

**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 18, 2010

10:00 AM in Room 2A of the LOB

The meeting was called to order at 10:13 AM by Chairman, John Tarutis.

The following task force members were present:

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

Absent were: Anne Foley, Deborah Parker.

Chairman Tarutis asked the members to review the minutes from the last task force meeting and noted that one correction was to be made on page three. He suggested emailing the clerk with any additional changes.

Chair Tarutis then summarized the last meeting and discussed the upcoming time line for the task force meetings and recommendations.

A panel of speakers from the Department of Social Services (DSS), Probate Court Administration and Area Agencies on Aging joined the group to share their understanding of the regulatory issues and service-related issues that the task force had identified as the focus of their recommendations.

Chair Morelli expounded upon the task force's work to date and introduced Mrs. Kathy Bruni, Manager of the Alternate Care Unit at DSS, as the first panelist. Mrs. Bruni

works closely with Ascend Management on the review process that hospitals use to determine if a patient is ready for transfer, called Preadmission Screening and Resident Review (PASRR).

PASRR was created in the Omnibus Budget Reconciliation Act of 1987 and was first implemented on January 1, 1989. There are three components to PASRR: the level one screening, the level of care evaluation and the level two evaluation. The level one screening is required for any individual entering a nursing facility, regardless of their payment source (e.g. private pay, Medicaid or Medicare). The purpose of this screening is to determine if a patient entering a home has mental illness, a developmental disability or mental retardation. If the individual is diagnosed with any of these issues, then a level of care review and a level two assessment must be conducted and a determination on the appropriateness of nursing home placement must be made. If the level of care evaluation is not completed pre-admission, then the facility may not receive their Medicaid reimbursement.

Prior to PASRR, every individual 65 and older who was Medicaid eligible or pending, or anyone of any age where a indication of a level two condition was present, was subject to a health screening before being admitted to a home.

Once PASRR was enacted, DSS conducted a two-paged level one screening and reviewed the information to determine if a level two assessment was needed. The process was done with DSS, Department of Developmental Services (DDS) and the Department of Mental Health and Addiction Services (DMHAS) working in conjunction; as structured in MOAs and MOUs. Information was sent over to DDS or DMHAS as needed. All information was transmitted by fax until 2010, when the assessments were outsourced to Ascend Management. DSS conducted about 4000 evaluations a month.

The level two evaluation is the most complex part of the preadmission screening process as it assesses the appropriateness for placement and makes care plan recommendations. DDS handled all assessments and determinations for their population of patients. DMHAS did assessments of folks in the community who were seeking nursing home placement. DMHAS also did a paper review of any level two assessments done by hospital staff, and made their determinations on the appropriateness of nursing home placement for their population of patients. The turn-around time for the preadmission screening varied, but was typically not longer than 24 hours.

There are categorical decisions and exemptions that are part of the PASRR regulations. For example, there is a thirty-day hospital discharge exemption that applies to hospitals that treat a patient who has mental illness or retardation and has suffered a physical injury or illness. Once the patient is admitted to the hospital, they may stay up to thirty days without needing the level two assessments to be conducted upon their discharge from the hospital to the nursing home, as placement is still appropriate. If thirty days lapses, then a level two assessment must be completed and care plan recommendations must be made.

The State decided to outsource PASRR for a few reasons.

A couple of years ago, the National Association of PASRR Professionals held a conference with the Centers for Medicaid and Medicare Services (CMS) and developed an assessment tool for each state to use, which assessed how well their state complied with PASRR regulations. DSS found some areas of concern after they did their self-assessment.

DSS discovered that the level one screening did not effectively identify or differentiate who needed or did not need the level two evaluations. For example, individuals who may have experienced a situational depression were included in the pool of patients who needed the level two evaluation, and patients who actually had a major depressive disorder were not assigned a level two evaluation.

DSS also conducted the level of care review twice for each patient. They did the preadmission health screening and a retrospective review once the nursing home sought Medicaid payment; also known as the W-10 process. Upon comparing the two reviews, DSS discovered that some health screenings did not match the W-10; so someone who appeared to meet the level of care from the health screening did not in the W-10 review.

Additionally, the level two assessment lacked some depth and did not address community options and what services may be available should they decide not to enter a home.

Simultaneously, CMS decided to raise the bar for state compliance with PASRR and implemented a new auditing system. They have already found shortfalls with a couple of states.

Another issue that surfaced is in regard to federal regulations, which state that the determinations cannot be done by an entity that has a direct or indirect affiliation or relationship with a nursing home. DSS felt that they could potentially be violating this clause when they allowed hospitals to conduct the level two evaluations that determine where the patients will ultimately reside. The level of care must also be clear, concise and transparent; where clear criteria for determinations must be applied without subjectivity. DSS felt that changes must be made in this area as well.

An institution for mental disease (IMD) is a facility with over 16 patients; half of which are placed with a focus on treating their mental health condition. It came to DSS' attention that some nursing home facilities qualified as IMDs, so the Alternate Care Unit formed a team to conduct nursing home reviews and they identified three homes that were in fact IMDs. Connecticut cannot claim federal Medicaid match on those facilities, so DSS lost millions of dollars in reimbursement during the period of time where they were assisting these facilities in reducing their mental health populations to under 50

percent. Some facilities were under 50 percent, but over 40 percent, and the State is required to monitor them so that they don't cross the threshold.

The Office of Protection and Advocacy for Persons with Disabilities filed a lawsuit against multiple state agencies due to alleged violations of the Olmstead Act, as the agencies did not keep patients with mental illness informed about options for placement in the community. This coupled with the conflicting level of care reviews really drove the need for outsourcing PASRR.

In April 2009 a Request for Proposal (RFP) was released from DSS and Ascend Management was awarded the contract for PASRR. They are a national leader in PASRR, with experience managing eight other states. Their contract with Connecticut started in November 2009 and they completely took over PASRR functions in February 2010.

Since Ascend has started, new and improved features to PASRR have surfaced:

The level one assessment is now web-based, uniform reporting has been facilitated with drop-down boxes and the reporting of psychotropic medications is now required. An algorithm in their system examines the medications and bases decisions about level two evaluations based off of the drugs that the patient takes. This algorithm has proven to exclude more people from the level two assessment.

The level of care assessment is now consistent, web-based, completed pre-admission and determines the length of stay. This new process allows DSS to time-limit Medicaid approvals for nursing home care.

The level two evaluation is now done by an independent clinician, is conducted face to face, is more comprehensive and gives alternative to nursing home services. Each patient receives a summary of findings that gives them information about community-based services for which they are eligible. Nursing homes feel that this helps give them data for their care plan process.

Now that the system is web-based they can link the minimum data set that nursing homes use with PASRR to capture patients who may have been improperly assessed, which is a helpful quality-assurance tool.

The new data helps DSS identify service gaps and needs, which allows the state agencies to work together to review and revise service planning. The State is now comfortable with a CMS audit as compliance has been met.

The timing of the screening process is very different since the shift to Ascend. The level one screening is done in less than an hour. The exempted hospital discharge, as mentioned above, is now a part of the automated process and is completed significantly faster. The level of care review averages 2.8 hours. The level two evaluation, from the point in time when the evaluation is determined to be necessary to when the hospital

receives an answer about placement in a nursing home, is, on average, 3.85 days. Contract requirements are five business hours for the level one and level of care screenings and five business days for the level two evaluation. DSS is looking into options on how to reduce the amount of time to complete the level two evaluations.

Mrs. VanTassel asked if DSS had any data on patients who were not meeting the nursing home level of care. She was curious how those numbers affected hospitals that were not able to discharge these patients. Mrs. Bruni acknowledged that there is an increase in the number of patients who do not meet the nursing home level of care (about 70 people in the first six months). In the past, only a “handful” of patients were not placed for failure to meet the level of care. A difference is also seen for the short-term nursing home stays, where a patient can be temporarily placed in a home until they are able to function without that level of care. In the past, this population may have stayed in the home longer than required for their treatment, but now they do not.

Mrs. VanTassel was concerned that the information Ascend collects on community placement does not take into account where the patient used to reside. Mrs. Bruni assured her that this information is collected during the level one screening. Mrs. VanTassel asked if DSS saw a difference in the number of community placements as a result of collecting this information. Mrs. Bruni said that it is too early to draw that conclusion. She explained that at the same time DSS was doing the PASRR shift, DMHAS was creating a diversion and transition program. DMHAS nurses can now assist with care planning for patients who do not meet the nursing home level of care, and DMHAS is automatically notified when one of their patients is eligible for this program.

Chair Morelli asked the hospitals if the problem is completing the level two assessment in 3.85 days or when the patient is determined not to meet the level of care resulting in a delay in discharge. Mrs. Ferrara-Tesla answered that the 3.85 days is the issue.

Mr. Bustow asked if the folks who were identified as not meeting the nursing home level of care needed more care than the nursing home could provide or less-intensive care that could be provided in the community. Mrs. Bruni confirmed that most needed less-intensive community services. Though, some of those who did not meet the level of care were not stable and were considered a risk to other nursing home residents; placing them would not have been appropriate. Those individuals end up staying in the hospital or going to a different setting other than a nursing home; potentially with the assistance of DHMAS.

Chair Tarutis asked if all 70 patients were denied transfer because the nursing home was not the appropriate setting for them. Mrs. Bruni answered that 20 of that pool were not transferred to a nursing home because they needed specialized care. Some of those people end up re-entering the PASRR process as their situation changes.

Chair Tarutis then asked Mrs. Tynan-McKiernan from Yale-New Haven Hospital to join the discussion. Mrs. Tynan-McKiernan thanked the Chairs and said that she and Mrs.

Bruni had worked together on the Ascend shift in PASRR through the Connecticut Hospital Association (CHA) work group. Yale-New Haven has had a very positive experience with Ascend and the level one screening. They are looking at how to streamline the level of care portion of PASRR. Yale-New Haven has also experienced delays in the level two evaluations. This portion of the process went much more quickly when they had a relationship with DSS or Advanced Behavioral Health (ABH). Overall, there are fewer level two evaluations, which is an improvement. DMHAS diversion nurses do not have the resources to create community plans for patients: they are working harder than they should to complete the plans.

Chair Morelli summarized Yale-New Haven's experience and concluded that the delay for level two evaluations is being examined by the CHA work group, so this issue would not be taken up by the task force.

Mrs. Bruni stated that the more complete the level one screening and level of care assessment are, the quicker the determination is made on the need for a level two assessment. Lack of information could be part of the reason for delays in the process. Ascend has assembled work groups with the nursing homes, hospitals and DSS district office employees to determine how to make the program easier to use and more efficient; without compromising the data that they need. The work groups haven't been active for too long, but Mrs. Bruni believes that they have already made some progress.

Chair Morelli asked Mrs. Bruni if she thought that it would be worthwhile to have the task force look at the data to determine if other levels of care are necessary and help locate services that may be difficult for them to find. Mrs. Bruni answered that there are work groups between DSS and DMHAS that are addressing this issue. They are finding that substance abuse, in particular, is a complicating factor. Resources may not be available to assist the population with transitioning back into the community.

Chair Tarutis asked Mrs. Bruni how many facilities were above 40 percent mental health beds. Mrs. Bruni answered approximately ten. DSS has continuously monitored them, and they are currently down to one facility that is over 40 percent.

Chair Tarutis asked if linking PASRR with MDS 3.0 would expedite the level of care evaluation. Mrs. Bruni believes that linking the two would be a quality assurance tool to make sure that patient needs are addressed. She did not see it as expediting a process in the nursing home. It could help the homes identify patients whose change in condition need to be reported. Chair Tarutis reframed the question and asked if PASRR could link into the databases used by nursing homes and hospitals to pull the information on a patient themselves instead of waiting for the facilities to provide it. Mrs. Bruni said that the information hubs are not linked.

Mrs. VanTassel asked if patients with developmental disabilities had been identified. Mrs. Bruni said that DSS continues to conduct the level two evaluations for this population. The level one screening and level of care screening are conducted through

Ascend and then Ascend makes the referral to DDS. There is no change in the number of people with developmental disabilities being admitted to nursing homes.

There being no further questions, Chair Tarutis thanked Mrs. Bruni for her presentation and invited Mrs. Parella to join the group. Mrs. Parella is the DSS Director of the Office of Legal Counsel, Regulations and Administrative Hearings and she was asked to attend to discuss the process of an administrative hearing when a person contests a transfer or discharge.

A hearing on a transfer of a patient to a facility is an anomaly for their department, as most of the hearings they hold are between DSS and a Medicaid client, but this situation is between a nursing home and a patient who may or may not be enrolled in Medicaid.

After a few of these hearings, Mrs. Parella invited Mrs. Furniss from the Department of Public Health (DPH), the DSS Long Term Care Ombudsman and the Legal Services community to discuss patient rights and nursing home rights. Her department had heard some very complex cases where the rights of each party were not clear, and the result was extensive and confusing hearings.

They determined that two state statutes address the process of transfer and discharge hearings, and bed-holding rights. It is not clear if once a patient is discharged from a nursing facility they have the right to return to that facility, and whether they have a right to a hearing on that basis. The issue lies in that a nursing home could say that a patient does not meet their level of care, but they as a facility are licensed to provide a broad range of care.

Many of the cases DSS is hearing involve medically complex patients who have physical needs and behavioral or mental health issues as well. It's not clear where the best placement for that patient would be. DSS has become more cautious when they receive a complaint for a facility's reluctance to re-admit someone upon discharge from the hospital. DSS is hesitant to automatically advocate on behalf of the hospital and tell the nursing home to take the patient back once discharge has been approved because that patient could be a threat to the health, safety and well being of other nursing home residents.

A team of professionals, the DSS Medical Director, Long Term Care Ombudsman, Mrs. Parella, and sometimes Mrs. Bruni will informally meet to discuss best placement for these highly complex patients. Chair Tarutis asked how often these situations arise over the course of a year. Mrs. Parella answered three or four.

State statute and federal regulations are not clear about what was required during the transfer of a medically complex patient; which prompted Mrs. Parella to pull together the team of professionals to assist in the decision making on what was best for this type of patient.

To compound that issue, many of the hearing officers reviewing these cases are DSS eligibility workers that climbed the ranks to this position. They are not clinicians and may not have a full grasp on the issues at hand. These decisions take time to make, and contribute to the time delays that hospitals experience when discharging a patient.

Chair Tarutis asked the task force members representing hospitals for their opinion on this issue. Mrs. Ferrara-Tesla responded that her hospital did not experience many of these transfer issues. Chair Tarutis acknowledged that this issue pertained to a very small population.

Mrs. Shanahan spoke from the nursing facilities' standpoint about the issue of patients who have been identified as always needing that specific home's services. The nursing homes are sometimes able to get them proper services in the community, and the hospitals generally help the homes secure a different placement if necessary.

Chair Morelli thanked Mrs. Bruni and Mrs. Parella for tackling these very specific issues and explained that since other work groups are toiling to resolve them, this task force would not need to focus their recommendations on changes in these areas.

Mrs. VanTassel asked Mrs. Furniss about a survey DPH is required to conduct with nursing homes: DPH must compare the level two evaluation with the care plan to see if the recommended care is consistent between the two documents. Mrs. Furniss answered that the DPH surveyors do pull a random sample of nursing homes and look at the care plans to see if the level two screening recommendations have been incorporated into the plans.

The home does not have to take the level two evaluation and incorporate it verbatim into their care plan. They must acknowledge the mental or behavioral health issue that the patient faces and demonstrate that they fully understand the issue by properly planning for its care. As it is a sample, it's possible to miss cases where care has not been properly planned. However, the surveyors are now casting a wider net as they have access to information on a larger pool of patients, so it is more likely for DPH to locate a case that has not been handled correctly. Additionally, the agency's branch managers are not focusing on this process during their monthly meetings, which indicates that it must be working.

Chair Morelli then introduced Tom Gaffey, Chief Counsel for the Office of the Probate Court Administration. She explained that the task force had invited him to the table so that he could delineate reasons for delayed discharge due to securing a conservator.

Mr. Gaffey gave a simple overview of the conservatorship process; placing emphasis on areas that are relevant to the work of the task force. There are three types of conservators: involuntary, voluntary and temporary. Within in each of those you can have a conservator of a person, which handles the care of the individual or a conservator of the estate, which handles the person's assets. We are most familiar with involuntary conservatorship where the courts have determined an individual incapable,



as defined by statute, and assign a conservator to handle that person's affairs after following the appropriate statutory process. In a voluntary conservatorship situation, the individual is capable of making decisions about their personal affairs, but seeks assistance with them. They are the only ones who can make this request of the court. A temporary conservator is appointed in an emergency situation, and is only appointed to avoid immediate and irreparable harm of the individual who is being conserved. This type of conservatorship is limited in its duration.

The deprivation of individual rights is involved with an involuntary appointment of a conservator, as we are removing their ability to make decisions about their own care and property. As a result, the legislature took up a comprehensive review of our conservator statutes in 2007, as to improve the protection of rights of the individual being conserved.

The review resulted in revisions, and Mr. Gaffey went on to discuss them. Anyone may apply to be a conservator for any other person, and the probate court (court) must have a hearing within thirty days of the filing of the application. It is required that a Marshal give notice of the hearing to the respondent at least ten days prior to the hearing. This allows the respondent more time to prepare their case should they wish to oppose the appointment of a conservator. The respondent has a right to counsel, and the court shall appoint an attorney, free of charge, to the respondent should they be unable to request or afford counsel.

Current medical evidence is required. A physician must have examined the individual being conserved within the forty five days prior to the hearing. The law requires the court to make its finding based on clear and convincing evidence; which is a heightened standard of proof, and alludes to the severity of the subject matter. The court has to present findings first as to whether it has jurisdiction under statute and then can proceed to accept evidence of incapacity. If the court finds incapacity by clear and convincing evidence, then the court has to examine the need for appointment of a conservator. The court also has to look at whether appointing a conservator is the least-restricting means of handling the affairs of the respondent. The court has to consider the powers that the conservator requires in order to do what needs to be done for the individual.

It is important to note that the conserved person retains any rights that are not specifically given to the conservator.

The conservator, in any event, cannot commit the person to an institution. They must apply to commit the individual. They cannot override the decisions of a health care representative. They cannot terminate a lease, sell property, dispose of household furnishings without prior authorization of the court. They cannot place an individual in a long term care facility or change that individual's residence without prior authorization of the court, typically.

Mr. Gaffey presented the task force with a copy of the statute pertaining to placement provisions. Prior to being placed in a long-term care facility, the conservator has to file

a report with the court that details the need for that and steps that have been taken to provide care for that individual in a less-restrictive environment. A hearing on the report is required within five days of the filing of the report. The court can then make the decision as to whether long-term care placement is necessary.

There is a very significant exception to this statute: if the placement is made following hospitalization, then the placement can be made before the filing of the report and without the authorization of the court. The court will hold a hearing post-placement to determine if placement continues to be necessary.

A voluntary conservatorship does not have the same requirements surrounding the request to be conserved. The notice of hearing does not have to be delivered by a Marshal and there is no appointment of counsel in order for a hearing to be set more quickly. The powers of the conservator are the same. Conservatorship can be terminated at will by written notice from the individual being conserved. It will be terminated within 30 days of receipt of the written notice.

Temporary conservatorship requires the same criteria as an involuntary conservatorship, but in a compressed time frame. The hearing is required not later than seven days from the filing of the application and the Marshal must make service not less than five days before the date of the hearing. If the situation is extremely serious, the court reserves the right to issue an appointment ex parte, without any hearing, and must immediately hold a hearing thereafter. Temporary conservatorship lasts for 30 days, with the exception that if an application for involuntary conservatorship is filed within that time an additional 30 days is given to prepare for the hearing.

As far as issues with timing, the task force may be concerned about the amount of time it takes to get a hearing and the inability of the court to find someone who is able and willing to serve as a conservator; the latter being a very serious issue for every probate court in the state. Mr. Gaffey said that he would be happy to entertain any questions that the members had.

Chair Morelli suggested that the task force hear from Kate McEvoy, Deputy Director of the South Central Area Agency on Aging, in order to get the advocate's perspective on the intent of the changes in conservatorship reform. Ms. McEvoy said that she was indebted to follow Mr. Gaffey as he was responsible for drafting much of the reform language. She and Mr. Gaffey both served on the committee that handled the reform. Hartford Probate Judge Robert Killian served as leadership on that committee.

Mrs. McEvoy's presentation was twofold: to provide context as to how the reform originated and its intent, and to discuss clinical and administrative practices that surrounding the process of discharge.

Connecticut's reform initiated due to national attention on guardianship over the past ten years. There has been concern about ensuring that an individual's due process rights are protected, and that there be attention placed on consideration of alternatives to

conservatorship. Least-restrictive alternatives have come to the forefront as the guiding principle.

Connecticut's reform reflects a shift to a person-centered approach that is tailored to individualized needs. The more fundamental aspect of the reform is a shift from plenary conservatorship to limited, evidence-based conservatorship. The Wingspan Conference (2001- Stetson University Law School in Florida) brought together clinicians, attorneys and people from different disciplinary orientations to discuss best practice recommendations for protection of due process and individual appointments for this process.

Prior to 1998, if a Connecticut Probate Judge found an individual to be incapable by legal standard, they were mandated to appoint a conservator in all situations.

Public Act (PA) 97-90 established that appointment of a conservator when the individual was determined to be incapable was no longer mandatory if the individual was being cared for properly and if their affairs were being properly managed. It distinguished between conservator of the person and conservator of the estate.

PA 98-219 permitted judges to limit the powers of a conservator, but this did not amount to be a significant change. Most conservatorships were still plenary in nature.

PA 05-155 outlined that in most situations, except for the discharge of patients from hospitals to nursing home facilities directly, the conservator must demonstrate to the court that a thorough investigation of community-based alternatives was conducted. There must be a rationale for nursing home placement that is compelling to the court. This supports the evolution of an individualized focus; where we place people in settings based on their preferences and what is least-restrictive to them.

PA 07-116 outlined new notice and jurisdictional requirements, established procedural obligations regarding where a hearing is held, established the court's obligation to provide counsel or allow the individual to make an informed decision not to be represented, ensured that courts observed rules of evidence and had a full and fair process and provided new guidance on standards of appointment of conservators.

The fact that Connecticut experiences difficulty in locating qualified conservators was also touched upon by Ms. McEvoy.

The presentation then moved to clinical and administrative considerations for hospitals in the process of a conservatorship proceeding. Those who drafted the reform respected issues that hospitals had with time, and understood the broad range of medical profiles they face.

Ms. McEvoy recommends developing skill sets on capacity determination. It would be ideal if everyone knew what legally incapable meant. She has seen other statutes that much more significantly address this question, e.g. Florida. The American Bar

Association, Commission on Aging and the American Psychological Association developed an excellent rubric on how to make capacity determinations. It is one of the few documents that have been prepared by both attorneys and clinicians.

It was suggested that the task force think about how hospitals could become better equipped to educate staff on community-based alternatives. Assessable and affordable alternative are limited, which is an issue all in of itself. Regardless, we can still educate staff on options such as the Medicaid Home and Community-Based Waivers.

Finally, Ms. McEvoy recommended making hospital staff aware of the intent behind conservatorship reform. It is vital that they respect self-determination and ensure that civil liberties are not compromised. The reform supports due process and is not just some arbitrary delay. It is also important for clinicians to understand the weight of the information that they provide on medical evidence for the conservator hearing. Sometimes information is submitted that is not dispositive of the court's determination, and does not focus on the patient's ability to make decisions and communicate them. Lack of detail in this area hinders the process for judges, and often prompts additional inquiries.

Chair Morelli thanked both Mr. Gaffey and Ms. McEvoy for their work on this reform and presentation of it during the task force meeting. She didn't think that anyone in the room disagreed with the intent behind the reform, but admitted that the data the task force saw on conservatorship delays was alarming. On average, a patient stays in a bed for 74 days due to delays in securing a conservator, and that is just too long to be unnecessarily in an acute care setting. She wondered if there was any way that the hospital community could work with the legal community to create a solution that would not compromise the intent behind conservator reform, but would shift patients out of the hospitals at a faster rate. She asked the hospitals to comment.

Mrs. Ferrara-Tesla indicated that Danbury Hospital has four to six patients a month that undergo the conservatorship process. The hearing doesn't happen for generally six weeks, which may be due to scheduling issues in the court calendar. Once a conservatorship appointment is made, then the Title 19 application starts. This additional responsibility is an unfair burden on the attorney as they have to collect information on the individual's finances and may not have the assistance of the individual's family members. Mrs. Ferrara-Tesla also expressed that locating a conservator is an issue that contributes to delayed discharge.

Mrs. Tynan-McKiernan expressed that Yale-New Haven Hospital also experiences the issue with the conservatorship process and the Medicaid application coinciding. She wondered why it was more difficult to get conservators under the new law. Perhaps the additional responsibilities keep potential conservators at bay.

Mr. Gaffey said that he couldn't say that folks aren't more hesitant to become conservators, but he does not believe that it is because of the new statutes. It has been an escalating problem for years and years.

Ms. McEvoy has observed that the process has become more rigorous with the introduction of rules of evidence; specifically the request to provide medical evidence. She also outlined that the court's responsibilities have increased. The court must first determine the person incapable, determine if the person's affairs are being properly managed without a conservator and ensure that the least-restrictive alternatives have been considered. Even then, appointment of a conservator is not obligatory. The time frame for appealing the appointment of a conservator may also contribute to delays, but is necessary for due process.

Finding people to serve as conservators is a huge issue, and Mrs. McEvoy pointed out that other states, such as California, have resolved it by creating a public guardianship program.

Ms. McEvoy was curious to see a breakdown of the data that showed delays in discharge due to conserving the patient. She wondered if it was due to more administrative issues with court scheduling or appeals. Perhaps an analysis of those numbers would be in order.

Mrs. Furniss added that, aside from having to handle the case of a Medicaid recipient, it would seem anecdotally that the issue with securing conservators is lack of payment. She recommended looking at that reimbursement system to consider better compensation for conservators.

Mr. Richter asked if there was a conservator resource model in any other state at which we could look. He also wondered how long Connecticut's conservatorship process, on-paper, took in comparison to other states. Ms. McEvoy said that we could look at both California and Florida as for guidance. The time frame of Connecticut's statutes was relatively typical, although there may be disconnect between the required time frames and the actual process.

Mr. Gaffey explained that in addition to court scheduling, there are many other issues may contribute to delays. The statute requires a hearing in 30 days, but it does not require an appointment within 30 days. If you have a matter that is contested, then it could go on for a considerable amount of time, as parties may request continuances.

Mr. Bustow quickly crunched some numbers and found that the 74 days mentioned earlier was just surrounding Medicaid patients that are delayed due to conservator issues. This issue seems to be a bigger problem for patients that are pre-Medicaid enrollment. If we annualize the number of people categorized in the DSS survey as pending conservator appointment /action court orders and individuals enrolled in Medicaid and pending a conservator appointment, we arrive at about 37,000 or more days of people staying in the hospital because they don't have a conservator. Mr. Bustow believes that this is close to half of the aggregate days surrounding discharge delays. Conservatorship must be addressed if we are looking to solve the issue of transfer.

Mrs. VanTassel was curious about advanced directives. A conservator has to go to the court to override a health care representative, but if we encourage people to use advanced directive this may not be as much of an issue. Chair Morelli thought that if the person had a health care representative then they did not need a conservator. Ms. McEvoy explained that if someone has appointed a health care representative, then that person is in the best position to continue to make the physical and mental health care decisions as they are a voluntary appointment and will reflect the wishes of the individual who appointed them. A health care representative is a less-restrictive alternative to a conservator. Ms. McEvoy reminded the task force that if an individual has the capacity and is capable of communication their own decisions, then they should be the ones to make decisions for themselves.

Chair Morelli thanked Mr. Gaffey and Ms. McEvoy and asked them to think of ways in which the state could generate a larger supply of conservators.

It is Mrs. Tynan-McKiernan's understanding is that if a patient is in the hospital pending Title 19, the hospital is not paid for that patient's stay, which is why they get a blanket reimbursement payment (Disproportionate Share Payment) for Title 19.

Mr. Richter suggested that we look to Florida and California to see what they have done with pending Title 19 patients, as our recommendations could have a ripple effect in the State budget.

Chair Tarutis reminded the task force of the burden that hospitals face when they cannot move a patient from the emergency room into an appropriate bed because a transfer patient is occupying it. Likewise, there are nursing homes that would love to take the patient if they could be adequately reimbursed, if they are reimbursed at all.

Chair Tarutis asked Mr. Richter how the task force could think outside the box on the financial side of these issues. Mr. Richter then circulated an analysis of a potential option to the members. He provide a payment scheme of what our state budget numbers could look like if the nursing homes we paid a higher rate of reimbursement. He discussed the difference in paying per discharge and a settlement.

Chair Morelli asked how DSH payments would be redistributed in this scenario. Mr. Richter said that he did not factor them into this scenario.

Chair Tarutis said that he might invite an LTAC to the next task force meeting to discuss their issues with placements. Mr. Bustow said that inviting the LTACs made sense and suggested that we invite Gaylord Hospital.

Mrs. Tynan Mc-Kiernan stated that LTACs have issues admitting patients because they are at maximum capacity for Medicaid patients. She also pointed out that Leeway set a precedent about 10 or 12 years ago when they negotiated a higher reimbursement rate

due to the unique difficulties their patient's experience and the additional care that is required to treat them.

Mr. Richter explained that there are specific regulations in state statute and federal code that dictate a different payment level for facilities that serve AIDS patients. Leeway and Trinity Hill are the two Connecticut facilities that receive that increased payment.

Mrs. VanTassel asked Mrs. Bruni if she understood her presentation correctly. She asked if 70 people had in fact been identified as not meeting nursing home level of care in six months. Mrs. Bruni confirmed that this is correct. Mrs. VanTassel expounded upon her concern that if a person doesn't meet the nursing home level of care they won't qualify for the Medicaid waivers or Money Follows the Person (MFP). This could make it more difficult to access community resources.

Mrs. Bruni explained that DSS helps those individuals who do not meet nursing home level of care with state plan services and services offered by DMHAS. Mrs. VanTassel pointed out that this is a problem considering our budget environment where we are considering limiting the state-funded grant services, and relying more heavily on Medicaid services.

Chair Morelli said that the discussion today reminded her that the task force needs to look at the models of care we have constructed.

Chair Tarutis requested that the members come to the next meeting prepared with well-thought recommendations. He cautioned that the next meeting may be the last.

The meeting was adjourned at 12:14 PM.

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Brie Johnston  
Task Force Clerk