February 24, 2016

Written testimony of Matthew V. Barrett, Executive Vice President of the Connecticut Association of Health Care Facilities (CAHCF), Inc. Re: S.B. No. 209 (RAISED) AN ACT CONCERNING THE DEPARTMENT OF PUBLIC HEALTH'S RECOMMENDATIONS REGARDING THE PROTECTION OF RESIDENTS IN HEALTH CARE INSTITUTIONS.

Good afternoon Senator, Representative Ritter and to the members of the Public Health Committee. My name is Matthew V. Barrett, Executive Vice President of the Connecticut Association of Health Care Facilities (CAHCF), our state's one hundred and sixty- member trade association of skilled nursing facilities and rehabilitation centers. Thank you for this opportunity to offer testimony this afternoon concerning S.B. No. 209 (RAISED) AN ACT CONCERNING THE DEPARTMENT OF PUBLIC HEALTH'S RECOMMENDATIONS REGARDING THE PROTECTION OF RESIDENTS IN HEALTH CARE INSTITUTIONS.

Section 1. Nursing Home Administrator Responsibility

This section proposes amending Conn. Gen. Stat. §19a-511 to add that the administrator "shall be responsible for the quality and safety of all services in the licensed nursing home." CAHCF asks that the committee take no action on the proposal as drafted and that our association be given the opportunity to work with the proponent of the bill on a substitute version of this section.

Subjecting the administrator for overall responsibility for the quality of care and services is troubling for a number of reasons. First, administrators typically are not clinicians. For this reason alone, the proposed language should not be permitted. Second, the Department already has the authority to initiate an action against an administrator's license under Conn. Gen. Stat. §19a-517 and §19a-17 for any "illegal, incompetent or negligent conduct; violation of any provision of state or federal law governing the license holder's practices within a nursing home; or violation of any provision of this chapter or any regulation adopted hereunder." The proposed language only conceivably adds responsibility for clinical issues.

Moreover, the proposed language could be interpreted as creating strict liability for administrators on issues that may be out of the administrator's control. In other words, there would not need to be any proof as to how the administrator failed but rather, for example, the facility's clinical failures will be imputed to the administrator leaving administrators very few defenses in actions against their licenses for quality of care failures.

This situation is similar to a medical director tag being assessed for overall quality of care issues without any specific findings about a medical director's failures. The Administrative Law Judges ("ALJ") have consistently held that such a finding is improper.

> CMS must do more than show the existence of other deficiencies in order to establish noncompliance with section 483.75(i)(2)[F501]. The regulation states that a medical director is "responsible for" implementation of care policies and coordination of medical care. . . CMS did not identify a specific instance in which the medical director's actions or inaction with respect to a resident, or to the

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resident community at large, resulted in or contributed to a failure to implement care policies. Nor did CMS identify an instance in which the medical director failed to coordinate medical care under circumstances where coordination by the medical director was necessary or required. Because it is conceivable that deficiencies may exist despite a medical director's best and reasonable efforts to oversee and supervise the medical care in the facility, the mere assertion by CMS that deficiencies were found to exist on the medical director's watch is insufficient to establish that the medical director failed to assume the specified responsibilities.

Western Care Management Corp. dba Rehab Specialties Inn Petitioner - v. - Centers for Medicare Medicaid Services, DAB No. 1921; 2004 HHSDAB LEXIS 73, *174-76 (May 10, 2004). While the language under F501 is not as broad as the proposed statutory language (F501 – the medical director is "responsible for implementation of resident care policies and the coordination of medical care in the facility"), the ALJ analysis is helpful in developing an argument as to why such a strict liability standard is not appropriate.

For the reasons stated above, CAHCF would like to work with the proponents on a compromise substitute for this section. The new language could mirror the regulation and say that the administrator is responsible for the overall management of the facility. See Conn. Agencies Reg. §19-13-D8t(f)(3). Such language would permit an action against an administrator's license for failing to manage but such failure could not be based on clinical issues that did not stem from management failures. Although such an action is already permitted under Conn. Gen. Stat. § 19a-517(b)(5), which permits actions for violations of regulations, the recommended substitute would provide a more explicit statement of the "overall management" responsibilities in the statute itself.

Section 4. Increase in Violation Fines

This section proposes increasing Class A violations fines to not more than $10,000 (currently $5,000) and Class B violation fines to not more than $5,000 (currently $3,000). We believe the that the current penalties already have punitive and deterrent effect and that increasing the penalties at this time will only harm SNFs already undergoing a period of financial distress due to the state budget deficit. In addition, SNF deficiencies upon which the citations are based are nearly always duplicative of the federal deficiencies cited which also frequently result in a CMS fine. Therefore, facilities are often being "double" fined by CMS and the state for the same deficient practice. We urge the committee to take no action on this provision for these reasons.

Section 5. Conflicting Temporary Manager Appointment

This provision also duplicates and confuses existing federal law governing the same area. Temporary management, as defined in the federal regulations, means "the temporary appointment by CMS or the State of a substitute facility manager or administrator with authority to hire, terminate or reassign staff, obligate facility funds, alter facility procedures, and manage the facility to correct deficiencies identified in the facility's operation." Moreover, the provision

in S.B. 209 conflicts with the CMS rule in the last clause: "for a period of time to be determined by the commissioner" whereas under the under federal regulations, the remedy has a definitive period: "(c) In the case of temporary management, the remedy continues until -- (1) CMS or the State determines that the facility has achieved substantial compliance and is capable of remaining in substantial compliance; (2) CMS or the State terminates the provider agreement; or (3) The facility which has not achieved substantial compliance reassumes management control. In this case, CMS or the State initiates termination of the provider agreement and may impose additional remedies." 42 CFR 488.454. The state should be subject to the same period of time requirements, not "for a period of time to be determined by the commissioner." Notably, 42 CFR 488.406, already provides that the States have temporary management as an available remedy: "(b) Remedies that must be established. At a minimum, and in addition to termination of the provider agreement, the State must establish the following remedies or approved alternatives to the following remedies: (1) Temporary management. . . ". To remove the conflict, CAHCF recommends the language be modified as follows: "Appoint temporary management for a facility in accordance with the provisions of 42 CFR 488.400 et seq related to the appointment of a temporary manager."

Thank you for this opportunity to submit written testimony. For additional information, contact Matthew V. Barrett, 860-290-9424 or mbarrett@cahcf.org.