LTCCC LONG TERM CARE COMMUNITY COALITION

MONITOR

Working to improve long term care through research, education & advocacy

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Potential Savings Generated from New York's Medicaid Redesign: LTCCC Report

New York's shift to a Mandatory Managed Long Term Care (MMLTC) model has the potential to provide significant savings for the state by shifting some costs from nursing home care to non-institutional care such as home and community-based services (HCBS).

Some evidence suggests that the cost of providing home and community-based services is far less than the cost of providing institutional care. In New York State, there are more consumers accessing HCBS than living in institutions, yet institutional expenses account for the majority of long term care spending. This apparent disparity between the number of consumers participating in each service and the Medicaid expenses incurred for each service may be indicative of non-institutional care being more cost-effective. However, potential savings derived from the use of HCBS are not unlimited. Potential savings will likely diminish for those who require very high levels of assistance, such as people who need 24-hour a day skilled care.

In 2009-2010, in New York City, the average annual Medicaid cost of nursing home care was approximately $112,000 per individual, while the average annual Medicaid cost of 24-hour home care (the highest level of HCBS for those who do not require regular care at night) was approximately $81,500 per individual. Some consumers, such as those with dementia (who may be awake during the night), may require more expensive coverage, such as two aides for two 12 hour shifts in order to provide care throughout the night. While the cost of providing care for some consumers with higher needs (who nonetheless have the right to the least restrictive environment for their care) may be significantly higher, cost savings still exist when considering the consumer population as a whole.

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New Resources on Antipsychotic Drugs & Dementia Care

The inappropriate use of antipsychotic drugs is a serious and widespread problem in nursing homes across the country. These powerful drugs are often administered to nursing home residents with Alzheimer's Disease or other forms of dementia as a way to treat so-called behavioral symptoms of dementia. Rather than addressing the underlying causes of these behaviors or attempting to provide comfort care through non-pharmacologic approaches, too often antipsychotics are used to simply sedate residents, as a form of chemical restraint. In addition to stupefying the individual, antipsychotics greatly increase the risk of heart attack, stroke, Parkinsonism, falls and other serious problems, including death. For these reasons, in 2005, the FDA issues a "black box warning" against using antipsychotic medications on elderly people with dementia.

LTCCC LONG TERM CARE COMMUNITY COALITION

Federal Requirements & Regulatory Provisions Relevant to Dementia Care & The Use Of Antipsychotic Drugs

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As noted in the last issue of *The Monitor,* the Centers for Medicare and Medicaid Services (CMS) launched an initiative in March 2012, with the goal of decreasing antipsychotic use in nursing homes nationwide by

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15% in 2012. The setting of this goal came after LTCCC and other advocates met with then CMS Administrator Donald Berwick on the pervasive but then under-recognized antipsychotic drugging issue. Following that meeting, Dr. Berwick held a meeting with the nursing home industry and demanded that they set meaningful goals to reduce the inappropriate use of antipsychotics.

Part of the CMS initiative is an effort to make the use of antipsychotic drugs in individual nursing homes more transparent. Now the public can view percentages of short-stay and long-stay residents who receive antipsychotic medications at facilities across the country, and compare these statistics with state and national averages, on "Nursing Home Compare," the national nursing home information resource on the medicare.gov website. CMS is also developing provider training programs to help facilities improve their dementia care and mandatory surveyor training programs to improve oversight of longstanding standards prohibiting the use of chemical restraints and the inappropriate use of antipsychotics.

In support of these efforts, LTCCC is developing resources for the public, consumers and other stakeholders to better understand the antipsychotic drugging issue and standards of care. We now have a dedicated page on our nursinghome411.org website (go to the website and click on "Antipsychotic Drugs & Dementia Care: Resources and Information" under "What's New") with information and resources related to dementia care and antipsychotic drugging.

In October we released a special report that presents an overview of the federal regulations that may be relevant when antipsychotic medications are used and the specific data tags, called "F-tags," that apply to each of the regulations and that are used by state and federal surveyors to code deficiencies. For example, if a surveyor finds that a facility is using drugs as a form of restraint on any of its residents residents, the surveyor could cite the facility under F-222, an F-tag that states that facilities cannot use chemical restraints. F-222 and F-329 (which addresses the use of unnecessary drugs by a facility) apply most directly to antipsychotic drugs. There are, however, numerous other F-tags that may be relevant in the context of questionable antipsychotic drug use, such as those relating to the standards preserving a resident's right to dignity (F-241) and mandating a monthly review of a resident's drug regimen (F-428). The report, titled, *Federal Requirements & Regulatory Provisions Relevant to Dementia Care & The Use Of Antipsychotic Drugs*, provides an easy-to-use listing of all the F-Tags we have identified as relevant in the context of antipsychotic drug use, along with their citations to the federal regulations, the relevant text from the regulations, and a brief explanation for each. We believe that this report, along with the other resources on the website, will be valuable to stakeholders, including surveyors, family members, Long Term Care Ombudsmen and direct care workers who are interested in reducing the misuse of these powerful and dangerous drugs on people with dementia. ❑

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Products from LTCCC's Advocacy Project on Managed Long Term Care

As readers of *The Monitor* know, New York State is implementing major changes to the very structure of the Medicaid program that will significantly affect long term care recipients. Most Medicaid and Medicaid/Medicare beneficiaries over the age of 21 who need community based services for over 120 days, as well as all nursing home residents on Medicaid, will be required to join a managed long term care program in the near future. The state received approval from the federal government on September 5, 2012 for its mandatory enrollment of Medicaid beneficiaries in the community and is awaiting approval for its proposal to enroll dually eligible beneficiaries (Medicare and Medicaid) and Medicaid nursing home residents.

The Governor's Medicaid Redesign Team, which generated the managed LTC requirement, had been tasked with overseeing wide-ranging initiatives to implement programmatic changes and realize significant savings. They released their recommendations at the end of 2011. As these Medicaid program changes are being implemented, government oversight offices, already understaffed and unable to ensure adequate protections, will have to deal with these changes with the same or possibly diminishing resources.

At the same time, as vulnerable consumers face these major changes, the federal government has taken steps that could actually improve quality of care, transparency and accountability for New Yorkers if they are appropriately implemented. The federal Affordable Care Act sets forth powerful new requirements for reporting crimes against nursing home residents that will be implemented by the states. In addition, the

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Transition to MLTC: The Need for Increased State Oversight

Mandatory managed long term care (MLTC) has the potential to improve long term care through better coordination of services and lower costs to the state. However, the major redesign of Medicaid currently underway in New York might result in new problems that require increased state oversight. LTCCC recently wrote a policy brief (available on our page dedicated to MLTC developments, http://ltccc.org/ManagedLongTermCareandACA.shtml), that brings together the research and analyses we have conducted over the past year to show policymakers the vital importance of state oversight during the transition to and implementation of MLTC.

It is important for both consumers and policymakers to fully understand how New York's move to mandatory MLTC and emphasis on home and community based services (HCBS) will alter the lives of consumers of long term care both in the community and in nursing homes. New York State is expected to save a significant amount of money through this move. In addition, it is expected that the federal government will also save significant amounts of money.

The brief discusses the potential positive and negative effects of MLTC. Though there are many potential benefits to managed care plans, such as coordination of care by a single care manager and lower costs to the state as a whole, there is also the potential for negative consequences. Some of the consequences noted in the brief include the fact that some consumers may be forced to give up their current care providers, the change (and manner in which it is being conducted) may result in consumer confusion about which plans best fit their needs and the longstanding concern that managed care, without vigorous oversight and accountability, may turn out to be more about managed costs. For instance, without appropriate safeguards, high cost individuals who could be cared for appropriately in their communities could be sent to nursing homes.

The brief lists the many reasons that this transition requires increased oversight by the state: many people are expected to be enrolled in managed care plans very quickly; with the vulnerable nature of the individuals who will be a part of MMLTC, it is imperative that care is taken to protect those who cannot protect themselves; care managers have few regulations regarding training; there are no standards regarding ratios of care managers to clients; some nursing home residents may have difficulty choosing an MLTC plan; issues may

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Products from LTCCC's Advocacy Project *continued from page 3*

federal Centers for Medicare and Medicaid Services (CMS) is taking an active role in holding individual states accountable for implementing the *Olmstead* decision, which held that states must help people access care in the least restrictive (and least institutional) setting possible for them as individuals.

With funding from the Robert Sterling Clark Foundation, LTCCC undertook an advocacy project to: assess the report of the Medicaid Redesign Team in terms of integrity with the stated goals of the MRT to improve care and outcomes and ensure consumer rights and protections; educate state policymakers, regulators and other relevant personnel about the new laws and rules (such as those promulgated under the Affordable Care Act) that provide protections for consumers and how they can be effectively implemented in New York; and work to ensure that there is sufficient surveillance staff and resources for DOH to protect consumers as these changes are implemented.

This project produced the following products:

• *Mandatory Managed Long Term Care, Consumer Response To Recommendations And Guidelines Of The NY State Medicaid Redesign Team's Managed Long Term Care Implementation And Waiver Work Group and Their State Implementation, Brief For Policy Makers.* This paper made a number of recommendations to improve this report. Many of the recommendations were accepted (see our Mandatory Managed Long Term Care web page at: http://www.ltccc.org/MandatoryManagedCare.shtml).

• *Mandatory Managed Long Term Care, Consumer Response To Recommendations And Guidelines Of The NY State Medicaid Redesign Team's Managed Long Term Care Implementation And Waiver Work Group and Their State Implementation, Brief For Consumers.* This brief, for consumers, discussed our response and urges consumers to get involved.

• *The Affordable Care Act (ACA): Federal Incentives Encouraging Home and Community Based Care.* This paper describes the federal incentives that New York State has applied for and should apply for to both save money as well as benefit long term care consumers. Please see an article discussing this paper in this edition of *The Monitor*.

• *Fact Sheets on Long Term Care Provisions of the ACA.* These are fact sheets summarizing the long term care provisions of the Affordable Care Act.

• *Potential Savings Generated From New York's Medicaid Redesign.* This paper describes the potential savings that New York State may garner from the Medicaid redesign.

• *New York's Olmstead Progress and Suggestions for The Future.* This paper makes recommendations for New York State's *Olmstead* plan.

• *A Comparative Assessment of Resource Allocation for Nursing Home Surveillance Systems in Ten States.* This research outlines the findings from both Medicaid directors and nursing home surveillance staff from ten states.

• *Transition To Mandatory Managed Long Term Care: The Need for Increased State Oversight - Brief for Policy Makers.* This brief brings together all of the products above to make a case for New York State to add funds for better oversight of both the behavior of the plans as well as the care quality of the plans' networks.

• *Reporting to Law Enforcement of Crimes Occurring in Federally Funded Long Term Care Facilities.* This brief describes a key provision in the Affordable Care Act that requires all nursing home employees (from management to direct care workers to outside contractors) to report suspicion of a crime occurring in a nursing home or face steep fines. It includes recommendations for providers, consumers, Long Term Care Ombudsmen and the state.

Please see other articles in this newsletter for more information on our findings and recommendations. All of these products can be downloaded for free by going to: http://www.ltccc.org/ManagedLongTerm Careand ACA.shtml.

For the latest information on Mandatory Managed Long Term Care, please go to our special web page which is updated frequently with the latest information: http://www.ltccc.org/MandatoryManagedCare.shtml. ❑

Affordable Care Act Long Term Care Provisions

New York has been attempting to provide citizens with more access to long term care in a less restrictive setting. Although New York has made some headway in encouraging access to home and community based care, there are still untapped resources for funding to help facilitate the move to community based long term care.

It is one of the federal Affordable Care Act's (ACA) goals to encourage making more long term services and supports available in the community. Through the financial federal incentives made possible by programs created or given funding by the ACA, NYS can access federal funds to improve the lives of New Yorkers who require long term care but wish to avoid nursing home placement. NYS is currently receiving some federal funding from the ACA for its long term care programs, however, there are other ACA federal incentives that NYS has not yet taken advantage of.

Our paper, *The Affordable Care Act (ACA): Federal Incentives Encouraging Home and Community Based Care*, describes the incentives, gives status on the progress, if any, New York has made toward each

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Update: The Implementation of *Olmstead* in New York State

In the Supreme Court case *Olmstead v. L.C. and E.W.*, the court held that states are required to place individuals in the least restrictive setting possible as appropriate for each individual. The court mandated that states make reasonable modifications (though not fundamental alterations) to their programs to foster such placement. In its letter to state Medicaid directors, the Centers for Medicare & Medicaid Services (CMS) suggested that states could comply with the *Olmstead* decision by developing "a comprehensive, effectively working plan for placing qualified persons with disabilities in less restrictive settings" and instituting "a waiting list that moves at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated."

On September 17, 2002, the Most Integrated Setting Bill was passed in New York. The new law created the Most Integrated Setting Coordinating Council (MISCC), a group responsible for developing an extensive plan that would allow all individuals to live in the least restrictive setting.

The MISCC plan aims to increase the number of individuals who live in community-based settings, make all individuals (regardless of the type of care they are currently receiving) more aware of their housing choices, and increase services necessary to facilitate transitions to less restrictive settings. The plan also lists identifying "specific priorities that increase access to community care and that improve quality assurance and accountability" among its stated goals.

Unfortunately, in many ways New York's 2010-2012 MISCC plan appears to have a limited scope, nebulous goals, and a lack of concrete, measurable results. The designated actions crafted to carry out these goals appear to lack the precision and clarity that is necessary to effectively institute *Olmstead* in New York State. For instance, the plan does not set out an exact number or percentage of individuals who will be transitioned out of nursing homes and adult homes over a specific period of time. There is no mention of what method will be undertaken to assess and select individuals who may be appropriate for transfer to a less restrictive setting. Furthermore, the plan fails to provide any information about who will be conducting the assessments and what qualifications are necessary to do so. Also noticeably absent are procedures to facilitate transfer of residents either back to the community or to a less-restrictive placement. However, some positive steps have been taken to promote change. New York State recently held hearings and solicited input on this topic and in response, LTCCC's full report detailing the implementation of *Olmstead* was submitted and our executive director testified at the statewide hearing held in September.

In order to facilitate the successful implementation of the *Olmstead* decision, LTCCC recommends that the state evaluate shortcomings in its current practices in order to improve upon the actions it has already taken. Ultimately, the state should lay out a plan that is consumer-centered, sets specific goals, enumerates definitive ways to accomplish these goals, selects timeframes for these tasks to be carried out, and consistently evaluates the progress being made. For our full report, go to: http://ltccc.org/documents/OlmsteadFinalDraft.pdf. ❑

LTCCC's 4th Annual Reception October 3rd, 2012

Richard Mollot, Executive Director

Dr. Bill Thomas, Honoree

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Affordable Care Act *continued from page 5*

incentive and then makes recommendations for how each of the incentives should be implemented. It is available at: http://www.ltccc.org/documents/TheAffordableCareActACAFinalFederalIncentivesEncouragingHomeandCommunityBasedCare_000.pdf.

NYS has already accessed funding for two of the ACA's programs: Money Follow the Person (MFP) and the Federal-State Health Reform Partnership. Unfortunately, even though enrollment has grown over the past couple of years, MFP currently has a number of problems: a slow start, difficulty locating safe, affordable housing, an insufficient supply of direct service workers, long waiting lists for housing vouchers and difficulty in finding qualified group housing.

The new funding from the Partnership program has been proposed for use in a variety of programs, however, according to a major provider association, many of these programs are unfinished. In addition, the association is concerned that although the proposed program states it will be increasing primary, ambulatory, and community based care it is unclear if, and how much, money would be allocated to these services.

Our paper describes a number of other opportunities that New York State is considering or has recently applied for: the Community First Choice (CFC), the State Balancing Incentives Program and the Aging and Disability Resource Center Program (ADRC). NYS is currently considering the CFC and the Balancing Program. LTCCC's perspective is that funding from the CFC Option and the Balancing Program could be very beneficial to consumers in NYS, as long as the use of the funds is guided by the needs of the clients. NYS has written a letter of intent for the ADRC program and, as of October, is competing to be one of the eight states given ADRC funding in 2012. With NY Connects available as an ADRC portal, the ADRC grant could be very helpful when used in conjunction with other ACA funded projects.

With all of these options, sufficient oversight staff will be extremely important to make sure money is being used responsibly and for the overall benefit of the consumer. ❑

Deborah Truhowsky,
Vice President of the Board &
Event Committee Chair

Potential Savings Generated *continued from page 1*

An additional way in which the state may curb spending is for more consumers to receive care in adult homes and assisted living rather than nursing homes. It is important to note, however, that assisted living facilities vary widely in their ability to fulfill the "promise" of assisted living to provide residential care in a setting that avoids the institutional nature of the traditional nursing home and provides for meaningful resident autonomy. Too many assisted living facilities are functionally very similar in their institutional nature to the traditional nursing home, but without the federal and state standards and safeguards that, on paper at least, provide significant protections and rights for nursing home residents.

Ultimately, while the potential cost savings from New York State's increase in individuals receiving non-institutional care seem to be evident, the quality, coordination, and delivery of care must not be forgotten. It is important to keep in mind that MLTC plans may have an incentive to skimp on care or leave consumers without access to the services they need. Thus, we urge the state to make sure that state contracts with plans are carefully designed and that careful monitoring and state oversight is conducted. For LTCCC's full report on this issue go to: http://ltccc.org/documents/FinalSavingsDraftAug28.pdf. ❑

Transition to MLTC *continued from page 3*

arise if a managed care plan removes a nursing home from its network; and we cannot rely on managed care plans to monitor the quality in the nursing homes in their network.

The paper discusses our support for the state's request to use $3 million a year for five years of federal savings for increased oversight of the transition and implementation of MMLTC. LTCCC had proposed this to the state, and this decision to invest money from the waiver into oversight would not have happened without the letters and support from consumers and advocates – including many readers of *The Monitor*.

LTCCC also recommended that in addition to the funds from the MRT waiver, New York State should also consider using some of the expected state savings to enhance Department of Health oversight. To download the full report, please go to: http://www.ltccc.org/documents/LTCCCMandatoryManagedLTCBriefforOversight-Aug23.pdf. ❑

Quarterly Enforcement Actions Against Nursing Homes

Selected Enforcement Actions of NYS Attorney General

Medicaid Fraud Control Unit[1] Took Action Against 7 Nursing Home Personnel 6/16/12 - 9/15/12

Nursing Home	Location	Defendant	Narrative	Sentence
Beechtree Care Center	Ithaca	Allen, Valerie, Certified Nurse Aide	Defendant stole a credit card from the room of a resident and used it to purchase $600 worth of merchandise.	9/7/2012: One-year Conditional Discharge[2] and Restitution of $666.82.
Beechwood Homes	Getzville	Jones, James, Certified Nurse Aide	With his hand, the defendant struck the leg of an 87 year old male resident, who sustained a fractured left femur.	8/15/2012: Eleven days Incarceration and three-years probation.
Pine Haven Home	Philmont	King, Volincia, Certified Nurse Aide	Defendant transferred a resident alone, in violation of the care plan, and also bandaged a laceration to the resident's leg without notifying the appropriate staff. The laceration was later discovered and treated with 7 stitches.	6/28/2012: One-year Conditional Discharge and surrender of CNA Certificate.
Roscoe Regional Rehab & Residential HCF	Roscoe	Ackerley, Miranda, Licensed Practical Nurse	Defendant made false entries in five diabetic patients' charts reflecting the results of blood sugar tests that were never administered.	9/6/2012: Three-years probation, conditions of which defendant agreed to surrender her license and refrain from being employed in any capacity pertaining to healthcare, homecare, or caring for the elderly or disabled.
Silver Lake Specialized Care Ctr.	Staten Island	Scano, Kathleen, Registered Nurse	Over the course of four months, defendant signed out Percocet tabs, falsely stating that they were for residents, and kept them for personal use.	6/20/2012: After successful completion of a drug treatment program, the defendant was sentenced to a one-year conditional discharge.
Valley View Manor Nursing Home	Norwich	Prewitt, Virginia, Registered Nurse	The defendant charted that medications were administered to approximately 15 residents, then was observed, via video recording from a surveillance camera, destroying and throwing out the medications.	7/17/2012: Three-years probation and 100 hours of community service.
Williamsville Suburban Nursing Home	Williamsville	Saow, Tweneboa, Certified Nurse Aide	Hidden Camera Investigation: CNA, observed, repeatedly transferring resident alone in violation of care plan.	6/27/2012: One-year Conditional Discharge and surrender of CNA certificate.

[1]The unit prosecutes cases of patient abuse in nursing homes.

[2]Conditional discharge means if similar act is committed during the time period defendant can be brought back to court.

Federal Civil Money Penalties[1] Against 1 Nursing Home: 6/1/12 – 8/31/12[2]

Name Of Home	Location	Survey Date	Amount
St. Joseph Nursing Home	Utica	1/20/2012	$24,050.00[3]

[1]Civil Money Penalties (CMPs) – a federal sanction against nursing homes that fail to comply with quality care requirements.

[2]As reported by CMS. For more detailed information contact the FOIA Officer at CMS 212-616-2220. This list will be posted on LTCCC's website every three months.

[3]Amount reflects a 35% reduction as the facility waived its right to a hearing as permitted under law.

Quarterly Enforcement Actions Against Nursing Homes

Selected Administrative Actions By The NYS Office of Medicaid Inspector General

Action Taken Against 6 Nursing Home Personnel 6/15/12 - 9/15/12[1]

OMIG works to protect New York State citizens residing in long term care facilities by making sure that those responsible for their care do not engage in abusive and fraudulent activities. This is done through OMIG's ensuring that those who are enrolled as providers into the Medicaid program are properly vetted, investigating allegations of fraud and abuse within long term care facilities, and finally, excluding providers who have abused their positions as care givers. In addition to conducting their own investigations, the OMIG makes determinations to exclude based on other agency actions, including the State Education Department (SED), the Medicaid Fraud Control Unit (MFCU), and Human Health Services (HHS). A single provider can receive multiple exclusions, based on different indictments and convictions. This involved process works to protect residents of Long Term Care Facilities, because it ensures that even if one conviction is overturned, the abusive provider is still banned from receiving Medicaid funds based on other convictions.

Nursing Home	Defendant	Location	Narrative	OMIG Exclusions[2] Based Upon
Glen Island Center for Nursing and Rehabilitation	Eufemia Fe Salomon-Flores, RN	New Rochelle	Between April 30, 2002 and March 8, 2010, Ms. Salomon-Flores inflated the PRI scores submitted on behalf of nursing home residents. This led to the nursing home being reimbursed at a higher rate than what they were entitled to. Ms. Salomon-Flores agreed to pay back 2.2 million dollars. She also failed to report on her 2008 tax return $307,000 worth of income she had received from Glen Island through bogus companies for which she had a tax liability of $31,000. She had not paid those taxes.	MFCU Conviction 4/16/2012 MFCU Indictment 4/17/2011
Williamsville Suburban Nursing Home (10-X-2014)	Laquita Jones, CNA	Williamsville	Ms. Jones used a mechanical lift to physically transfer a patient without the assistance of another person, in violation of the resident's care plan.	MFCU Conviction 4/17/2012
Dr. William Benenson Rehabilitation Pavilion	Jessie Joiner, LPN	Flushing	Ms. Joiner knocked an 85 year old resident out of her wheelchair and then left the woman on the floor without reporting the incident or seeking medical attention for the resident. The resident suffered a broken hip which required subsequent surgery. Ms. Joiner also admitted to stealing over 20 Percocet pills from another resident for her own personal use.	MFCU Conviction 6/13/2012 SED License Surrender 6/06/2011 MFCU Indictment 7/11/2010
Cold Spring Center for Nursing and Rehabilitation	Tara Lynn Jennings, LPN	Woodbury	On at least three occasions, Ms. Jennings withdrew Percocet for patients who had not been prescribed that drug. She took the drugs for her own use.	SED Consent Order[3] 6/19/2012
Mountain View Nursing and Rehabilitation Centre	Tabitha Hearn, LPN	New Paltz	On multiple occasions, and with fraudulent intent, Ms. Hearn withdrew Percocet for six patients and failed to administer the medication to the patients. Ms. Hearn also falsely wrote the name of another nurse on a Controlled Substance Administration Record for a patient, and then withdrew the Percocet intended for that patient.	SED Consent Order 7/2/2012
Evergreen Valley Nursing Home	Lindsay Colleen Farnsworth, LPN	Plattsburgh	Ms. Farnsworth practiced nursing while her ability to do so was impaired by the use of controlled substances, including opiates and propoxyphene.	SED Consent Order 6/18/2012

[1]In addition to these actions, all of the providers which were reported as having actions taken against them by the Medicaid Fraud Control Unit in previous newsletters have been excluded by OMIG. Please see our newsletter archives at www.ltccc.org/newsletter for their names.

[2]Exclusion means that no payments will be made to or on behalf of any person for the medical care, services or supplies furnished by or under the supervision of the defendant during a period of exclusion or in violation of any condition of participation in the program. Additionally, any person who is excluded from the program cannot be involved in any activity relating to furnishing medical care, services or supplies to recipients of Medicaid for which claims are submitted to the program, or relating to claiming or receiving payment for medical care, services or supplies during the period. OMIG may take a variety of exclusion actions against a provider based upon: indictments; convictions; consent orders or HHS exclusion.

[3]An agreement between the State Education Department Office of Professional Discipline, Board of Regents, Committee of the Professions and the licensee who admits guilt to at least one of the alleged acts of misconduct. The Consent Order provides the details of the misconduct and the assigned penalties.

Quarterly Enforcement Actions Against Nursing Homes

Special Focus Facilities (SFF)

The federal Centers for Medicare and Medicaid Services (CMS) initiated the Special Focus Facility (SFF) program to address nursing homes that have ongoing serious problems. Often these facilities will exhibit "yo-yo" compliance: they address the problems found during an inspection in order to stay in business but then are unable or unwilling to maintain standards and fall out of compliance again. From a consumer perspective, the SFF program can be a valuable tool to crack down on nursing homes that are persistently failing their residents and, by identifying and fixing (or removing) a state's worst nursing homes on an on-going basis, eventually improve nursing home care overall.

Once a facility is selected for inclusion in the SFF program it receives special attention from the state, including a federally mandated requirement that the state conduct at least twice as many survey inspections as normal (approximately two per year). The goal is that within 18-24 months of being in the program a facility will either: (1) develop long term solutions to its persistent problems or (2) be terminated from participation in the Medicare and Medicaid programs. Termination usually means that a facility is sold to a new operator or closed. Due to resource limitations, only 136 nursing home across the country are selected for participation in the SFF program at any given time. On average, states have about two SFFs; since New York is one of the largest states in the country it is supposed to have at least five.

Since CMS started to make the names of SFFs public, this program is an important tool that consumers can use to learn about facilities in their communities with persistent problems.

SPECIAL FOCUS FACILITIES IN NEW YORK STATE - As of September 20, 2012
The numbers in parenthesis indicate the number of months the home has been on the list and identified as an SFF.

Facilities Newly Identified as a SFF	Facilities That Have Shown Improvement[1]	Facilities That Have Not Improved[2]	Facilities That Have Recently Graduated from the SFF Program[3]	Facilities No Longer Participating in the Medicare & Medicaid Program[4]
None	Marcus Garvey Nursing Home (8)* Van Duyn Home And Hospital (11)	Blossom South Nursing And Rehabilitation Center (16)* Countryside Care Center (22) Pleasant Valley (6) Rosewood Heights Health Center (6)	Loretto Utica Residential HCF (25)	None

[1]Nursing homes that have shown significant improvement, as indicated by the most recent survey, and CMS is waiting to see if the improvement continues over time. If the improvement continues for about 12 months (through two standard surveys), these nursing homes will graduate from the SFF list.

[2]Nursing homes that have failed to show significant improvement despite having had the opportunity to show improvement in at least one survey after being named as a SFF nursing home.

[3]These nursing homes not only improved, but they sustained significant improvement for about 12 months (through two standard surveys). "Graduation" does not mean that there may not be problems in quality of care, but does generally indicate an upward trend in quality improvement compared to the nursing home's prior history of care.

[4]These are nursing homes that were either terminated by CMS from participation in Medicare and Medicaid within the past few months, or voluntarily chose not to continue such participation.

*On the list for the second time; graduated and then put back as a special focus facility.

CMS updates a list of all SFFs in the country quarterly. See http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/downloads//sfflist.pdf.

The following NY homes were previously on the special focus list but have since graduated: Achieve Rehabilitation and Nursing Facility, , Blossom North Nursing and Rehabilitation Center, Central Park Rehabilitation and Nursing Center, Dr. William Benenson Rehabilitation Pavilion, Elant at Newburgh, Evergreen Valley Nursing Home, The Hamptons Center For Nursing & Rehabilitation, Harbour Health Multicare Center for Living, Highland Care Center, Mt. Loretto Nursing Home, Pathways Nursing & Rehabilitation Center, Pleasant Valley, Rosewood Heights Health Center, Whittier Rehabilitation and Skilled Nursing Center, Williamsville Suburban.

Nursing Home Surveillance Systems in Ten States

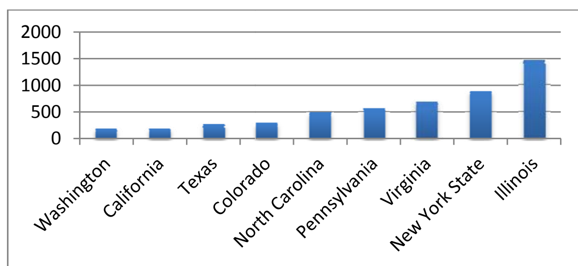
As part of the Robert Sterling Clark Foundation funded advocacy project discussed elsewhere in this edition of *The Monitor*, LTCCC conducted a study to gather financial and programmatic information on the nursing home surveillance systems of a select sample of states across the U.S. The study also aimed to gain insights into the challenges facing the state offices responsible for ensuring quality and safety in our nation's nursing homes and other settings.

Ten states, including New York State, were selected. With an on-line survey and follow-up phone interviews, Medicaid directors and heads of state nursing home surveillance agencies were asked to provide both quantitative data on state spending on oversight and the amount and breakdown of survey staff as well as qualitative data related to obstacles they have identified to effective oversight. Under the Freedom of Information Act, copies of each state's CMS-435 form for fiscal year 2010 (required by the federal government) were obtained and used to gather information on state Medicare and Medicaid expenditures related to nursing home oversight.

Our data indicated that there are notable differences among these states in the number of total staff dedicated to nursing home oversight, the breakdown of staff, and overall spending for nursing home oversight. The study also identified a number of state-reported barriers to meeting federal performance guidelines. A few of the findings (see http://www.ltccc.org/documents/NursingHomeSurveillanceSystemsFINAL.pdf for a copy of the full report) are:

Average Number of Residents Per Nursing Home Surveyor

As the graph below indicates, NYS was second to Illinois in terms of worst ratios of residents to surveyors (inspectors), with a ratio of one surveyor to 889 residents. Of the nine states shown in the graph, the average ratio of the four states which performed better than the middle state (North Carolina) was 237 residents per surveyor. Thus, with a ratio of 889 to one, New York surveyors have responsibility for close to four times as many nursing home residents as those in states performing above the median level (i.e., having lower ratios).



Surveillance Expenditures

The Medicaid program is financed through a combination of federal and state funding. The study found that Colorado, with the least number of nursing homes of the states studied and the smallest resident population, had the lowest federal and state Medicaid LTC expenditures. However, given that NYS has the highest number of nursing home residents to monitor of all the states in the study, it was unexpected that the state did not rank at the top in terms of federal Medicaid LTC expenditures. In fact, both California's and Texas's federal and state Medicaid LTC expenditures were well over double those for New York.

Obstacles to Meeting Federal State Performance Guidelines

State survey officials responding to the survey cited a variety of state issues that they believe affect their state's ability to meet federal performance mandates: (1) insufficient number of surveyor positions allowed for the agency; (2) inadequate salary to attract and retain surveyors; (3) high turnover of surveyor staff; (4) staff shortages; (5) challenges related to training of new survey staff; (6) lack of upward mobility in management positions; and (7) legislative limitations on the number of allowed full-time equivalent employees (FTE).

Some state officials also pointed to the issues related to the federal process and federal requirements as areas that impede states' fulfillment of performance guidelines. Specifically, officials noted: (1) continued increasing expectations by CMS without commensurate reimbursement; (2) federal funding delays which limit ability to implement changes which would improve ability to meet performance standards; (3) lack of clarity or reasonability in performance measure calculations (e.g., no triage time for timeliness of complaint determination); and (4) QIS [Quality Indicator Survey] survey process takes too long and is too resource intensive. ❑

LTCCC LONG TERM CARE COMMUNITY COALITION
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To obtain the names of your personal state government representatives, go to The Citizen Action Center on our website: www.ltccc.org.

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