Agency Legislative Proposal - 2016 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
11302015_SDA_CHOICESstatute

(If submitting electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency: **State Department on Aging**

Liaison: **Pam Toohey**
Phone: **860-424-5993**
E-mail: **pamela.toohey@ct.gov**

Lead agency division requesting this proposal: **State Unit on Aging**

Agency Analyst/Drafter of Proposal: **Pam Toohey**

Title of Proposal: **AAC Elimination of Specific Sections of the CHOICES Statute**

Statutory Reference: **17a-314 sec. (a)(3), (e),(f), and (g)**

Proposal Summary:
This proposal will eliminate unnecessary sections from the current CHOICES statute

PROPOSAL BACKGROUND

◊ **Reason for Proposal**

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?
(3) Have certain constituencies called for this action?
(4) What would happen if this was not enacted in law this session?

The referenced sections were put in place when there were a great number of Medicare Managed Care Plans, many of which no longer exist. The Department of Insurance does not require Medicare organizations to file reports; consequently the Healthcare Advocate does not provide any reports to the General Assembly regarding the lack of filings by Medicare organizations.

◊ **Origin of Proposal** ☒ **New Proposal** ☐ **Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

Click here to enter text.

PROPOSAL IMPACT

◊ **AGENCIES AFFECTED** (*please list for each affected agency*)

Agency Name: Department of Insurance / Healthcare Advocate **Agency Contact (*name, title, phone*):** Agencies contacted by OPM **Date Contacted:** Click here to enter text. Approve of Proposal ☒ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments No agency objects to elimination of 17a-314 sec. (a)(3), (e),(f), and (g)
Will there need to be further negotiation? ☐ **YES** ☒**NO**

◊ **FISCAL IMPACT** (*please include the proposal section that causes the fiscal impact and the anticipated impact*)

Municipal *(please include any municipal mandate that can be found within legislation)* none
State none
Federal none
Additional notes on fiscal impact Click here to enter text.

◊ **POLICY and PROGRAMMATIC IMPACTS** *(Please specify the proposal section associated with the impact)*

Click here to enter text.

Insert fully drafted bill here

AN ACT CONCERNING ELIMINATION OF SPECIFIC SECTIONS OF THE CHOICES STATUTE.

Section 17a-314 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

CHOICES health insurance assistance program. Definitions. Requirements. Reports. Responsibilities of hospitals re Medicare patients. Regulations.

(a) As used in this section:

(1) "CHOICES" means Connecticut's programs for health insurance assistance, outreach, information and referral, counseling and eligibility screening;

(2) "CHOICES health insurance assistance program" means the federally recognized state health insurance assistance program funded pursuant to P.L. 101-508 and administered by the Department on Aging, in conjunction with the area agencies on aging and the Center for Medicare Advocacy, that provides free information and assistance related to health insurance issues and concerns of older persons and other Medicare beneficiaries in Connecticut.[;and

(3) "Medicare organization" means any corporate entity or other organization or group that contracts with the federal Centers for Medicare and Medicaid Services to serve as a Medicare health plan organization to provide health care services to Medicare beneficiaries in this state as an alternative to the traditional Medicare fee-for-service plan.]

(b) The Department on Aging shall administer the CHOICES health insurance assistance program, which shall be a comprehensive Medicare advocacy program that provides assistance to Connecticut residents who are Medicare beneficiaries.

(c) The program shall provide: (1) Toll-free telephone access for consumers to obtain advice and information on Medicare benefits, including prescription drug benefits available through the Medicare Part D program, the Medicare appeals process, health insurance matters applicable to Medicare beneficiaries and long-term care options available in the state at least five days per week during normal business hours; (2) information, advice and representation, where appropriate, concerning the Medicare appeals process, by a qualified attorney or paralegal at least five days per week during normal business hours; (3) information through appropriate means and format, including written materials, to Medicare beneficiaries, their families, senior citizens and organizations regarding Medicare benefits, including prescription drug benefits available through Medicare Part D and other pharmaceutical drug company programs and long-term care options available in the state; (4) information concerning Medicare plans and services, private insurance policies and federal and state-funded programs that are available to beneficiaries to supplement Medicare coverage; (5) information permitting Medicare beneficiaries to compare and evaluate their options for delivery of Medicare and supplemental insurance services; (6) information concerning the procedure to appeal a denial of care and the procedure to

request an expedited appeal of a denial of care; and (7) any other information the program or the Commissioner on Aging deems relevant to Medicare beneficiaries.

(d) The Commissioner on Aging may include any additional functions necessary to conform to federal grant requirements.

[(e) The Insurance Commissioner, in cooperation with, or on behalf of, the Commissioner on Aging, may require each Medicare organization to: (1) Annually submit to the Insurance Commissioner any data, reports or information relevant to plan beneficiaries; and (2) at any other times at which changes occur, submit information to the Insurance Commissioner concerning current benefits, services or costs to plan beneficiaries. Such information may include information required under section 38a-478c.

(f) Each Medicare organization that fails to file the annual data, reports or information requested pursuant to subsection (e) of this section shall pay a late fee of one hundred dollars per day for each day from the due date of such data, reports or information to the date of filing. Each Medicare organization that files incomplete annual data, reports or information shall be so informed by the Insurance Commissioner, shall be given a date by which to remedy such incomplete filing and shall pay said late fee commencing from the new due date.

(g) Not later than June 1, 2001, and annually thereafter, the Insurance Commissioner, in conjunction with the Healthcare Advocate, shall submit a list, in accordance with the provisions of section 11-4a, to the Governor and to the joint standing committees of the General Assembly having cognizance of matters relating to aging, human services and insurance, of those Medicare organizations that have failed to file any data, reports or information requested pursuant to subsection (e) of this section.]

[(h)] (e) All hospitals, as defined in section 19a-490, which treat persons covered by Medicare Part A shall: (1) Notify incoming patients covered by Medicare of the availability of the services established pursuant to subsection (c) of this section, (2) post or cause to be posted in a conspicuous place therein the toll-free number established pursuant to subsection (c) of this section, and (3) provide each Medicare patient with the toll-free number and information on how to access the CHOICES program.

[(i)] (f)The Commissioner on Aging may adopt regulations, in accordance with chapter 54, as necessary to implement the provisions of this section.

Agency Legislative Proposal - 2016 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): Click here to enter text.
11302015_SDA_LTCOP/LOI

(If submitting electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency: **State Department on Aging**

Liaison: **Pam Toohey**
Phone: **860-424-5993**
E-mail: **pamela.toohey@ct.gov**

Lead agency division requesting this proposal: **Long Term Care Ombudsman Program**

Agency Analyst/Drafter of Proposal: **Pam Toohey/Nancy Shaffer**

Title of Proposal: **AAC the Long Term Care Ombudsman's Notice to Nursing Home residents regarding the home's intent to file for closing.**

Statutory Reference: Sec. 17b-352d

Proposal Summary: **The proposed amendment will require that a nursing home facility's *Letter of Intent* (LOI) to close, which is the facility's official notice to the State that it desires to close the home, be accompanied by a letter to the residents and families from Office of the State Long Term Care Ombudsman.**

PROPOSAL BACKGROUND

◊ **Reason for Proposal**

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?
(3) Have certain constituencies called for this action?
(4) What would happen if this was not enacted in law this session?

Current legislation requires that a Letter of Intent (LOI) to close a facility be provided to residents/families by the facility. The LOI is sent to the Commissioner of the Department of Social Services and sets in motion the process of the facility's request to close. The next step is a public hearing at which time DSS hears testimony from interested parties regarding a potential closing. Often times, many residents have already discharged to other nursing homes by the time this public hearing is held (not later than thirty days after DSS receipt of the LOI +/or CON). The LOI presents only the facility/business's perspective and usually has strong language that gives the sense there is no alternative but to close. This initial message can be devastating to the resident and family. Therefore, balancing that message with the assurance that the residents have rights and protections needs to be heard at the same time. The mandate of the Long-Term Care Ombudsman Program is to ensure that residents' welfare and rights are protected. The addition of this letter from the Office of the State Ombudsman will present a more balanced picture to the residents and their families of what

is happening, their rights and protections and advises them that they can take time and not be rushed into any decisions. The Ombudsman letter also has the potential to enhance opportunities for Money Follows the Person to engage residents and families in discussing options for community living, thus forwarding the Governor's initiatives to rebalance the State's long-term services and supports systems.

The State of Connecticut is likely to experience more nursing home closures in the future. Enacting this legislation now will provide assurances to residents at a difficult time and will ensure they have greater opportunity to review all their options should the DSS Commissioner decide to grant the home's request to close.

◊ **Origin of Proposal** ☒ **New Proposal** ☐ **Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

Click here to enter text.

PROPOSAL IMPACT

◊ **AGENCIES AFFECTED** (*please list for each affected agency*)

Agency Name: Department of Social Services
Agency Contact (*name, title, phone*): Krista Ostaszewski, Legislative Analyst, 860-424-5612
Date Contacted: 10/13/15, 11/30/15

Approve of Proposal ☒ **YES** ☐ **NO** ☒ **Talks Ongoing**

Summary of Affected Agency's Comments
Discussions between SDA Commissioner, DSS Commissioner, Legislative Analyst resulted in full support.

Will there need to be further negotiation? ☐ **YES** ☒**NO**

◊ **FISCAL IMPACT** (*please include the proposal section that causes the fiscal impact and the anticipated impact*)

Municipal *(please include any municipal mandate that can be found within legislation)* **none**
State **Anticipate there could be a positive impact to the State if residents are able to exercise informed choice and utilize the resources of Money Follows the Person Program and choose community living rather than a transfer to another skilled nursing facility.**
Federal **none**
Additional notes on fiscal impact Click here to enter text.

◊ **POLICY and PROGRAMMATIC IMPACTS** *(Please specify the proposal section associated with the impact)*

Click here to enter text.

Insert fully drafted bill here

CT General Statute 17b-352 (d) shall be amended as follows:

(d) Any facility acting pursuant to subdivision (3) of subsection (b) of this section shall provide written notice, at the same time it submits its letter of intent, to all patients, guardians or conservators, if any, or legally liable relatives or other responsible parties, if known, and shall post such notice in a conspicuous location at the facility. The facility's written notice shall be accompanied by an informational letter from the Office of the Long Term Care Ombudsman. The notice shall state the following: (A) The projected date the facility will be submitting its certificate of need application, (B) that only the department has the authority to either grant, modify or deny the application, (C) that the department has up to ninety days to grant, modify or deny the certificate of need application, (D) a brief description of the reason or reasons for submitting a request for permission, (E) that no patient shall be involuntarily transferred or discharged within or from a facility pursuant to state and federal law because of the filing of the certificate of need application, (F) that all patients have a right to appeal any proposed transfer or discharge, and (G) the name, mailing address and telephone number of the Office of the Long-Term Care Ombudsman and local legal aid office.

Agency Legislative Proposal - 2016 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
11302015_SDA_PDCaregivers

(If submitting electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency: **State Department on Aging**

Liaison: **Pam Toohey**
Phone: **860-424-5993**
E-mail: **pamela.toohey@ct.gov**

Lead agency division requesting this proposal: **State Unit on Aging**

Agency Analyst/Drafter of Proposal: **Pam Toohey-SDA/Melissa Morton-OPM**

Title of Proposal: **AAC Expanding Utilization of Patient-Designated Caregivers**

Statutory Reference: **Sec. 19a-504c PA 15-32**

Proposal Summary:
This proposed amendment will require skilled nursing home facilities (SNFs) to provide the same discharge planning services to residents as hospitals are required to provide to patients.

PROPOSAL BACKGROUND

◊ **Reason for Proposal**

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?
(3) Have certain constituencies called for this action?
(4) What would happen if this was not enacted in law this session?

Recently passed legislation in 2015 (The CARE Act PA 15-32) requires hospitals to provide patients with the opportunity to designate caregivers and provide applicable information in providing care upon discharge to home. This legislation ensures that caregivers are given direct contact with hospital staff by being put on medical records at hospitals, notified in advance of discharges from hospitals, and given plain language instruction on any medical tasks that the family caregiver will need to take on at home. It does not address the increasing number of residents discharged to home from skilled nursing home facilities, and cared for by their loved ones. This proposal is intended to support those residents and the more than 500,000 caregivers who provide care for their loved ones at home, and promotes aging in place.
19 other states have passed the CARE act, some including facilities such as rehabilitation centers in addition to hospitals. This proposal would add skilled nursing home facilities.

◊ **Origin of Proposal** ☒ **New Proposal** ☐ **Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

Click here to enter text.

PROPOSAL IMPACT

◊ **AGENCIES AFFECTED** (*please list for each affected agency*)

Agency Name: N/A
Agency Contact (*name, title, phone*): Click here to enter text.
Date Contacted: Click here to enter text.

Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**

Summary of Affected Agency's Comments
Click here to enter text.

Will there need to be further negotiation? ☐ **YES** ☐**NO**

◊ **FISCAL IMPACT** (*please include the proposal section that causes the fiscal impact and the anticipated impact*)

Municipal *(please include any municipal mandate that can be found within legislation)*
none

State
none

Federal
none

Additional notes on fiscal impact
Click here to enter text.

◊ **POLICY and PROGRAMMATIC IMPACTS** *(Please specify the proposal section associated with the impact)*

Click here to enter text.

Insert fully drafted bill here

AN ACT CONCERNING EXPANDING UTILIZATION OF PATIENT-DESIGNATED CAREGIVERS.

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

Section 1. Section 19a-504c of the general statutes, as amended by section 1 of Public Act 15-32, is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(a) For purposes of this section and section 2 of this act:

(1) "Caregiver" means any individual who a patient designates as a caregiver to provide post-discharge assistance to the patient in the patient's home in the community. The term caregiver includes, but is not limited to, a relative, spouse, partner, friend or neighbor who has a significant relationship with the patient. For the purposes of this section and section 2 of this act, the term caregiver shall not include any individual who receives compensation for providing post-discharge assistance to the patient.

(2) "Home" means the dwelling that the patient considers to be the patient's home in the community. The term home shall not include, and the provisions of this act shall not apply to, a discharge to any rehabilitation facility, hospital, nursing home, assisted living facility, group home or any other setting that was not the patient's home in the community immediately preceding the patient's inpatient admission.

(3) "Hospital" has the same meaning as provided in section 19a-490.

(4) ""Nursing home facility" has the same meaning as provided in section 19a-521.

[(4)] (5) "Post-discharge assistance" means nonprofessional care provided by a designated caregiver to a patient following the patient's discharge from an inpatient admission to a hospital or nursing home facility in accordance with the written discharge plan of care signed by the patient or the patient's representative, including, but not limited to, assisting with basic activities of daily living, instrumental activities of daily living and carrying out support

tasks, such as assisting with wound care, administration of medications and use of medical equipment.

(b) The Department of Public Health [shall] may adopt regulations, in accordance with the provisions of chapter 54, to set minimum standards for hospital and nursing home facility discharge planning services. Such standards shall include, but not necessarily be limited to, requirements for (1) a written discharge plan prepared in consultation with the patient, or the patient's family or representative, and the patient's physician, and (2) a procedure for advance notice to the patient of the patient's discharge and provision of a copy of the discharge plan to the patient prior to discharge.

(c) Whenever a hospital refers a patient's name to a nursing home as part of the hospital's discharge planning process, or when a hospital patient requests such a referral, the hospital shall make a copy of the patient's hospital record available to the nursing home and shall allow the nursing home access to the patient for purposes of care planning and consultation.

(d) Whenever a discharge plan from a hospital['s discharge planning] or nursing home facility indicates that an inpatient will be discharged to the patient's home, the hospital or nursing home facility shall allow the patient to designate a caregiver at, or prior to, the time that a written copy of the discharge plan is provided to the patient. A patient is not required to designate any individual as a caregiver and any individual designated as a caregiver under this section is not obligated to perform any post-discharge assistance for the patient.

(e) If an inpatient designates a caregiver pursuant to subsection (d) of this section prior to receiving written discharge instructions, the hospital or nursing home facility shall:

(1) Record the patient's designation of caregiver, the relationship of the designated caregiver to the patient, and the name, telephone number and address of the patient's designated caregiver in the discharge plan.

(2) Make reasonable attempts to notify the patient's designated caregiver of the patient's discharge to the patient's home as soon as practicable. In the event the hospital or nursing home facility is unable to contact the designated caregiver, the lack of contact shall not interfere with, delay, or otherwise affect the medical care provided to the patient or an appropriate discharge of the patient.

(3) Prior to discharge, provide caregivers with instructions in all post-discharge assistance tasks described in the discharge plan. Training and instructions for caregivers may be conducted in person or through video technology, as determined by the hospital or nursing home facility to effectively provide the necessary instruction. Any training or instructions provided to a caregiver shall be provided in nontechnical language, to the extent possible. At

a minimum, this instruction shall include: (A) A live or recorded demonstration of the tasks performed by an individual designated by the hospital or nursing home facility who is authorized to perform the post-discharge assistance task and is able to perform the demonstration in a culturally competent manner and in accordance with the [hospital's] requirements of such hospital or nursing home facility to provide language access services under state and federal law; (B) an opportunity for the caregiver to ask questions about the post-discharge assistance tasks; and (C) answers to the caregiver's questions provided in a culturally competent manner and in accordance with the [hospital's] requirements of such hospital or nursing home facility to provide language access services under state and federal law.

(4) Document in the patient's medical record any training for initial implementation of the discharge plan provided to the patient, the patient's representative or the designated caregiver. Any instruction required under subdivision (3) of this subsection shall be documented in the patient's medical record, including, at a minimum, the date, time and contents of the instruction.

Sec. 2. Section 2 of Public Act 15-32 is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(a) Nothing in section 19a-504c of the general statutes, as amended by this act, or this section shall be construed to create a private right of action against a hospital or nursing home facility, a hospital or nursing home facility employee, or any consultants or contractors with whom a hospital or nursing home facility has a contractual relationship.

(b) A hospital or nursing home facility, a hospital or nursing home facility employee, or any consultants or contractors with whom a hospital or nursing home facility has a contractual relationship shall not be held liable, in any way, for the services rendered or not rendered by the caregiver to the patient at the patient's home.

(c) Nothing in section 19a-504c of the general statutes, as amended by this act, or this section shall be construed to obviate the obligation of an insurance company, health service corporation, hospital service corporation, medical service corporation, health maintenance organization or any other entity issuing health benefits plans to provide coverage required under a health benefits plan.

(d) (1) An individual designated as caregiver pursuant to subsection (d) of section 19a-504c of the general statutes, as amended by this act, shall not be reimbursed by any government or commercial payer for post-discharge assistance that is provided pursuant to section 19a-504c of the general statutes, as amended by this act.

(2) Nothing in section 19a-504c of the general statutes, as amended by this act, or this section shall be construed to impact, impede or otherwise disrupt or reduce the reimbursement obligations of an insurance company, health service corporation, hospital service corporation, medical service corporation, health maintenance organization or any other entity issuing health benefits plans.

(3) Nothing in section 19a-504c of the general statutes, as amended by this act, or this section shall delay the discharge of a patient or the transfer of a patient from a hospital or nursing home facility to another facility.

(4) Nothing in section 19a-504c of the general statutes, as amended by this act, or this section shall affect, nor take precedence over, any advance directive, conservatorship or other proxy health care rights as may be delegated by the patient or applicable by law.