

**State of Connecticut**  
GENERAL ASSEMBLY



**TASK FORCE TO STUDY THE TRANSFER OF MEDICAID PATIENTS TO LONG  
TERM CARE FACILITIES**

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**MEETING MINUTES**

Thursday, November 4, 2010

1:00 PM in Room 2A of the LOB

The meeting was called to order at 1:07 PM by Chairman, John Tarutis.

The following task force members were present:

Margaret Morelli, Chair; John Tarutis, Chair; Matthew Barrett, Sheldon Bustow, Kathy Ferrara-Tesla, Anne Foley, Wendy Furniss, Gary Richter, Jan VanTassel;

Absent were:

Bonnie Gauthier, Deborah Parker, Kathy Shanahan.

Each of the members present introduced themselves; indicating their name, the organization for which they work and whether they were a new member.

Mrs. Kathy Tynan-McKiernan, Associate Director for Care Coordination at Yale-New Haven Hospital, joined the group to provide further insight on reasons for the delayed discharge of Medicaid patients from hospitals.

Notes from the previous meeting, held Wednesday, September 15, 2010, were circulated to the members and the Chair Tarutis requested that they be reviewed for any additions or corrections. Chair Morelli mentioned that additions to the notes had been included and that they would be turned into official minutes by the next committee meeting. The notes were broken down into the three areas in skilled nursing that the task force had identified as possible areas for recommendations: regulatory issues, service-related issues and reimbursement issues. Chair Morelli confirmed that the members would start thinking about which issues they could address, ways we could address them and a timeline for doing so.

Chair Morelli mentioned that the task force would invite to the next meeting Kathy Bruni and Brenda Parrella from the Department of Social Services (DSS), and an individual

from the Probate Court Administration so that they could share their insight on regulatory, service-related and reimbursement issues.

During the summer of 2010, DSS had sent out a survey to Connecticut hospitals requesting reasons for delayed discharge of Medicaid patients. Mr. Richter presented the data they collected during the previous task force meeting, and said that he would try to get additional data by requesting completion surveys that had not been submitted. Mrs. Bujwid from the DSS Office of Certificate of Need and Rate Setting had worked with Mr. Richter to collect the data, and due to scheduling issues she was not able to attend this meeting.

Mr. Richter informed the group that 16 of the 29 general hospitals completed the survey over the summer, and since the last meeting two additional hospitals also submitted responses. They extrapolated information from these responses based on the number of days that the survey covered (approximately eight percent of the year) and Medicaid utilization. The data represented approximately 68 percent of the volume of hospital stays in the state. DSS achieved their estimated and annualized numbers by dividing the actual number of patients by 7.76 percent and then again by 68 percent. Data that showed the seasonal variations of hospital admissions and discharges was not available for this meeting. Mrs. Bujwid had made a couple of adjustments to the categories within the survey, but those changes were not substantial. Mr. Richter highlighted that the number of patients with Medicare, but pending Medicaid status, stayed in the hospital for a significant period of time before being discharged and that navigating obstacles to enrolling in the Medicaid program is on the radar screen of this task force. Mr. Richter also looked into how many of the Medicaid patients had Medicare coverage (dual eligibility), and it amounted to approximately one-third of the patients.

Chair Tarutis asked Mr. Richter if the extrapolated data estimated numbers that pertained to the 18 hospitals who participated in the survey or hospital facilities state-wide. Mr. Richter confirmed that the data estimated was state-wide and accounted for the missing hospitals based on the percentage of patient days that were missing from survey responses; assuming that the hospitals that did not file were experiencing the same issues as the ones who did file a survey response. The survey results covered a little over two-thirds of hospital volume.

Chair Morelli asked Mr. Richter if he had looked into the issue of not offering or having appropriate beds for patients upon discharge. Mr. Richter said that they did look at that information and would send it around after the meeting. Mrs. Foley confirmed that the data that had previously been sent pertained to the Department of Developmental Services.

Chair Tarutis mentioned that a few hospitals were concerned about releasing patient information due to HIPAA compliance; particularly regarding patients who are dual eligibles. In light of this, he would look at the data as a conservative estimate. He then recognized Kathy Tynan-McKiernan of Yale-New Haven Hospital to provide testimony on the transfer of Medicaid patients to long term care facilities.

Mrs. Tynan-McKiernan Associate Director for Care Coordination at Yale-New Haven Hospital thanked Chair Tarutis for the invitation and explained that she was happy to attend. Yale-New Haven Hospital has 941 acute care beds and she is responsible for

850 of them. For the past ten years her main job has been to have patients in the right place at the right time using the right resources. The transfer of this population of patients is one of the most-discussed issues among her and her staff and her and her patients. The hospital's first priority is to get patients home and ensure that they are provided wrap-around services in order to keep them in the community where they will do best. As an example, she then thanked the people responsible for getting Title 19 patients wound vacs, because that is what is allowing them to be discharged to their homes. The diversion program is also helping to guide patients to the right care facility, and keeps them out of the hospital.

Mrs. Tynan-McKiernan then said that she was fortunate to have access to the program "All-Scripts," which allows her to collect data on why patients don't leave the hospital in a timely fashion. One of the main reasons for detaining a patient is their pending Title 19 enrollment. She ran data from the past year on Yale-New Haven's experience with this situation and found that 86 patients waited in a hospital bed under they were granted Title 19, which totaled 2,584 days of patients unnecessarily staying in the hospital. This meant that, at any given time, Yale New Haven Hospital housed 5 to 7 patients who were just waiting for Medicaid coverage so that they could be moved to a more appropriate facility. Sometimes this included skilled services, but most of the time these patients received custodial services in an acute care bed.

Many hospitals are looking forward to the new DSS modernization initiative that will allow for patients to track where the Title 19 application is located in the determination process. One frustration that hospitals experience is discovering that a Medicaid application is incomplete. Often the application is submitted to DSS by the patient or their family and is not immediately reviewed by the Department. If the application is incomplete it takes away from the window of time that the applicant has to submit a complete application and move through the determination process. This new program will help identify why an application isn't moving through the proper channels and will most likely speed the determination process.

The delay for determining the eligibility of Medicaid patients is so cumbersome that Yale- New Haven Hospital is currently covering the costs of two Title 19 patients who have transitioned into long-term care; as they continue to work towards determining the patients' Medicaid eligibility. This situation is in part due to the fact that both patients have complicated conservatorship issues.

Another frustration that facilities face is reaching their quota of patients who require skilled nursing placement or long-term acute care hospital placement. In order to remain financially solvent, nursing homes cannot afford to admit more than a certain number of patients who receive such involved care due to the low Medicaid reimbursement rate.

Another challenge is placing an individual in a long-term care facility that is near the area where they previously lived. This is particularly difficult for Medicare patients, who must take one of the first three beds that are offered to them; whereas Medicaid patients are able to refuse placement if they do not approve of the location. Also, Medicaid patients who take methadone have difficulty finding long term placement, as many homes won't administer that particular drug within their facility.

Mrs. Tynan-McKiernan then confirmed that other issues that the task force had already identified are the same issues that hospitals “live and breathe” every day. “No appropriate beds, isolation mix is wrong, no long-term male beds, care beds needed exceed capacity of ability to care for the patient, bariatric patients, high-cost medicines” are common problems in hospitals. Mrs. Tynan-McKiernan then thanked the Chairs for the opportunity to testify before the task force.

Chair Tarutis thanked Mrs. Tynan-McKiernan for attending the meeting and asked her if her hospital experiences such demand in their emergency room that they have difficulty placing patients into in-patient stays. She confirmed that they do face that problem. Currently, their emergency room is being renovated to be much larger in order to accommodate the greater need. Sometimes patients stay in the hallway or are placed in an overflow bed before being moved into an in-patient room.

Mr. Barrett asked Mrs. Tynan-McKiernan if she found that delays in determining Medicaid eligibility were administrative or a matter of ineligibility. He acknowledged that both reasons could be the cause of the delay: a complicated transfer of assets it may determine an individual is ineligible, or paperwork may not be processed quickly due to short staffing at DSS. Community-based Medicaid eligibility is much simpler to get as it does not required a look-back analysis. Mrs. Tynan-McKiernan explained that a majority of her patients have complex situations with their financial assets, which take a long time to settle, and that is why the eligibility determinations take time. Most of her patients are found to be eligible. She provided a chart that showed the waiting time for Title 19 determination.

Mr. Barrett wondered if the delays are a product of the more complicated rules under the deficit mitigation packages, the hiring freeze and agencies not having the staff needed to meet the higher demand. Mrs. Tynan-McKiernan admitted that the process has become more difficult, but that she has been seeing these outliers for the past ten years.

Mrs. VanTassel added that she had enrolled her mother into the Medicaid program last year, had every bit of documentation needed and it still took several months to process. She also raised the question as to whether this is a staffing issue.

Mrs. Tynan-McKiernan agreed that it is in part due to understaffing, but they are aware of cases where the applications submitted are complete and they sit on the desk on a staff member for four weeks before being touched. She acknowledged that on occasion the applications are not complete, so that would be a reason for further delay.

Mrs. Van Tassel also clarified that the quota mentioned during Mrs. Tynan-McKiernan’s presentation described nursing homes that could only afford to take a certain number of patients due to the Medicaid rate. Mrs. Tynan-McKiernan confirmed that to be correct.

Mr. Richter thanked Mrs. Tynan-McKiernan for attending and stated that moving the modernization initiative and speeding up the determination process was a high priority for DSS and a frustration that they share with the hospitals. He asked if any of the delays happened to patients who had Medicare. Mrs. Tynan-McKiernan responded that some were Medicare patients, but ultimately they were all going to long-term care facilities, and these facilities would not consider them until they had a long-term payor

source. It's too much of a risk to take the patient if they are uncertain of the payment source after the first 20 days.

Mr. Richter revisited the issue that was raised regarding the high cost of pharmaceuticals. If a nursing home takes a Medicare patient, then they are responsible for the cost of the patient's pharmaceuticals. So the high-cost issue pertains to Medicaid patients, primarily. Mrs. Tynan-McKiernan confirmed that this is the case for patients who have Medicare part D; but high-cost drugs are still an issue for those Medicare patients who are not enrolled in Part D. Additionally, the hospitals are not allowed to supplement funding for high-cost drugs to the nursing homes as an incentive to have the home take the patient.

Mr. Richter thought that some of the cost issues may not have a bearing on the nursing home. It may just be that the Medicare payment rate is not adequate. Chair Tarutis affirmed that Mr. Richter was correct in that upon discharge of a Medicaid patient from the hospital, the reimbursement rate is sometimes too low to offset the costs of medications. He mentioned that, for a Medicare patient, even if the pharmaceutical costs are covered, there are still soft costs like additional care, testing and nursing assessment that have to be completed which might be more than the reimbursement rate.

Mr. Bustow then asked Mrs. Tynan-McKiernan about trends she had seen in the discharge of patients over the past ten years. Mrs. Tynan-McKiernan answered that we are discharging patients with more complex needs, but she still hasn't felt much relief from the delayed transfers.

Chair Morelli asked if Yale-New Haven Hospital had a DSS eligibility worker on-site. Mrs. Tynan-McKiernan stated that they had two. Chair Morelli then asked if Mrs. Tynan-McKiernan had seen changes in conservatorship issues over the past couple of years. Mrs. Tynan-McKiernan confirmed that it had started to become worse because you have to wait longer to get the conservator and the patient needs a conservator who can speak for them and gather information on their behalf before they can apply for Title 19.

Chair Tarutis asked why the wait for a conservator was longer and Mrs. Tynan-McKiernan responded that it had to do with the legislation surrounding who is a conservator and what decisions they make. She is also of the opinion that some of the nice attorneys that become conservators, pro-bono, don't have the time to dedicate to these complex cases.

Chair Tarutis asked what the average length of stay was for a patient at her hospital. Mrs. Tynan-McKiernan responded that it was 5.05 days. Chair Tarutis acknowledged that this is far less than the 30 day average length of stay of the population at hand. He also asked if the volume of patient discharge had increased. Mrs. Tynan-McKiernan could not site a specific number, but indicated that they were moving routine patients so fast that it was frightening.

Mr. Barrett asked if Yale-New Haven Hospital had a positive experience with the DSS staff who work with hospital discharge planners to facilitate the discharge of individuals enrolled in the Money Follows the Person program. Mrs. Tynan-McKiernan said that

their experience was very positive; stating that the DSS staff and diversion nurses are wonderful to work with: they just need more of them.

Chair Tarutis then thanked Mrs. Tynan-McKiernan for sharing her experience and guided the discussion to barriers to access. Mr. Richter made the comment that the legislature was not in the position to pass a budget that made increases to the reimbursement rates for complex care and bariatric care without looking at where we are over-paying for the light care cases. He acknowledged that the trend is that folks are staying at home longer, Medicare is providing more home-care coverage and nursing homes are subsequently taking care of more of the complex cases. Although there is not data to substantiate that, it seems to be the trend. Looking towards the future, nursing homes might have to address dropping payment for long-term cases that don't have that resource requirement.

Chair Morelli put on her CANFPA hat and said that she understood the point Mr. Richter was making, but cautioned that we should wait for more sophisticated level-of-care data from Ascend Management Innovations regarding Preadmission Screening and Resident Reviews (PASRR) to be released before entertaining that idea. She mentioned that many in the industry were surprised when the last round of data came from Ascend, as there were so few complex medical cases. Since there are so few extremely complex cases we might be able to give DSS the authority to provide an additional rate for those beds. That way, the quality of life for this small population could be enhanced without redesigning the whole payment process.

Chair Morelli reminded the committee that the problem of the location of a skilled nursing facility and patient location preference is not something that we should forget. If one nursing home becomes highly skilled in handling a specific type of complex medical issue, do patients who have that complex medical issue have to live in that facility even if they prefer to go to a home that is closer to their family or where they used to live? She urged the task force to think about this circumstance and how we should recommend DSS proceed.

Mr. Richter urged the task force to examine the issue identified earlier on Medicare coverage: Medicare patients must take one of the first three beds that are offered to them or they are denied coverage. We would have to look at the federal parameter on that and see if we have the jurisdiction to amend the Medicaid program.

Chair Tarutis affirmed that what Mr. Richter said was true. He discussed his own experience at his hospital, where complex medical cases aren't the majority of the cases that they handle, but placing them is a very difficult task. This is for two reasons: providers may not receive adequately reimbursement for these specialized services and they must have the clinical skill set to care for the medically complex.

Chair Tarutis then reminded the task force that they are up against a short timeline to produce their recommendations (January 1, 2011) and proposed that one recommendation be to create a pilot study in order to gather more data on the discharge issues identified. He envisions it consisting of a few in-state providers and nursing homes and would like it to look at the funding, type of care required, skill level of the provider, etc. of specific cases. Chair Tarutis encouraged the task force to submit their recommendations to him and Chair Morelli via email, and noted that they would consider each one submitted.

Mrs. Furniss agreed that a pilot study would be a good recommendation, but acknowledged that Chair Morelli was on to something when she talked about putting the focus on administrative processes as opposed to complex care. Mrs. Furniss stated that the ratio of administrative issues to complex care placements is three to one. It would be prudent of us to take care of three-quarters of our problems by streamlining administrative processes (pending Title 19, PASRR and conservatorship). The numbers from the study completed by Mr. Richter and Mrs. Bujwid steer us in that direction. Mrs. Furniss mentioned that she did not have any proposals in mind, but weighed in on the focus of the recommendations.

Mr. Bustow informed the task force that some states are currently doing pilot projects or demonstration projects with the special needs population under Medicaid, and asked if anyone was doing that in Connecticut or if we had looked at those other states' projects. Mr. Richter responded that Connecticut has Medicaid waiver programs for individuals with disabilities, mental illness and who require home care services, but he wasn't positive that they addressed the scope of the projects to which Mr. Bustow was referring. Mr. Bustow responded that he was referring to cases where special rates would be negotiated for the higher level of care that was needed. Mr. Richter answered that two nursing facilities are given higher rates for complex care individuals; totaling 60 beds between the two facilities. Mr. Bustow asked if DSS was studying the effectiveness of those programs or considering applying that rate to other populations as well. Mr. Richter answered that no studies have been done, but the utilization rate remains high.

Chair Morelli asked about language that was in the budget a few years ago regarding special needs plans, and suggested that the task force look into that a little bit. Mr. Richter said that he didn't know how that wouldn't have gotten on his radar as he didn't recall ever seeing the language. Mr. Barrett clarified that "special needs plan" was the term used by the federal government. It is commonly known as "managed care" in Connecticut.

Mr. Barrett revisited the comment Mr. Richter made regarding special rates for the two complex care facilities. He asked if DSS had some authority to renegotiate standard rates, or if permission was needed to do so. Mr. Richter responded that the different rates were established under pilots. He didn't think the Department could renegotiate rates without additional funding and amending the state Medicaid plan.

Mrs. Foley echoed the sentiments of Chair Morelli and Mrs. Furniss and was surprised that the complex cases were of much less significance than the administrative issues. During the last meeting, the statutory changes to conservatorship were discussed and the general consensus is that they have made that process more of a burden. Mrs. Foley asked if we could bring someone in who is familiar with the statutory changes so that they could walk us through why the changes were implemented.

Chair Morelli stated that when the conservatorship statutes were changed, Legal Aid and the Area Agencies on Aging were very involved, and she is hesitant to tinker with the language as it was drafted to improve the individual's rights and ability not to be conserved against their will. There may be a very valid reason as to why it takes a while to be conserved, and Chair Morelli did not want to make any recommendations about the conservator statutes without hearing from the folks who drafted the language.

Mrs. VanTassel explained that the changes they made were not to the timeline of conservatorship, but rather, specified the authority that the conservator had. It also tried to put a greater emphasis on the self-determination of the individual. It was done through a task force at the request of Probate Judge Killian. There was additional legislation passed about four years ago that dealt with the authority of a conservator to have an individual admitted to a nursing home. Due to the concerns of the hospitals, the law specifically allowed an individual to be admitted to a nursing home and also have the right to a hearing if they did not approve of their placement.

Mrs. Tynan-McKiernan mentioned that Yale-New Haven Hospital had a great relationship with their Probate Judge, Jack Keyes. Unfortunately, she knew of other geographical areas where issues surrounding judicial interpretation exist. There are different ideas as what judges will allow conservators to do. She pointed out that it takes six weeks to obtain the aforementioned hearing, and that's six weeks where the patient is waiting in a facility.

Mrs. VanTassel mentioned that having attorneys trained in conservatorship is an issue that each probate court faces.

Chair Morelli asked if we could have both Kate McEvoy from the Agency on Aging of South Central Connecticut and someone from probate court attend the next meeting to clarify these issues. All members agreed on this motion.

Chair Tarutis requested that Mr. Richter clarify the definition of complex care within the study he conducted. He responded that it could be a number of medical issues that placed them in this category. Chair Tarutis asked if a patient could have been placed in more than one category within the study and Mr. Richter confirmed that they could not be in more than one category.

Chair Tarutis explained that, even though the task force had been discussing their experience with a small population of complex cases, most of the cases that stay in his hospital for an extended period of time are medically complex. They don't necessarily stay due to pending Medicaid determination or conservatorship.

Mrs. Tynan-McKiernan stated that often it's hard to categorize medically complex patients, and said that Yale-New Haven also has many that they have to treat and place.

Chair Tarutis suggested studying the restructuring of the payment system.

Mrs. VanTassel requested clarification on the PASRR assessment delays and why they were occurring. Mrs. Tynan-McKiernan informed the task force that she worked on the Connecticut Hospital Association Utilization Group which discussed how to streamline the assessment process. She worked closely with Kathy Bruni and Dr. Mark Schaefer of DSS to define some of the problems. The State has contracted with Ascend to have a five day turn-around time, but the timeline is broken up into stages, which could bring the assessment period up to ten days. Once the assessment is complete it can take two to three days to get a decision. Although, Mrs. Tynan-McKiernan acknowledged that PASRR has helped to streamline the assessment process.



The Utilization Group is also looking at the work it takes to complete the level of care form. Short-term patients who are not going into the hospital for a complex treatment may have staff spending 20- 40 minutes on this form; when filling out a form that detailed may be unnecessary considering their treatment.

Mrs. Ferrara-Tesla mentioned that the case reviews done by Ascend are completed after-hours, so there isn't much interaction with case management. Having those extra few days to make a decision does hold patients in the hospital for a longer amount of time.

Mr. Barrett stated that he liked Chair Tarutis' idea of performing the pilot study, and that even though complex cases aren't the lion's share of the problems at hand, they should still be addressed. There are costs that the hospitals are taking on that would be considerably less in a different setting. A pilot could look at what would be most cost-effective way to administer services. Chair Morelli seconded that concept and reinforced that it would be a great way to study the transition of medically complex patients; considering how useful that data could be to quality control within health care reform.

Mrs. Foley warned about the cost implications and the importance of looking at not just the administrative costs for DSS, but the rate implications and increased cost to the Medicaid system as well.

Mr. Barrett agreed and offered that the pilot could be constructed in a way where it wouldn't be triggered unless the model had a cost-savings component. Chair Tarutis echoed that comment. Chair Morelli said that we could also achieve cost savings in keeping a medically complex patient from being re-admitted to the hospital at a later date.

Mrs. VanTassel asked if there was way to streamline administrative issues such as pending Medicaid applications and the PASRR process. Mrs. Tynan-McKiernan answered that the hospitals would like to be able to prioritize applications for patients pending long-term care. Currently, there is no method to prioritize them.

Chair Morelli confirmed that we would have panelists from probate and DSS attend the next meet to discuss conservatorship and discharge issues.

The meeting was adjourned at 2:14 PM.

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Brie Johnston  
Task Force Clerk