Safeguarding Residents & Program Integrity in New York State Nursing Homes

An Assessment of Government Agency Performance

- - - EXECUTIVE SUMMARY - - -

by

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NOTE: The full report and charts are posted in Excel on our nursing home website at http://www.nursinghome411.org/articles/?category=lawgovernment.

The charts provide information for all of the states on their nursing home populations; number and amount of annual fines levied; citations; and rates and rankings on the three important indicators which are focused on in the report.

The Excel format allows for easy sorting of the state data, for instance to see how a state ranks on a given criteria. The various rates and relative rankings enable one to get a useful snapshot of how any state is performing in terms of protecting its residents and how that performance compares against that of other states and the national average.

Executive Summary

Overview

LTCCC conducted this study to assess the efficacy of the state agencies responsible for (1) protecting nursing home residents and (2) ensuring appropriate use of the billions of tax-payer dollars spent on nursing home care each year. In New York, the Department of Health (DOH) is chiefly responsible for nursing home quality and program integrity and, thus, it is the principal focus of this report. In addition to DOH, we also assessed the state Medicaid Fraud Control Unit (housed in the NYS Attorney General's Office) and the state Office of Medicaid Inspector General. Last year we conducted an assessment of the state Long Term Care Ombudsman Program (LTCOP), which is not included in this report.[1] Though the LTCOP does not have regulatory authority, it plays a critical role in monitoring nursing home care and ensuring that residents are protected and their complaints addressed.

Fundamentally, our approach is predicated on the idea that it is the resident that is important….

In addition to providing an assessment of each agencies' oversight performance in respect to their respective missions, this report seeks, particularly in regard to DOH, to relate performance directly to the impact it has on individual nursing home residents. In our experience, quality and performance are most often viewed in respect to the provider. [For example, Nursing Home Compare provides information on the number of deficiencies per nursing home, individually and for state and national averages.] In this study, we sought to focus on the resident and to assess, wherever the data permitted, the extent to which enforcement actions are responsive to problems experienced by residents. Thus, for example, in the section on enforcement of pressure ulcer standards – a significant problem for nursing home residents in New York and nationally – we assess DOH's performance in terms of the number of citations for F-314 – failure to provide "proper treatment to prevent new bed (pressure) sores or heal existing bed sores" – against the number of residents in the state identified by their nursing homes as having a pressure ulcer (rather than citations per facility).

Fundamentally, our approach is predicated on the idea that it is the resident that is important, not the facility. The public, including (and especially) residents and families, does not generally care whether a facility is meeting a certain standard because they care about the facility but, rather, because they care about the safety and well-being of the people in the facility. Similarly, our approach presumes that the public – and our state leaders elected (or appointed) to protect the public interest – are principally interested in ensuring the integrity of public programs so that those programs are providing good value to our communities and the state (i.e., are paying for the provision of decent and appropriate care to beneficiaries), not merely to provide a source of income to the nursing home business sector.

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[1] *The New York State Long Term Care Ombudsman Program: An Assessment of Current Performance, Issues & Obstacles* (April 2014). Available at http://www.nursinghome411.org/?articleid=10080.

To that end, the report provides a comparative assessment of DOH's performance on several key criteria. First, we looked at states' citation rates as a whole, to identify the amounts of fines that each state has imposed in the last three years for deficiencies it uncovered and the rates at which the state agencies identified these deficient practices as causing resident harm. Then, in addition to pressure ulcers (mentioned above), we assessed performance in relation to nursing home staffing and antipsychotic drugging. While no data are perfect, we felt that assessing overall citation and penalty rates, as well as citations for three important indicators, would together provide valuable insights into State Survey Agency (SA) performance and the extent to which serious problems are being addressed.

Under-identification of harm is a national problem.

About Our Findings

Our findings are provided in the report in descriptive charts to allow for easy comparison between states as well as specific insights into DOH's performance in New York. The national charts include rankings of the states, so the reader can easily assess relative performance of the SAs. To facilitate easy access, the Table of Contents includes internal links to sections of interest. In addition, the tables are posted in Excel on our nursing home website at http://www.nursinghome411.org/articles/?category=lawgovernment. The Excel format allows for easy sorting of the state data, for instance to see how a state ranks on a given criteria. The various rankings enable one to get a useful snapshot of how any state is performing in terms of protecting its residents and how that performance compares against that of other states and the national average.

NYS Department of Health: Key Findings

We found that New York DOH ranks among the lowest SAs in terms of overall citations *per capita* (i.e., in respect to the size of our state's nursing home resident population). In addition, of the violations that DOH does identify, it rates about 97% of them as not having caused harm to residents. Though this is very low, DOH is about average in identifying harm among the states, indicating that the under-identification of harm is a national problem.

Antipsychotic Drugging: As the chart in the report shows, New York has a slightly lower average off-label AP drugging rate (18.04%) than the nation, but its F-329 citations are drastically lower: approximately 1/4 of the low national rate (0.08%). Of these citations, NY identifies resident harm 2.32% of the time. While miniscule, this is actually above the national average.

Pressure Ulcers: Pressure ulcers are a problem for almost one in 10 NYS nursing home residents. Though pressure ulcers are largely preventable, NY DOH cites nursing homes the equivalent of less than 1% of the time that a resident has a pressure ulcer (second lowest in the country). Furthermore, when NY DOH does cite a facility for poor pressure ulcer care or prevention, it rarely finds that this failure has caused harm to the resident(s).

Staffing: Staffing levels have long been widely recognized as key to quality of care and quality of life for both residents and workers. Yet, as data in the report show, insufficient staffing is rarely cited in US nursing homes. Low staffing is an especially serious and longstanding problem in NY State nursing homes, with NY persistently ranking in the bottom quarter of the country in average staffing levels. Nevertheless, DOH only cites for insufficient care staff about 13 times each year. When considered on the resident level (*per capita*) DOH's citation rate for inadequate care staff is roughly equal to an individual's chances of dying in a plane crash. Furthermore, DOH has not identified inadequate staff as resulting in harm or immediate jeopardy to a resident's well-being in at least three years.

Residents and families depend on DOH to ensure that providers are meeting - or exceeding - standards of care.

Taxpayers depend on DOH to assure financial integrity of the billions of dollars spent each year on nursing home care.

Recommendations for DOH

Following are our recommendations for DOH to improve safety and quality of care, as well as program integrity and value, in New York State nursing homes:

1. **Re-commit to its mission as an enforcement agency**. Residents and families depend on DOH to ensure that providers are meeting - or exceeding - standards of care. Taxpayers depend on DOH to assure financial integrity of the billions of dollars spent each year on nursing home care. While other agencies do important and valuable work, DOH is ultimately responsible for oversight and enforcement and its dedication to its mission as a Survey Agency is essential.
2. **Comply with federal Survey Agency requirements**. DOH should focus on achieving both the *letter* and the *spirit* of the State Operations Manual. For example, it is not adequate to conduct 100% of the federally required surveys per year if those surveys are not effectively ensuring that standards are met and deficiencies are appropriately cited. Given that NYS nursing homes are twice as big as the national average, the state should identify and implement ways to overcome basic structural barriers to effectively identify and cite deficiencies. Simply put, how can it be possible to adequately survey a 200 or 700 bed facility with the same number of surveyors, in the same amount of time, as it takes to adequately survey a 70 or 100 bed facility? Nevertheless, this is the longstanding practice in New York State.
3. **Improve resource allocation**. DOH should dedicate its limited resources to fostering vigorous oversight, rather than training, engaging or otherwise trying to persuade providers to attain the minimum standards of care for which they are already being paid to achieve. Providers are professionals who are expected to provide services in accordance with professional standards. The public has the right to expect that providers have – and maintain – the skills and knowledge necessary to meet those standards.
4. **Improve performance assessment & integrity**.
    a. DOH should improve training and direction of surveyors. For instance, to reduce inappropriate and illegal antipsychotic drugging, survey teams should review all instances of off-label antipsychotic drugging. Is there a record of informed consent?

Non-pharmacological interventions? Gradual dose reduction? When the answer is *no*, surveyors must assess whether other relevant standards are being met (such as appropriate medical supervision, sufficient staffing and necessary care to achieve highest practicable well-being) and, if not, whether this has resulted in harm.

b. DOH should coordinate trainings with the state Medicaid Fraud Control Unit and other law enforcement entities to improve surveyor investigative techniques. In addition to the potential for improving surveyor practice, such coordinated trainings could have other benefits, such as improving law enforcement's understanding of its role in protecting residents, for instance in ensuring that the federal requirement on reporting any suspicion of crimes against residents is properly implemented.
c. DOH should collect and assess data on survey teams and regions relating to identification of deficiencies and identification of harm (when a deficiency is identified) and assess these data in relation to relevant measures (including, inter alia, antipsychotic drug use, staffing levels and pressure ulcer rates). For example, if staffing is not being cited when facilities have reported low staffing levels and/or problems that are likely to be staffing related, DOH should conduct a data-driven assessment to determine if there are deficiencies that are being missed or under-rated (in terms of scope and severity). These assessments should be conducted for a certain number of survey teams per year and for all of the state regional offices on at least an annual basis. The results of the regional office assessments should be made public in an annual report.

NYS Medicaid Fraud Control Unit: Key Findings

1. **Investigations Overall**: NY MFCU conducts approximately twice the number of investigations *per nursing home resident* than the national average for state MFCUs (one investigation per 71 residents for New York vs. one per 141 residents for US).
2. **Investigations of Abuse & Neglect**: NY MFCU conducts more than double the national average of investigations of resident abuse and neglect *per capita* than the national average (one investigation per 314 residents in NY, vs. one for every 822 residents nationally).
3. **Recovering Public Funds (Such as For Sub-Par & Fraudulent Services)**: NY MFCU's recovery of $378,434,543.00 in funds for fraud, abuse and neglect (etc…) in 2014 is by far the largest in the country. While this is to be expected, given the size of NY State's nursing home population, it is important to note that the NY MFCU's recoveries far outpace the national average. NYS MFCU recovered $3597 per resident in 2014, more than double the national average of $1708.
4. **Convictions**: NY MFCU's conviction rate is slightly above the national average, with an average of one conviction per 892 residents vs. the national average of one conviction for every 890 residents. Because the US OIG does not break down convictions in terms of occupation (for example, CNAs vs. RNs vs. owners), and given NY MFCU's strong performance in recovering funds, it is not possible to draw conclusions as to whether this is a positive or negative finding in terms of holding providers accountable for poor care. For instance, it is possible that these findings, together, indicate that NY MFCU is holding

poorly performing nursing homes accountable at a higher level (by fining owners and operators, rather than convicting lower level employees).

Recommendations for MFCU

1. **Increase investigative capacity**. MFCU should continue and expand its nursing home work, which benefits both residents and taxpayers and delivers a significant "bang for the buck" in terms of resources allocated to the Unit.
2. **Redirect and expand outreach and trainings**.
   a. Expand outreach to the state LTC Ombudsman Program and the new managed LTC Independent Consumer Advocacy Network to learn about problems they are dealing with which may be related to fraud and abuse. This will become particularly important, we believe, as the state implements its transition to mandatory Medicaid LTC for nursing home residents.
   b. Conduct outreach and trainings to other relevant governmental and non-governmental entities to improve their knowledge and use of investigative skills and techniques employed by MFCU. As noted earlier in regard to DOH, MFCU dedicates resources to engaging and training providers. We do not believe that this is appropriate. Providers are already expected – and paid – to provide services that meet or exceed minimum standards. In addition, there are a plethora of both private pay and free, government-based services to help provider who have meeting longstanding minimum standards.[2] We believe that to the extent MFCU allocates staff time and other resources to trainings and outreach, this should be dedicated to improving monitoring and oversight in other state agencies, local agencies and organizations dedicated to helping individuals and families. At a minimum, these entities should be included in any trainings or programs that MFCU provides to the nursing home industry.

NYS Office of the Medicaid Inspector General: Key Findings

OMIG's mission is "…to improve and preserve the integrity of the Medicaid program by conducting and coordinating fraud, waste, and abuse control activities for all State agencies responsible for services funded by Medicaid." These activities include:

1. Solicit, receive and investigate fraud and abuse complaints;
2. Pursue civil and administrative enforcement actions against any individual or entity that engages in fraud, abuse, illegal or inappropriate acts or unacceptable practices perpetrated within the medical assistance program…; and

[2] For examples, CMS provides services through the Quality Improvement Organizations (in New York, IPRO) and supports (financially and otherwise) Advancing Excellence, the provider industry based quality improvement organization. In addition, many organizations provide educational and other services to providers, including numerous companies that provide trainings focused on improving survey outcomes, avoiding litigation, etc…. **NOTE**: While nursing homes have a range of resources to help them when they fail to meet minimum standards it is important to note that, the vast majority of the time, they continue to receive full reimbursement while providing substandard or worthless services, even when doing so results in harm to residents.

3. Investigate complaints of alleged failures of state and local officials to prevent, detect, and prosecute fraud and abuse in the medical assistance program.

Despite these requirements, and the fact that it specified addressing inappropriate antipsychotic drugging in nursing homes as one of its two "initiatives" for the last year (in its annual report), our findings indicate that OMIG has done little of substance to protect nursing home residents or to address the widespread and serious problem of inappropriate antispychotic drugging of nursing home residents. Almost five years ago, LTCCC met with OMIG staff, including investigators, and we were encourage by the depth of investigations about which we were told of nursing homes and, in particular, regarding the use (and misuse) of antipsychotic drugs. In late 2010, we were informed that OMIG had conducted a review of prescribing practices of atypical antipsychotics for the period 2007-8. This review found that 40% of nursing home residents on Medicaid who had been prescribed this drug "had no diagnosis of psychosis in the twelve months preceding the start of the atypical antipsychotic treatment."[3] Besides sending a joint letter (with the DOH Commisioner) to all nursing homes alerting them of longstanding standards and providing access to some resources on dementia care and antipsychotic drugging, OMIG has taken no action of which we are aware to address this serious and expensive problem.

To our knowledge, OMIG has never conducted a single audit of antipsychotic drugging in nursing homes or other settings, despite the known, significant dangers to individuals and enormous public expense.

Recommendations for OMIG

1. **Overall monitoring and assessment**. OMIG should reinvigorate and strengthen its efforts to monitor and assess program integrity in nursing homes. Nursing home care is, increasingly, a highly sophisticated, profit-driven industry in New York. Numerous state and federal studies, including our own as well as those conducted by other researchers, the US Government Accountability Office and the US Inspector General have consistently indicated that substandard care is a pervasive problem for both Medicaid and Medicare beneficaries in nursing homes. In addition to protecting the welfare of these individuals through on-site investigations, OMIG is uniquely positioned to effectively use the available data to improve conditions for residents and the efficiency of public funds spent on nursing home care. In New York, 83% of nursing home care is paid for by the public. In 2013, this was approximately $10.8 billion.[4]

[3] In conducting our assessment we repeatedly requested a copy of the "white paper" which OMIG staff told us they had written on the nursing home antipsychotic drugging problem and, repeatedly, our requests (including under the Freedom of Information Law) have been denied.

[4] Data on health spending are from the Kaiser Family Foundation, *State Health Facts,* and are for 2009; see note below for how we estimate current (2013) spending. Accessed February 2015 at http://kff.org/other/state-indicator/health-spending-by-service/#graph. Citing Centers for Medicare & Medicaid Services (2011), *Health*

2. **Crack down on inappropriate antipsychotic drugging**. OMIG should aggresively investigate and audit antipsychotic drugging practices in nursing homes (as well as in other settings) and hold providers accountable for appropriate prescribing of these medications and related requirements, including those related to medical supervision. To our knowledge, OMIG has never conducted a single audit of antipsychotic drugging in nursing homes or other settings, despite the known, significant dangers to individuals and enormous public expense.
3. **Increase accountability for failure to provide quality care**. In its 2007 annual report, OMIG stated that it "…is incorporating quality of care considerations in its detection and enforcement strategies. These efforts will include assessment of interventions and outcomes, pattern outcomes…, tracking of "never" events, detection of unreported adverse events/outcomes and unanticipated deaths." Seven years later, serious problems relating to so-called "never events" and "adverse events" have garnered significant national attention. For instance last year, the US Inspector General found that an astonishing one in three Medicare (rehab) beneficiaries were harmed in nursing homes within about a month of their arrival. Nevertheless, OMIG has not, to our knowledge, conducted substantive activities to reduce adverse events or, therefore, to hold providers accountable when such "events" are the result of substandard (or even wortheless) services. In fact, this provision from the 2007 annual report is absent from OMIG's most recent annual report.

Expenditures by State of Provider. Retrieved (December 2011) at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsStateHealthAccountsProvider.html. **Note**: The CMS website does not provide more recent data for individual states. The $13 billion figure is based on the Kaiser Family Foundation's 2009 number of $11.689 billion adjusted by 11.1%, which represents the increase in annual spending on nursing home care indicated in the CMS national data from 2009 to 2013.