an access agency; one representative of adult daycare centers, and one representative of assisted living services agencies. The Governor should appoint one member at-large.

The subcommittee recommends that the commission should articulate a comprehensive long-term care plan and study issues related to long-term care. The subcommittee generally agrees with Program Review's proposal for what should be included in the long-term care plan. Specifically, the plan should include:

1. A vision/mission statement for a long-term care system

2. The current number of elders receiving services

3. Elder demographics by service type

4. The current aggregate cost of the service system

5. Forecasts of future demand for services

6. The type of services available and the funding necessary to meet the demand

7. Projected costs for programs associated with the system

8. Strategies to promote the Connecticut Partnership for Long-Term Care

9. Resources necessary to accomplish future goals

10. Available funding sources

11. The number and types of providers needed to deliver services.

In addition, the subcommittee recommends that the state fund a study, perhaps conducted by the long-term care commission, with balanced participation in its design, to determine if there are access problems **(a) in certain geographic areas, (b) for those with certain payment sources, (c) for people with certain diagnoses, (d) for people who only require long-term care, and (e) as a result of the designation of special care or subacute units.** The study should integrate existing data base systems in a coordinated effort to avoid duplication and maximize utilization of current resources. Creation of a central database on waiting lists could aid these efforts. If access problems are found, the study should explore whether state laws and regulations affect nursing home access and utilization. The study should also **assess the need for nursing home beds and the demand for their use and for other types of long-term care.**

2) The subcommittee recommends that Medicaid-covered nursing home residents be allowed to utilize their Medicaid home leave days with hospital bed hold days when they require extensive, inpatient psychiatric hospitalization, provided that the nursing facility receives payment for such home leave days.

3) The subcommittee recommends that training for assisting long-term care providers who care for people with behavioral symptoms be coordinated and intensified by creating a partnership of provider groups and relevant state agencies.

4) The subcommittee recommends that this partnership develop interdisciplinary mobile teams to assist long-term care providers in caring for individuals experiencing behavioral symptoms in the settings where they reside.

5) The subcommittee recommends that the state explore the funding and design of geriatric psychiatric services, including those provided in specialty care facilities.

6) The subcommittee recommends that the state build further upon the existing home- and community-based care system in order to effectively identify, target, and provide care management for clients. The Connecticut Home Care Program for Elders funding should be increased substantially. Last session, the legislature made a good start by increasing funding so that waiting lists for the services have been eliminated. The proposal started out as SB 610 in the Aging Committee with a proposed $20 million appropriation, but was later reduced and incorporated into the budget bill. The actual increase for the state-funded portion was $1 million, from $13,601,835 in (FY) 1996-97 to $14,601,735 in FY 1997-98 and FY 1998-99. **The subcommittee further recommends changing one of the eligibility criteria, namely, including medically needy as well as categorically needy.**

7) **The subcommittee recommends that the state explore additional community-based service options, such as assisted living services and adult day care centers, including federal waivers, when appropriate.** The state should work with the U.S. Department of Housing and

Urban Development (HUD) to provide services that enable elderly people to remain in HUD housing to "age in place."

ACCESS AND UTILIZATION SUBCOMMITTEE MEMBERS

Representative Christel Truglia, Chair

Molly Rees Gavin Jesse Tucker

Theresa Cusano William Eddy

Toni Fatone Lloyd Nurick

Ray Cruess Irving Kronenberg

Patricia Thomas Cynthia Matthews

APPENDIX III

QUALITY CARE SUBCOMMITTEE REPORT

TO: Nursing Home Working Group

FROM: Representative Wade Hyslop, Subcommittee Chair

RE: Recommendations on Nursing Home Quality Care

DATE: February 10, 1998

SCOPE OF REVIEW

The subcommittee was asked to review issues concerning quality of care in nursing homes.

BACKGROUND

The quality care subcommittee was composed of representatives from the nursing home industry, agency representatives, and advocates. The subcommittee met three times. It discussed the overall picture of nursing home care today and how the industry and its clients have changed over the years. Nursing homes are now dealing with people who are sicker than in the past – people who need more medical interventions that would have been provided in hospitals years ago. There are also more people with behavioral or mental problems that need special care and require more specialized training of staff to manage them, such as Alzheimer's or psychiatric patients.

The subcommittee discussed needed improvements in training for nurse's aides and other staff so they can better meet the challenges of caring for people with greater medical needs, behavioral or

psychiatric problems, or drug dependency. It also discussed the possibility of improving staff to patient ratios.

The subcommittee received and discussed a draft and summary of proposed regulations from the Public Health Department that addresses these issues, improves training, increases staff-to-patient ratios, and focuses more on outcomes.

RECOMMENDATIONS

1) The subcommittee recommends adoption and implementation of the proposed changes in the new Public Health Code regulations of the Department of Public Health and specifically the new Section 19a-X-III on quality of life, care and services.

2) **The subcommittee recommends that additional training in different types of care be given to ensure the quality of care at nursing homes.**

QUALITY CARE SUBCOMMITTEE MEMBERS

Representative Wade Hyslop, Chair

Cynthia Denne Theresa Cusano

William Eddy Leslie Frane

Patricia Thomas Toni Fatone

Lloyd Nurick Cynthia Matthews

Attachment:

Summary of Proposed Revisions to the Nursing Home Regulations by Cynthia Denne, DPH

APPENDIX IV

CONTINUING CARE RETIREMENT COMMUNITY

SUBCOMMITTEE REPORT

TO: Representative Peter Villano, Chairman

Nursing Home Working Group

FROM: Representative James W. Abrams, Subcommittee Chair

RE: Recommendations on Oversight of CCRCs

DATE: January 8, 1998

SCOPE OF REVIEW

The subcommittee was asked to review the following issues:

1) Should regulation of continuing care retirement communities (hereinafter CCRCs) remain with the Department of Social Services or be shifted to another agency?

2) What changes, if any, are necessary in the regulation of CCRCs?

BACKGROUND

A CCRC is a facility "in which a provider undertakes to furnish shelter or care to a person pursuant to a continuing–care contract" (CGS Sec. 17b-520(c)). A continuing-care contract is defined as "an agreement pursuant to which a provider undertakes to furnish to a person . . . shelter and medical or nursing services or other health-related benefits for the life of the person or for a period in excess of one year, and which requires a present or future transfer of assets or an entrance fee in addition to or instead of periodic charges . . . " (CGS Sec. 17b-520(a)). The relationship between the resident and the CCRC is one of private contract. The impetus behind the formation of this subcommittee was the financial problems experienced by a number of Connecticut CCRCs and the fear that residents' investments and the care contracted for would be imperiled.

COMMITTEE'S MEETINGS AND WORK PROCESS

The subcommittee held five meetings beginning in November 1997 and concluding in January 1998. Members of the subcommittee included legislators, CCRC residents, providers, representatives of senior citizen groups, and members of the general public. During the course of its discussions, the committee decided that it should first determine what changes in CCRC oversight were necessary prior to determining which agency could most appropriately carry out those oversight responsibilities.

RECOMMENDATIONS

The subcommittee recognizes that many of the recommendations contained in this report cannot be implemented absent additional resources. CCRCs currently pay an annual filing fee of $24.00 per unit. This money, which amounts to about $75,000, currently goes into the General Fund. The subcommittee recognizes that proposals which expand the discretionary role of the commissioner, as most of these recommendations do, depend on the Department's having adequate staffing and access to consultants with appropriate accounting and legal expertise. This expansion also presumes that the Department will have adequate financial resources, such as the ability to charge back extraordinary expenses, so that the Department's role can be a meaningful one. On the other hand, the subcommittee also recognizes that the small number of CCRC residents in the state (about 3,000) make more comprehensive solutions economically unfeasible.

1) The subcommittee recommends that the supervision of CCRCs remain with the Department of Social Services (DSS). While there are portions of CCRC oversight responsibilities that arguably fall within the scope of responsibility of the Department of Insurance (DOI) or the Department of Banking, the subcommittee felt that oversight responsibility for CCRCs should remain with the Department of Social Services. The primary reason for this determination is that with the exception of the investment portion of the CCRC contract, CCRCs are similar to entities that have traditionally been monitored by DSS. The subcommittee also was opposed to splitting oversight responsibility between different agencies, as has been done in some states. The subcommittee felt that this would lead to either a duplication of services or gaps in responsibility. It concluded that it would be better to require DSS to become more familiar with the investment element of CCRCs than to have DOI monitoring compliance with standards of care.

2) The subcommittee recommends shifting certain CCRC requirements from statute to regulation. The statutes ought to contain broad guidelines, rather than specific requirements, regarding what DSS should demand from a CCRC. The specific requirements are more appropriately contained in regulation, with an eye towards giving DSS greater flexibility in oversight. For example, the very specific requirements for what must be contained in the disclosure agreement provided to prospective CCRC residents should be shifted from statute to regulation to enable updating of minor aspects without the need for statutory changes (CGS Secs. 17b-522, 17b-527, 17b-528).

3) The subcommittee recommends giving the DSS commissioner authority to strengthen preconstruction and reporting requirements for CCRCs. One specific recommendation is to require a new CCRC facility to meet the projections contained in its plan of occupancy, which is part of its initial disclosures and filings. Another recommendation is to require a CCRC to notify the DSS commissioner before it refinances its debt or undergoes any kind of corporate restructuring. A third recommendation is to require each CCRC to provide a new resident with an updated disclosure statement within a reasonable period prior to the closing. A final recommendation is to give the DSS commissioner the discretion to require more frequent reporting from specific CCRCs if the commissioner has reason to believe that a new facility poses a higher risk or if an existing facility is deemed to be in financial trouble.

4) The subcommittee recommends requiring prospective CCRC residents to sign a notice document. The document would warn the prospective resident that the CCRC contract is a financial investment, that their money may be at risk, and that the CCRC's ability to meet its contractual obligations depends on its financial performance. In addition, the notice should advise prospective residents that they are strongly encouraged to consult an attorney or accountant experienced in CCRC finance, or other financial professional who has such experience. The document should also contain a statement that the Department of Social Services does not guarantee the safety of their investment.

5) The subcommittee discussed the issue of whether all CCRCs should have a requirement that fire insurance proceeds should go to a trustee for the purpose of rebuilding the complex. The subcommittee is concerned about fire insurance clauses for CCRCs. If a complex burns down, there is apparently no requirement that it be rebuilt. If a bank has lent the money for

the complex, the insurance money goes to the bank. As a result, the subcommittee considered a recommendation that all CCRCs should have a requirement that the insurance money should go to a trustee for the purpose of rebuilding the complex. However, the proposal was not adopted because the subcommittee could not resolve the issue of how to exempt CCRCs that are no longer viable from the requirement.

6) The subcommittee recommends that a CCRC be required to promptly notify the DSS Commissioner whenever it taps into its reserves.

7) The subcommittee recommends that the legislature should budget an amount at least equivalent to the fees CCRCs pay DSS ($75,000) to hire staff or outside consultants with specific expertise to review feasibility studies, disclosure statements, annual filings and changes in corporate structure.

8) The subcommittee recommends that DSS be empowered to charge back to the affected CCRC its costs in "extraordinary" situations (e.g., cost of corporate restructuring, remedial action for financially troubled CCRCs, and potential bankruptcies and receiverships).

SUBCOMMITTEE MEMBERS

Rep. Jim Abrams, Chair

Sen. Thomas Bozek

Rev. Robert Broesler

Joseph Brucella

Ron Dischinger

Dave Duffy

Bill Eddy

Rep. Steve Fontana

Dennis Ferguson, Esq.

Sarah Gauger

Lisa Giller

Debra Guertin

Royal "Gus" Gustafson

Richard Kisner

M.H. Libbey, Esq.

Paul Liistro

Irving Kronenberg

Lloyd Nurick

Rep. Arthur O'Neill

Larry Santilli

ATTACHMENTS

Law

Regulations

CCRC chart

OLR Memos

APPENDIX V

NURSING HOME WORKING GROUP MEMBERS

Rep. Peter Villano, Chairman

Rep. James Abrams, Subcommittee Chair

Rep. Thomasina Clemons, Subcommittee Chair

Rep. Wade Hyslop, Subcommittee Chair

Rep. Christel Truglia, Subcommittee Chair

Sen. Thomas Bozek

Sen. Eileen Daily

Rep. Steve Fontana

Rep. Arthur O'Neill

Gary Richter, DSS

Cynthia Denne, DPH

Cynthia Matthews, Exec. Dir. Commission on Aging

Theresa Cusano, Long-term Care Ombudsman

Rev. Robert Broesler

Joseph Brucella

Raymond Cruess

Ron Dischinger

Dave Duffy

William Eddy

Toni Fatone

Dennis Ferguson

Leslie Frane

Marvin Fried

Sarah Gauger

Molly Rees Gavin

Lisa Giller

Debra Guertin

Royal “Gus” Gustafson

Judy Hoberman

Robert Kisner

Irving Kronenberg

M.H. Libbey

Paul Liistro

Michael Lipnicki

Sara Johnson McDuffie

Lloyd Nurick

Lawrence Santilli

Barry Spero

Patricia Thomas

Jesse Tucker

Rick Wallace

The working group was assisted by the following staff:

Helga Niesz, OLR

Spencer Cain, OFA

Neil Ayers, OFA

Louise Nadeau, LCO

Laura Jordan, OLR

Kelly Kirkley-Bey, Human Services Committee Clerk

Maggie Ewald, Aging Committee Clerk

HN:tjo