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NORTH CAROLINA LAW REVIEW

Volume 57 | Number 6

Article 6

8-1-1979

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Recommended Citation

Patricia A. Butler, *Assuring the Quality of Care and Life in Nursing Homes: The Dilemma of Enforcement*, 57 N.C. L. REV. 1317 (1979).
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ASSURING THE QUALITY OF CARE AND LIFE IN NURSING HOMES: THE DILEMMA OF ENFORCEMENT

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The elderly population of our society is growing at a rate greater than that of any other group,¹ but the number of extended families in which younger generations care for older ones is declining.² Approximately 1.5 million older Americans with chronic illness or disability, six percent of the population over sixty-five,³ now reside in nursing homes.⁴ Although many of the elderly infirm or disabled who require long-term health care could be served by noninstitutional services while living at home,⁵ the Medicaid and Medicare programs create almost insurmountable obstacles to the development and survival of outpatient long-term care providers and instead guarantee the continued existence of the nursing home as the primary provider of long-term health care services for the elderly, at least in the foreseeable future. Recent history demonstrates, however, that nursing homes in general provide neither a dignified, homelike, supportive atmosphere for their

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1. See Butler, *The Economics of Aging: Are We Asking the Wrong Questions*, 44 NAT'L J. 1792 (1978).

2. See F. MOSS & V. HALAMANDARIS, *TOO OLD, TOO SICK, TOO BAD: NURSING HOMES IN AMERICA* (1977). See also Levey & Amidon, *The Evolution of Extended Care Facilities*, NURSING HOMES, August 1967, at 14, 17.

3. See CONGRESSIONAL BUDGET OFFICE, *LONG-TERM CARE FOR THE ELDERLY AND DISABLED* 8 (Feb. 1977). Of the 25 million persons over 65 in the United States today, 5 million are chronically ill and require some form of long-term health care, while another 3 million are physically disabled. *Id.* Yet fewer than one-third are receiving care under formal programs, DEP'T HEW, OFFICE OF POLICY, PLANNING & EVALUATION, *STATISTICS* (1977), while the others receive care from families or no care at all.

4. A profile of these residents reveals that their average age is 82; 70% are over age 70, with the percentage of residents in this age bracket increasing; women outnumber men 3 to 1; only 10% have a living spouse; more than 50% have no close relatives; 96% are white; fewer than 50% are ambulatory; they remain in the nursing home an average of 2.4 years; at least 55% are mentally impaired; 33% are incontinent; more than 60% have no visitors at all; and only 30% will return home—some will transfer to other institutions, but many die in the nursing home. F. MOSS & V. HALAMANDARIS, *supra* note 2, at 8.

5. *Id.* at 18-19.

residents nor the rehabilitative services necessary to assist their residents in attaining a maximum level of functional capacity and independence.⁶ Since these services are arguably required as a condition of receiving public funds,⁷ both the residents and taxpayers, who furnish approximately one-half of the \$12 billion required to run these homes,⁸ are defrauded by their absence.

The task of establishing standards by which to measure the quality of care in nursing homes and a system of enforcing those standards has fallen to the state agencies that license nursing homes and certify their qualification to participate in Medicaid and Medicare. These standards, however, are usually patterned after those of hospitals and have generally emphasized physical facility structure and staffing ratios, disregarding the differences between the medical, residential, social and emotional needs of nursing home and hospital patients. The Medicaid program, which finances sixty percent of all nursing home costs,⁹ exacerbates this "medical model" by reimbursement policies that favor institutional rather than outpatient long-term care services. State agencies charged with the responsibility to enforce quality of care requirements have failed to administer even the standards that do exist because they are stymied by sluggish bureaucrats and limited, ineffective administrative remedies. This article will look at some possible

6. See SUBCOMM. ON LONG-TERM CARE OF THE SENATE SPECIAL COMM. ON AGING, NURSING HOME CARE IN THE UNITED STATES: FAILURE IN PUBLIC POLICY, INTRODUCTORY REPORT, S. REP. NO. 93-1420, 93rd Cong., 2d Sess. (1974) [hereinafter cited as INTRODUCTORY REP.]. See also AFL-CIO, AMERICA'S NURSING HOMES: PROFIT IN HUMAN MISERY (1977); Brown, *An Appraisal of the Nursing Home Enforcement Process*, 17 ARIZ. L. REV. 304, 311-13 (1975); COLORADO ATT'Y GEN., REPORT CONCERNING THE REGULATION OF THE NURSING HOME INDUSTRY IN THE STATE OF COLORADO (1977); JOINT LEGISLATIVE AUDIT COMMITTEE, OFFICE OF THE AUDITOR GENERAL, REPORT TO THE CALIFORNIA LEGISLATURE, LONG-TERM CARE FOR THE AGED, PART II (1977); NEW YORK STATE MORELAND ACT COMMISSION, LONG TERM CARE REGULATION: PAST LAPSES, FUTURE PROSPECTS (1976); OHIO NURSING HOME COMMISSION, A PROGRAM IN CRISIS (1978) [hereinafter cited as OHIO REP.].

7. See INTRODUCTORY REP., *supra* note 6.

8. The nursing home industry currently receives over \$6 billion annually in government funds out of total revenues of \$12 billion. NATIONAL CENTER FOR HEALTH STATISTICS, DEP'T HEW, AN OVERVIEW OF NURSING HOME CHARACTERISTICS: PROVISIONAL DATA FROM THE 1977 NATIONAL NURSING HOME SURVEY, ADVANCEDATA FROM VITAL & HEALTH STATISTICS, No. 35 (1978) [hereinafter cited as ADVANCEDATA No. 35] at 6. Over \$5 billion of these funds come from Medicaid alone. INSTITUTE FOR MEDICAID MANAGEMENT, DEP'T HEW, DATA ON THE MEDICAID PROGRAM: ELIGIBILITY/SERVICES/EXPENDITURES FISCAL YEARS 1966-77 (1978) [hereinafter cited as MEDICAID DATA] at 31. Total government funding of nursing homes has increased 2000% since 1960 and is expected to reach \$9 billion in 1979. *Id.*

9. Classified by source of payment, nursing home residents nationally are supported 60% by Medicaid, 2% by Medicare and 38% by private sources. MEDICAID DATA, *supra* note 8, at 6-7. On the average, 40% of the nation's expenditures for Medicaid go to nursing home care; the percentage of these payments varies substantially from state to state from as low as 14% to as high as 77%. *Id.* at 42-43.

means by which regulating agencies and the public, including nursing home residents themselves, can improve the quality of nursing home care, as well as discuss some of the legal, political and practical difficulties they face in attempting to do so.

I. ENFORCING THE QUALITY OF CARE AND LIFE IN NURSING HOMES

A. State Licensing

The growth of the nursing home industry was spurred by the availability of federal funds under the Old Age Assistance provisions of the Social Security Act of 1935.¹⁰ Over the next fifteen years, thirty-five states began to license or otherwise regulate these facilities.¹¹ The impetus for state regulation was increased, however, by Congress' 1950 amendments of the Act, which permitted the payment of federal funds directly to the providers of care (called "vendors"), rather than to beneficiaries, on the condition that states establish and enforce standards for institutions receiving such funding.¹² In response to this legislation, the remaining states developed licensing systems for nursing homes.¹³ The state licensing standards were based on hospital standards¹⁴ and thus reflected the tenor of thinking in long-term health care—that the chronically ill and disabled in nursing homes primarily required medical intervention, albeit at a less intensive level than that provided by hospitals. They also reflected the contemporary view of how to regu-

10. 42 U.S.C. § 1396; (1976). See Wing & Craige, *Health Care Regulation: Dilemma of a Partially Developed Public Policy*, this Symposium, at text accompanying notes 116-19.

11. Lander, *Licensing of Health Care Facilities*, in ISSUES IN HEALTH LAW: A RESOURCE HANDBOOK (R. Romer & G. McKray, eds. 1979).

12. Social Security Act Amendments of 1950, ch. 809, § 303, 64 Stat. 477 (1950) (codified as amended in scattered sections of 42 U.S.C.). The 1935 Act, *supra* note 10, provided federal funds (to be matched by state funds) for income maintenance for the elderly and expressly prohibited payments for persons in public institutions. The existence of public funds, available for the first time to private boarding home owners, spurred a cottage industry of nursing homes. After more than a decade of experience, Congress recognized that a sufficient number of good homes did not exist and in the 1950 Amendments altered the limitation on the receipt of funds by public institutions to exclude only public nonmedical institutions, opening the door to the development of public nursing care facilities. See CONGRESSIONAL RESEARCH SERVICE, NURSING HOMES AND THE CONGRESS: A BRIEF HISTORY OF DEVELOPMENTS AND ISSUES, HD7106D (1972) [hereinafter cited as CONGRESSIONAL RESEARCH SERVICE]; Levey & Amidon, *supra* note 2, at 17.

13. See Lander, *supra* note 11. State licensing authority has been upheld against constitutional challenge as a proper exercise of the state's police power to promote public health and protect public safety. See, e.g., *Dent v. West Virginia*, 129 U.S. 114 (1888); *Goodwin v. Oklahoma*, 436 F. Supp. 583 (W.D. Okla. 1977); *Father Basil's Lodge, Inc. v. City of Chicago*, 393 Ill. 246, 65 N.E.2d 805 (1946).

14. DEP'T HEW, LONG-TERM CARE FACILITY IMPROVEMENT STUDY: INTRODUCTORY REPORT 3 (1975) [hereinafter cited as IMPROVEMENT STUDY].

late quality of care in acute care settings in their emphasis upon standards for the physical plant and the numbers and type of staff to attend hospital patients, standards that were later to be characterized as "structural."¹⁵

B. Medicaid and Medicare Certification

1. The Medicaid and Medicare Programs

The Medicaid and Medicare programs, which were established by the 1965 amendments to the Social Security Act,¹⁶ were conceived amidst a long and bitter debate between forces attempting to develop a comprehensive health insurance program for the elderly and those opposing all federal intervention in delivering health care. In a compromise designed to enlist the support of competing interest groups, congressional leaders developed a three-part program. Medicare, Title XVIII of the Social Security Act, had two parts: Part A, Hospital Insurance for the Aged, which paid for a specified number of hospital, nursing home and home nursing services, was financed and administered by the Social Security Administration and was designed to please the hospital lobby; and Part B, Supplementary Medical Insurance, which was financed through individual premiums and administered through private insurance carriers, paid for physicians' services according to their "usual and customary" fees, and was designed to attract support from the medical profession and the insurance industry. Medicaid, Title XIX of the Social Security Act, was drafted at the end of four years of debate over health insurance for the elderly. It provided a broad range of services to the indigent and was jointly administered and funded by the state and federal governments. Medicaid was designed to appease numerous interests, including state and local governments, the medical establishment, and the hospital industry, all of which felt that they had borne too great a burden in providing charity care in the previous decade. Medicaid extended the existing welfare vendor payment system, which previously had paid for health care for welfare recipients, to groups of non-welfare recipients as well.

Although nursing home standards for Medicaid and Medicare became identical under the 1972 Social Security amendments,¹⁷ the two

15. See note 65 and accompanying text *infra*.

16. Social Security Act Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (1965) (codified as amended in scattered sections of 42, 45 U.S.C.).

17. Social Security Act Amendments of 1972, Pub. L. No. 92-603, § 246, 86 Stat. 1329 (1972) (codified as amended in 42 U.S.C. §§ 1395x(j), 1396a(a)(38) (1976)).

programs are quite distinct, serving different population groups and providing a different scope of nursing home benefits. Medicare is drafted to resemble a health insurance program. All recipients of Social Security payments who reach age sixty-five¹⁸ or have received social security disability payments for twenty-four months¹⁹ are eligible for Part A of the Medicare program, which provides limited hospital services²⁰ and services in a skilled nursing facility for up to 100 days²¹ per "spell of illness,"²² but only for persons hospitalized for the same illness for at least three days. Nursing homes under Medicare were originally called "Extended Care Facilities" (ECFs), denoting the original concept of a short-term, less intensive "extension" of a hospital stay. Part A also provides home health care—the services of visiting nurses and nurse's aides for persons discharged from a hospital or nursing facility.²³ Part B of the Medicare program, for which persons over 65 or disabled must pay a monthly premium,²⁴ finances physician services and home health care services without the prerequisite institutionalization required by Part A.²⁵

Medicaid serves an entirely different population: persons receiving welfare under one of the federal categories—the aged, blind or disabled, or families with children deprived of parental support (the "categorically needy").²⁶ States may also cover persons physically "linked" to those categories whose incomes exceed the welfare eligibility levels, yet who are unable to meet the costs of health care (the "medically needy").²⁷ States choose to participate in Medicaid and design their systems individually, within the parameters of federal requirements regarding eligibility, benefits, payment for providers of health care and standards for provider participation.²⁸ Medicaid law

18. 42 U.S.C. §§ 1395c, 426(a) (1976).

19. *Id.* §§ 1395c, 402(d)-(f), 423.

20. *Id.* § 1395d(a)(1).

21. *Id.* § 1395d(a)(2).

22. A spell of illness is an acute illness requiring institutionalization; it ends after 60 days have passed in which the Medicare beneficiary was not an inpatient of a hospital or nursing home. *Id.* § 1395x(a).

23. *Id.* § 1395d(a)(3).

24. *Id.* §§ 1395p, 1395r.

25. *Id.* §§ 1395k(a), 1395x(s).

26. *Id.* §§ 1396, 1396a(a)(10)(A).

27. *Id.* § 1396a(a)(10)(C).

28. At the state level, Medicaid is administered by a "single state agency," *id.* § 1396a(a)(5)(1976), which is often the state welfare agency but rarely the state health department. The federal government shares between 50% and 83% of the cost of the program's administration. *Id.* § 1396d(b). Medicaid law also requires states to provide certain basic services: inpatient and outpatient hospital services, physician services, x-ray and laboratory services, skilled nursing

requires that all states pay for care in skilled nursing facilities (SNFs), and permits coverage of care in intermediate care facilities (ICFs).²⁹

2. Development of Medicaid Standards and Medicare Conditions of Participation

The Medicaid statute did not set standards for nursing homes, but left that task primarily to each state, with the congressional directive to improve quality of care standards and enforcement.³⁰ Originally, the Department of Health, Education and Welfare (HEW) required states to apply Medicare standards for ECFs to Medicaid nursing homes.³¹ But after congressional pressure and the enactment of a minimum set of statutory Medicaid nursing home requirements in 1968, HEW adopted regulations that established much less stringent conditions for Medicaid-certified nursing homes.³²

facility services, and family planning and early childhood screening services. *Id.* § 1396d(a)(1)-(5). States may also choose to provide, with matching federal funds, various optional services, including drugs, prosthetic devices, dental care and intermediate care facility services. *Id.* § 1396d(a)(6)-(17).

29. *Id.* § 1396d(a)(15). ICFs are institutions that provide less intensive nursing care than SNFs, and therefore presumably serve a more functional and less ill population. The average SNF under Medicaid and Medicare contains 100 beds; the average Medicaid ICF contains 57 beds. Kane & Kane, *Care of the Aged: Old Problems in Need of New Solutions*, 200 SCIENCE 813, 814 (Table 1) (1978). All nursing care facilities average 64 employees per 100 beds. This profile contrasts sharply with that of the average American hospital, which has 160 beds and 243 employees per 100 beds. *Id.* ICF services were added to the Medicaid program in 1971. Act of Dec. 28, 1971, Pub. L. No. 92-223, § 4(a), 85 Stat. 809 (1971) (codified at 42 U.S.C. § 1396d (1976)).

30. S. REP. No. 404, 89th Cong., 1st Sess. 76 (1975).

31. DEP'T HEW, HANDBOOK OF PUBLIC ASSISTANCE ADMINISTRATION, cited in *President's Proposal for Revision in the Social Security System: Hearings on H.R. 5710 Before the House Ways and Means Comm.*, 90th Cong., 1st Sess. 355 (1967) [hereinafter cited as *Hearings on H.R. 5710*].

32. 33 Fed. Reg. 16,165 (1968); 34 Fed. Reg. 9788 (1969). The American Nursing Home Association, representing proprietary facilities and joined by many congressional leaders, argued that HEW was not authorized to establish national standards. *Hearings on H.R. 5710, supra* note 31, at 353-58. In a sharply worded rebuttal, former HEW Secretary Wilbur Cohen testified before the House Ways and Means Committee that the agency did indeed have the power to issue fairly detailed nursing home standards for Medicaid participation. *Id.* at 353-63. The 1967 Social Security Amendments to Medicaid and Medicare included requirements that state Medicaid programs compel nursing homes to maintain an organized nursing service, plan menus, maintain satisfactory policies and procedures for medical records, drugs, physician care and emergency medical services, set up a transfer agreement with a hospital, and comply with the 1967 Life Safety Code. Social Security Amendments of 1967, Pub. L. No. 90-248, § 234(a), 81 Stat. 906 (1968) (codified at 42 U.S.C. § 1396a (1976)); see *Hearing Before Senate Finance Comm. on H.R. 12080*, 90th Cong., 1st Sess. 893-97 (1967). Since these standards were narrower than those under Medicare, HEW may have felt that their adoption undermined its earlier posture. It first published guidelines and later adopted formal regulations on nursing home standards in which it retreated from requiring application of the Medicare standards and established much less stringent conditions for Medicaid nursing homes. 33 Fed. Reg. 16,165 (1968); 34 Fed. Reg. 9788 (1969).

In 1969, Senator Frank Moss, chairman of the Long-Term Care Subcommittee of the Senate Special Committee on Aging, began a series of thirty hearings on problems in the nursing home industry. *Senate Special Comm. on Aging, Trends in Long-Term Care: Hearings Before the*

Medicare certification standards, called "Conditions of Participation," were developed in 1966 and revised in 1974.³³ They followed the pattern set by state licensing standards of the 1950's and the perspective that persons in Medicare nursing homes primarily required *medical* services. The standards were developed under the "hospital model," regulating the physical and staffing structure of the facilities and requiring the existence of written policies and procedures.³⁴

After the 1972 Social Security amendments, which provided a common definition of skilled nursing facilities under both Medicaid and Medicare, HEW issued regulations establishing eighteen "Conditions of Participation" to be applied to SNFs that are certified under either program. These conditions include standards for administration, resident services, sanitation and physical plant.³⁵

Subcomm. on Long-Term Care of the Senate Special Comm. on Aging, 91st-94th Congresses (1969-1975). The hearings resulted in a seven-volume report that revealed scandalous problems of fire safety violations, patient abuse, financial mismanagement and corruption and a shockingly low quality of care in the nation's nursing homes, combined with a total failure by HEW and the states to adopt standards and enforcement techniques to provide protection against those abuses. The Subcommittee on Long-Term Care drafted nine supporting papers to its overall report. THE LITANY OF NURSING HOME ABUSES AND AN EXAMINATION OF THE ROOTS OF CONTROVERSY (1974); DRUGS IN NURSING HOMES: MISUSE, HIGH COSTS, AND KICKBACKS (1975); DOCTORS IN NURSING HOMES: THE SHUNNED RESPONSIBILITY (1975); NURSES IN NURSING HOMES: THE HEAVY BURDEN (1975); THE CONTINUING CHRONICLE OF NURSING HOME FIRES (1975); WHAT CAN BE DONE IN NURSING HOMES: POSITIVE ASPECTS OF LONG-TERM CARE (1975); THE ROLE OF NURSING HOMES IN CARING FOR DISCHARGED MENTAL PATIENTS (1976); ACCESS TO NURSING HOMES BY U.S. MINORITIES (1976); and PROFITS AND THE NURSING HOME: INCENTIVES IN FAVOR OF POOR CARE (1976).

33. 42 C.F.R. § 405.1101, .1120-.1137 (1977). After a 1953 congressional study under the auspices of the Hill-Burton Hospital Construction program revealed that out of 25,000 long-term care institutions, only 7,000 provided "skilled nursing care," Congress amended the Hill-Burton Act to provide federal construction funding for long-term care facilities that were connected to hospitals or run by public or non-profit organizations. CONGRESSIONAL RESEARCH SERVICE, *supra* note 12, at 21. A further congressional study in 1956 disclosed a uniformly poor quality of care. *Id.* at 22. These findings were confirmed by a 1960 congressional report that cited problems of untrained administrators and aides, too few staff, limited services (especially rehabilitation), lack of physician attendance or medical supervision, inadequate state licensing programs and gross safety hazards. SUBCOMM. ON PROBLEMS OF THE AGED AND AGING OF THE SENATE COMM. ON LABOR & PUBLIC WELFARE, THE AGED AND AGING IN THE UNITED STATES: A NATIONAL PROBLEM, S. REP. NO. 86-1121, 86th Cong., 2d Sess., Pt. VII (1960). In response to these findings, Congress, with the adoption of Medicaid and Medicare in 1965, required that nursing homes participating in Medicare comply with specified federal standards. Social Security Act Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (1965) (codified as amended in scattered sections of 42, 45 U.S.C.). The Conditions of Participation are the standards established as a result of this directive. See 42 C.F.R. § 405.1101 (1977).

34. See IMPROVEMENT STUDY, *supra* note 14, at 3, 14-15.

35. The Conditions of Participation set standards for (1) state licensure; (2) governing body and management (including patients' rights); (3) medical direction; (4) physical services; (5) nursing services; (6) dietetic services; (7) specialized rehabilitative services; (8) pharmaceutical services; (9) laboratory and X-ray services; (10) dental services; (11) social services; (12) patient activities; (13) medical records; (14) transfer agreement; (15) physical environment; (16) infection control; (17) disaster preparedness; and (18) utilization review. 42 C.F.R. § 405.1120-.1137 (1977). In June

3. Meeting Certification Requirements

State Medicaid agencies and HEW are required to certify skilled nursing facilities as fully complying with the Medicaid-Medicare certification standards.³⁶ Facility inspections, which may be unannounced,³⁷ are performed by state facility licensing agencies (usually state health departments) under contract with HEW and Medicaid agencies.³⁸ Teams of surveyors composed of nurses, sanitarians, administrators and engineers perform a physical inspection of nursing home premises, interview patients and staff, and examine documents and records. If state inspectors discover deficiencies, they submit a "deficiency list" to the facility, which must in return file a "plan of correction" with the agency, proposing a reasonable schedule for its correction of the deficiencies. The state agency then visits the facility again to determine whether the deficiencies have been corrected and

1978, HEW published a notice of its intent to develop new standards, along with "draft specifications," and a schedule of regional public hearings to entertain comments on the draft and the need for new regulations. 43 Fed. Reg. 24,873 (1978).

36. 42 C.F.R. § 405.1908 (1977); 43 Fed. Reg. 43,235 (1977) (to be codified in 42 C.F.R. § 442.110(a)).

37. Some states expressly require unannounced inspections. See CAL. HEALTH & SAFETY CODE § 1421 (West Cum. Supp. 1978); IOWA CODE ANN. § 135C.39 (West Cum. Supp. 1978); KAN. STAT. § 39-935(4) (Cum. Supp. 1978); MINN. STAT. ANN. § 144A.10(2) (West Cum. Supp. 1978). The use of unannounced nursing home inspections was upheld in California against a challenge based on the fourth amendment protection against unlawful searches and seizures in *People v. White*, 65 Cal. Rptr. 923, 259 Cal. App. 2d 936 (1968). A nursing home owner convicted of a misdemeanor for not keeping 40 hours of registered nurse coverage, as required by state law, challenged the unannounced inspection that formed the basis of the conviction. The court had to contend with the recent Supreme Court cases of *Camara v. Municipal Court*, 387 U.S. 523 (1967), and *See v. City of Seattle*, 387 U.S. 541 (1967), which invalidated searches under state police powers. The California court held that "searches or seizures made pursuant to licensing statutes which require inspection are valid and not subject to constitutional objection," on the grounds that the licensee had consented to inspections as a condition of licensure and that the facility was open to the public. The court said that "acceptance of a license to operate a hospital is an implied consent to such supervision and inspection as is required by the licensing statute involved." 65 Cal. Rptr. at 927, 259 Cal. App. 2d at 939.

The recent Supreme Court case of *Marshall v. Barlow's, Inc.*, 436 U.S. 307 (1978), invalidating as a violation of the fourth amendment warrantless inspections by the Department of Labor under the Occupational Safety and Health Act of 1970, does not undercut the holding in *White*. The Supreme Court held that an exception to the fourth amendment's requirement of a search warrant exists in cases of "pervasively regulated businesses" in which each owner has "voluntarily chosen to subject himself to a full arsenal of governmental regulation," *id.* at 313, the second ground of the decision in *White*. Moreover, one of the reasons for the *Marshall* Court's application of the warrant requirement to OSHA inspections was that such a requirement would not hamper OSHA's enforcement. *Id.*; see Note, 57 N.C.L. REV. 320, 329-30 (1979). Although Federal law permits, but does not require, unannounced nursing home inspections, at least one state has found them necessary for meaningful enforcement of the Medicaid-Medicare certification standards, OHIO REP., *supra* note 6, at 23, and the reasoning of the Court in *Marshall* therefore should not apply to such inspections.

38. 42 U.S.C. §§ 1395aa(a), 1396a(a)(33) (1976).

whether others have developed. If, in the opinion of the state inspectors, the facility complies with the federal standards, it recommends that HEW certify the facility for participation in Medicare and that the state Medicaid agency certify it for participation in Medicaid. If HEW accepts this recommendation, it will execute a one-year Provider Agreement with the facility that entitles it to accept Medicare patients and receive reimbursement for them.

Institutions are now required by law to comply with the Medicaid-Medicare standards in order to be certified to participate in either program. The regulations, however, permit a facility with deficiencies to be certified if the deficiencies do not jeopardize patient health and safety nor seriously limit the facility's capability to provide adequate care and if it submits an acceptable plan for correcting the deficiencies within twelve months of inspection.³⁹ If the same deficiency is apparent during a subsequent certification period, the nursing home cannot be certified for continued Medicare or Medicaid participation unless it was in compliance at some time during this subsequent period, made a "good faith effort" to comply and was unable to do so "for reasons beyond its control."⁴⁰ The state agency must document the evidence in support of these required findings.⁴¹

A facility with deficiencies may be certified for fewer than twelve months under the above conditions. In addition, the Medicaid agency or HEW may certify a facility for a period ending not more than sixty days after the last day specified in its plan for correcting the deficiencies or may issue a conditional certification with an automatic cancellation clause.⁴² The certification would thus expire upon the condition subsequent that the facility had not made substantial progress in correcting the deficiency by a certain date, which must be no longer than sixty days after the date for correction in the plan of correction.⁴³

Nursing home certification under Medicaid was traditionally handled differently from that under Medicare, but since the 1972 Social Security Act amendments⁴⁴ the two systems have been identical. Origin-

39. 42 C.F.R. §§ 442.105(a), (b), 405.1905(a), 1907(a) (1977).

40. *Id.* §§ 405.1908(d), 442.105(d).

41. *Id.* §§ 405.1903, 442.105(a). That the certifying agency has only these choices and must document them in its records suggests that, despite the recognized doctrine of prosecutorial discretion, an agency could be required to take some action against facilities not meeting the certification conditions.

42. *Id.* §§ 405.1908(a), 442.111(b), (c).

43. *Id.*

44. Social Security Amendments of 1972, Pub. L. No. 92-603, § 246, 86 Stat. 1424-25 (1972) (codified in scattered subsections of 42 U.S.C. §§ 1395, 1396 (1976)).

nally, the state Medicaid agency (often the state welfare department rather than the health department) was required to survey facilities for participation under Medicaid. Sometimes state Medicaid agencies contracted with state licensing agencies to perform this function, but such arrangements were not mandatory. Furthermore, states developed their own Medicaid nursing home certification standards, which were not necessarily identical to those under Medicare. Concern over recognized problems of the quality of care in nursing homes and the inefficiency of different standards and survey processes among state licensing and certification agencies prompted Congress in 1972 to consolidate ECFs under Medicare and SNFs under Medicaid into the single rubric of "skilled nursing facility."⁴⁵ In addition to adopting a single set of nursing facility standards, Congress required that the state licensing agency inspect and recommend certification for both Medicaid and Medicare, ending the bifurcation of this function in some states. SNFs certified by HEW to participate in Medicare are automatically qualified for Medicaid participation.⁴⁶ They must, however, execute separate annual Provider Agreements—one with HEW for Medicare and one with the Medicaid agency. Facilities choosing to serve only Medicaid beneficiaries must be certified by the state Medicaid agency, with HEW determining compliance with Life Safety Code requirements.⁴⁷

State Medicaid agencies certify intermediate care facilities under circumstances similar to those for certification of SNFs.⁴⁸ The federal regulations, however, contain special provisions for certifying ICFs with deficiencies in environmental, sanitation, Life Safety Code and physical space standards.⁴⁹

In 1972 Congress also mandated the payment of the entire cost of the state survey-certification process under Medicaid out of federal

45. Social Security Amendments of 1972, Pub. L. No. 92-603, § 249A, 86 Stat. 1424-25 (1972) (codified at 42 U.S.C. §§ 1395x(j), 1396a(a) (38)(1976)).

46. Social Security Amendments of 1972, Pub. L. No. 92-603, § 248, 86 Stat. 1424-25 (1972) (codified at 42 U.S.C. § 1396i(a) (1976)).

47. In proposing this amendment, the Senate Finance Committee stated that it was not intended to result in any dilution or weakening of standards for skilled nursing facilities. As at present, a State may continue to require higher standards of skilled nursing facilities than those mandated by Federal statute and regulation. Where a State imposes additional requirements in its own right, then, as under the present section 1863, those standards would apply to both Medicare and Medicaid skilled nursing facilities in the State.

S. REP. No. 92-1230, 92d Cong., 2d Sess. 281-82 (1972).

48. 42 C.F.R. §§ 442.30, .105, .111 (1977).

49. *Id.* §§ 442.112, .113.

funds.⁵⁰ Medicare survey costs had always been exclusively federally funded, but prior to 1972 Medicaid survey costs had only been matched at the administrative matching rate of seventy-five percent.⁵¹ By paying one hundred percent of the costs of surveying and certifying SNFs under Medicaid and by adopting federal standards for SNF certification and the surveying process, Congress made a major commitment to enforcing quality of care and life in the nation's nursing homes.

II. PROBLEMS IN QUALITY OF CARE ENFORCEMENT

There are several theories about the forces that operate in a regulated industry. One theory is that the regulators are captured by the regulated industry and champion its objectives.⁵² For example, it is often alleged that federal regulatory agencies, such as the Interstate Commerce Commission and the Civil Aeronautics Board, advocate the interests of the regulated industry rather than the public interests they were presumably established to protect.⁵³ Another theory is that the regulated industries demand regulation, such as professional licensure, in order to maintain a market monopoly.⁵⁴ Still other theorists maintain that the regulatory bureaucracy itself drives and sustains the initiative for regulation.⁵⁵ For instance, one study of the demand for licensing clinical laboratory technicians in California concluded that the state licensing agency rather than the public or the licensees initially demanded and then sustained interest in regulating this profession.⁵⁶ It is possible to find all these forces at work in the life cycle of a regulatory process: a regulatory system is born out of public pressure to solve an identified social problem; initially, the established agency handles problems aggressively and creatively, but is faced with mounting pressure from the regulated activity; the agency loses vocal and ac-

50. Social Security Amendments of 1972, Pub. L. No. 92-603, § 239, 86 Stat. 1424-25 (1972) (codified at 42 U.S.C. § 1396b(a)(4) (1976)).

51. 42 U.S.C. § 1396b(a)(2) (1976).

52. See M. BERNSTEIN, REGULATING BUSINESS BY INDEPENDENT COMMISSION 25-49 (1955); Jaffe, *The Effective Limits of the Administrative Process: A Reevaluation*, 67 HARV. L. REV. 1105 (1954); Navarro, *Social Class, Political Power, and The State*, 1 J. HEALTH POL., POL'Y & L. 256 (1976); Posner, *Theories of Economic Regulation*, 4 BELL J. ECON. & MANAGEMENT SCI. 335 (1974).

53. Jaffe, *supra* note 52, at 1109-1113.

54. Stigler, *The Theory of Economic Regulation*, 5 BELL J. ECON. & MANAGEMENT SCI. 1, 3-21 (1971). The Federal Trade Commission is investigating the monopolistic potential of health personnel licensure.

55. Wilson, *The Dead Hand of Regulation*, 25 THE PUBLIC INTEREST 39, 47-48 (1971).

56. W. WHITE, PUBLIC HEALTH AND PRIVATE GAIN: THE ECONOMICS OF LICENSING CLINICAL LABORATORY PERSONNEL (1979).

tive public support and becomes devitalized, adjusting to an atmosphere in which it functions less as a regulator and more as a consultant-manager and begins to be the captive of the regulated industry; the agency is abandoned by the public and does not undertake an active regulatory role; finally, with diminished funding, public support and internal initiative, the agency becomes debilitated and ineffectual.⁵⁷

The nursing home enforcement processes in most states are characterized by this regulatory life-cycle. Despite periods of creative and aggressive enforcement, most licensing agencies are ineffective because of inadequate funding, apathetic personnel, cumbersome legal remedies, inappropriate standards, interagency fragmentation and maldistribution of long-term care resources. Enforcement agencies are generally underfunded and thus limited in the personnel available to perform adequate inspections. This situation has developed because many state licensing agencies are financed almost exclusively with the one hundred percent federal funding available for the inspection process. Unlike the costs of Medicaid *program* services, which are reimbursed on the basis of all actual expenditures,⁵⁸ however, inspection costs are reimbursed in response to fixed annual budgets, which state survey agencies must submit to and negotiate with regional HEW offices. Colorado, for instance, whose state licensing standards are similar to the federal conditions of participation, performs few independent state licensing functions. Its licensing responsibilities are subsumed within its federal certification duties. The state relies on over ninety percent federal funding for its state licensing and Medicare-Medicaid certification budget.⁵⁹ Thus, the availability of federal funds directly determines the extent of the state's nursing home enforcement efforts under even its own licensing power.

Because of budgetary limitations and limited enforcement powers,⁶⁰ agency personnel often become frustrated by a lack of a real ability to improve nursing home quality, and this frustration leads to apathy. Nursing home inspectors also face a dilemma of roles, uncertain whether they are "police" or "consultants."⁶¹ When the public is not regularly confronted with the immediate and shocking problems in

57. Ruchlin, *A New Strategy for Regulating Long-Term Care Facilities*, 2 J. HEALTH POL., POL'Y & L. 190, 191 (1977).

58. See notes 50-51 and accompanying text *supra*.

59. See COLORADO ATT'Y GEN., *supra* note 6.

60. See text accompanying notes 142-169 *infra*.

61. OHIO REP., *supra* note 6, at 24.

the industry, public support for regulatory efforts diminishes. This lack of active public support, combined with the industry's criticism of the regulators and the fact that inspectors' daily contacts are only with the regulated facilities, makes it difficult for inspectors to see themselves as purely objective public servants. There has been a pronounced tendency by surveyors to seek good relationships with, if not cater to, the nursing homes they regulate.

The lengthy and complicated legal process accompanying revocation of nursing home licenses or certification also delays effective regulation and deters agencies from taking aggressive steps. Facilities have succeeded in applying due process concepts to elevate owners' rights over the patients' interests, which enforcement agencies purport to protect.⁶² Courts require a high standard of proof to sustain agency revocation of a state license or a Medicaid certification and have resisted efforts to enforce licensing and certification standards that are vague or subjective.⁶³

Effectiveness of the regulatory system is further compromised by the fragmentation that exists among regulatory agencies; even after the 1972 Social Security amendments integrating Medicaid and Medicare enforcement, many states have several agencies responsible for establishing and enforcing nursing home standards. In many states one agency may issue certificates of need to build facilities or set facility rates, another may license and recommend certification of facilities, another may reimburse under Medicaid, another may license health professionals, another may inspect for fire safety and another may place adults in facilities, while Professional Standards Review Organizations (PSROs) may perform medical review, and the state attorney general's office may spearhead actual enforcement. At the federal level, HEW reimburses under Medicare and uses its own system to enforce compliance or revoke certification.⁶⁴ Government tends to solve quality of care problems by adding more agencies rather than consolidating and reforming existing ones. Not only is interagency communication and data sharing usually inadequate or altogether nonexistent, but the power of Medicaid reimbursement as a quality assurance tool⁶⁵ is often lost when the Medicaid agency is not the licensing-certification agency.

62. See notes 129-155 and accompanying text *infra*.

63. OHIO REP., *supra* note 6, at 20.

64. NATIONAL ASSOCIATION OF ATTORNEYS GENERAL, ENFORCING QUALITY OF CARE IN NURSING HOMES 10-12 (1978) [hereinafter cited as NAAG REP.].

65. See notes 90-122 and accompanying text *infra*.

Distribution of long-term health care resources also has a negative impact upon regulation if a state or an area is undersupplied with nursing home beds. In many rural communities with only a single nursing home, it is politically and practically impossible to close a facility; the lack of alternative enforcement remedies poses a serious problem in those situations. The absence of noninstitutional alternatives to nursing homes, resulting largely from the institutional bias of Medicaid and Medicare, further aggravates the ineffectiveness of nursing home enforcement.

III. POSSIBILITIES FOR REFORM

A number of options exist for reform of the existing regulatory processes that attempt to control the quality of care in nursing homes: (a) elimination of existing programs and increased reliance on competition among providers of nursing home services; (b) change in the focus of regulation to provide new and challenging functions for regulators in order to revitalize the moribund regulatory system; (c) development of economic incentives for individual nursing homes to provide high quality care; (d) enhancement of enforcement mechanisms to provide regulators a greater array of enforcement remedies; and (e) increased public support for and involvement in the regulatory process. The remainder of this article will examine each of these options, most of which are complementary, not exclusive.

A. Stimulating Competition in an Unregulated Market

There is little reason to believe that elimination of regulatory programs and reliance on market place competition will operate to improve the quality of care, given the present structure of the nursing home industry and the means by which it is currently financed.⁶⁶ Without truly informed consumer judgment and complete freedom of choice, which will not exist if there is a shortage of facilities or noninstitutional alternatives in an area, simply eliminating the regulatory processes seems inappropriate. Consumers of nursing home services are not in a position to judge quality, since they are usually ill and often impaired. Furthermore, unless accurate quality indices are developed and made available to the public, individual consumers are incapable of identifying high quality homes in their area that will meet

66. Ruchlin, *supra* note 57, at 199-200.

their needs.⁶⁷ Even if consumers were informed about quality of care in various institutions and if sufficient beds were available to permit them to exercise a real choice, consumers often could not make an informed decision about whether to enter a nursing home without access to noninstitutional alternatives. It is estimated that at least one-third of the nursing home population is inappropriately placed and would be capable of remaining in a residential setting if supportive services such as social services, homemaker services, home health services and recreational activities were available to them.⁶⁸

The insufficient supply of noninstitutional long-term care results primarily from the failure of its funding by Medicaid and Medicare. There have been some proposals to expand Medicare home health care services.⁶⁹ A few Medicaid demonstration projects, providing adult day care services and other non-traditional health care services for the elderly and disabled, have been federally funded.⁷⁰ These few projects can hardly be expected to serve even a fraction of the nursing home population that is inappropriately placed.

The existence of a spectrum of alternatives in long-term health care, along with informed awareness, could provide the competitive circumstances that would compel nursing homes to provide visible, high-quality care at a reasonable cost. But conditions do not currently exist to permit competition alone to assure nursing home quality of care without some form of active government intervention.

B. *Changing the Regulatory Focus*

Some regulation must exist in the long-term health facility field in order to assure quality of care, but the current regulatory mechanisms apparently cannot achieve this objective. It might be possible to mini-

67. OHIO REP., *supra* note 6, at 16-17.

68. The Congressional Budget Office, for example, estimated that 10-20% of SNF residents and 20-40% of ICF residents are placed at too high a level of care and that many could be cared for at home or in sheltered living arrangements. CONGRESSIONAL BUDGET OFFICE, *supra* note 3, at 18-19.

69. Proposed H.R. 13097, 95th Cong., 1st Sess. (1975) would have eliminated limitations on home care services under Medicare.

70. The best known adult day care system is provided by On Lok, a center in the Chinatown section of San Francisco. Lurie, *On Lok Senior Day Health Center: A Case Study*, GERONTOLOGIST, February 1976, at 16. Another experimental approach to providing noninstitutional long-term care is the community care organization, a channeling agency that assesses the needs of persons about to enter nursing homes and "brokers" services to fill those needs in the community to permit long-term care patients to remain at home. Community care organizations have been funded by HEW in Wisconsin and Colorado. New York is experimenting with home health care services under a federal grant. See N.Y. PUB. HEALTH CODE § 2382 (McKinney 1977).

mize bureaucratic apathy by changing the bureaucrats' jobs and/or by automating those jobs' inherently unchallenging aspects.⁷¹ Changing the focus of regulation sufficiently to provide a more creative job and to infuse new interest and energy into regulators would begin a new regulatory life cycle and at least renovate the process temporarily. One means of refocusing regulation would be to eliminate many of the extant licensing and certification standards that center only on regulatory structure and substitute standards that relate to the outcomes of care. For example, regulators could determine whether nursing home residents improve or maintain their health status over time rather than deteriorate and whether they meet objective or subjective norms and expectations.

Long-term care facility regulation since 1965 has been based, as noted above, upon the premise that nursing homes are merely extensions of hospitals, that residents primarily require medical treatment and that the only valid quality standards are those defining the structure of the facility. Considering that nursing home services are funded by Medicare and Medicaid, which pay for medical care, this emphasis is not surprising. But it has increasingly been recognized that although some nursing home residents do require fairly intensive nursing care while recuperating from acute illnesses or when suffering from terminal illnesses, such as those involving hospitalization, the vast majority of them have long-term chronic disabilities requiring some nursing care, but more importantly requiring aid in daily living activities, social services, organized activity programs and help in coping with the emotional and psychological problems of old age, debility and isolation. Thus, the so-called "medical hospital model" is inappropriate for most nursing home residents; yet the Medicaid-Medicare certification standards and most state licensing standards rely upon it.

Three approaches to establishing quality of care regulations for health facilities have been recognized since the advent of Medicaid and Medicare—structure, process and outcome measures.⁷² *Structural standards* measure facilities and equipment, numbers and qualifications of staff, administrative organization and operations, and fiscal systems. For instance, the Medicare-Medicaid Conditions of Participation include requirements that facilities have certain physical plant features

71. For an analysis of how job description and responsibility affect performance, see Herzberg, *One More Time: How Do You Motivate Employees?*, 46 HARV. BUS. REV. (1968).

72. Regan, *Quality Assurance Systems in Nursing Homes*, 53 U. DET. J. URB. L. 153, 160-61 (1975).

and also have policies regarding patients' rights, patient care, staff organization and services provided. The Conditions generally do not require examination of the content of the policies or whether they are implemented. Fewer than 20 of the 541 items on the Medicare-Medicaid survey inspection form⁷³ require an examination of the care given to patients or require surveyors to observe patients.⁷⁴ Most of the surveyors' time in the facility is spent reviewing documents, including staffing charts, menus, policies and procedures. This approach is based on the assumption that if the structure is appropriate, and the facility has the *capacity* to provide good care, good care will be provided.⁷⁵ The logic of this approach is specious, particularly when better and more appropriate standards exist to determine whether residents receive the care to which they are entitled.

Process standards measure the actual care delivered to patients and compare it to established norms of care throughout the area. For instance, surveyors using process standards would examine, on a sample basis, the completeness of information received about a patient through testing and diagnosis, the appropriateness of prescribed therapies to the diagnoses, and the technical competence of the performance of diagnostic and therapeutic procedures. Peer review processes, such as institutional utilization review in hospitals⁷⁶ and the Professional Standards Review Organizations (PSROs)⁷⁷ employ such a process approach, using standards developed by community norms of medical practice.⁷⁸ In long-term care, as contrasted with hospital care, however, process standards are more difficult to determine. Norms of care are relatively easy to establish for acute illnesses for which medical outcomes can be defined and evaluated. But treatment for chronic medical conditions, and especially for social problems, is far less easy to validate. Thus, while some process measures for the long-term care setting exist, many are still developmental, being demonstrated by, for example, PSRO long-term care projects.⁷⁹

73. Form No. SSA 1569. This and all medicare SNF forms are available from the state licensing agency and HEW offices.

74. OHIO REP., *supra* note 6, at 14-15.

75. See IMPROVEMENT STUDY, *supra* note 14, at 14-15.

76. See, e.g., 42 U.S.C. §§ 1395x(k), 1396a(a)(30) (1976); 42 C.F.R. §§ 456.50 -.145, 456.250 -.348 (1978).

77. 42 U.S.C. § 1320(c) (1976).

78. For an overview of PSRO and utilization review, see Price, Katz & Provence, *An Advocate's Guide to Utilization Review*, 11 CLEARINGHOUSE REV. 307 (1977).

79. Fifteen demonstration projects were funded wherein PSROs assessed quality of care in nursing homes under Medicaid and Medicare. Some of these projects, such as the one in

The final approach to regulating quality of care, *outcome standards*, focus on the outcome of care and determine whether patients achieve an expected recovery or stabilize rather than deteriorate. Outcome measures have been developed to test the effect of a few severe but chronic conditions such as stroke, heart attacks and hip replacement on activities of daily living,⁸⁰ but very few outcome measures exist for long-term care patients' conditions. Theoretically, in applying an outcome test to a patient, a regulator need not generally be concerned with the means used to achieve the desired outcome so long as the outcome is achieved.⁸¹ Under this theory of regulation, facilities would be given great flexibility to experiment with innovative forms of treatment and would be held accountable only for their results. An outcome approach to regulating quality of care requires considerably different regulating skills and inspection techniques. A question remains, however, whether outcome standards alone are sufficient. For example, safety and sanitation standards must remain in effect to protect patients from disaster or institutional infection. It is often asserted that required safety equipment such as sprinklers are very costly and unnecessary for buildings of modern construction.⁸² Certainly, many safety requirements, such as the door width standards in the Life Safety Code, seem minimally related to patient safety and might be eliminated as outcome standards become the primary basis for enforcement. But some fire safety standards should persist to protect residents in older buildings, where nursing home fires have occurred with fatal consequences.⁸³ Sanitation standards, to protect residents against foodborne or airborne contamination, are also necessary, and, unlike some safety regulations, should not be unduly costly to apply. In light of these considerations, outcome standards may be inappropriate for safety and sanitation regulation. Unlike most areas of patient care, in which patients are not put directly in jeopardy by a retrospective re-

Colorado, developed and tested certain process and outcome standards for long-term care residents of nursing homes.

80. Katz & Akpom, *A Measure of Primary Sociobiological Functions*, 6 INT'L J. HEALTH SERVICES 493 (1976); Katz & Akpom, *Index of ADL*, 14 (Supp.) MED. CARE 116 (1976).

81. There might, however, be legitimate reasons why a given individual did not achieve an expected norm. Therefore, the regulator would have to fall back upon process standards to evaluate the actual care provided to persons who failed to meet given outcome standards.

82. Feeley, Walsh & Fielding, *Structural Codes and Patient Safety: Does Strict Enforcement Make Sense*, 3 AM. J. L. & MED. 447, 453 (1976). The authors examine Massachusetts' experience with nursing home fires and conclude that sprinklers cost from \$86,000 to \$137,000 per potential year of life saved.

83. SUBCOMM. ON LONG-TERM CARE OF THE SENATE SPECIAL COMM. ON AGING, THE CONTINUING CHRONICLE OF NURSING HOME FIRES, *supra* note 32.

view on a frequent basis, applying fire safety, infection and sanitation standards on a retrospective basis would subject nursing home residents to an unacceptable risk.

Both process and outcome measures of quality of care require that facilities have the capacity to assess accurately the status of their residents, to determine the care required for a given discovered condition, to provide that care, and to evaluate continuously its effectiveness. A regulatory agency employing either of these measures must have the capacity to validate the facility's own assessment of the resident and either the outcome of care or the care provided. The agency must also have the capacity to collect, store and retrieve the information collected by facilities through their resident assessments and evaluate facility performance by applying quality of care standards that validly measure patient status. A certain amount of the routine work of the regulatory agency can thus be automated, freeing inspectors to perform actual resident assessment and draw conclusions about facility quality performance.

Considerable work has been done through government and private research over the last decade on systems of patient assessment in long-term care. One of the best known patient assessment systems is "PACE," the Patient Assessment and Care Evaluation system developed by the Office of Nursing Home Affairs in HEW from 1974 to 1978.⁸⁴ Drawing upon the work of Densen, Katz and Jones at the Harvard Center for Community Health, the PACE system provides an instrument by which nursing home staff can assess an individual's functional level and determine medical, nursing and social needs. The "Care Evaluation" component of the system requires the facility staff to develop a plan of care to meet the assessed needs and to evaluate the effectiveness of the care by periodic reassessment.⁸⁵ The use of such a system of patient assessment can provide the opportunity for regulators to look at the actual care delivered to patients rather than merely at a facility's theoretical capacity to provide the care. In fact, it was the recognition of this critical flaw in the extant nursing home quality of care enforcement system that led the Office of Nursing Home Affairs to

84. *See, e.g.*, DEP'T HEW, THE PACE PROGRAM FOR LONG-TERM CARE (1978).

85. Numerous other systems have been developed. Since they derive primarily from the same base, however, they are quite similar. *See, e.g.*, COLORADO DEP'T OF HEALTH, VITAL STATISTICS DIVISION, LONG-TERM CARE PATIENT EVALUATION ABSTRACT (1975); DUKE UNIV. CENTER FOR THE STUDY OF AGING AND HUMAN DEVELOPMENT, MULTIDIMENSIONAL FUNCTIONAL ASSESSMENTS: THE OARS METHODOLOGY (1975).

develop PACE.⁸⁶ This system can also form the basis for reimbursing facilities according to resident outcomes.⁸⁷

A prerequisite to an outcome-oriented system is the definition of the expected changes in patient status that should occur at various points in time if appropriate health care is provided. Similarly, the structure and process standards that are currently being employed should be sufficiently well-defined and should avoid the open-ended and imprecise terms currently contained in the Conditions of Participation. While it is appropriate that state agencies or HEW have the discretion to establish standards, that discretion should be exercised to circumscribe the discretion of individual surveyors by avoiding the use of such vague and subjective terms as "adequate," "qualified" and "sufficient" that fill the current federal standards⁸⁸ but are difficult to enforce.⁸⁹ Neither facilities nor surveyors can be completely sure of their meaning. It is difficult to prosecute enforcement actions with vague standards; administrative bodies and courts are not comfortable with state agency application of ill-defined standards that leave great discretion to surveyors, and surveyors themselves prefer specific standards that they can apply with confidence. On the other hand, imposition of highly specific and detailed standards leads to the charge of bureaucratic nitpicking, harassment and undue government interference with facility management.⁹⁰ Although detailed standards are easier to enforce and, by minimizing the exercise of surveyor judgment, assure uniform and objective enforcement in agencies with several surveyors,⁹¹ establishing management, personnel and patient care policies may stifle facility innovation and creativity.⁹²

Because current federal and state standards (most of which are patterned after the federal Conditions) do not focus on whether the needs of individual residents are being fulfilled, they do not assure

86. See generally IMPROVEMENT STUDY, *supra* note 14.

87. See notes 133-40 and accompanying text *infra*.

88. See, e.g., 42 C.F.R. §§ 405.1124, .1125(a), .1126, .1126(a), .1130, .1130(b), .1131(a)-(b), .1135(c) (1977).

89. NAAG REP., *supra* note 64, at 34; see *Levine v. Whalen*, 39 N.Y.2d 510, 349 N.E.2d 820, 384 N.Y.S.2d 721 (1976).

90. See Brown, *An Appraisal of the Nursing Home Enforcement Process*, 17 ARIZ. L. REV. 304, 316 (1975).

91. Nursing homes in Colorado frequently allege that different surveyors are inconsistent in finding deficiencies in the same facilities. This often justified criticism results from the broad discretion left to each surveyor by state and federal standards.

92. The debate over the extent of detail in which the government should set standards will never be fully resolved, but decisions will have to be made as HEW issues new conditions of participation in 1979.

quality of resident care. The solution to this problem is resident-focused standards, such as outcome standards, but few currently exist. New measures of quality of nursing home care and new enforcement techniques for surveyors to use in applying them must be developed.⁹³ Changing the standards to a resident orientation and enhancing survey capacity with different professional skills, such as resident assessment, could kindle a new spirit of dedication and energy in a regulatory agency staff that could lead, at least for a time, to improved enforcement activity and begin another regulatory life-cycle.⁹⁴

C. *Economic Incentives for the Provision of Quality Care*

Because most nursing homes are proprietary, most nursing home owners are motivated primarily by a concern for maximization of profits rather than residents' welfare. It would thus seem possible to improve the quality of nursing home care through economic incentives, such as rewards for good care or financial penalties for poor care, encouraging competition within regulatory guidelines. It must, of course, be recognized that while adequate reimbursement is a prerequisite to quality care, and while reimbursement can be designed to furnish incentives for facilities to provide good care, it cannot guarantee that the care will be provided,⁹⁵ just as establishing structural standards that examine a facility's theoretical capacity to provide quality care does not ensure its actual delivery. Thus, even if reimbursement is high enough to cover the actual costs of quality care, a means to examine the process or outcome of care must be tied to reimbursement to assure that care is appropriately delivered.

Before discussing reimbursement policies, however, it is necessary to highlight briefly the primary characteristics of nursing home financing and economic behavior and then to examine alternative means of reimbursement and their effect on facility conduct regarding resident care.

1. Nursing Home Financing

The nursing home industry, most of which is proprietary,⁹⁶ is capi-

93. See IMPROVEMENT STUDY, *supra* note 14, at 14-15.

94. See notes 52-60 *supra*.

95. OHIO REP., *supra* note 6, at 9.

96. The nursing home industry grew from 7000 nursing care homes in 1954 to 9500 in 1960, 12,000 in 1965, F. MOSS & V. HALAMANDARIS, *supra* note 2, at 7, and 18,000 in 1976, NATIONAL CENTER FOR HEALTH STATISTICS, MASTER FACILITY INVENTORY 15 (1976). At present, 93% are privately owned and 75% of those are proprietary. Kane & Kane, *supra* note 29, at 814 (Table 2).

tal-intensive, generating lower annual revenues than would otherwise be generated by the capital used by the industry.⁹⁷ Profit from the nursing home industry as a whole is generally lower than that in other businesses—about four percent in 1976.⁹⁸ The industry, however, is attractive to investors not because of its profits, but because of its potential for cash flow. Because the primary capital investment in the nursing home business is real estate, and because Medicaid and Medicare generously reimburse depreciation (a non-cash flow item), if amortization of debt-financed principal is less than depreciation expense, nursing homes generate cash flow at the rate of about thirty cents per dollar invested.⁹⁹

Because a higher net cash flow, the principal factor in the attraction of capital to the nursing home industry, is based primarily on larger depreciation deductions, it is clear that nursing home owners will seek to maximize their depreciable basis (by transferring a facility to increase its tax basis) and to maintain revenue sufficient to cover mortgage payments in order to assure a tax-sheltered cash flow by either maximizing income or minimizing expenses. An owner can maximize income by attempting to increase Medicaid and private pay rates (although the owner may have little actual control over them) and by maintaining high occupancy rates in his facilities. The owner, however, has far more control over operating expenses, such as those for labor, food and patient care services. Because these costs directly or indirectly affect patient care in nursing homes, the means of nursing home financing of and reimbursement for these items have obvious implications for quality of care.¹⁰⁰

By comparison, of the 6500 hospitals in the United States, only 13% are proprietary. *Id.* Since 1967, the nursing home industry has been "big business"; many facilities are owned by national chains and are publicly traded on the major stock exchanges. Shulman & Galanter, *Reorganizing the Nursing Home Industry: A Proposal*, 10 MILBANK MEM. FUND Q. 129 (1976). Although cut-backs in Medicare reimbursement in 1967-68 caused a sharp decline in proprietary nursing home profits, Butler, *An Advocate's Guide to the Medicare Program*, 8 CLEARINGHOUSE REV. 831, 837 (1975), the industry continues to enjoy a substantial profit margin and is an attractive investment, F. MOSS & V. HALAMANDARIS, *supra* note 2, at 73-101. One hundred proprietary chains control one-fifth of the nursing home beds in the United States; the largest of these operates 121 facilities with over 20,000 beds and had gross revenue in 1976 exceeding \$97 million. *See Dole, An Investigation into the Business of Caring for the Elderly*, 23 NURSING HOMES 2 (1979).

97. Shulman & Galanter, *supra* note 96, at 134 (1976). *See also* F. MOSS & V. HALAMANDARIS, *supra* note 2, at 73-85.

98. Shulman & Galanter, *supra* note 96, at 135.

99. *Id.* at 134-37.

100. *Id.* at 137-38. The authors propose government ownership of nursing home real estate and private management contracts for providing patient care services as one means of shifting incentives for profit maximization away from diverting resources to cover capital and toward applying resources to patient care costs. They suggest that management contracts could be

While some commentators attribute nursing home quality of care problems to the profit-making status of the facilities and suggest that a solution is to mandate that nursing homes be only not-for-profit entities, evidence generally shows that nonprofit homes do not provide a higher quality of care than proprietary facilities.¹⁰¹ Moreover, the principals in a nonprofit corporation may obtain significant compensation by providing goods and services (often at inflated rates) to the corporation, by selling or leasing, and, of course, by the same fraudulent practices engaged in by some owners of profit-making entities. Since nonprofit nursing homes are exempt from property and other local taxes, they can be highly "profitable" enterprises. Although state taxing authorities are empowered to disqualify nonprofit corporations that actually generate profits, neither they nor state licensing agencies set standards for accounting, purchasing, compensation or investment practices of nursing homes.¹⁰² There is thus no means of assuring that nonprofit facilities return income to patient care services instead of to the pockets of principals, who are essentially their owners. Those nonprofit nursing homes that provide a high quality of care to their residents do so because of the dedication, commitment and beneficent motivations of their managers and employees. The absence of a need to generate profits for owners may certainly support these motivations, but it in no way guarantees their existence.

2. Reimbursement Approaches Under Medicaid and Medicare¹⁰³

Before the 1972 Social Security amendments provision requiring Medicaid to reimburse SNFs and ICFs on a "reasonable-cost-related basis,"¹⁰⁴ states used a variety of methods for nursing home reimburse-

negotiated periodically on a competitive bid basis. The authors argue that such a system would provide greater control over quality by providing time-limited, non-vested agreements, public accountability for contract performance, and competitor scrutiny of cost and quality. *Id.* at 139-42.

101. See M. MENDELSON, *TENDER LOVING GREED* 195-212 (1974). See also ACTION COALITION OF ELDERS, *KANE HOSPITAL: A PLACE TO DIE* (1975). Experience in California with pre-paid health plans (organized providers of health care who contracted with the state Medicaid agency to serve Medicaid beneficiaries) demonstrated that not-for-profit entities actually generate profits that were hidden through deceptive or fraudulent accounting practices and provided a generally poor quality of health care service. S. REP. NO. 95-749, 95th Cong., 2d Sess. 9-12 (1978).

102. Federal regulations on Medicaid nursing home reimbursement, however, now prohibit costs of services furnished to "related organizations" exceeding the market price of the services. 43 Fed. Reg. 45,259 (1978) (to be codified in 42 C.F.R. § 447.284 (a)).

103. For an extensive overview of nursing home reimbursement, see Coleman & Schneider, *An Advocate's Guide to Nursing Home Reimbursement* (1979) (available from the National Health Law Program, 2401 Main Street, Santa Monica, Calif. 90405).

104. Social Security Amendments of 1972, Pub. L. No. 92-603, § 246, 86 Stat. 1426 (1972) (codified at 42 U.S.C. § 1396a(a)(13)(E) (1976)).

ment. Some paid on a flat rate, usually differentiating between SNFs and ICFs. Others paid on a cost-plus basis, paying all costs plus a factor for profit; among the latter reimbursement systems were variations including cost reimbursement up to a ceiling and costs up to a ceiling plus a profit factor. Medicare reimburses nursing homes on the basis of "reasonable cost,"¹⁰⁵ which amounts to full payment for most facility costs, without a ceiling, plus a profit factor computed as a reasonable return on net invested equity, currently set at 10.5 percent.¹⁰⁶

Different reimbursement mechanisms provide incentives for different economic behavior, produce different regulatory atmospheres, and can advance different social goals. Flat rates, for instance, create incentives for facilities to reduce variable costs (which will likely be those costs attributable to patient care) in order to maximize profits; such a system does tend to hold down costs of care as well as the expenses of administration and produces more budget predictability for the paying agency. It may produce poor quality care, however, and to the extent that the rate is seen as unduly low, facilities will discriminate against publicly financed patients.¹⁰⁷

A cost-plus reimbursement system under which states pay "allowable costs" is inherently inflationary and contains no incentives for efficiency, although it also provides no disincentives for quality care as long as states cover all patient care costs. It is more expensive to administer, since cost reports must be audited. Some facilities have inflated their allowable costs by sale and leaseback arrangements, excessive interest payments, inflated initial costs, and refinancing to minimize their own invested equity and maximize the rate of return.¹⁰⁸ Furthermore, determination of what costs are allowable is politically sensitive and difficult. To curb the inflationary impact of cost reimbursement, some states have imposed ceilings beyond which they will not reimburse. Under this approach, high cost institutions whose costs exceed the ceiling will behave as if they were reimbursed on a flat rate; for lower cost homes the system resembles cost reimbursement and provides an incentive for them to increase costs over time up to the ceiling.

105. 42 U.S.C. §§ 1395(f), (p) (1976).

106. *Id.* § 1395(x)(v)(1)(B) (1976); 42 C.F.R. § 405.429 (1978); [1977] 1 MEDICARE & MEDICAID GUIDE (CCH) ¶ 5782.

107. Minnesota law prohibits nursing homes from charging private patients over 10% more than Medicaid patients. MINN. STAT. ANN. § 256B.48 (West Cum. Supp. 1979). This statute is being challenged by the industry in *Minnesota Ass'n of Health Care Facilities v. Perpich*, No. 377-CN-467 (D. Minn., filed Oct. 15, 1977).

108. See F. MOSS & V. HALAMANDARIS, *supra* note 2, at 90-100, for a discussion of some common means of profiteering.

The costs of administration and audit are similar to those under a cost system, but the state is protected from unchecked strains on its budget. The placement of the ceiling in this method is critical to determining whether patient care suffers. If the ceiling merely penalizes inefficient homes it might not adversely affect patient care; however, a ceiling placed too low may jeopardize care to patients.

States may also pay costs up to a ceiling plus an additional profit factor beyond the ceiling, calculated as a return on the owner's net invested equity.¹⁰⁹ Payment of profit based on net invested equity (the Medicare method) is viewed as a means of encouraging more personal investment in a facility (as opposed to using borrowed funds for capital) on the theory that if one has invested his own money in a business he will be more likely to safeguard its reputation and provide a higher quality of care for patients. While this method may thus provide a greater incentive than the other two cost-plus mechanisms, it does not relate profit directly to a facility's quality of care, but rather assumes that quality will accompany return on an owner's personal investment, an assumption of very questionable validity.

Federal Medicaid regulations issued to implement the new cost-related nursing home reimbursement requirement of the 1972 Social Security amendments¹¹⁰ indicate that flat rates (which would not be cost-related) and cost reimbursement without a ceiling are not acceptable.¹¹¹ Furthermore, states are not required to provide a profit.¹¹² In no event may rates exceed those paid under Medicare,¹¹³ but they must be high enough to cover "actual allowable costs of a facility that is economically and efficiently operated,"¹¹⁴ including the costs of meeting state licensing and federal certification requirements¹¹⁵ and of routine services (room and board, nursing care, medical supplies and equipment).¹¹⁶ The regulations permit states to provide incentives to participating facilities to upgrade the quality of care through reimbursement.¹¹⁷

109. 43 Fed. Reg. 4862 (1978).

110. 42 C.F.R. § 447.272-.316 (1978).

111. 43 Fed. Reg. 4863 (1978).

112. *Id.* 4862-63.

113. 42 C.F.R. § 447.316. (1978). Rates set prospectively may be effectively higher than Medicare rates. *Id.* § 447.306(b).

114. *Id.* § 447.302(b); *see* Alabama Nursing Home Ass'n v. Califano, 465 F. Supp. 605 (M.D. Ala. 1979).

115. *Id.* § 447.279.

116. *Id.* § 447.281.

117. *Id.* § 447-306.

Traditionally, under Medicaid and Medicare, health care institutions that are paid on a cost basis, which includes hospitals under both programs as well as Medicare nursing homes, are periodically reimbursed at an estimated rate during the accounting period (usually a fiscal year), after which the facilities account for their allowable costs and the paying agency adjusts the rate upward or downward. Such a retrospective system is inflationary. To curb health care cost inflation, the federal government under Medicare and the state Medicaid agencies are experimenting with prospective reimbursement, in which rates are set in advance and no adjustment is made to reflect actual costs incurred.¹¹⁸ While this approach permits states to budget accurately and may save the administrative cost of auditing facilities, it has the serious disadvantage of promoting discrimination against publicly financed patients if a facility feels that its rate does not reflect true cost.

3. Reimbursement as a Quality Assurance Device

Several mechanisms have been proposed or are being used to employ the leverage of Medicaid reimbursement as a means of regulating quality of care for publicly supported residents.¹¹⁹ Some, such as the system used in Illinois, are based on process measures, but most are based on the structural standards of the federal Conditions of Participation. A necessary prerequisite to any such quality enforcement system is, of course, established standards that can form the basis for reimbursement.

The state of Michigan, which had paid nursing homes on a flat rate and then on the basis of costs up to a ceiling, adopted a penalty system related to reimbursement after two studies showed that the state's nursing homes averaged a forty percent return on net invested equity,¹²⁰ four times the Medicare allowable rate and over three times the "normal" rate accepted in the investment community. The Michigan system now pays costs plus a \$1.25 per patient per day profit factor up to a ceiling. If a facility fails to comply with any of the eighteen Medicaid-Medicare Conditions of Participation, the facility's profit factor is reduced according to a point system with the maximum reduction being one dollar per patient per day. The system has several flaws. Because the penalty comes from profit rather than variable costs, pre-

118. These are the demonstration projects authorized under the Social Security Amendments of 1972, Pub. L. No. 92-603, § 222(a), 86 Stat. 1390 (1972).

119. See note 141 *infra*.

120. See generally Coleman & Schneider, *supra* note 103.

sumably patient care does not suffer. But because the penalty comes from profit that is only available under the system to facilities whose costs fall below the ceiling, a facility can avoid being penalized by becoming inefficient, that is, raising costs above the ceiling.¹²¹ Whether the penalty really comes from profit depends upon the accuracy and detail of the audits that safeguard against owners and operators withdrawing funds from patient care sources. Another problem with the system is its dependence upon the federal Conditions of Participation as indicators of quality of care. As discussed above, most of the Conditions merely examine the capability of the facility to provide care rather than the care actually provided. Tying penalties to the Conditions, rather than to their component standards or elements, also raises the problem that there may be serious violations of some standards that do not, in the surveyors' judgment, amount to violations of the entire Condition, and hence will not trigger application of the penalty. In addition, enforcement personnel may be reluctant to find noncompliance with Conditions knowing that financial penalties will attach.¹²² Another potential problem with this approach is that if providers assert the right to contest the surveyors' judgments regarding compliance with standards, the entire reimbursement system can become mired in lengthy administrative and judicial proceedings.

The state of Illinois adopted a different approach, paying three types of costs: capital costs up to a maximum, nursing costs at a flat rate, and support (administrative, dietary and maintenance) costs at the level of the fiftieth percentile of all homes in various geographic regions. Homes falling below the fiftieth percentile of support costs could keep half of the difference as an incentive profit; those above the fiftieth percentile received none.¹²³ In addition, the state would pay nursing homes according to a "point count system." Patients were assessed, and, based on their conditions, the state determined the types of nursing care or rehabilitative services that should be provided. Homes were then paid according to the "point" assigned to each of these services and the state would survey to determine whether the services were actually rendered. While this system does encourage facilities to accept and treat higher risk patients with greater needs, it creates the perverse incentive for facilities to maintain patients at their sickest in order to

121. *See id.*

122. This behavior has been noted in other penalty systems. *See* notes 223-24 and accompanying text *infra*.

123. ILL. DEP'T OF PUBLIC AID RULES §§ 4.142, .144(d) (1977).

maximize profits, and creates no incentive for facilities to rehabilitate or assist patients in achieving their maximum potential for independence or self-care. It also raises the question of what services in a nursing home should be routinely available to everyone in the facility and what services are really "extra."¹²⁴

The Massachusetts Rate Commission proposed another quality-related nursing home reimbursement scheme that would pay a thirty cent per patient per day bonus for facilities achieving a high quality score. To receive the bonus a facility must have a composite score of ninety-five or more on the 541 items found on the federal SNF survey form, be above average on the nursing, medical and social services components of the state's Medical Review program, have no pending enforcement actions against it, be within the range of normal nursing and variable cost screens, and be above average in Medicaid patient census levels.¹²⁵ While such a system would overcome the incentive for facilities to keep patients disabled and debilitated, as in the Illinois scheme, it still relies on the federal Conditions of Participation as its quality indicators and on the validity and reliability of the actual weighting of the 541 quality indicators.¹²⁶

New York has also developed a reimbursement system tied to quality of care. Facilities are grouped according to bed size, geographic location and whether they are SNFs or ICFs. Facilities are rated according to their scores on state licensing standards for nursing service, dietary service, housekeeping service, social work, and activities, and according to their scores on the medical review of resident conditions by state officials.¹²⁷ Based on these scores, the state ranks facilities as "very good," "satisfactory" or "needs improvement."¹²⁸ Costs of each of the five services noted above plus administrative costs are averaged for each of the three categories. The state computes a ceiling for the "satisfactory" category at the group's weighted average, and computes ceilings for "very good" and "needs improvement" at

124. The State of Utah proposed a similar system to provide incentive reimbursement according to nursing home patients' needs. The system was apparently approved by HEW but never implemented. See Utah Long-Term Care Payments System (Feb. 1976) (available from Bruce Walter, Utah State Division of Health, Medical Care & Facilities Branch, Salt Lake City, Utah 84110).

125. 114.2 CODE OF MASS. REGULATIONS § 2.16 (1977).

126. The weights were assigned by subjective judgments of a group of surveyors. The state's own estimates were that over one-fourth of facilities qualifying for the incentive would not actually deserve it. See CONSUMER HEALTH ADVOCACY PROGRAM OF MASSACHUSETTS, MEMORANDUM FOR THE RATE SETTING COMMISSION 4-8 (1978).

127. See N.Y. DEP'T. OF HEALTH, HOSPITAL MEMORANDUM NO. 76-57 (1976).

128. *Id.*

110 percent and 90 percent of the "satisfactory" cost ceiling or at the group's average, whichever is higher.¹²⁹ In addition to paying for capital costs, depreciation, interest expense and return on net invested equity,¹³⁰ the state reimburses each facility at the rate of the lower of its actual costs for the six items mentioned above or the ceilings on costs attributable to the facility's rating category.

Since the ceiling on reimbursement for any facility is the lower of its actual cost or the group's actual cost, it is questionable whether this system provides a meaningful incentive to achieve a "very good" score. An advantage to the system, however, is that the New York quality indicators are more precise and certainly more patient-focused than the federal Conditions of Participation.¹³¹ It has been observed, however, that the rating system is so strict that, of 550 nursing homes in the state, only 4 or 5 qualify as "very good," and the value of the "incentive" system is greatly diminished.¹³²

A reimbursement approach could create more appropriate incentives for facilities to improve patient care, rather than to maintain patient dependence, if it were based upon the outcome of care rather than the care process.¹³³ No states have yet developed such a system, although research directed to this end is under way.¹³⁴ Nor has HEW met its primary responsibility for quality enforcement by developing such a reimbursement scheme. An obstacle to the implementation of an outcome reimbursement system is the lack of clearly defined and statistically valid outcome measures for long-term care that would allow judgment of facility performance¹³⁵ and reimbursement through a bonus for patients achieving expected outcomes or a penalty for patients failing to achieve them. The scheme would depend upon a system of patient assessment performed regularly by facilities and audited

129. 10 N.Y. CODE OF RULES AND REGULATIONS § 86-2.11 (1978).

130. *Id.* § 86-2.19-28.

131. New York regulations also permit facilities to seek exemption from these rates for aberrations in services, patient mix, and lengths of stay by state departmental "management assessment reviews." *Id.* § 86-2.14(a)(17). The rules also permit the state to penalize facilities for poor quality of care. *Id.* § 86-2.14(f).

132. Interview with Phil Gassel, Legal Services for the Elderly Poor, 1095 Broadway, New York, N.Y. (Dec. 17, 1978).

133. For a proposal to develop such a system, see Ruchlin, Levey & Muller, *The Long-Term Care Marketplace: An Analysis of Deficiencies and Potential Reform by Means of Incentive Reimbursement*, 13 MED. CARE 979 (1975).

134. See, e.g., CENTER FOR HEALTH SERVICES RESEARCH, UNIV. OF COLORADO MED. CENTER, *LONG-TERM CARE REIMBURSEMENT AND REGULATION: A STUDY OF COST, CASE MIX AND QUALITY* (1978) (continuing study funded by the Health Care Financing Administration, HEW, in December 1978 for a three-year period).

135. See note 80 and accompanying text *supra*.

by the state agency. As noted above,¹³⁶ the technology for this assessment exists and could be rapidly put into place.¹³⁷ Patients would be grouped according to their conditions or status, and their progress, maintenance or regress would be measured according to key health status indicators. The average progress, maintenance or regress of each group at each assessment would be summed to create a facility health status profile that could be compared to an absolute standard (when one could be developed) or to the relative performance of other facilities.

Such an assessment and reimbursement system could reveal the ability of a facility to provide the types of services that its residents need to improve or maintain their health. It requires a sophisticated model to be developed, including the choice of key health status indicators, the weight to be accorded each one, the size and nature of patient groupings, and the choice of an equitable bonus or penalty mechanism. Because the system could be abused through fraud, the state agency would have to establish a thorough and sensitive monitoring system to assure accurate information about patient status. The system would create an incentive for selection of only easily remediable patients unless it prohibits that discrimination and/or includes as an acceptable outcome an individual's *maintenance* of status in addition to *improvement* in status. Furthermore, it must accommodate patients who will not achieve expected outcomes despite the best and most dedicated efforts of facility staff; this safeguard could occur through the averaging process or a more complicated system that would examine inputs of care for those persons not achieving expected outcomes and not penalize the facility if it had provided appropriate care.¹³⁸

While it would be more complex than the current regulatory program, an outcome reimbursement system could eliminate many of the present structural standards that are irrelevant to patient care.¹³⁹ In addition, the system appears to create the most appropriate incentives for a facility to provide high quality care—at least care designed to improve or maintain resident status. In view of the complexities of developing and implementing such a system, it is not an immediately attainable goal; it is, however, one toward which HEW and state

136. See notes 84-87 and accompanying text *supra*.

137. See Memorandum to Massachusetts Rate Setting Commission from Paul Denson and Ellen Jones, Harvard Center for Community Health and Medical Care (December 12, 1978).

138. See note 81 and accompanying text *supra*.

139. See notes 80-83 and accompanying text *supra*.

Medicaid agencies should strive (by, for instance, implementing mandatory resident assessment by all facilities) while developing other reimbursement systems to use the competitive behavior of proprietary facilities to provide incentives for high quality of care.¹⁴⁰

D. Improving Enforcement Mechanisms

1. Practical Enforcement Problems

Were patient-focused standards properly designed and outcome reimbursement in place today, regulators might not need additional enforcement remedies to ensure provision of high quality care to publicly supported residents of nursing homes.¹⁴¹ Until those programs are developed, however, state agencies will need a broad array of enforcement remedies, tailored to the seriousness of violations, with which to enforce quality standards. Prior to the recent enactment of legislation to permit enforcement mechanisms in some states, the only remedies for violations of state licensing or Medicaid certification standards were license revocation, refusal to renew the annual Medicaid contract,¹⁴² or decertification during the contract term. Such exclusive remedies are difficult to enforce because facilities demand lengthy administrative hearings and because closing a facility and moving its residents can often have serious consequences.

Licenses are viewed legally as property that cannot be revoked without due process—usually timely and adequate notice and a full hearing on the charges before revocation.¹⁴³ Courts also view ongoing Medicaid participation during the annual contract term as a property right subject to the same procedural protections.¹⁴⁴ It might appear that a state's refusal to renew a Medicaid contract (as opposed to termination of the contract during the period) involves no property right, since the facility has no right to expect a renewal of its Medicaid participation agreement. Some courts have analyzed the contract situation in

140. See, e.g., Shulman & Galanter, *supra* note 96.

141. Privately supported residents (about 38% of all nursing home residents) would be aided directly by resident-oriented state licensing standards and indirectly by Medicaid quality-oriented reimbursement policies, which should improve overall facility care. Arguably, even with improved reimbursement policies, some of the state enforcement remedies discussed in notes 142-289 and accompanying text *infra* would be necessary to protect non-publicly supported nursing home residents.

142. Under certain circumstances, agencies can execute short-term contracts with Medicaid and Medicare nursing homes, but this authority is limited. See notes 39-40 *supra*.

143. See COLO. REV. STAT. § 24-4-104 (Cum. Supp. 1978)

144. See, e.g., Shady Acres Nursing Home, Inc. v. Canary, 39 Ohio App. 2d 47, 316 N.E.2d 481 (1973).

this manner, holding that no pretermination hearing is constitutionally required.¹⁴⁵ The Second and Seventh Circuits, however, have tended to find a property right in the "expectancy interest" of a facility that its contract would be renewed and have required notice and hearing *before* a state may refuse to renew a Medicaid participation agreement.¹⁴⁶ Pending that hearing, these courts have ordered state agencies to continue to pay the facilities for their Medicaid residents regardless of the availability of federal funds for those patients.¹⁴⁷

The Second Circuit, in *Case v. Weinberger*,¹⁴⁸ followed the Supreme Court's direction in *Weinberger v. Salfi*¹⁴⁹ in determining the type of hearing that must be provided to the facility to satisfy due process. The court of appeals balanced the government's interest in the health and safety of the nursing home patients against the facility's need for some type of adequate review mechanism in regard to reimbursement and determined that the informal discussions between the facility owner and the government authorities, combined with the opportunity of a full-scale post-contract evidentiary hearing, provided due process protection against arbitrary government action.¹⁵⁰ The court also acknowledged the legitimacy of a state agency's summary revocation or refusal to renew a contract in emergencies that seriously threaten patient safety, and noted that a later hearing would satisfy due process under those circumstances.¹⁵¹ Thus, both the court's holding and its dictum render a desirable result.

Facilities sometimes invoke the rights of their patients not to be moved without a hearing,¹⁵² a legitimate concern if the state Medicaid

145. *See, e.g.*, *Paramount Convalescent Center, Inc. v. Department of Health Care Services*, 15 Cal. 3d 489, 542 P.2d 1, 125 Cal. Rptr. 265 (1975); *Convalescent Care Center, Inc. v. Bates*, 44 U.S.L.W. 3539 (Franklin County Ct. App., May 15, 1975), *cert. denied*, 425 U.S. 952 (1976); *Shady Acres Nursing Home, Inc. v. Canary*, 39 Ohio App. 2d 47, 316 N.E.2d 481 (1973).

146. In *Case v. Weinberger*, 523 F.2d 602 (2d Cir. 1975), and *Hathaway v. Matthews*, 546 F.2d 227 (7th Cir. 1976), the courts found a property right in the expectancy interest of renewal of the Medicaid provider agreement. Despite the language of these holdings, however, it is unclear from the facts of those cases whether they did indeed involve a refusal to renew or a decision to terminate a Medicaid contract during its term. In *Case* the Court of Appeals for the Second Circuit said that HEW determined that the facility would "no longer be certified" as a Medicaid provider. 523 F.2d at 605. In *Hathaway*, the Court of Appeals for the Seventh Circuit indicated that the home received a one-year Medicaid contract in December 1975 and was notified in March 1976 that payment would be terminated for violations of state licensing standards. 546 F.2d at 228.

147. *See, e.g.*, *Hathaway v. Matthews*, 546 F.2d 227, 232 (1976).

148. 523 F.2d 602 (2d Cir. 1975).

149. 422 U.S. 749 (1975).

150. 523 F.2d at 607-11. *See also* *Schwartzberg v. Califano*, 453 F. Supp. 1042 (S.D.N.Y. 1978).

151. 523 F.2d at 606.

152. *See, e.g.*, *Schwartzberg v. Califano*, 453 F. Supp. 1042, 1046 (S.D.N.Y. 1978).

agency is threatening to terminate a Medicaid beneficiary's eligibility for services on the ground that the services are not medically necessary.¹⁵³ But when the facility is subject to closure for failure to meet licensing or certification standards, one must be suspicious of a facility's motives when it invokes the threat to patient safety from transfers out of the closed facility. While the danger of transfer trauma is quite real,¹⁵⁴ and a period of time for "transfer planning" must be afforded to residents in all but emergency cases, one must carefully weigh the relative harm from transfer against that of remaining in an unsafe institution, recognizing that many violations of standards do not actually jeopardize patient safety. These lines are difficult to draw, but some courts have grappled with them.¹⁵⁵ Even the actual presence of beneficiaries as intervenors in cases in which facilities challenge government revocation of licensure or certification¹⁵⁶ does not assure that nursing home residents' interests are completely protected, because neither the residents themselves nor their representatives can fully appreciate what is in their best interest when faced with the untenable choice between moving or remaining in a substandard facility that threatens their lives.¹⁵⁷

States face a peculiar dilemma in all certification cases. Federal law prohibits the continuation of federal funds under Medicaid for more than thirty days after a decision to revoke a certification.¹⁵⁸ Thus, the state itself may be required to pay for care in a facility for an indefinite period of time pending legal proceedings, even if the facility poses a serious threat to patient life or safety.¹⁵⁹ This substantial state expense in time and money, coupled with the severe dilemma posed by

153. All suits by Medicaid beneficiaries challenging the termination of medical eligibility without prior hearings when termination resulted in transfers out of nursing facilities have been successful. See, e.g., *Feld v. Berger*, 424 F. Supp. 1356 (S.D.N.Y. 1976).

154. See notes 164-66 and accompanying text *infra*.

155. See, e.g., *Schwartzberg v. Califano*, 453 F. Supp. 1042 (S.D.N.Y. 1978).

156. See, e.g., *Caton Ridge Nursing Home, Inc. v. Califano*, 447 F. Supp. 1222 (D. Md. 1978); *Klein v. Mathews*, 430 F. Supp. 1005 (D.N.J. 1977), *aff'd sub nom. Klein v. Califano*, 586 F.2d 250 (3d Cir. 1978); *Kane v. Perry*, 82 Misc.2d 1019, 371 N.Y.S. 2d 605 (Sup. Ct. 1975), *rev'd*, 55 App. Div. 2d 678, 390 N.Y.S. 2d 191 (1976).

157. See note 164 *infra*.

158. 43 Fed. Reg. 45,234 (1978) (to be codified in 42 C.F.R. § 442.15(c)). Such a deprivation seems unconstitutional, but the Supreme Court has held that states have no due process rights because they are not "persons" within the meaning of the fifth amendment. *South Carolina v. Katzenbach*, 383 U.S. 301 (1966). States may contest HEW's refusal to reimburse costs of nursing home services in a decertified home, under 42 U.S.C. § 1316 (1976). See *Klein v. Mathews*, 430 F. Supp. 1005, 1006 n.2, 1008 n.8 (D.N.J. 1977). Furthermore, facilities such as Town Court Nursing Home masquerade as resident representatives. *Town Court Nursing Center, Inc. v. Beal*, 586 F.2d 280 (3d Cir.), *cert. granted*, 47 U.S.L.W. 3683 (1979).

159. See OHIO REP., *supra* note 6, at 26-27.

the inhumane position of leaving patients in a facility that actually threatens their lives or health and the potential danger of moving them, immobilizes agencies and deters invocation of decertification or license revocation except in extreme circumstances.

In a license or certification revocation situation a pretermination hearing is clearly required by the Constitution and most state laws, unless there is an immediate threat to patient health and safety, in which case summary revocation is usually permissible.¹⁶⁰ These license revocation proceedings, however, are costly and time consuming.¹⁶¹ Furthermore, license revocation and Medicaid decertification is a drastic step that, if successful, eventually results in the closing of the facility and the moving of its residents. Other than acting as a possible deterrent to other facilities violating the law, it is not a means of improving the quality of life or health in institutions. Moving residents causes at least three serious problems. First, in communities without alternative beds, residents may be moved far from families and friends.¹⁶² Since visits by relatives and friends not only are desired by nursing home residents, but are arguably a quality enforcement tool,¹⁶³ they should be encouraged rather than discouraged. Second, closing a facility may also pose a problem in urban areas where there is an insufficient number of nursing home beds to accept residents moving from a closed home. Finally, resident relocation may cause the phenomenon known as "transfer shock" or "transfer trauma."¹⁶⁴ Many nursing home resi-

160. See, e.g., COLO. REV. STAT. § 24-4-104 (Cum. Supp. 1978). But see *Ross v. Wisconsin Dep't of Health & Social Services*, 369 F. Supp. 570 (E.D. Wis. 1973) (invalidating a state statute permitting emergency moving of patients from facilities that violated state health and safety standards).

161. For example, the attempt to revoke the license and Medicaid certification of a nursing home in Colorado involved an administrative hearing of 20 days, 4000 pages of testimony and exhibits, over \$10,000 in legal expenses, and more than a year's delay in final agency action. See *In re Geriatrics, Inc.*, Colorado Dep't of Health Action No. H-77-01 (1977). Since the facility is currently seeking judicial review of the state's order, the process will be more costly and further delayed before the matter is finally settled.

162. This is especially a problem in rural areas such as the southern Colorado region served by Geriatrics, Inc., see note 161 *supra*, which was the only nursing home over sixty miles of mountainous terrain.

163. See note 356 and accompanying text *infra*.

164. Aldrich & Mendkoff, *Relocation of the Aged and Disabled: A Mortality Study*, 11 J. AM. GERIATRICS SOC'Y 185 (1963); Blenker, *Environmental Change and the Aging Individual*, 7 GERONTOLOGIST 101 (1967); Kasl, *Physical and Mental Health Effects of Involuntary Relocation and Institutionalization of the Elderly: A Review*, 62 AM. J. PUB. HEALTH 377 (1972); Kastler, Gray & Carruth, *Involuntary Relocation of the Elderly*, 8 GERONTOLOGIST 276 (1968); Killian, *Effect of Geriatric Transfers on Mortality Rates*, 15 SOCIAL WORK 19 (1970); Kral, Grad & Berenson, *Stress Reactions Resulting from the Relocation of an Aging Population*, 13 CAN. PSYCH. A.J. 201 (1968); Smith & Brand, *Effects of Enforced Relocation on Life Adjustment in a Nursing Home*, 6 INT'L J. AGING & HUMAN DEV. 249 (1975).

dents, especially those who are incompetent or disoriented, develop a physical, psychological and emotional dependence upon their surroundings. This usually happens within six months of admission to a nursing home when the expected stay is indefinite, and the reliance is so complete that any move, whether to another room in the facility or to a second facility, can cause serious emotional and psychological damage, physical stress, and a dramatic increase in the rate of mortality. The serious potential for transfer trauma has given rise to constitutional challenges to individual or group transfers from nursing homes.¹⁶⁵ The potential for irreparable injury under these circumstances usually compels courts to grant temporary injunctive relief.¹⁶⁶ The threat of transfer trauma in moving an individual or an entire population from a nursing home has spurred the development of "transfer planning" regulations and programs designed to protect persons from the dangers of relocation, including advance notice, counseling and patient preparation.¹⁶⁷ Courts have recognized that when the facility itself poses an immediate threat to patient life or safety, when the provider itself decides to terminate Medicaid participation, and when there is no expectation of continued residence in the home (because, for instance, the provider agreement is time limited), the balance between the state's interest in closing the facility expeditiously and the potential of transfer trauma to the residents tips in favor of the state.¹⁶⁸

In view of the problems of time, expense, lack of available beds, transfer trauma and political pressure, it is not surprising that few states have ever revoked a nursing home license or Medicaid certification.¹⁶⁹ Enforcement of licensing standards would be greatly enhanced by the availability of a variety of civil and criminal remedies less severe than closure. Several states have recently enacted such remedies as receiverships, fines, citations, injunctive relief, private citizen actions and the authority to refuse to permit capital construction or facility transfers under Certificate of Need programs. Although most of these remedies have only recently been adopted, and experience under them is limited,

165. See note 153 *supra*.

166. See *Klein v. Mathews*, 430 F. Supp. 1005, 1008-12 (D.N.J. 1977), *aff'd sub. nom.* *Klein v. Califano*, 586 F.2d 250 (3d Cir. 1978); *Hathaway v. Mathews*, 546 F.2d 227, 231-32 (7th Cir. 1976).

167. NAAG REP., *supra* note 64, at 59-61.

168. *Id.* at 64-65 (citing *Paramount Convalescent Center, Inc. v. Department of Health Care Services*, 15 Cal. 3d 489, 542 P.2d 1, 125 Cal. Rptr. 265 (1975)).

169. See *F. Moss & V. HALAMANDARIS*, *supra* note 2, at 152-61. *But see* *Town Court Nursing Center, Inc. v. Beal*, 586 F.2d 280 (3d Cir.), *cert. granted*, 47 U.S. L.W. 3683 (1979) (recognizing an expectancy interest of continued residency that entitled residents to participate in the facility's decertification hearing).

they do offer the potential for a more appropriate and rational array of enforcement powers for state agencies and the public, and are more creative than the unwieldy federal remedy of decertification.

2. State Licensing Remedies¹⁷⁰

a. Receivership

Receivership is a traditional equitable remedy in which the court appoints a third party to manage a party's assets in order to preserve the property at issue in the case for ultimate disposition.¹⁷¹ As noted by the first commentator to suggest this remedy as an alternative to health facility license revocation, "[it] would provide for a temporary takeover of the institution, not for the sake of preserving its financial or economic status, but rather for the sake of putting it into the kind of condition that would best serve the interests of the patients."¹⁷²

The use of receiverships has been expanded by courts¹⁷³ and by state law¹⁷⁴ beyond the protection of physical property to the protection of the civil rights of third parties.¹⁷⁵ At least six states—Connecticut, Kansas, Minnesota, New Jersey, New York and Wisconsin—have enacted legislation authorizing the appointment of receivers to manage nursing homes that fail to comply with licensing standards or otherwise jeopardize resident health and safety.¹⁷⁶ In addition to these involuntary receiverships, facility owners can seek a voluntary receivership of a failing business.¹⁷⁷ In some other states, courts have imposed receiverships upon nursing homes under common law or general statutory powers of equity.¹⁷⁸

170. For an overview of current state licensing remedies, see NAT'L SENIOR CITIZENS' LAW CENTER, *NURSING HOME LAW LETTER*. This monthly publication reports news of general interest to advocates for nursing home residents and updates statutory and litigation developments.

171. See Grad, *Upgrading Health Facilities: Medical Receiverships as an Alternative to License Revocation*, 42 U. COLO. L. REV. 419, 431-32 (1971).

172. *Id.* at 432.

173. See, e.g., *Turner v. Goolsby*, 255 F. Supp. 724 (S.D. Ga. 1965) (county school system placed in receivership when injunction of illegal expenditure of funds to protect rights of black students would result in irreparable injury to white students).

174. See, e.g., N.Y. MULT. DWELL LAW § 309(4),(5) (McKinney 1974).

175. Note, *Receivership as a Remedy in Civil Rights Cases*, 24 RUTGERS L. REV. 115 (1969).

176. See CONN. GEN. STAT. ANN. §§ 19-621a (West Cum. Supp. 1979); KAN. STAT. §§ 39-926, -931, -935, -936 (Cum. Supp. 1978); MINN. STAT. ANN. § 144A.15 (West Cum. Supp. 1978); N.J. STAT. ANN. § 26:2H-42 (West Cum. Supp. 1977); N.Y. PUB. HEALTH LAW § 2862(4) (McKinney 1977); WIS. STAT. ANN. § 50.05 (West Cum. Supp. 1978).

177. See, e.g., N.Y. PUB. HEALTH LAW § 2801(1) (McKinney 1977).

178. See, e.g., *State v. Forest Manor Nursing Home*, No. 77-8555-H (Dallas Dist. Court, 160th Judicial Dist., Aug. 1977).

All these state nursing home receivership statutes permit courts to appoint receivers upon application of various state agencies, usually the state health departments. None authorizes an administrative agency itself to appoint a receiver. Although this authority seems appropriate, at least in emergencies,¹⁷⁹ it would be politically difficult to enact since it would be open to charges of conflict of interest and abuse. Expedited judicial proceedings¹⁸⁰ and the power to order emergency receivers *ex parte*,¹⁸¹ however, appear to provide necessary flexibility in the remedy, while still protecting owners' rights.¹⁸² As is true with many applications for equitable judicial remedies, receivership petitions are given priority on state court calendars and may be heard as soon as five days after they are filed.¹⁸³ While most state laws require a hearing before imposition of a receivership, Connecticut and Wisconsin permit courts to issue receivership orders *ex parte* when an emergency exists that must be remedied immediately to ensure the health, safety and welfare of residents.¹⁸⁴ Several statutes authorize the court to appoint as the receiver either the state health director or his designee¹⁸⁵ or another qualified person.¹⁸⁶

The conditions under which courts may appoint nursing home receivers vary according to the philosophy underlying the remedy. Under New York law, for instance, the court may only appoint a receiver after the state has revoked a facility's license and the licensee has completed administrative and judicial appeals. The receivership, which is limited to eighteen months, is imposed to provide an opportunity for the owner to sell the facility or for the orderly and protected transition of residents to another facility.¹⁸⁷ In other states, however, the receivership is seen as a means of improving management of the facility to protect residents during the actual license revocation proceedings, and thus may be invoked at the commencement of a license

179. See Grad, *supra* note 170, at 433.

180. See, e.g., WIS. STAT. ANN. § 50.05(4) (West Cum. Supp. 1978) (authorizing a court hearing within five days).

181. See, e.g., *id.* § 50.05(5).

182. The New Jersey law significantly extends the receivership remedy by permitting a resident or his guardian to seek it. N.J. STAT. ANN. § 26:2H-38 (West Cum. Supp. 1977).

183. See note 180 *supra*.

184. CONN. GEN. STAT. ANN. § 19-621b(b) (West Cum. Supp. 1979); WIS. STAT. ANN. § 50.05(5) (West Cum. Supp. 1978).

185. See, e.g., MINN. STAT. ANN. § 144A.15(1) (West Cum. Supp. 1978); N.Y. PUB. HEALTH LAW § 2810(2)(A) (McKinney 1977).

186. See, e.g., N.J. STAT. ANN. § 26:2H-42(a) (West Cum. Supp. 1977).

187. N.Y. PUB. HEALTH LAW § 2810(2)(a) (McKinney 1977).

revocation.¹⁸⁸ Some state statutes go still further, permitting the state to apply for appointment of a receiver even without initiating a license revocation action.¹⁸⁹ The preamble to the New Jersey statute, for example, states the purpose of the law to be the elimination of deficiencies. Thus, the state or a resident may seek a receivership upon filing a complaint alleging that the facility is in substantial violation of the health, safety or resident care standards of federal or state law or "any other conditions dangerous to life, health or safety," or that the facility habitually violates those standards.¹⁹⁰ Connecticut law permits application for a receivership for the same reasons,¹⁹¹ but unlike the other statutes, permits a facility owner to defeat an application for receivership if he establishes that he had no actual or constructive knowledge of the violations, that he had insufficient time to correct them, or that they did not exist.¹⁹²

Receivers under all six state laws are generally authorized to operate and manage the facility as a sound business, preserve the owners' assets, and provide for the health, safety and welfare of residents by, among other means, correcting or eliminating the deficiencies that gave rise to the receiver's appointment.¹⁹³ Some laws prohibit major alterations of the physical plant¹⁹⁴ or major expenses without court consent.¹⁹⁵ A particularly creative provision, in light of the recognized manner in which nursing home owners make profits, permits the receiver to refuse to honor preexisting leases, mortgages and contracts that were executed with owners, operators or other controlling persons, or whose rental, price or interest rate "substantially" exceeds a reason-

188. See, e.g., MINN. STAT. ANN. § 144A.15(1) (West Cum. Supp. 1978); WIS. STAT. ANN. § 50.05(2) (West Cum. Supp. 1978).

189. See, e.g., CONN. GEN. STAT. ANN. §§ 19-621a through -621i (West Cum. Supp. 1979); KAN. STAT. §§ 39-954 through -963 (Cum. Supp. 1978); N.J. STAT. ANN. § 26:2H-38, -39 (West Cum. Supp. 1977).

190. N.J. STAT. ANN. § 26:2H-36, -38 (West Cum. Supp. 1977). In Kansas, the state may seek receivership whenever conditions exist that threaten resident health or safety. KAN. STAT. §§ 39-954 through -963 (Cum. Supp. 1978).

191. CONN. GEN. STAT. ANN. § 19-621b, -621c (West Cum. Supp. 1979).

192. *Id.* § 19-621d.

193. *Id.* § 19-621e; KAN. STAT. § 39-959 (Cum. Supp. 1978); MINN. STAT. ANN. § 144A.15(3) (West Cum. Supp. 1978); N.J. STAT. ANN. § 26:2H-42(c) (West Cum. Supp. 1977); N.Y. PUB. HEALTH LAW § 2810(2)(c) (McKinney 1977) (expressly prohibiting receiver from making "major alterations of the physical structure of the facility"); WIS. STAT. ANN. § 50.05(7) (West Cum. Supp. 1978).

194. See, e.g., MINN. STAT. ANN. § 144A.15(3) (West Cum. Supp. 1978); N.Y. PUB. HEALTH LAW § 2810(2)(c) (McKinney 1977).

195. See, e.g., CONN. GEN. STAT. ANN. § 19-621f (West Cum. Supp. 1979); WIS. STAT. ANN. § 50.05(7)(e) (West Cum. Supp. 1978).

able rate.¹⁹⁶ In Connecticut and Wisconsin receivers have special fiduciary duties to residents during transfer. They must aid in location or alternative placement, allowing the resident and guardian to participate in placement selection; assist in discharge planning; and provide orientation to minimize transfer trauma and transport the resident, his records and belongings to the new location.¹⁹⁷

Receiverships terminate when the state issues a new license, the residents are moved, the facility is sold,¹⁹⁸ or the circumstances that occasioned appointment of the receiver are corrected.¹⁹⁹ Notwithstanding these conditions, four states establish limits upon the duration of receivership: ninety days in Wisconsin,²⁰⁰ eighteen months in New York²⁰¹ and Minnesota,²⁰² and twenty-four months in Kansas.²⁰³ While the existence of time limits may assuage due process concerns, they may arbitrarily limit the ability of a receiver to correct problems and to find suitable owners or managers to assume control of the facility.

Recognizing that a major impediment to correcting physical plant or resident care deficiencies may be inadequate financial management, reimbursement or reserves, two statutes authorize state funds for which the receiver may apply.²⁰⁴ Without these appropriations it may be difficult to attract qualified receivers and to permit them adequately to manage facilities, even for a limited time. Arguably, provisions of state laws or constitutions requiring states to provide for the indigent sick²⁰⁵ or the general welfare²⁰⁶ obligate states to fund the additional costs that a receiver legitimately must spend to discharge his duties.

Although owners have frequently alleged that receivership violates due process of law, apparently no one has directly challenged the constitutionality of the nursing home receivership statutes or the exercise of judicial receivership authority to order a receiver for a nursing home

196. CONN. GEN. STAT. ANN. § 19-621e (West Cum. Supp. 1979); WIS. STAT. ANN. § 50.05(9) (West Cum. Supp. 1978).

197. CONN. GEN. STAT. ANN. § 19-621e (West Cum. Supp. 1979); WIS. STAT. ANN. § 50.05(7)(i) (West Cum. Supp. 1978).

198. *See, e.g.*, KAN. STAT. § 39-963 (Cum. Supp. 1978); N.Y. PUB. HEALTH LAW § 2810(2)(e) (McKinney 1977); WIS. STAT. ANN. § 50.05(14) (West Cum. Supp. 1978).

199. *See, e.g.*, N.J. STAT. ANN. § 26:2H-45 (West Cum. Supp. 1977).

200. WIS. STAT. ANN. § 50.05(4) (West Cum. Supp. 1978).

201. N.Y. PUB. HEALTH LAW § 2810(2)(e)(i)(a) (McKinney 1977).

202. MINN. STAT. ANN. § 144A.15(5) (West Cum. Supp. 1978).

203. KAN. STAT. § 39-960 (Cum. Supp. 1978).

204. *Id.*; WIS. STAT. ANN. § 50.05(10) (West Cum. Supp. 1978).

205. CAL. HEALTH & SAFETY CODE § 1750 (West Cum. Supp. 1979).

206. *See, e.g.*, N.Y. CONST. art. 7, § 8; art. 17, § 1.

that has violated health and safety standards. Even if challenged, the exercise of this remedy would seem to fall within the police powers of the state if used to protect the general health, safety and welfare of its citizens. Receiverships have been upheld as a proper exercise of state police power in cases under the New York housing law providing for appointment of receivers to manage housing complexes that endanger health and safety,²⁰⁷ and nursing home receiverships could be constitutionally justified on similar grounds—demonstrably poor conditions that actually threaten resident health, safety or well-being. They may also be upheld as a legitimate condition of licensure that states may impose for violations of the terms of the license. Like license revocation, however, receivership is permissible only if the procedural due process requirements of timely notice and hearing have been met.

All the statutes discussed above provide generally for a court hearing before appointment of the receiver, which clearly satisfies the due process test. The Wisconsin and Connecticut statutes permitting *ex parte* appointments in emergencies involve circumstances in which the state interest in the health and welfare of the nursing home residents is elevated over the interest of the facility owner in maintaining full management and control of the institution,²⁰⁸ and therefore should survive constitutional scrutiny. The receiverships that are time-limited are merely temporary deprivations of property that arguably require less extensive due process protections.

b. Civil Fines and Citations

Receivership may be an appropriate remedy for serious violations that jeopardize the health and safety of all facility residents and that can best be corrected by new management; less severe penalties than either license revocation or receivership, however, can be administratively simpler and can often force facilities to correct violations that are not necessarily life threatening, such as those of individual care and certain sanitation standards. Several states have developed systems of "citations," whereby facilities are cited for violations that are classified according to severity. The notices of citations typically are publicly displayed and may be accompanied by fines for continued violation. The number of citations issued to each facility can be the basis for reimbursement, for ranking facilities according to the quality of care they

207. See, e.g., *In re Dep't of Bldgs.*, 16 N.Y.2d 915, 212 N.E.2d 154, 264 N.Y.S.2d 701 (1965); *In re Dep't of Bldgs.*, 14 N.Y.2d 291, 200 N.E.2d 432, 251 N.Y.S.2d 441 (1964).

208. See, e.g., *North American Cold Storage Co. v. City of Chicago*, 211 U.S. 306 (1908).

provide, and for refusal to admit new residents. California adopted the first citation system in 1973²⁰⁹ and several other states have patterned legislation after it.²¹⁰

Under the California citation system, the state licensing agency is obligated to classify all nursing home licensing standards according to their seriousness and relationship to resident health and safety.²¹¹ Class A violations are those posing an imminent danger to residents or a substantial probability that serious harm or death will result.²¹² Class B violations are those directly related to health, safety or security.²¹³ State surveyors inspecting facilities must classify each violation they find as either Class A or B and issue a citation within three working days.²¹⁴ Class A violations must be remedied immediately;²¹⁵ Class B violations must be remedied within the time set forth on the citation.²¹⁶

Final citations (after appeals) must be prominently posted in public view until the deficiencies are corrected.²¹⁷ Financial penalties may be imposed for the two types of citations: \$1000-\$5000 for Class A violations and \$50-\$250 for Class B violations.²¹⁸ For every day that a Class A or B violation goes unabated beyond the time allowed for its correction, facilities are subject to penalties of \$50.²¹⁹ The state may collect treble damages against facilities penalized for repeating a violation within twelve months;²²⁰ however, since penalties for Class B violations are only assessed if the violations remain uncorrected after the allotted time, the treble damages sanction is rarely used with respect to those violations.²²¹

209. CAL. HEALTH & SAFETY CODE §§ 1417-1439 (West Supp. 1979).

210. See, e.g., CONN. GEN. STAT. ANN. §§ 19-607 to -613 (West Cum. Supp. 1979); IOWA CODE ANN. §§ 135C.36-135C.48 (West Cum. Supp. 1978). See also KAN. STAT. § 39-923(2) (Cum. Supp. 1978); MINN. STAT. ANN. § 144A.10 (West Cum. Supp. 1978); N.J. STAT. ANN. § 30:11-4(a) (West Cum. Supp. 1977); N.Y. PUB. HEALTH LAW § 2803(3), (6) (McKinney 1977); OHIO REV. CODE ANN. § 3721.17(E) (Page Cum. Supp. 1978). Wisconsin has for many years had a citation system accompanied by monetary "forfeitures." WIS. STAT. ANN. § 50.04 (West Cum. Supp. 1978).

211. CAL. HEALTH & SAFETY CODE § 1426 (West Cum. Supp. 1979).

212. *Id.* § 1424(a).

213. *Id.* § 1424(b).

214. *Id.* § 1423.

215. *Id.* § 1424(a).

216. *Id.* § 1424(b).

217. *Id.* § 1429.

218. *Id.* § 1424.

219. *Id.* § 1425.

220. *Id.* § 1428(e).

221. JOINT LEGISLATIVE AUDIT COMMITTEE, *supra* note 6, at 14. The Wisconsin law avoids this problem by permitting treble damages to be collected if notice of repeat violations has been

In the three years of experience with the California citation system, numerous problems have arisen with its structure and implementation. A Legislative Audit Committee identified some of these issues: state agency delays in filing complaints to enforce citations and penalties, ineffective use of the treble damages provision, and lack of enforcement of Class B violations.²²² The last problem is particularly troubling, as it indicates the means by which facilities can, at least partially, avoid the law. Because facilities do not want Class B citations that have been corrected within the time limits on the citations to appear in public records, they will contest the citations through administrative review. The attorney general's office will typically not prosecute the citations because to do so would waste time and resources since the violation has been corrected. The citations are dismissed, even though they were legitimately issued, and are erased from public record, so that even if the violations are repeated they cannot form the basis for treble damages because no previous penalty has been assessed.²²³

Another difficulty inherent in the citation-penalty system concerns the role of surveyors—are they consultants or police? Surveyors who have difficulty citing facilities for licensing violations are even less comfortable knowing that a citation is likely to lead to a financial penalty. Furthermore, surveyors require careful training in the proper methods of documenting violations in order to support citations through the appeal process. Still another problem is the emphasis of the California law on violations of licensing standards that may not directly relate to resident health and safety. While the California licensing standards are extremely detailed and comprehensive,²²⁴ they maintain the structural orientation and medical model typical of state licensing and federal certification regulations, which generally miss the mark of examining care actually needed by and delivered to nursing home residents.

Litigation on the constitutionality of a penalty system has thus far only occurred in California. In one of the early state prosecutions of a citation and penalty assessment, *Lackner v. Perkins*,²²⁵ a state superior court dismissed the complaint on the grounds that the statute deprived the facility of due process. The court reasoned that because a facility

given rather than only when a penalty has been assessed. WIS. STAT. ANN. § 50.04(5)(a)(5) (West Cum. Supp. 1978).

222. JOINT LEGISLATIVE AUDIT COMMITTEE, *supra* note 6, at 14-25.

223. *Id.*

224. 22 CAL. ADMIN. CODE §§ 72301-72395 (West Cum. Supp. 1979).

225. No. 386673 (Sup. Ct. of San Diego Cty. Oct. 27, 1977), *rev'd*, 91 Cal. App. 3d 433, 154 Cal. Rptr. 138 (1979).

can either pay the minimum amount set forth in the statute or contest the citation,²²⁶ the law improperly penalizes the exercise of the statutory right to contest citations through the appeal process. Seizing that decision, the state association of proprietary nursing homes challenged the constitutionality of the entire citation system on several due process grounds in *California Association of Health Facilities v. Director, Department of Health*.²²⁷ In addition to relying on the *Perkins* holding, plaintiffs asserted that the statute was unconstitutionally vague in its definitions of Class A and B violations because it did not provide standards by which licensees could know what conduct was prohibited. Further, they contested the statute's delegation to licensing agencies of the authority to adopt licensing regulations, classify violations, and fix and assess penalties because it was made without specific legislative standards and because it created a conflict of agency functions.²²⁸ Finally, plaintiffs asserted that the informal conference procedure did not satisfy due process.²²⁹

Because other states have adopted penalty systems that may face similar challenges, it is instructive to examine the issues raised by *Perkins* and *Health Facilities*. Whether the California statute's definition of citations is sufficiently precise is debatable.²³⁰ Arguably, even without adequate standards in a statute, a court will not invalidate it if the law establishes appeal procedures adequate to safeguard the rights of persons subject to administrative action.²³¹ The question of administrative rulemaking authority, however, and the conflict between legisla-

226. CAL. HEALTH & SAFETY CODE § 1428(b) (West Cum. Supp. 1979). The Iowa law does not provide this choice; it permits the cited licensee either to contest the citation or pay the entire fine. IOWA CODE ANN. § 135C.41 (West Cum. Supp. 1978).

227. No. 73J-028 (Sup. Ct. of San Francisco City, filed Nov. 25, 1977) (preliminary injunction denied March 24, 1978), No. 442-43 (1st Dist. June 1, 1978) (writ of prohibition denied).

228. The Department of Health had used the same person to write citations and conduct the informal conferences, but changed this practice before the case was filed. Conversation with Bill Smith, Chief of Health Services Section, Licensing and Certification Division, California Dep't of Health (Dec. 23, 1977). The Iowa statute specifically forbids the person writing the citation from officiating at the informal conference. IOWA CODE ANN. § 135C.42 (West Cum. Supp. 1978).

229. Contrary to the nursing home association's contention that the informal hearing violates due process of law, it would appear that it meets the rudiments of due process as stated in such recent cases as *Case v. Weinberger*, 523 F.2d 602 (2d Cir. 1975), and *Weinberger v. Salfi*, 422 U.S. 749 (1975). Furthermore, since an entire trial de novo is available in the state court to a licensee dissatisfied with the hearing officer's decision, that subsequent full trial satisfies the concerns of due process. 1 K. DAVIS, ADMINISTRATIVE LAW TREATISE § 7.10 (1958).

230. Compare *People v. Barksdale*, 8 Cal. 3d 320, 503 P.2d 257, 105 Cal. Rptr. 1 (1972) and *McMurty v. Board of Medical Examiners*, 180 Cal. App. 2d 760, 4 Cal. Rptr. 910 (1960) with *People v. Hellner*, 43 Cal. 2d 715, 227 P.2d 393 (1954) and *People v. Fowler*, 178 Cal. 657, 174 P. 892 (1918).

231. See K. DAVIS, *supra* note 229, at § 7.10.

tive and enforcement functions seems to be well settled.²³² All licensing agencies establish standards for their licensees and then enforce compliance with those standards through administrative proceedings. It is the violation of a licensing standard that subjects a facility to a citation and penalty. Clearly the agency has the power to revoke a facility's license for violation of its standards, and the state agency is acting no differently when it invokes the more lenient remedy of a penalty short of license revocation. As in the case of the receivership power, the agency seems to be acting under a delegation of the state's police powers, but employing less severe remedies, and a court should uphold the constitutionality of the system.

Perhaps the most serious challenge to the citation-penalty system was that accepted by the court in *Lackner v. Perkins*—that the statute coerced facilities into paying a minimum penalty and forfeiting their appeal rights, a Hobson's choice that the court felt rose to unconstitutional status.²³³ Because a facility always retains the right to appeal a particular penalty, the logic of this decision is curious. Rather than being comparable to the constitutional waiver of a right to jury trial as a quid pro quo for the guarantee that a prosecutor would not seek capital punishment,²³⁴ the citation law seems more analogous to a common penalty system for traffic violations, under which the cited driver may pay a minimal fine rather than contest the citation in court, where he might obtain dismissal of the penalty but could also be subject to a more severe fine.²³⁵ Since the legislature adopted the provision to permit a facility to pay a minimum fine, and thereby avoid the imposition of a possibly stiffer fine on appeal, in order to save the facility and the state the time and expense of the appeal process, it is ironic that the choice formed the basis for the *Perkins* court's invalidation of the statutory scheme. Without that option,²³⁶ apparently the court would not have invalidated the law. Although the *Perkins* decision was recently reversed on appeal,²³⁷ because the nursing home association's general challenge to the statute in *Health Facilities* has not been finally decided

232. See, e.g., *People v. Adams*, 43 Cal. App. 3d 697, 117 Cal. Rptr. 905 (1974); *Nardoni v. McConnell*, 48 Cal. 2d 500, 310 P.2d 644 (1957).

233. No. 386673 (Sup. Ct. of San Diego Cty., Oct. 27, 1977).

234. *United States v. Jackson*, 390 U.S. 570 (1968).

235. See, e.g., CAL. VEH. CODE §§ 40512, 42004 (West 1971). See also Note, *California Traffic Law Administration*, 12 STAN. L. REV. 387, 400-401 (1960).

236. See, e.g., IOWA CODE ANN. § 135C.41 (1)(a) (West Cum. Supp. 1978), which does not provide such a choice.

237. 91 Cal. App. 3d 433, 154 Cal. Rptr. 138 (1979).

by the superior court pending that appeal, legislative authority to adopt a citation-penalty system of this scope remains unclear.

Despite questions about the constitutionality of the citation-penalty approach, an examination of its effectiveness over the course of its three-year history remains warranted. California state officials, who believe that the system is working effectively to improve patient care in nursing homes, cite the decrease in the number of citations from the first to the second year of operation, the decrease in the average number of facility deficiencies during that time, and expedited facility correction of violations.²³⁸ Few citations have been challenged, and most of those have been sustained.²³⁹ Administration of the system has been expensive, costing over \$150,000 in legal fees for the state agency in 1976,²⁴⁰ and about two hours per citation of surveyor and clerical time²⁴¹ to process the 2500 Class A and B citations.²⁴² Of approximately \$1,180,000 in penalties assessed against facilities from October 1975 through March 1977, the state collected \$46,000.²⁴³ Costs of collection to the state, therefore, substantially exceed actual returns to the treasury, but may be offset by the intangible benefit of improved health and well-being of nursing home residents.

A general problem with any system of penalties is that a monetary forfeiture will probably come directly out of patient care funds, since it is unlikely that the facility administrator or owner would pay the penalty out of profits. Thus, the statutes should prohibit payment of the penalties from direct care funds and should prohibit them as reimbursable costs under Medicaid. While such prohibitions might be difficult

238. Interview with Bill Smith, Chief of Health Services Section, Licensing and Certification Division, California Dep't of Health (Dec. 23, 1977). See also DIVISION OF LICENSING AND CERTIFICATION, STATE DEP'T OF HEALTH, REPORT TO THE STATE LEGISLATURE ON THE LONG-TERM CARE, HEALTH, SAFETY AND SECURITY ACT OF 1973, at 1, 16 (Feb. 1977) [hereinafter cited as HEALTH DEP'T REP.].

239. In 1976, 23% of the 3250 citations issued by the Health Department were contested. HEALTH DEP'T REP., *supra* note 238, at 17 & Appendix I. Of the 90 Class A citations contested, 60% were sustained, 20% were dismissed entirely, and 20% were either reduced in penalty amount or reclassified as a Class B violation. *Id.* at 17 & Appendix J. Of the 650 Class B citations contested, 60% were sustained, 17% were dismissed, and 23% were reduced in penalty amount. *Id.* at 17 & Appendix K. During that year, 36 cases were appealed to court; two were decided in favor of the state and one, *Perkins*, was decided against the state. *Id.* at 17.

240. JOINT LEGISLATIVE AUDIT COMMITTEE, *supra* note 6, at 34-35. Facility owners, on the other hand, have estimated the costs of contesting a citation to be between \$900 and \$1300. See Letter from Western Medical Enterprises, Inc., to Joint Legislative Audit Committee (Aug. 30, 1977), in JOINT LEGISLATIVE AUDIT COMMITTEE, *supra* note 6, at 42-43.

241. Interview with Bill Smith, Chief of Health Services Section, Licensing and Certification Division, California Dep't of Health (Dec. 23, 1977).

242. See HEALTH DEP'T REP., *supra* note 238, at 15.

243. See JOINT LEGISLATIVE AUDIT COMMITTEE, *supra* note 6, at 48 (Table 3).

to enforce because they require a careful financial audit to trace the accounting for penalties, failure to resolve this problem will accrue to the detriment of the nursing home residents, whose interests the penalty system was designed to protect.

Since most of the penalty systems were recently enacted,²⁴⁴ other states have had little experience with them. State agencies, however, report success in their application to the problem of improving nursing home care,²⁴⁵ and, in combination with other remedies, a system of civil fines seems to be a useful approach to quality enforcement.

c. Other State Licensing Remedies

As an adjunct to licensing authority, several other remedies are available to state licensing agencies, including injunctive relief, suspension of public referrals and admissions, consideration of past performance in license renewals and reduction of bed quotas.

(i) Injunctions

State agencies or attorneys general acting on their behalf are typically empowered by statute to seek compliance with the laws they administer through injunctive relief.²⁴⁶ In addition to this general statutory authorization, several states have enacted broad consumer protection laws that prohibit deceptive practices and unconscionable conduct and permit state attorneys general to enforce them through suits for damages and injunctions.²⁴⁷ These laws have been liberally interpreted in cases involving nursing homes to prohibit patient neglect, infringement of patients' rights, and failure to notify attending physicians of changes in patient status, to maintain sanitary conditions, to provide adequate nursing care and to maintain sufficient staff.²⁴⁸ Other states have enacted specific legislation authorizing state agencies to enforce nursing home licensing laws and regulations through injunctions.²⁴⁹

244. See note 210 *supra*.

245. See, e.g., Letter from Dana L. Petrowsky, Director, Health Facilities Licensure Program, Iowa State Dep't of Health, to Author (Aug. 31, 1978) (copy on file in the office of the *North Carolina Law Review*).

246. See, e.g., CAL. CIV. CODE § 3369 (West 1970).

247. See, e.g., TEX. BUS. & COM. CODE ANN. tit. 2, §§ 17.41-63 (Vernon Cum. Supp. 1978).

248. See, e.g., *id.*, enforced against a nursing home in *State v. Southwest Mediplex*, No. 77-1587 (Dist. Ct., Travis County) (TRO issued Feb. 23, 1978).

249. See, e.g., CAL. HEALTH & SAFETY CODE § 1430 (West Supp. 1979); MINN. STAT. ANN. § 144a.12 (West Cum. Supp. 1978); N.J. STAT. ANN. § 30:11-4(a) (West Cum. Supp. 1978); N.Y. PUB. HEALTH LAW § 2801-C (McKinney 1977).

Injunctive relief is in theory particularly appropriate to remedy violations of licensing standards: courts of equity are familiar and comfortable with issuing injunctive orders; hearings and relief can be obtained expeditiously in urgent cases; and unlike financial penalties, which do not directly assure correction of the licensing violations and which may actually impair provision of resident care services, injunctions can directly mandate correction of violations. On the other hand, although injunctive relief is couched in prohibitory language, it most frequently requires affirmative action on the part of the facility. For example, an order to "refrain from failing to provide adequate nursing care" really mandates that the facility provide sufficient personnel, services and supplies to meet resident needs. Some courts, therefore, hesitate to issue injunctions, especially when they will require oversight and active judicial involvement in nursing home administration and management. Furthermore, obtaining an order does not guarantee compliance. The penalty for contempt is usually a fine or jail sentence, but courts may be reluctant to hold nursing home owners or operators in contempt if they are making any apparent attempt to correct the deficiencies at issue. The effectiveness of the injunctive remedy, therefore, depends upon the willingness of the facility management to comply and its perception of the consequences of refusing to do so, that is, the likelihood of the court taking aggressive steps to enforce its order.

(ii) Suspension of Referrals

Because nursing homes rely heavily upon public financing under Medicaid,²⁵⁰ a potentially powerful agency remedy for violations of licensing standards is suspension of resident referrals by public agencies while violations remain uncorrected. This remedy is justified both to prompt compliance with standards and to protect potential residents from entering facilities with deficiencies, although the latter ground suggests that the state ought to remove or otherwise protect the existing residents of the facility as well. The California citation law prohibits public agencies from referring residents to facilities with any uncorrected Class A violations or five or more Class B violations, making an important exception for facilities in areas of shortage.²⁵¹ A noteworthy quid pro quo for this limitation on public referral to deficient facilities is the state licensing agency's obligation annually to notify public agencies of facilities without any A or B violations and the obligation im-

250. See note 12 *supra*.

251. CAL. HEALTH & SAFETY CODE § 1434 (West Cum. Supp. 1979).

posed upon those agencies to give such facilities priority in referring public patients.²⁵² Wisconsin law goes further, requiring the state to prepare a monthly list of facilities with Class A violations or five or more of any violations for which a plan of correction has not been filed, implemented or accepted.²⁵³ Facilities on that list may not accept public patients,²⁵⁴ as under California law, nor may they admit *any* new patients—public or private—while a Class A or five or more Class B citations remain uncorrected.²⁵⁵ Referral suspension, however, has only been imposed sporadically; officials of the California licensing agency, for example, indicate that while the referral system is functioning effectively in Los Angeles County, it is not used in other parts of the state.²⁵⁶

Regardless of the effectiveness of referral suspensions, their imposition, at least under the California citation statute, is constitutionally suspect. Because a suspension seems to constitute as much of a deprivation of property as a revocation of a facility's license or Medicaid certification, its imposition arguably requires a prior hearing in order to comport with due process of law, unless the suspension can be justified on the basis of an emergency.²⁵⁷ The Wisconsin law expressly permits facilities to seek a hearing to contest the state's determination to suspend referrals or admissions.²⁵⁸ It is not clear, however, whether a similar hearing is required under the California law. While other sections of the citation statute refer to "final" citations, occurring after opportunity for appeal,²⁵⁹ the referral section prohibits referrals when there are "uncorrected violations."²⁶⁰ Because a violation can remain uncorrected while a citation is being contested, it may be argued that the legislature did not intend to permit hearings before the suspension of referrals. Although this issue has apparently not been raised, were the California statute so construed, it might be found constitutionally deficient.

252. *Id.*

253. WIS. STAT. ANN. § 50.04(4)(d) (West Cum. Supp. 1978).

254. *Id.* § 50.04(4)(d)(2).

255. *Id.* § 50.04(4)(d)(3).

256. JOINT LEGISLATIVE AUDIT COMMITTEE, *supra* note 6, at 33-34; interview with Aileen Adams, formerly with Los Angeles City Attorney's Office (Nov. 25, 1977).

257. For situations in which a particular facility might not be seriously harmed, a subsequent hearing might suffice. In any case, an expeditious and informal hearing would seem to satisfy due process. See notes 150-51 and accompanying text *supra*.

258. WIS. STAT. ANN. § 50.04(4)(e) (West Cum. Supp. 1978).

259. CAL. HEALTH & SAFETY CODE §§ 1428(a), 1429(a) (West Cum. Supp. 1979).

260. *Id.* § 1434.

States without specific legislation authorizing suspension of referrals can accomplish similar ends through publicizing the results of inspections and/or ranking facilities according to the number and severity of deficiencies.²⁶¹ Informed public agencies and prospective nursing home residents and their relatives can then make decisions about nursing home placement according to the relative quality of the facilities indicated by this rating.

(iii) Reducing Bed Quotas

Another creative enforcement mechanism that can be employed by state licensing agencies is to reclassify a facility not providing a given level of care to the level of care it can in fact provide, or to reduce the bed quota of a facility commensurate with the type, quality and quantity of care it can provide. West Virginia has adopted such legislation,²⁶² permitting the state agency to reclassify or reduce bed quotas upon a finding "that the licensee is not providing adequate care under the facility's existing classification or quota, and that reclassification, reduction in quota or both would place the licensee in a position to render adequate care."²⁶³ Since this provision was only recently enacted, there has been no experience with its implementation. Obviously, however, reclassification raises the procedural due process problems discussed earlier. In addition, the usefulness of this approach is limited to situations in which a reduction in bed capacity or classification, for example, from SNF to ICF, would remedy a violation of a licensing standard, such as an insufficient number of registered nurses. Within these constraints, however, it provides the potential for state agencies to tailor enforcement mechanisms to precise license violations.

(iv) Consideration of Past Performance

A final license remedy that states are adopting is consideration of the past performance of a facility in determining whether to renew an annual license for that facility or others involving the same owners and managers. The West Virginia licensing statute directs the state agency to issue a license to a facility whose principals and controlling persons have not had licenses revoked during the previous five years.²⁶⁴ Kansas law permits the state to deny a nursing home license to any person

261. See, e.g., N.Y. PUB. HEALTH LAW § 2803(c) (McKinney 1977).

262. See W. VA. CODE § 16-5C-11(a) (Supp. 1978).

263. *Id.* § 16-5C-11(c).

264. *Id.* § 16-5C-6(b)(1).

who has wilfully or repeatedly violated the state licensing standards, has failed to "assure that nutrition, medication and treatment of residents" accord with acceptable medical practice, or has assisted in any violation of the licensing standards.²⁶⁵ Similarly, Colorado regulations permit the state agency to consider a licensee's compliance with state licensing and Medicaid-Medicare certification standards in determining whether the licensee is "fit" to hold a license.²⁶⁶ New Jersey law forbids the state agency from issuing a license to a person "who has been twice found guilty of violating" the state licensing standards by a court or who has admitted guilt.²⁶⁷ Minnesota law forbids issuing a license to a facility if its controlling persons operated another nursing home during the previous two years with uncorrected violations for which a fine was assessed and collected, if there were two or more violations creating an imminent risk of harm to a resident, or if there were ten or more violations of any type.²⁶⁸ These statutes vary in the weight that a state agency must accord past licensing violations, and in the weight given to the nature of past violations. Furthermore, all of them do not clearly permit licensing agencies to look at the quality of care in other facilities owned or managed by the licensee.²⁶⁹ To the extent that the licensing standards do indicate quality of care, this authority to consider past performance in all facilities where the licensee exercises management or control is an important tool for licensing agencies to employ in continuing quality enforcement, especially as nursing homes are increasingly multiply-owned or operated by chains.

(v) Certificate of Need Authority

Particularly since enactment of the National Health Planning and Development Act of 1974,²⁷⁰ many states have adopted programs by which they review the necessity and desirability of capital expansion, construction, or equipment acquisition by or on behalf of health facilities.²⁷¹ These "certificate of need" programs prohibit health facilities, including hospitals and nursing homes, from making certain capital ex-

265. KAN. STAT. § 39-923(9)(b) (Cum. Supp. 1978).

266. Standards for Health Facilities Licensure, ch. 2, § 2.4.1.4.3 (1977). See also WIS. STAT. ANN. § 50.03(4)(a)(2) (West Cum. Supp. 1978).

267. N.J. STAT. ANN. § 30:11-1 (West Cum. Supp. 1978).

268. MINN. STAT. ANN. § 144A.04(4) (West Cum. Supp. 1978).

269. Compare the Colorado Regulations, *supra* note 266, and the Minnesota statute, *supra* note 268, with the Kansas, New Jersey and West Virginia statutes, *supra* notes 265, 267 & 264.

270. National Health Planning and Development Act of 1974, Pub. L. No. 93-641, 88 Stat. 2225 (1974) (codified in scattered sections of 42 U.S.C.).

271. See generally Wing & Craige, this Symposium.

penditures without the approval of local and state health planning agencies.²⁷² It is not made clear in either the federal legislation or in state certificate of need laws whether quality of care is one of the criteria that can be used to make certificate of need decisions. Local and state certificate of need agencies should examine the quality of care prior to approval of requests by nursing homes that want to make further capital expenditures. In determining the need for nursing home beds, states should also discount the availability of poor quality beds.²⁷³ These approaches may be difficult without explicit state statutory authority, and few states have incorporated such criteria into their certificate of need programs. The Colorado law, however, expressly requires a certificate for the acquisition of a nursing home by lease or purchase if the planning agencies determine that a poor quality of care was provided by the acquiring owner or lessee in other facilities it had managed or owned.²⁷⁴ Under this law the planning agencies examine the record of quality of care of prospective owners and lessees, using compliance with licensing standards and Medicaid-Medicare certification requirements as quality indicators.²⁷⁵ Inquiry into the compliance with similar standards in other states has resulted in the Colorado state agency's refusal to issue certificates of need for prospective owners or lessees to acquire facilities in the state when those persons have had a record of providing poor quality care in facilities in other states in which they were principals.²⁷⁶

Although the state licensing agency may be separate from the agency performing certificate of need and health planning, the potential for coordination between these agencies, using planning and certificate of need power to assist in enforcement of quality of care in nursing homes, should not be overlooked. It is regrettable that licensing-certification functions and health planning-certification of need functions have rarely been closely coordinated and that the power of each of these programs has been diluted as a result.²⁷⁷

272. 42 C.F.R. § 123.404 (1977).

273. See OHIO REP., *supra* note 6, at 10.

274. COLO. REV. STAT. § 25-3-506(1)(i) (Cum. Supp. 1978).

275. COLORADO DEP'T OF HEALTH, CERTIFICATE OF NEED PROJECT REVIEW MANUAL § I(A)(9)(c) (1979).

276. The Colorado Department of Health refused to issue a certificate of need to the owner of a Texas nursing home chain to purchase a Colorado nursing home on the ground that the owner had a poor quality record in its Texas facilities.

277. The Colorado Department of Health was organized with both planning and licensing under one assistant director. Few other state agencies are thus constituted.

(vi) Criminal Sanctions

While operating a nursing home without a license is typically defined as a misdemeanor under state law,²⁷⁸ violations of licensing standards are not generally defined as criminal.²⁷⁹ Under its general authority to prosecute violations of state law, however, the Los Angeles City Attorney's Office in 1975 and 1976 undertook a major criminal investigation and prosecution of nursing home violations of state licensing standards, including failure to provide for therapeutic diets, commingling of resident funds, unsanitary conditions, insufficient staff, medication charting errors, and failure to provide required resident care.²⁸⁰ Out of fifteen prosecutions initiated in 1975, the office obtained fourteen convictions, resulting in fines up to \$15,000 and/or probation. Most of the owners convicted of the misdemeanors sold their facilities.²⁸¹ Officials in the City Attorney's Office felt that using the criminal process improved quality of care in nursing homes since they did not receive further complaints about any of the same facilities after the successful prosecutions. These officials also felt that criminal actions were more successful than civil ones, because, although harder to prove, they had a greater deterrent impact and were brought to trial more quickly than civil actions because of the expedited discovery proceedings and acceleration of criminal cases in the courts.²⁸² Despite this apparent success in Los Angeles, the criminal enforcement effort has not been replicated elsewhere in California.²⁸³ Furthermore, while prosecutors can prove specific acts of patient abuse, it may be difficult to assign criminal responsibility for patient *neglect* because of the variety of persons generally responsible for patient care in nursing homes.²⁸⁴

278. See, e.g., IOWA CODE ANN. § 1352C21(1) (West Cum. Supp. 1978); MINN. STAT. ANN. § 144A.02(2) (West Cum. Supp. 1978); WIS. STAT. ANN. § 50.03(1) (West Cum. Supp. 1978).

279. But see N.Y. PUB. HEALTH LAW § 12-b (McKinney 1977), OHIO REV. CODE ANN. § 3721.99 (Page Cum. Supp. 1978).

280. Interview with Aileen Adams, formerly of Los Angeles City Attorney's Office (Nov. 25, 1977).

281. *Id.*

282. *Id.*

283. *Id.*

284. See NAAG REP., *supra* note 64, at 52. Another problem with criminal prosecution for nursing home licensing violations is the allegation that evidence gained through unannounced inspections is the fruit of an unlawful search and seizure that violates the fourth amendment of the Constitution. See, e.g., *People v. White*, 259 Cal. App. 2d 936, 65 Cal. Rptr. 923 (1968); *Uzzillia v. Commissioner*, 47 A.D.2d 492, 367 N.Y.S.2d 795 (1975). It has also been argued that to subpoena records of nursing homes that are sole proprietorships would violate the fifth amendment protection against self-incrimination. See, e.g., *Sigety v. Hynes*, 83 Misc. 2d 648, 372 N.Y.S.2d 771, *aff'd*, 49 A.D.2d 700, 373 N.Y.S.2d 848, *rev'd*, 38 N.Y.2d 260, 342 N.E.2d 518, 379 N.Y.S.2d 724

Some states have enacted laws prohibiting fraud or concealment of facts to obtain Medicaid reimbursement, which includes obtaining Medicaid payment for services, such as nursing home services, not actually provided to beneficiaries as needed.²⁸⁵ The Medicare-Medicaid Anti-Fraud and Abuse amendments of 1977,²⁸⁶ a recent addition to the Social Security Act, create federal penalties for making false statements in applications for Medicare and Medicaid reimbursement. The amendments also increase the rate of federal funding to ninety percent for states that establish Medicaid Fraud Control Units and coordinate them with the state Medicaid agency, attorney general's office and district attorneys.²⁸⁷ The units are specifically responsible for receiving complaints about abuse and neglect of patients in Medicaid health facilities and prosecuting violations under criminal law or referring them to other state agencies for appropriate actions.²⁸⁸ Despite the generous federal financing of these units and their potential for prosecuting serious cases of resident abuse and neglect, few states have established them.²⁸⁹

3. Enforcement Actions by Private Parties

Traditionally, private parties injured by the failure of health institutions to meet standards of care will assert their right to collect damages through civil actions for negligence, assault or battery. A prerequisite for recovery in these tort cases, however, is that the plaintiff's injury be measurable in monetary damages, calculated according to life expectancy and earning potential.²⁹⁰ While clear standards have been developed to evaluate the loss of life or limb for persons of young age or wage-earning capacity, it has been assumed that the life or

(1975); *Lewis v. Hynes*, 82 Misc. 2d 256, 368 N.Y.S.2d 738 (1975). In New York, where both these contentions have been extensively litigated, courts have rejected them. See *Uzzillia v. Commissioner*, 47 A.D.2d 492, 367 N.Y.S.2d 795 (1975); *Sigety v. Hynes*, 83 Misc. 2d 648, 372 N.Y.S.2d 771 (1975). The New York Special Prosecutor's Office has obtained numerous criminal convictions for nursing home fraud and abuse. NEW YORK SPECIAL PROSECUTOR'S OFFICE, SECOND ANNUAL REPORT TO GOVERNOR CAREY 12 (1977).

285. See, e.g., MICH. COMP. LAWS § 400.601 (MICH. STAT. ANN. § 16.614(3)) (Cum. Supp. 1978); N.J. STAT. ANN. § 30:40-17 (West Cum. Supp. 1978).

286. 42 U.S.C. §§ 1395nn, 1396h (1976).

287. *Id.* § 1396(q).

288. *Id.* § 1396(q)(4); 43 C.F.R. § 455.300(f) (1977).

289. As of December 20, 1978, only 22 states had requested HEW certification for their Medicaid Fraud Control Units and only 19 had received certification. [1979] MEDICARE & MEDICAID GUIDE (CCH) ¶ 252. Units in Colorado, California and Louisiana have been undermined by personal and political difficulties and scandals.

290. Damages for personal injury are usually based in part on actuarial life expectancy. See D. DOBBS, HANDBOOK ON THE LAW OF REMEDIES 549 (4th ed. 1975).

health of an elderly person in a nursing home is incapable of financial evaluation and therefore cannot be compensated in a suit for damages. Despite this widespread view, some residents have recovered substantial awards for violations of state licensing and Medicaid certification standards,²⁹¹ and private litigation on behalf of nursing home residents is increasing.²⁹²

Private litigation is made even more difficult to pursue, however, if the plaintiff must remain in the institution, where he legitimately fears direct or indirect retaliation. For this reason, many dissatisfied and/or abused residents of nursing homes do not even complain about mistreatment, much less pursue legal remedies for it. At least one court, however, has permitted the use of pseudonyms for plaintiffs in such cases to preserve their anonymity and protect them from retaliatory treatment.²⁹³ Additional protection is available through state statutes that expressly prohibit facilities from retaliating against persons filing complaints with state agencies or proceeding against the facilities directly.²⁹⁴ These statutes create a rebuttable presumption that any discriminatory treatment within a given time of the resident's action was done in retaliation for the action.

Having overcome the reluctance of courts, private attorneys and residents to pursue private civil litigation for patient abuse or neglect, the question becomes what causes of action can an aggrieved plaintiff assert. The most traditional cause of action is one for injury resulting from the negligence of facility staff—either physical abuse, such as the improper use of restraints or medication, lack of protection from other patients,²⁹⁵ or neglect, such as the failure to provide care resulting in decubitus ulcers or failure to observe a medically prescribed diet.²⁹⁶ Employees directly responsible for such acts can be held accountable for them, and employers can be subjected to liability for employee misconduct under the doctrine of respondeat superior.²⁹⁷ The extent to

291. In one case, plaintiff class of nursing home residents obtained \$16,000 in compensatory damages and \$500,000 in punitive damages in a challenge to a nursing home's conversion of patient care funds. *Brandenburg v. Charapata*, No. 422-112 (Multnomah City, Or. Cir. Ct., 1978).

292. *See, e.g., Smith v. O'Halloran*, No. 75-M-539 (D. Colo., June 5, 1975).

293. *Resident v. Emmanuel Family Training Center, Inc.*, No. C78-477 (D. Ohio, 1978). The court applied the test of anonymity from *Roe v. Wade*, 410 U.S. 113, 124 (1973), whether "disclosure of a litigant's name would subject the litigant to undue and unnecessary injury."

294. *See, e.g., CAL. HEALTH & SAFETY CODE* § 1432(a), (b) (West Cum. Supp. 1979); *IOWA CODE ANN.* § 135C.46 (West Cum. Supp. 1978); *OHIO REV. CODE ANN.* § 3721.17(G) (Page Cum. Supp. 1978).

295. *See, e.g., Bezark v. Kostner Manor, Inc.*, 29 Ill. App. 2d 106, 172 N.E.2d 424 (1961).

296. *See, e.g., Hendricks v. Sanford*, 216 Or. 149, 337 P.2d 974 (1959).

297. *See, e.g., Jefferson Hosp., Inc. v. Van Lear*, 186 Va. 74, 41 S.E.2d 441 (1947).

which a facility is responsible for the conduct of individuals it does not employ is unclear. Under the doctrine espoused in *Darling v. Charleston Community Memorial Hospital*,²⁹⁸ health facilities are responsible for the negligent acts of not only their employees, but also those persons practicing independently within the institution, as long as the facility had reason to believe the person might be seriously negligent and the facility had the opportunity to protect the patient against the harm. Thus, it would appear that facilities have a responsibility for protecting residents against the gross negligence of outside consultants and attending physicians and that this doctrine may be applied in some circumstances to simply negligent treatment.²⁹⁹

In determining the standard of care to be applied in a case of nursing home negligence, it may be possible to assert that the federal Medicaid Conditions of Participation and state licensing standards establish the underlying duty.³⁰⁰ Furthermore, although the standard of care remains that of the reasonable man, the frailty of nursing home residents may require the facility to exercise the greater care commensurate with the physical condition of its residents.³⁰¹

A breach of the facility's contract with the resident can also form the basis of a claim for relief for the facility's failure to provide adequate quality of care. Admission agreements rarely include express terms requiring facilities to provide high quality care, but arguably can be held to incorporate implicitly the requirements of state licensing standards, Medicaid standards (for Medicaid beneficiaries), and warranties of habitability provided in state housing laws.³⁰² Many admission contracts disclaim liability for resident safety or the acts of employees following physician orders. These provisions, however, would appear to be unconscionable and contrary to public policy, and the Federal Trade Commission is considering adopting a rule prohibiting such disclaimers.³⁰³

298. 33 Ill. 2d 326, 211 N.E.2d 253 (1965).

299. See Hackler, *Expansion of Health Care Providers' Liability: An Application of Darling to Long-Term Health Care Facilities*, 9 CONN. L. REV. 462 (1977).

300. But see *Stogsdill v. Manor Convalescent Home, Inc.*, 35 Ill. App. 3d 634, 664, 343 N.E.2d 589, 611 (1976); *Darling v. Charleston Community Memorial Hosp.*, 33 Ill. 3d 326, 211 N.E.2d 253 (1965). See also Hackler, *supra* note 299, at 470-71.

301. See *Dunahoo v. Brooks*, 272 Ala. 87, 128 S.E.2d 485 (1961).

302. See *Javins v. First Nat'l Realty Corp.*, 428 F.2d 1071 (D.C. Cir. 1970); *Steele v. Latimer*, 214 Kan. 329, 521 P.2d 304 (1974); *Pines v. Persson*, 14 Wis. 2d 590, 112 N.W.2d 409 (1961). Implied warranties of fitness and merchantability apply to goods, not services. Regan, *When Nursing Home Patients Complain: The Ombudsman or the Patient Advocate*, 65 GEO. L.J. 691, 714 (1971).

303. The Federal Trade Commission is investigating deceptive and misleading advertising

In addition to asserting breaches of contracts with residents, nursing home patients have been permitted to assert the rights of third party beneficiaries to any contract between the facility and the state,³⁰⁴ such as the Medicaid Provider Agreement,³⁰⁵ which includes all the Medicaid-Medicare Conditions of Participation, including the patients' rights standards.

Beyond contract claims, it is also possible in some states to derive a cause of action directly from state or federal nursing home standards. Some state statutes, such as California's, expressly provide such a private right of action, permitting any person acting for himself or the general public to seek injunctive relief or damages for a facility's continuing violation after a citation has been issued.³⁰⁶ Other statutes provide a much broader private remedy. The New York and West Virginia laws authorize a private right of action for injuries to the rights of any nursing home resident created by a contract or by any state or federal law or regulation.³⁰⁷ These laws provide for compensatory and punitive damages and injunctive relief. They permit the defense that the facility exercised all care reasonably necessary to prevent the injury, but expressly prohibit the defense of exhaustion of administrative remedies. Both statutes also exempt any damage award to Medicaid recipients from consideration as income or assets in determining initial or continuing Medicaid eligibility,³⁰⁸ which is an important consideration in encouraging injured residents to assert their rights. The laws further nullify any oral or written waiver of the right to commence legal action.³⁰⁹ New York's law also provides for attorneys' fees³¹⁰ and prohibits premiums for liability insurance to cover

and business practices by nursing homes, including contractual disclaimers, extra charges for apparently routine items, lack of free choice in obtaining drugs and personal supplies, theft of residents' funds and belongings, and improper accounting for bills. Since the FTC's jurisdiction extends only to commercial aspects of the industry, it is considering issuing a Trade Regulation Rule prohibiting unconscionable contract disclaimers, mandating freedom of choice of suppliers, and requiring disclosure of services for which extra charges will be made, termination policies, and refund practices. Dole, *supra* note 96, at 2.

304. See *Fuzie v. Manor Care, Inc.*, 461 F. Supp. 689 (N.D. Ohio 1977).

305. See *Euresti v. Stenner*, 458 F.2d 1115 (10th Cir. 1972).

306. CAL. HEALTH & SAFETY CODE § 1430 (West Cum. Supp. 1979).

307. N.Y. PUB. HEALTH LAW § 2801-d (McKinney 1977); W. VA. CODE § 16-5C-15(c) (Supp. 1978). The New York law sets a minimum level of damages recoverable in such an action at 25% of the daily Medicaid patient rate.

308. N.Y. PUB. HEALTH LAW § 2801-d(5) (McKinney 1977); W. VA. CODE § 16-5C-15(c) (Supp. 1978).

309. N.Y. PUB. HEALTH LAW § 2801-d(7) (McKinney 1977); W. VA. CODE § 16-5C-15(c) (Supp. 1978).

310. N.Y. PUB. HEALTH LAW § 2801-d(6) (McKinney 1977). See also OHIO REV. CODE ANN. § 3721.17(I) (Page Cum. Supp. 1978).

private action awards from being allowable costs reimbursable to the nursing home under Medicaid.³¹¹

The existence of these statutes creating private rights of action is particularly important in view of conflicting judicial interpretations of whether aggrieved nursing home residents have implied rights of action under the federal Medicaid-Medicare Conditions of Participation or state licensing standards. The Medicaid statute, which generally directs state Medicaid agencies to design their programs to conform to broadly outlined federal policies, has been enforced by beneficiaries of the program without first seeking relief from HEW, the federal agency charged with its general enforcement.³¹² Courts have permitted such direct actions by beneficiaries since the Supreme Court, in *Rosado v. Wyman*,³¹³ expressly held that beneficiaries of the Social Security Act need not seek relief from HEW but can sue offending state agencies directly. In essence, the Court held that there was a private right of action for a beneficiary of the Social Security Act against a state for neglect of its duties under the Act.

Few courts, however, have addressed the question whether there is also a private right of action under the Social Security Act or its regulations against other entities, such as nursing homes, that have express duties under the legislation.³¹⁴ The three reported cases that have thus far raised the issue have reached inconsistent conclusions. In *Berry v. First Healthcare Corp.*,³¹⁵ plaintiffs challenged the nursing home's policy of transferring persons who became eligible for Medicaid after residing in the facility for less than two years. The Federal District Court for the District of New Hampshire held that the plaintiff nursing home residents properly stated a claim under the federal Medicaid regulations regarding a patient's right not to be transferred except under certain circumstances.³¹⁶ The court briefly examined the question whether the Medicaid statute created a private right of action, noting that Congress had not specifically refused to grant such a right. The court also found that since there was no HEW provision permitting plaintiffs to seek administrative review of the nursing home's action, it must permit

311. N.Y. PUB. HEALTH LAW § 2801-d(9) (McKinney 1977).

312. See, e.g., *Hayes v. Stanton*, 512 F.2d 133 (7th Cir. 1975); *Blue v. Craig*, 505 F.2d 830 (4th Cir. 1974); *Schaak v. Schmidt*, 344 F. Supp. 99 (E.D. Wis. 1971); *Triplett v. Cobb*, 331 F. Supp. 652 (D. Miss. 1971); *Wilczynski v. Harder*, 323 F. Supp. 509 (D. Conn. 1971); *Fullington v. Shea*, 320 F. Supp. 500 (D. Colo. 1970), *aff'd* 404 U.S. 963 (1971).

313. 397 U.S. 397 (1970).

314. See, e.g., *Yanez v. Jones*, 361 F. Supp. 701 (N.D. Utah 1973).

315. No. 77-208 (D.N.H., Oct. 26, 1977).

316. *Id.*; see 42 C.F.R. § 405.1121(4) (1978).

judicial review, citing other cases in which private rights of action have been directly implied from federal statutes and the Constitution.³¹⁷ While this analysis might seem simplistic, it is consistent with the treatment of beneficiaries enforcing the Medicaid law against state agencies.

In *Roberson v. Wood*,³¹⁸ the Federal District Court for the Eastern District of Illinois found a private right of action in a suit by Medicaid nursing home residents threatened by transfer. The court followed the tests for implying such a claim set forth by the Supreme Court in *Cort v. Ash*,³¹⁹ a case in which stockholders unsuccessfully attempted to assert a private right of action for damages under a federal election law providing criminal penalties for corporate campaign contributions. The court found that the Medicaid statute was enacted for the particular benefit of nursing home resident plaintiffs, that Congress must implicitly have intended that they could enforce those rights, that the remedy of private enforcement was consistent with the underlying purposes of the Medicaid statute, and that since the program was exclusively federal the remedy was not one traditionally relegated to state law.³²⁰

The *Roberson* court expressly distinguished *Fuzie v. Manor Care, Inc.*,³²¹ in which the Federal District Court for the Northern District of Ohio denied a private right of action on facts identical to those in *Berry*. After a lengthy discussion of the background and purposes of the Medicaid program and the involvement of private nursing homes in the program, the *Fuzie* court held that because defendant nursing home was not acting under color of state law, plaintiff could not state a claim against it under 42 U.S.C. section 1983 or the Constitution,³²²

317. No. 77-208 (D.N.H., Oct. 26, 1977) (citing *Bivens v. Six Unknown Agents*, 403 U.S. 388 (1971); *J.I. Case Co. v. Borak*, 377 U.S. 426 (1964); *Bell v. Hood*, 327 U.S. 678 (1946)).

318. 464 F. Supp. 983 (E.D. Ill. 1979).

319. 422 U.S. 66, 78 (1975).

320. 464 F. Supp. at 983.

321. 461 F. Supp. 689 (N.D. Ohio 1977). This decision was important for establishing federal jurisdiction, see 28 U.S.C. § 1343 (1976), and the right of the prevailing party to seek attorney's fees, see 42 U.S.C. § 1988 (1976). In *Buscho v. Northwest Care Centers, Inc.*, No. A7706.08560 (D. Or., June 22, 1978), a "transfer case" arising out of patients' rights regulations regarding transfers, the court denied the nursing home's motion to dismiss, holding that plaintiff did state a claim under 42 U.S.C. § 1983 (1976). See also *Fried v. Straussman*, 82 Misc. 2d 121, 369 N.Y.S.2d 591, *aff'd mem.*, 50 A.D.2d 919, 377 N.Y.S.2d 953 (1975), *rev'd*, 41 N.Y.2d 376, 361 N.E.2d 984, 393 N.Y.S.2d 334 (1977). In *Buscho*, plaintiff also sued the Medicaid and licensing agencies on the ground that the state negligently insisted that the facility correct deficiencies or close in five days. The facility then moved plaintiff's decedent, leading to her death. The court denied the state's motion to dismiss, which had been based on the contention that the Medicaid plan created no duty to plaintiff's decedent or that any duty so created was discretionary.

322. No. C77-265 (N.D. Ohio, July 7, 1977), reprinted in [1977] *MEDICARE & MEDICAID GUIDE* (CCH) ¶ 28,694. Plaintiff in *Buscho v. Northwest Care Center, Inc.*, No. A7706.08560 (D. Or., June 22, 1978) alleged that the State of Oregon had required that the facility move residents

that the Social Security Act provided no implied right of action for enforcement of the federal nursing home standards, and that a private right of action under the Medicaid nursing home regulations met none of the tests enunciated in *Cort v. Ash* for implying a private right of action.³²³ The *Fuzie* court found, however, that plaintiff had stated a claim for breach of contract because she was a third party beneficiary of the provider agreement, which incorporated the federal standards, including the transfer limitations that underlay her claim, between the state Medicaid agency and the nursing home defendant.³²⁴ The court

needing a higher level of nursing care, increase staff or close the nursing home. *See also* *Stitt v. Manor Care, Inc.*, No. C78-630 (N.D. Ohio, Oct. 24, 1978), *reprinted in* [1978] *MEDICARE & MEDICAID GUIDE (CCH)* ¶ 29,409.

323. The first test in *Cort* is whether the plaintiff is a member of the class for whose benefit the statute was enacted. 422 U.S. at 78. The *Fuzie* court, while conceding that the Medicaid law and regulations seem to indicate that Medicaid beneficiaries are "among the class of persons for whose benefit this legislation was enacted and the regulations promulgated," inexplicably concluded that plaintiffs did not satisfy the test because they did not have an absolute right not to be transferred. For instance, residents could not prevent transfer if the nursing home's provider agreement was cancelled by the state. No. C77-265 (N.D. Ohio, July 7, 1977), *reprinted in* [1977] *MEDICARE & MEDICAID GUIDE (CCH)* ¶ 28,694. Whether an absolute right exists under the federal law should make no difference in determining whether the statute creates a private cause of action for its enforcement. That concern relates only to ultimate remedy.

The second *Cort* test is whether any legislative pronouncement explicitly or implicitly suggests the intent to create or deny a private cause of action. 422 U.S. at 78. In reaching its conclusion, the *Fuzie* court pointed to the requirements for judicial review of administrative decisions under Medicare, 42 U.S.C. § 1395ff(c) (1976), and noted the absence of any parallel in the Medicaid statute. What the court failed to note is the distinction between Medicare, an exclusively federal program in which all terms of eligibility, benefits and appeal systems are specifically described, and Medicaid, in which states are given discretion to develop programs under federal guidelines. The failure to spell out judicial review of Medicaid claims for beneficiaries does not, therefore, prove that there is no private right of action intended under the Medicaid statute. More than ten years of experience under Medicaid, during which courts have permitted beneficiaries to sue states for failures to follow federal law, *see* note 312 *supra*, and several subsequent amendments to the Medicaid statute, in which Congress has implicitly acquiesced in these judicial decisions, support the better view that there is no legislative intent to deny a private right of action under the Medicaid statute.

While it is true that states may have the primary enforcement role under Medicaid, their failure to monitor nursing home compliance, which has been recognized by Congress, S. REP. NO. 404, 89th Cong., 1st Sess. 76 (1965), reinforces the need for a right of the beneficiary to pursue the enforcement, especially when he or she has no right to trigger administrative enforcement at either the federal or state level. *See, e.g.,* *Rosado v. Wyman*, 397 U.S. 397 (1970). In *Cort v. Ash*, the Supreme Court held that stockholder derivative suits are such cases.

324. While breach of contract claims are certainly an area of state law, it would have been disingenuous for the court to hold that when the very contract term at issue is one created by federal law the federal courts should not permit its enforcement in a federal forum. The final twist to the convoluted logic of this case came, however, when the court determined that plaintiff had pleaded a contract claim as a third party beneficiary, which was proper under state law, and permitted plaintiff to remain in federal court by asserting jurisdiction over the pendent state claim and the pendent party, despite the lack of a federal claim presumably required for pendent jurisdiction. To achieve this objective the court unconvincingly distinguished *Aldinger v. Howard*, 427 U.S. 1 (1976), in which the Supreme Court had refused to extend pendent party jurisdiction to parties over whom there was no independent basis for federal jurisdiction.

then permitted plaintiff to proceed on this contract claim in her federal action.

The finding of the *Fuzie* court that defendant nursing home was not acting under color of state law is understandable in view of recent Supreme Court decisions requiring a high degree of state involvement in the actual challenged policy or action for such a finding.³²⁵ Mere government subsidy and regulation are not enough to turn private action into state action, although active participation in challenged conduct (such as requiring the transfer contrary to the federal standard) should constitute sufficient state involvement. The approach of the *Fuzie* case, however, would make it impossible for most beneficiaries deprived of Medicaid statutory rights by providers to enforce them, since nursing homes are among the few Medicaid providers that execute annual contracts with state agencies and the vast majority of health care providers, including hospitals and physicians, do not do so.³²⁶

Even if courts are willing to imply private rights of action, private enforcement of quality of care in long-term care institutions is no greater than the underlying quality standards in federal certification rules or state licensing regulations. Because of the significant weaknesses of these standards in assuring quality of care,³²⁷ the right of residents to protect themselves through such litigation is correspondingly limited.

E. Public Involvement in Nursing Home Quality of Care Enforcement

While state and federal agencies should better perform their responsibilities to establish and enforce standards to assure quality of care for nursing home residents, and while private actions may enhance the right to such care, any regulatory or judicial action is insufficient to fulfill this task completely. The public should be actively involved in monitoring the care in nursing homes as well as the functioning of the enforcement agencies. Because there is no real constituency supporting

325. See, e.g., *Jackson v. Metropolitan Edison Co.*, 419 U.S. 435, 451 (1974).

326. In *Yanez v. Jones*, 361 F. Supp. 701 (N.D. Utah 1972), plaintiffs challenged private physicians' refusal to follow a Medicaid regulation, 42 C.F.R. § 447.15 (1978), which required them to accept Medicaid rates as full payment and prohibited them from charging to their Medicaid patients any additional sums. The court permitted the action to proceed against the state Medicaid agency, which was required by the regulation to enforce the provision against all providers, but declined to permit an action directly against the offending physician, despite the apparently contrary precedent in the Tenth Circuit of *Eureste v. Stenner*, 458 F.2d 1115 (10th Cir. 1972).

327. See notes 79-95 and accompanying text *supra*.

agency enforcement efforts, licensing agencies are subject to constant industry pressure without the counterpressure—or reinforcement—from nursing home reform interests representing the community in general and residents in particular. The Nursing Home Ombudsmen funded in each state by the federal Administration on Aging³²⁸ are ill-suited for this task since they are usually state agencies rather than community groups, which are less subject to industry pressure.³²⁹ Without a strong, vocal constituency representing nursing home residents' interests, even the best-intentioned regulators and policymakers are worn down and enervated by constant industry pressure to weaken enforcement efforts.

Community interest and concern is perhaps the single most important reason that small, rural nursing homes (which may not comply fully with safety or fire standards) often have the best reputations for providing a high quality of care and life to residents. When the residents and their families are neighbors and acquaintances of the nursing home owners, operators and staff, and when the community actively supports and encourages the facility in efforts to provide good care, residents report a high degree of satisfaction with services. As one commentator has noted:

To make the point that institutions do a better job when outsiders are constantly coming in and out is *not* to suggest that they maintain their standards only for show. Rather, it is to recognize that we all depend on the interest and appreciation of other people to keep our morale and the quality of our work high. Dressing for dinner in the desert is not a standard most of us could keep to. We tidy the house for the visit of friends because of standards they and we share, and because we want them to appreciate our house as we do.³³⁰

Community groups supporting nursing home residents have developed in some parts of the country. Organizations such as Citizens for Better Care in Detroit,³³¹ Friends of Nursing Home Patients in Chapel Hill,

328. 42 U.S.C.A. § 3027 (a)(12) (West Cum. Supp. 1979). Several states have also adopted ombudsmen legislation. See, e.g., MD. ANN. CODE art. 43, § 565(c), art. 70B, § 4(a) (1978); N.J. STAT. ANN. § 52:27G-1-16 (West Cum. Supp. 1978).

329. The Colorado Nursing Home Ombudsman was located in the office of the Denver Legal Aid Society for several years, but because of its strong pro-resident, often controversial, positions it was moved by the state Medicaid Agency to the State Office on Aging. See generally Regan, *supra* note 302, at 698, 704.

330. Barney, *Community Presence as a Key to Quality of Life in Nursing Homes*, 64 AM. J. PUB. HEALTH 265 (1974).

331. For information about Citizens for Better Care, write: 163 Madison, Detroit, Mich. 48226 (313-962-5571).

North Carolina,³³² Save the Village Nursing Home in New York City,³³³ and the National Citizens' Coalition for Nursing Home Reform³³⁴ have been effective advocates for nursing home patients' rights at the local, state and national levels. Many more such groups must be established to assure active, regular and continuing public involvement in nursing home activities.

Meaningful public involvement in nursing home quality monitoring and enforcement can take the form of broad scale legislative and administrative advocacy, as well as concern with the care provided by a single facility or the appropriateness of placing an individual in a given nursing home. This public participation at all levels cannot occur unless adequate information is made available to the public about conditions in facilities and facility compliance with licensing and Medicare-Medicaid standards. The federal Medicaid and Medicare statutes, as amended in 1972, require public disclosure of the certification survey reports;³³⁵ these provisions were enacted as the result of successful litigation in various states requiring disclosure under the federal Freedom of Information Act.³³⁶ Since the federal law only requires that the deficiency lists (and facility responses) be made available by the certification agency, the Medicaid agency and the local office of the Social Security Administration,³³⁷ public access to the reports under this law is somewhat limited. Some state laws, however, expressly authorize such disclosure of licensing inspection reports.³³⁸

A few states now require that facilities either post citations or deficiency lists they receive,³³⁹ make the information available to any prospective resident upon request,³⁴⁰ or publish the citations.³⁴¹ The requirement of posting notices of violation can certainly serve as a de-

332. For information about Friends of Nursing Home Patients, write: 207 Wilson Court, Chapel Hill, N.C. 27514 (919-967-6198).

333. For information about Save the Village Nursing Home, which assumed ownership of a facility in Greenwich Village for which the state had obtained appointment of a receiver, write: Friends and Relatives of Institutionalized Aged, 400 E. 26th Street, N.Y., N.Y. 10010.

334. For more information, write: 1424 16th Street, N.W., Washington, D.C. 20036.

335. 42 U.S.C. §§ 1395aa(a), 1396(a)(27) (1976).

336. See generally Regan, *Quality Assurance Systems in Nursing Homes*, 53 J. URB. L. REV. 153, 196-98 (1975).

337. 42 C.F.R. § 431.115(f) (1978).

338. See, e.g., W. VA. CODE § 16-5C-16 (Supp. 1978).

339. See, e.g., CAL. HEALTH & SAFETY CODE § 1429 (West Cum. Supp. 1979); KAN. STAT. § 39-935 (Cum. Supp. 1978); MINN. STAT. ANN. § 144A-10(3) (West Cum. Supp. 1978).

340. See, e.g., WIS. STAT. ANN. § 50.04(3)(c) (West Cum. Supp. 1978).

341. Kansas law requires publication in a newspaper of general circulation in the county in which the facility is located. KAN. STAT. § 39-946(a) (Cum. Supp. 1978). Iowa law requires the state licensing agency to publish annually a list of the facilities with and without citations and the

terrent to facility violations of licensing standards and as a means of informing the public of the relative status of the nursing home. One must ponder the effect of such public deficiency notices upon the psychological and emotional well-being of the residents in the facility. The discomfort of knowing one resides in a substandard facility, however, is probably outweighed by the need to correct violations and permit public knowledge.

Several states are experimenting with approaches to encourage greater public and community involvement in nursing home quality assurance. California and Iowa permit any person to request a facility inspection upon written complaint and protect the identity of the complainant from disclosure.³⁴² The complainant may, however, accompany the inspector if he or she wishes.³⁴³ Although this authorization of citizen participation in nursing home surveys is rarely used in California,³⁴⁴ it could be an important source of community involvement.

Access of resident advocates and interested members of the public to nursing homes has often been a source of difficulty.³⁴⁵ Cases authorizing the public to enter private property imbued with a public purpose have provided some relief for this problem,³⁴⁶ but subsequent pronouncements from the Supreme Court have characterized such apparently public property as shopping centers as private and have substantially undercut rights of public access.³⁴⁷ Some state laws expressly provide the right of access to facilities by "members of recognized community organizations and community legal services programs,"³⁴⁸ and courts have enforced these provisions.³⁴⁹

Some states have established various types of community advisory

actions taken on each citation. IOWA CODE ANN. § 135C.38 (West Cum. Supp. 1978). *See also* CAL. HEALTH & SAFETY CODE § 1420 (West Cum. Supp. 1979).

342. CAL. HEALTH & SAFETY CODE § 1419 (West Cum. Supp. 1979). IOWA CODE ANN. § 135C.38 (West Cum. Supp. 1978).

343. CAL. HEALTH & SAFETY CODE § 1420 (West Cum. Supp. 1979); IOWA CODE ANN. § 135C.38(2) (West Cum. Supp. 1978).

344. Interview with Bill Smith, Chief of Health Services Section, Licensing and Certification Division, California Dep't of Health (Dec. 23, 1977).

345. *See* The Health Law Project, *Legal Problems Inherent in Organizing Nursing Home Occupants*, 6 CLEARINGHOUSE REV. 203, 203-06 (1972).

346. *See, e.g.*, *Food Employees Local 590 v. Logan Valley Plaza, Inc.*, 391 U.S. 308 (1968); *Marsh v. Alabama*, 326 U.S. 308 (1945).

347. *See* *Lloyd Corp. v. Tanner*, 407 U.S. 551 (1972).

348. *See, e.g.*, W. VA. CODE § 16-5C-5(b)(1) (Cum. Supp. 1978). *See also* OHIO REV. STAT. ANN. § 3721.14(D) (Page Cum. Supp. 1978); MASSACHUSETTS ATTORNEY GENERAL, RULES AND REGULATIONS RELATING TO NURSING HOMES, rule 4 (1975).

349. *Commonwealth v. Q.T. Service, Inc.*, No. 78-564 (Mass. Sup. Ct., Jan. 31, 1978) (order granting temporary restraining order).

boards or committees to provide oversight and input into the nursing home enforcement process. Minnesota, for example, has a fifteen-member state Nursing Home Advisory Council to the Department of Health, which has representatives of residents and the public as members, although it is dominated by persons who either control nursing homes or provide services to them.³⁵⁰

In Iowa, Care Review Committees, composed of disinterested citizens appointed by local health planning agencies, must exist for each nursing home in the state. The committees' function is to "represent the rights" of nursing home residents, process complaints, and "consider" their personal and social needs to determine if they are being met.³⁵¹ The committee members may not, however, examine medical records or medical needs.³⁵² The committees, which have been functioning for about two years, have been criticized for ineffectiveness, partially due to lack of training. Out of 4000 nursing home complaints submitted to the state Health Department in 1977, only twelve had come through the Care Review Committees, although they are statutorily responsible for accepting and processing complaints.³⁵³ Furthermore, the committees have no enforcement authority except to report to the Department for follow-up and possible citation.

North Carolina has adopted similar legislation, requiring county-wide community advisory committees for nursing homes appointed by the county commissioners and nursing home administrators.³⁵⁴ Each committee has the responsibility to visit each home in the county quarterly, apprise itself of conditions in the home, and "work for the best interests" of the residents, including representing them in grievances with the facility.³⁵⁵ While there is no experience yet with these committees, their authority seems broader than that of the advisory committees in Iowa, and they may provide more effective community involvement in quality of care enforcement.

These diverse experiments to involve the public in nursing home affairs and quality of care enforcement are critical both to an effective

350. MINN. STAT. ANN. § 144A.17 (West Cum. Supp. 1978).

351. IOWA CODE ANN. § 135C.25 (West Cum. Supp. 1978); IOWA DEP'T OF HEALTH, RULES AND REGULATIONS FOR SKILLED NURSING FACILITIES § 470-59.32 (1978).

352. IOWA DEP'T OF HEALTH, RULES AND REGULATIONS FOR SKILLED NURSING FACILITIES § 470-59.32(3)(b) (1978).

353. Interview with Randi Youells, Staff Attorney, Legal Services Corporation of Iowa, in Des Moines, Iowa (Nov. 14, 1978).

354. N.C. GEN. STAT. § 130-9(e)(7) (Cum. Supp. 1978).

355. *Id.*

and vital state enforcement system and to the continuous provision of a high quality of care in the facilities. Without active community support and prodding, state licensing agencies languish and fail to fulfill their public responsibilities. Cooperation and, when necessary, healthy conflict can maintain an appropriate level of energy and dedication in the state agency. Even without such coordination, greater public knowledge about and concern for nursing homes and their residents can provide more informed placement decisions, more meaningful advocacy to facilities on behalf of residents, and a more open atmosphere in nursing homes that is bound to provide a higher quality of resident services.³⁵⁶ Furthermore, the better the community understands the problems and needs of the elderly, the more likely it will be to propose, develop and fund noninstitutional alternatives and to provide a generally more dignified and humane approach to long-term health care services. The ultimate result of public knowledge and scrutiny should be a significant improvement in the quality of long-term care.

IV. COSTS OF IMPROVED NURSING HOME QUALITY ENFORCEMENT

In view of the general theme of this symposium, a legitimate question to ask is what would be the costs of the various proposed solutions to quality of care enforcement in nursing homes. It has been alleged that the costs of legal enforcement actions and facility appeals under the California citation system are extreme.³⁵⁷ Similarly, imposition of receiverships,³⁵⁸ especially those requiring additional outlays of state funds to correct deficiencies,³⁵⁹ could be considerable. On the other hand, shifting the approach of the Medicare-Medicaid Conditions of Participation to a resident focus, using a resident assessment instrument, could save resources. By surveying facilities and residents on a sample basis, using computers, and eliminating surveyor and facility time now allotted to "paper compliance" with the extant structural standards, a revitalized system could actually cost less than the current en-

356. See generally Barney, *supra* note 330.

357. See note 204 *supra*.

358. A group of economists analyzing the impact of housing code enforcement on rents concluded that of the three enforcement remedies studied (repair and deduct, withholding rent and receivership), receivership had a statistically significant impact on rent increases. Hirsch, Hirsch & Margolis, *Regression Analysis of the Effects of Habitability Laws upon Rent: An Empirical Observation on the Ackerman-Komesar Debate*, 63 CALIF. L. REV. 1098, 1129 (1975). The authors examined only the cost increases for the consumers of housing, not other costs associated with enforcement of housing codes, but the analogy to enforcing nursing home quality of care should be considered.

359. See notes 243-45 *supra*.

forcement system. The development of noninstitutional community-based resources for long-term care and the diversion of the current Medicaid emphasis from nursing homes to these more appropriate services, could also be more economical than paying for nursing home services alone, although whether cost savings would result in each case would depend upon the precise mix of services required. The National Institute on Aging has suggested that concentrating on medical intervention for the elderly instead of socioeconomic considerations is more costly to society in both fiscal and human terms.³⁶⁰

V. CONCLUSION

The history of nursing home services in the United States and government regulation of their quality has been shameful. After many years of recognized abuse and failure, new methods of enforcing the quality of care in nursing homes by revision of standards, incentive reimbursement and more varied licensing compliance remedies are now being adopted. Early indications of their effectiveness provide some hope for success. As the number of elderly needing long-term health care services increases exponentially and the costs of nursing home care skyrocket, we owe the older generation and the taxpayer the assurance that care is delivered in a responsible, high quality, humane and cost-efficient manner. The effectiveness of government regulation of health care has not been highly regarded by the public. Nursing home surveyors are easily demoralized by industry pressure and public apathy. No merely cosmetic or organizational changes will assist these regulators in performing their public duties more creatively. The regulatory system must be revitalized and reconstructed to examine more closely the care delivered to nursing home residents, and the public must be involved in the ongoing conduct of local nursing care facilities to encourage delivery of good care and to support regulatory efforts. In light of the frequent attacks on the costly and ineffective nature of regulation, the development in the next decade of a regulatory system that assures high quality nursing home care will be a major test of the potential of government regulation in a field in which success is critical to the quality of human life.

360. See Butler, *supra* note 1, at 1797.