

Thank you for inviting us here today. Comptroller Dinapoli would like to thank Jack Kupferman of the Gray Panthers, New York City Network for arranging this panel as well as for his tireless work to protect New York's senior citizens.

Over the last several years, health care advocacy groups, the media, and other stakeholders have expressed concerns about the oversight of nursing homes.

In the United States, nursing home oversight is a shared federal-state responsibility, with specific duties performed by each. The Centers for Medicare and Medicaid Services (CMS) oversees the inspection program for the Nation's approximate 15,450 nursing homes that participate in the federal Medicare and Medicaid programs. CMS sets *minimum nursing home standards*; provides official interpretations of federal regulations, guidelines, and policies; and establishes and monitors inspection procedures.

CMS also enters into agreements with state agencies such as the NY State Department of Health (DOH) to conduct the required surveys or inspections of nursing homes; and requires them to certify that nursing homes meet federal and state regulatory standards; that complaints are investigated and resolved timely and that deficiencies are cited with the appropriate fines levied.

So in this schema, what is the role of audit organizations such as the Office of the State Comptroller? Audit organizations play a critical role in ensuring the system works effectively. Not only do we evaluate whether nursing homes and oversight agencies are meeting their compliance responsibilities, we also assess if these programs are effective. Moreover, since audits are conducted by individuals who are independent, the public can have confidence in the results. So what is the ultimate aim of an audit? It is to effectuate positive change. Audits do this by providing relevant information about how these programs are functioning as well as recommendations to improve the programs to those responsible for governance, such as the executive and legislators, but also to the public through the media.

When performing an audit, auditors conduct a risk assessment. In order to do this effectively, we must understand the key issues that face families and nursing home residents. Toward this end, advocacy groups such as the Grey Panthers play a critical role by bringing insight and perspective that cannot be gained through traditional audit techniques.

Many New Yorkers are caring for aging family members. When a loved one goes into a nursing home, families should have assurance that it is a safe and nurturing environment.

Unfortunately, when we perform audits at the request of advocates such as Jack, serious issues often arise about how well oversight entities and nursing homes are carrying out their responsibilities.

In 2016, New York State had the most residents nationwide residing in nursing homes at 104,000; ranked 7th in the nation in certified nursing homes with 622; and had a significant number of nursing homes with one-star overall ratings (indicating quality much below average). Yet, while quality measures have not show significant improvement, the percentage of nursing homes receiving a deficiency for actual harm or jeopardy of residents has steadily declined, from about 23 percent in 2009 to under 8 percent in 2016. That raises some serious issues about nursing home violations and how DOH is issuing fines.

In 2015, the Grey Panthers, along with Richard Mollot of the Long Term Care Community Coalition; Gail Myers of the Statewide Senior Action Council; and Laurie Kash of Last Stop Advocacy Project of Rochester, brought their concerns to Comptroller Dinapoli and, based on their advocacy, OSC conducted an audit of DOH's compliance with federal and State regulations and examined whether survey processes, including the issuance of fines and other enforcement actions, were effective in improving the quality of care and safety in nursing homes.

Released in 2016, the audit found that, although DOH was inspecting nursing homes and acting on serious complaints as required, it let some facilities with repeated violations face limited, if any, consequences. Simply put, we found numerous problems with DOH's enforcement process, sometimes resulting in substantial delays in the assessment of fines.

These problems resulted in delays of up to six years between when a violation was cited and when a fine was issued, and it appeared to worsen over time. In 2014, the average time between when deficiencies were first identified and when fines were imposed was nearly four years. This compared to just six months in 2007.

At the same time, fewer fines were being issued. We found the number of fines and total amount of monetary penalties peaked several years before the period audited, and they steadily declined since. In fact, DOH chose not to levy fines for categories of violations that accounted for almost 85 percent of the problems found.

DOH only imposed fines if it found that a problem had already resulted in actual harm to an individual or was currently placing people in immediate jeopardy – less than 4 percent of all violations.

Between January 2014 and July 2015, DOH collected a mere \$152,000. This compared to \$628,000 in fines levied in 2011.

These trends undermined the credibility and took the teeth out of a significant deterrent to unsafe practices and conditions.

What was the cause of these findings?

- DOH had only one part-time employee assigned to process enforcement referrals and prepare enforcement packets.

- The agency routinely waited at least six months before taking any action.
- Finally, DOH used a database that, by its own staff's admission, was fragmented and incomplete.

Our audit recommended that DOH immediately eliminate the problems causing the backlog in enforcement activity and initiate the assessment of fines earlier in the enforcement process.

We also suggested the agency develop a single, more comprehensive system to track all enforcement actions, as well as consider assessing fines for lower-level infractions, especially for those facilities that demonstrated a pattern of repetitive violations. The audit received significant news coverage as well as public and legislative interest.

In 2018, we followed up on the actions taken by DOH in response to the audit.

We found that:

- DOH officials either pursued enforcement activity for backlogged cases or had legitimate reasons for not doing so and added additional staff to prevent further backlogs from developing.
- That they no longer delayed enforcement decisions for the six-month waiting period and instituted a process where citations are generally reviewed within two months.
- They also developed an automated suite of reports to track and monitor the status of enforcement processing, allowing managers to identify deficiencies that are eligible for enforcement to ensure fines are assessed in a timely manner.
- And while DOH officials met to consider additional citations, in the end they decided to implement a Performance Monitoring Program

(PMP), which they say progressively monitors nursing homes with repeat deficiencies -this will be the subject of a future audit.

Over the past 2 years, our agency began meeting quarterly with a group of long-term care advocates to listen to their concerns, get their suggestions for future audits, as well as their feedback on audits we have in progress.

Ultimately, Comptroller Dinapoli believes that such partnerships can help drive significant improvements to programs that are critical to so many vulnerable individuals and their families and we believe that this model can work for others as well.