



## HUMAN SERVICES COMMITTEE

### Public Hearing

March 8, 2016

### Written testimony of State Ombudsman, Nancy Shaffer

Senator Moore and Representative Abercrombie, Senator Markley, Representative Wood and esteemed members of the Human Services Committee, my name is Nancy Shaffer and I am the Connecticut State Long-Term Care Ombudsman. Per the Older American's Act and CT General Statutes 17a-405-422 inclusive, it is the duty of the State Ombudsman to provide services to protect the health safety, welfare and rights of individuals who reside in skilled nursing facilities, residential care homes and managed residential communities/assisted living facilities. The Ombudsman Program serves approximately 30,000 residents in the state of Connecticut who reside in one of these facilities whether for a short or long-term stay. It is the responsibility of the Long-Term Care Ombudsman Program to respond to concerns of residents and their families about their care and services and to facilitate resolution of those complaints. It is the responsibility of the State Ombudsman to advocate for changes in laws and governmental policies and actions that affect the health, safety, welfare and rights of residents.

I appreciate this opportunity to testify on behalf of the individuals who reside in long-term care institutions throughout Connecticut.

#### **H.B. No. 5589 (RAISED) AN ACT CONCERNING AN ACUITY-BASED SYSTEM FOR MEDICAID REIMBURSEMENT**

The purpose of this bill is to establish the components of an acuity-based Medicaid reimbursement system for nursing home services here in Connecticut. There are a variety of potentially positive outcomes of this proposal: 1) a standardized resident assessment instrument, 2) an admission protocol that is not biased against individuals who require "heavy care", 3) rate adjustment add-on's for special care needs residents, 4) cost differential for different county costs, 5) a pay for performance add-on-assuming quality incentive, 6) phase-in transition to limit possible decreases in reimbursement, and 7) annual report of the rate impact on each.

There are accompanying questions to this proposal that should be addressed, including, but not limited to: 1) Does the bill permit DSS to develop methodology? and will stakeholder feedback be allowed during development of the methodology and before implementation? 2) Will there be opportunity for stakeholder review and recommendations after implementation? 3) Will there be new minimum staffing requirements specific to each special care need population? how will that be determined? and



how will it be operationalized within a nursing home serving a variety of resident populations with special care needs? 4) Are there other special care need resident populations that should be included in the list (for example, residents who require specialized feeding techniques such as Total Parenteral Nutrition? (TPN is a type of nutrition delivery and requires specialized staff training to deliver and monitor the patient), 5) Are there penalties for non-compliance? How are those penalties implemented?

To better understand the complex issues regarding an acuity-based system for Medicaid reimbursement I consulted with a national expert on this subject, Dr. Cynthia Rudder. Dr. Rudder was the co-founder and director of the Long-Term Care Community Coalition. From the consumer's perspective, she has extensively researched and examined whether different ways nursing facilities receive funding impact good care. Her studies can be reviewed at these links:

[http://www.ltccc.org/publications/documents/ModifyingRUGsRespondingtoConsumerConcernsinNYS\\_000.pdf](http://www.ltccc.org/publications/documents/ModifyingRUGsRespondingtoConsumerConcernsinNYS_000.pdf)

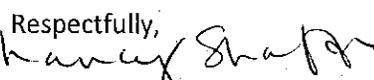
<http://www.nursinghome411.org/NursingHomeReimbursement.php>

Based on Dr. Rudder's research and what we know today about quality of care issues, access to admission issues and surveillance and enforcement issues, The Long-Term Care Ombudsman Program recommends:

- nursing facility reimbursement be linked to quality outcomes
- quality incentives should be linked to spending in direct care areas (rather than indirect care areas such as administration)
- address potential disincentives for improved patient outcomes (e.g. what happens if a resident improves enough to move to a lower-paying category)
- advocates and consumers along with providers and state agencies should have input into the development of a methodology and opportunity to review and make recommendations once a system is implemented
- surveillance and enforcement: link enforcement and fines specifically to the poor outcomes or deficient practices (e.g. if the deficient practice is in the area of preventing pressure ulcers require additional resources be identified for that area of care)

**Most importantly, an acuity-based system for Medicaid reimbursement should encourage good care.**

I appreciate your consideration of my testimony and am available to answer questions on behalf of the residents who will be impacted by this proposal.

Respectfully,  
  
Nancy Shaffer, State Ombudsman