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NURSING HOME REGULATION IN NEW JERSEY: AN OUTLINE WITH PROPOSALS FOR REFORM

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Introduction

The birth of the modern nursing home industry may be traced to the creation in 1965 by the federal government of the Medicare[1] and Medicaid[2] programs.[3] Though brief, the history of this industry has been fraught with public scandal[4] and that scandal has been compounded by the presence of an extensive governmental

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1 Act of July 30, 1965, Pub. L. 89–97, § 102, 79 Stat. 291, 42 U.S.C.A. § 1395.

2 Act of July 30, 1965, Pub. L. 89–97, § 121, 79 Stat. 343, 42 U.S.C.A. § 1396 (Supp. 1976).

3 Subcommittee on Long-Term Care of Senate Special Committee on Aging, 93d Cong., 2d Sess., NURSING HOME CARE IN THE UNITED STATES, FAILURE IN PUBLIC POLICY, INTRODUCTORY REPORT 20 (Comm. Print 1974), [hereinafter cited as *Moss Introductory Report*], describes the growth of the nursing home industry. This report and its nine supporting papers constitute the basic reference source for nursing homes in the United States. The titles of the nine supporting papers are:

SUPPORTING PAPER NO. 1, THE LITANY OF NURSING HOME ABUSES AND AN EXAMINATION OF THE ROOTS OF THE CONTROVERSY.

SUPPORTING PAPER NO. 2, DRUGS IN NURSING HOMES: MISUSE, HIGH COSTS, AND KICKBACKS.

SUPPORTING PAPER NO. 3, DOCTORS IN NURSING HOMES: THE SHUNNED RESPONSIBILITY.

SUPPORTING PAPER NO. 4, NURSES IN NURSING HOMES: THE HEAVY BURDEN (THE RELIANCE ON UNTRAINED AND UNLICENSED PERSONNEL).

SUPPORTING PAPER NO. 5, THE CONTINUING CHRONICLE OF NURSING HOME FIRES.

SUPPORTING PAPER NO. 6, WHAT CAN BE DONE IN NURSING HOMES: POSITIVE ASPECTS IN LONG-TERM CARE.

SUPPORTING PAPER NO. 7, THE ROLE OF NURSING HOMES IN CARING FOR DISCHARGED MENTAL PATIENTS.

SUPPORTING PAPER NO. 8, ACCESS TO NURSING HOMES BY U. S. MINORITIES.

SUPPORTING PAPER NO. 9, PROFITS AND THE NURSING HOME: INCENTIVES IN FAVOR OF POOR CARE.

[hereinafter cited as *Moss Supp. Papers*]

4 *See generally, Moss Supp. Paper 1.*

regulatory apparatus charged with its oversight.[5] Because of the apparent inability of existing regulatory structures to prevent extensive abuse of the Medicare and Medicaid programs, federal[6] and state[7] commissions formed to study the nursing home industry have offered proposals for its reform. This article will draw on reports of these commissions, while focusing on the existing nursing home regulatory system in New Jersey. Part I[8] will describe the State's current regulatory system. Based on this description, Parts II and III will focus on areas[9] in which the effectiveness of the regulatory apparatus could be improved.[10] Part II proposes that the New Jersey regulatory system be restructured by transferring the Medicaid program from the Department of Institutions and Agencies (I & A) to the Department of Health (DOH), while Part III analyzes several means by which consumer input could be utilized to strengthen existing departmental enforcement.

PART I: DESCRIPTION OF THE NEW JERSEY NURSING HOME REGULATORY SYSTEM

There are three major categories of medical institution defined by the Federal Medicare[11] and Medicaid[12] statutes for reimbursement under these programs: hospitals,[13] skilled nursing facilities

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5 Part I of this paper discusses the regulatory activities required under Federal Medicare and Medicaid Regulations as performed in New Jersey.

6 *See* note 3, *supra.*

7 This article will utilize the reports of both the New York and New Jersey Commissions. In New York, nursing homes were initially investigated by the Temporary State Commission on Living Costs and the Economy (The Stein Commission). The New York investigation was continued by the New York State Moreland Act Commission on Nursing Homes and Residential Facilities (The Moreland Commission).

In New Jersey, the Nursing Home Study Commission (The Fay Commission) was created by SCR 15, 1974, investigate nursing homes in New Jersey. The commission held public hearings on April 16, 1975, May 2, 1975, June 24, 1975 and October 17, 1975. These are reported as *Hearing on Personal Care Facilities For The Elderly in New Jersey Before the New Jersey Nursing Home Study Commission* (1975) [hereinafter cited as April 16, 1975 *Hearing*, May 2, 1975 *Hearing*, June 24, 1975 *Hearing*, and Oct. 17, 1975 *Hearing*].

8 *See* notes 11-151 *infra*, and accompanying text.

9 No attempt has been made in this paper to deal with each area of needed reform in the nursing home field. For more extensive treatments of nursing home problems, the reference material cited throughout the paper should be consulted. Especially useful in this regard are the materials cited at note 3, *supra.*

10 *See* notes 182-221 *infra*, and accompanying text.

11 42 U.S.C.A. § 1395 (1965).

12 *Id.*, § 1396 (1965).

13 *Id.*, § 1395X (e) (1974).

(SNF)[14] and intermediate care facilities (ICF).[15] Both the skilled nursing facilities and the intermediate care facilities are nursing homes.[16] The New Jersey scheme of institutional long-term care differs from this federally-mandated one, however, in that New Jersey provides for three rather than two levels of institutional long-term care. In addition to skilled nursing facilty care, *two* levels of ICF care are offered in New Jersey: ICF "A" care, also referred to as the ICF medical care level, and ICF "B" care, the ICF non-medical care level.[17]

The current scope of New Jersey's regulation of nursing homes is defined by the New Jersey Medical Assistance and Health Services Act (MAHSA) of 1968[18] and the Health Care Facilities Planning Act (HCFPA) of 1971.[19] The 1968 Act declared New Jersey's intent to participate in the Medicaid program,[20] denominated the Department of Institutions and Agencies (I & A) as the single state agency[21] in charge of the administration of Medicaid[22] and created the Division of Medical Assistance and Health Services (DMAHS), within I & A to administer the program.[23] The 1971 Act granted the DOH the "central, comprehensive responsibility for the development and administration" of the State's policy with respect to health planning[24] and hospital and related health care facility services,[25] instituted the Certificate of Need program and transferred several Medicaid administrative activi-

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14 *Id.*, § 1395X (j) (1974).

15 *Id.*, § 1396d (c) (1974).

16 ICF's and SNF's differ, however, in the level of nursing care which they provide and in the cost of that care to the federal and state governments. The term "skilled nursing facility" was created and defined in the Medicare statute [*See, id.*, at 1395x (j) (1974)], while the term "intermediate care facility" was created and defined in the Medicaid statute [*See, id.*, at § 1396d (c) (1974]. The Medicare program provides a benefit of up to 100 days care "per illness" in a SNF [*id.*, at § 1395d (b) (2) (1974)], but will not reimburse care in an ICF. The Medicaid program will reimburse care in Both SNF's and, if the state so chooses, ICF's [*id.*, at § 1936a (a) (13) (1974)]. The discussion of licensure standards at notes 89-112 *infra* and accompanying text further distinguishes these two levels of care.

17 *See* notes 97-103 *infra* and accompanying text.

18 N.J. STAT. ANN. § 30:4D-1 (1968).

19 *Id.* at § 26:2H-1 (1971). In addition, N.J. REV. STAT. §30:11-1 (1927) must be read *in pari materia* with this act. This act is referred to in the text as Title 30.

20 N.J. STAT. ANN. § 30:4D-2 (1968).

21 The federal Medicaid Regulations require that a state Medicaid plan be administered by a single state agency. 42 U.S.C.A. § 1396a (a) (5) (1965).

22 N.J. STAT. ANN. § 30:4D-4 (1968).

23 *Id.*

24 *Id.* § 26:2H-7 (1971).

25 *Id.* § 26:2H-1 (1971). The term "health care facility" is defined at *Id.* § 26:2H-2a (1971) as including SNF's and ICF's.

ties from I & A to the Department of Health.[26] Thus, the current nursing home regulatory structure in New Jersey, apart from the Certificate of Need program as it applies to nursing homes, is in large part a product of the State's participation in the Federal Medicaid program,[27] and of the requirements placed upon the State which condition the financial participation of the federal government in the Medicaid program. Among the administrative programs a State must conduct pursuant to federal Medicaid regulations are: the licensure of nursing homes[28] and the certification of nursing homes for participation in Medicaid;[29] the creation and maintenance of standards used in conjunction with licensure and certification;[30] the inspection and monitoring of nursing homes to enforce these standards;[31] the contracting with certified nursing homes to establish the duties and obligations of the State and the institutions in conjunction with the Medicaid program;[32] the setting of reimbursement rates for participating nursing homes;[33] the definition of eligibility for nursing home services under the Medicaid program;[34] the institution of a utilization review procedure to promote cost-efficient use of medical facilities;[35] the creation or monitoring of a medical review procedure to assess the quality of care delivered to Medicaid recipients in nursing homes;[36] the collection of informaton concerning the ownership of all nursing homes in the State;[37] and a program for the licensing of nursing home administrators in the State.[38]

At the present time these administrative functions are performed in New Jersey in the following manner: Both the Department of Health and the Department of Institutions and Agencies partici-

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26 *See* notes 154-167 *infra* and accompanying text.

27 For example, although New Jersey has required nursing homes to be licensed since 1927 [N.J. REV. STAT. § 30:11-1 *et seq.* (1927) the state's participation in the Medicaid program has made this regulatory program mandatory for the receipt of federal matching funds.

28 42 U.S.C.A. § 1396a (a)9 and § 1396a (a)33 (1974).

29 45 C.F.R. 249.33 (a) (1974).

30 42 U.S.C.A. § 1396a (a) (9) (A) (1974).

31 *Id.* § 1396a (a) 9 and § 1396a (a)33 (1974).

32 *Id.* § 1396a (a) (27) (1974).

33 45 C.F.R. 350 (a) (5) (1974).

34 42 U.S.C.A. § 1396a (a) (17) (1974).

35 *Id.* § 1396a (a) (30) (1974).

36 *Id.* § 1396a (a) (26) (1974).

37 *Id.* § 1396a (a) (35) (1974).

38 *Id.* § 1396a (a) (29) (Supp. 1976).

pate in the creation and maintenance of standards,[39] inspect and monitor long-term care facilities[40] and collect ownership information on the homes.[41] I & A, as the designated single state agency, contracts with provider institutions,[42] relying on the DOH certification recommendation of these providers.[43] Also, I & A sets the reimbursement rate for nursing homes, a responsibility soon to be moved to the Department of Health, but which will remain under the "authority" of I & A.[44] The DOH's chief administrative responsibilities relating to nursing homes are the licensure of nursing homes,[45] the making of a certification recommendation to I & A or HEW for participation in Medicaid or Medicare,[46] the licensure of nursing home administrators,[47] the inspection of nursing homes for licensure purposes[48] and the administration of the certificate of need program.[49] Also, the local county welfare boards are involved in the determination of client eligibility for the Medicaid program[50] and in the provision of social services to Medicaid-reimbursed nursing home patients.[51]

These administrative procedures will be grouped together as to the agency which performs them and discussed in detail.

A. The Department of Health

The Department of Health has the potential for the most direct and comprehensive control of nursing homes in New Jersey. The

39 The DOH is officially empowered to create licensure standards under the Health Care Facilities Planning Act, N.J. STAT. ANN. § 26:2H-5b (1971). However, such I & A programs as Utilization and Medical Review are in effect standard setting activities.

40 The DOH inspects nursing homes in conjunction with its licensure procedure N.J. STAT. ANN. § 26:2H-4a (1971). I & A, on the other hand, maintains an extensive inspection presence in the nursing homes because of the utilization and medical review procedure. *See* notes 77-81 *infra* and accompanying text.

41 DOH collects this information as a condition of licensure, while I & A collects it in the course of the cost study.

42 This power is not specifically delegated to I & A, but is implied by N.J. STAT. ANN. § 30:4D-5 (1968). *See also* May 2, 1975 *Hearing* at 35X-39X, where the 1974-75 provider contract is reproduced.

43 *See* note 86, *infra*.

44 For a full discussion of this situation *see* notes 160-167 *infra* and accompanying text.

45 *See* notes 55-65 *infra* and accompanying text.

46 *See* notes 58-65 *infra* and accompanying text.

47 *See* notes 73-76 *infra* and accompanying text.

48 *See* notes 77-88 *infra* and accompanying text.

49 *See* notes 52-54 *infra* and accompanying text.

50 Division of Public Welfare, Department of Institutions and Agencies, State of New Jersey, Public Assistance Manual, Transmittal Letter #1 (April 10, 1975), Chapter 8000, Page 16, § 8540 and Chapter 1000, Page 3, § 1220.

51 *Id.* at Chapter 7000, Page 16, § 7450.

most important control which it exercises is licensure and the related functions of standard setting and inspection. In addition, the Department has the authority to control the initial establishment and subsequent expansion of nursing home services through the Certificate of Need program, as well as the authority to set standards for the licensing of nursing home administrators.

Certificate of Need

Before a nursing home is constructed or expanded or any new health care service is instituted, the Department of Health must issue a Certificate of Need.[52] The Certificate of Need procedure gives the Department considerable latitude in controlling and monitoring nursing home establishments at an early stage. The Health Care Facilities Planning Act provides that a Certificate of Need can be issued only where:

> the action proposed in the application for such certificate is necessary to provide required health care in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of adequate and effective health care services.[53]

The control envisaged by a Certificate of Need is, therefore, based on geographical or demographic need and the financial viability of the particular project. Only after the application has been approved and a Certificate of Need issued can the nursing home obtain a license for operation.[54]

Licensure

Under the Health Care Facilities Planning Act no nursing home may be operated unless it possesses a valid license issued by the Department of Health.[55] The DOH is authorized to issue a license

> upon its findings that the principals and managements, finances, rules and bylaws, and standards of health care service are fit and adequate and there is reasonable assurance the health care facility will be operated in the manner required by this act and rules and regulations thereunder.[56]

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52 N.J. STAT. ANN. § 26:2H–7 (1971).

53 *Id.* § 26:2H–8 (1971).

54 *Id.* § 26:2H–7 (1971).

55 *Id.* § 26:2H–12 (a) (1) (1971).

56 *Id.* § 26:2H–12 (b) (2) (1971).

The Act also gives the Department the correlative functions of adopting nursing home licensure standards with the approval of the Health Care Administration Board,[57] and of periodically inspecting nursing homes to monitor compliance with those standards.[58] Where a nursing home is found to be in violation of or in noncompliance with the provisions of the Act or the regulation, the Department has the authority to deny, revoke or suspend a license[59] or to place the nursing home on probationary or provisional license,[60] and even, in certain instances, to assess and collect penalties.[61]

These three closely related State powers of licensure, standard-setting and inspection are no less important for those nursing homes which participate in Medicaid and/or Medicare.[62] Under

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[57] *Id.* § 26:2H-5 (b) (3) (1971).

[58] *Id.* § 26:2H-5 (a) (1971).

[59] *Id.* § 26:2H-13 (1971).

[60] *Id.*

[61] *Id.* § 26:2H-13, 14, 16 (1971). Before DOH pursues any of these remedies it must serve the applicant or licensee notice of the action to be taken with a specification of charges. The assessment, denial, suspension, placing on probationary or provisional license or revocation becomes effective 30 days after the mailing of such notice unless the applicant or licensee 1) has in the interim corrected the deficiency or 2) has filed an answer to the charges and has requested a hearing. *Id.* § 26:2H-13 (1971). The Department may assess penalties in the following situations: 1) where a facility is operated without a license or after the revocation or suspension of its license; 2) where a licensee is found guilty of violating a rule or regulation relating to patient care and has failed to correct such violation after 7 days notice thereof; 3) where a licensee fails to commence (within 7 days after notice) repairs on a hazardous or unsafe condition existing in or upon the structure; or 4) where a licensee maintains patients in excess of the number he is licensed to maintain (except in cases of emergency). *Id.* § 26:2H-14 (1971).

The allowable penalties in the second and third categories may range from $10 to $100 for each day of violation (*Id.* § 26:2H-14) and these penalties may be doubled where the license is found guilty of the same violation within one year and tripled for a third violation within one year, *id.* Unfortunately, the Department has not attempted to assess penalties for such violations, perhaps, as the Public Advocate suggests, because of the procedural complexity involved. May 2, 1975 *Hearing* at 19X. License revocation and Medicaid decertification are the sole remedies on which the state bases relief to penalize a noncomplying nursing home. However, both procedures ultimately force the offending nursing home to be closed. *Id.* at 17X. The Public Advocate has noted that these remedies are rarely used since closing a nursing home might aggravate a shortage of nursing home beds and could have a traumatic effect on patients when they are tarnsferred to other institutions. *Id.* at 17X, 18X. In addition, agencies and courts have demonstrated a reluctance to close nursing homes without lengthy procedural checks, because of the serious financial losses to owners which would result. *Id.* at 18X. DOH has stated that it is attempting to "streamline" its license revocation procedure for habitually non-complying nursing homes. Heretofore, this procedure consisted of a long series of warnings and reinspections, and often resulted in violations not being corrected until the time a preliminary hearing was held. The Star Ledger (Newark, N.J.) Feb. 25, 1976, at 7, col. 4.

[62] Based on figures furnished by the Department of Health, approximately 75% of all skilled nursing facilities and approximately 60% of all intermediate care facilities partici-

the Medicare statute (Title 18), the Department of Health is authorized to conduct surveys of participating skilled nursing facilities to determine whether they comply with federal standards for participation.[63] Similarly, under the Medicaid statute (Title 19), the Department is authorized to conduct surveys of skilled nursing facilities and intermediate care facilities participating in the Medicaid program to determine whether these facilities comply with federal standards for participation.[64] State control remains significant in this area, however, since Federal standards for participation in both Medicaid and Medicare require that the nursing home comply with State standards and be licensed by the State.[65]

Ownership Controls

Title 30 requires an applicant for a license to disclose to the Department of Health the identity of those having designated ownership interests in the facility and establishes certain ownership qualifications.[66] Where the applicant is a corporation, the names and addresses of and the amount of stock held by, all stockholders holding one or more percent of any of the stock,

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pate in one or both of the federal programs. Statement of Commissioner of Health Finley in April 16, 1975 *Hearing* at 2.

[63] 42 U.S.C.A. § 1395aa (a) (1974).

[64] *Id.* § 1396a (a) (9) and § 1396a (a) (33) (1974).

[65] *Id.* § 1395x (j) (9) (1974). 20 C.F.R. 405.1120, (referring to SNF: Title 18); 42 U.S.C.A. § 1396a (a) (28) (1974) (referring to SNF: Title 19); *Id.* § 1396 (c) (1) (1974). 45 C.F.R. 249.12 (referring to ICF: Title 19).

[66] N.J. STAT. ANN. § 30:11–1-5 (1968). The Health Care Facilities Planning Act provides that an application for licensure include the name of the facility, the kind or kinds of health care service to be provided, the location and physical description of the institution, and such other information as the department may require. N.J. STAT. ANN. § 26:2H–12 (b) (1) (1971). Regulations promulgated under this Act specify that each application for licensure be reviewed on the basis of character, financial and State Police references, N.J.A.C. 8:30–1.1 (b) (2), and, where corporations and lessees are "involved", a detailed statement of corporate relationships and ownership be included in the application and a copy of the lease arrangement be forwarded to the department. N.J.A.C. 8:30–1.1 (b) (5). Both the Medicare and Medicaid Acts, in identical language, require that nursing homes disclose the identity

> . . . 1) of each person who has any direct or indirect ownership interest of 10 per centum or more in such [facility] or who is the owner (in whole or part) of any mortgage, deed of trust, note or other obligation secured (in whole or part) by such [facility] or any of the property or assets of such [facility];
> 2) in case a [facility] is organized as a corporation, of each officer and director of the corporation, and
> 3) in case a [facility] is organized as a partnership, of each partner.

42 U.S.C.A. § 1395x (j) (ii) and § 1396a (a) (28) (1974) (SNF), U.S.C.A. § 1396a (a) (35) (1974) (ICF).

and the names and addresses of all officers and of all members of the board of directors must be stated on the application.[67] Where the applicant is a partnership, the names and addresses of all partners must be included on the application.[68]

No person may receive a license who has been convicted of a crime involving moral turpitude, or who has twice been found guilty of violating the provisions of the Act, or who has admitted such guilt; in addition, the Department must find that the applicant is "of good moral character" before it issues a license.[69] Where a corporation is the applicant, all legal or equitable owners of more than 10% of its stock and all officers and members of the board of directors must qualify in all respects as individual applicants.[70] Similarly, all partners in an application by a partnership must qualify as individual applicants.[71]

Through both licensure and Certificate of Need procedures, the Department of Health has the authority to monitor certain transactions involving transfers of or changes in ownership.[72]

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67 N.J. STAT. ANN. § 30:11–1.1 and 1.2 (1964).

68 *Id.* § 30:11–1.3 (1964).

69 *Id.* § 30:11–1.4 (1964).

70 *Id.* § 30:11–1.2 (1964).

71 *Id.* § 30:11–1.3 (1964).

72 Regulations promulgated under the Health Care Facilities Planning Act require that a nursing home apply for a new license in the following situations:

1. Transfer of title and property by a proprietor to another person, company or government entity;
2. The addition, removal or substitution of a partner in an existing partnership or changes in corporate stock members;
3. The merger of an incorporated licensee with an incorporated institution which is not licensed and the nonparticipating institution is the surviving corporation;
4. The consolidation of two or more corporate licensees with the resulting consolidation creating a new corporate entity;
5. The incorporation of an unincorporated licensee;
6. The operation of all or part of a licensed facility by a lessee;
7. The establishment of a relationship between the licensee and another company whereby the parent company or a subsidiary managing firm is created with the new company exercising authority for fixing policies for the operation of the licensee.

N.J.A.C. 8:30–1.2 (d).

Title 30, on the other hand, requires a licensee to give notice to the Department of any changes in the facts as stated on the license application. N.J. STAT. ANN. § 30:11–1.5 (1964). However, where there are changes in corporate stock holdings notice is not required "unless and until the aggregate of such changes, if made before the time of said application, would have prevented the issuance of the license." *Id.*

Certificate of Need regulations adopted in October, 1975 (7 N.J.R. 503) greatly enhance the ability of the Department of Health to review the character of certain proposed transactions to determine whether they are at "arms-length". A Certificate of Need is required if there is an acquisition or a transfer of ownership which will increase or establish an interest in a health care facility through sale, lease or by other means. New

Nursing Home Administrators

No nursing home in New Jersey may be licensed for operation unless the person acting as administrator has first been licensed by the Department of Health.[73] With the advice of the Nursing Home Administrator's Licensing Board, the Department has the power to promulgate regulations and minimum standards of training, experience and education with which the administrator must comply.[74] Some of the qualifications which are required of an administrator are spelled out in Title 30: no person who has been convicted of a crime involving moral turpitude or who has been found guilty of violating the provisions of the Act or who has admitted such guilt may be issued a license.[75] In addition, the Department must investigate the applicant and find that he or she is "of good moral character".[76]

Inspections

The number of inspections which the Department of Health must make of nursing homes to monitor compliance with licensure

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Jersey State Department of Health, "Guidelines and Criteria for Submission of Applications for Certificate of Need," Sect. B-VI, at 13. Such an acquisition or transfer is deemed to take place in the following circumstances:

A. CORPORATIONS:

1. There is an acquisition by or a transfer of ownership to an individual, partnership or corporation through purchase, contract, donation, gift, stock option, etc., of 25% or more of a corporation's outstanding stock (preferred or common).
2. There is acquisition of the physical assets of a corporation, partnership or individually owned health care facility by a newly formed or existing corporation.

B. PARTNERSHIPS:

1. There is acquisition by or a transfer of ownership to an individual, partnership, or corporation of 10% or more of the existing partnership's total capital interest.
2. There is acquisition of the physical assets of a corporation, partnership or individually owned health care facility by a newly formed or existing partnership.

C. PROPRIETORSHIP:

There is a purchase of the physical assets of a health care facility.

Id. at 13-14. For a discussion of the administrative review procedure applicable to this type of Certificate of Need and the information required to be submitted for such an application, *See Id.* at D-1, 21-25.

[73] N.J. STAT. ANN. § 30:11-11 (1968) and § 26:2H-27, 28 (1972). Also, federal regulations require that all participating nursing homes have an administrator licensed by the State. 20 C.F.R. 405. 1101 (a) (1) (1974), 45 C.F.R. 249.12 (b) (1) (1974).

[74] N.J. STAT. ANN. § 30:11-13, and N.J.A.C. 8:34.

[75] N.J. STAT. ANN. § 30:11-23 (1968).

[76] *Id.* § 30:11-13 (1968).

standards is not specified by statute or regulation.[77] However, since a license is valid for one year from date of issue,[78] DOH considers the "minimum surveillance requirement" to be an annual inspection.[79] These inspections are conducted on an unannounced basis[80] and they evaluate a broad spectrum of performance by the nursing home. Included in the inspection are such areas as nursing services, physician services, pharmaceutical services and dietetic services, as well as physical environment, housekeeping, clinical records, patient activities, patient care policies and administrative management.[81]

The inspection staff of the Department consists of nurses, dieticians, pharmacists, building inspectors, sanitarians and a paramedic.[82] Where there are violations discovered during the annual inspection, the practice of the Department has been to make unannounced follow-up visits.[83] There is also a surveillance team which inspects a facility in response to a specific complaint.[84]

The above procedure is followed for all nursing homes in the State, but the picture becomes more complicated when the Department makes its inspection of Medicare/Medicaid-certified facilities. In these instances, the Department is governed by Title 18 and Title 19 requirements, regulations thereunder, and HEW policies, as well as State statutes and regulations. The federally-mandated survey for Medicaid/Medicare purposes is conducted simultaneously with the annual licensure inspection.[85] After it has completed its annual survey-inspection of nursing homes participating in either the Medicare program alone or in both Medicaid and Medicare, the Department of Health forwards the results of the survey and a certification recommendation to the HEW regional office and HEW makes the certification decision.[86] If the facility is certified for participation solely in Medicaid, the Department

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[77] The Health Care Facilities Planning Act gives the Commissioner of Health the power to conduct "periodic inspections" [*Id.* § 26:2H–5 (a) (1971)], while Title 30 authorizes inspections "from time to time" as the department "may deem necessary". *Id.* § 30:1103.1 (1964).

[78] N.J.A.C. 8:30–1.4 (a).

[79] Statement by Commissioner of Health Finley in April 16, 1975 *Hearing* at 4X.

[80] *Id.*, at 5x (NOTE).

[81] *See generally,* N.J.A.C. 8:30 and 8:37.

[82] Testimony of Commissioner of Health Finley, April 16, 1975 *Hearing,* at 19.

[83] *Id.*, at 18.

[84] *Id.*, at 19.

[85] This is essentially the same procedure as that followed in New York. *See* REPORT OF THE NEW YORK STATE MORELAND ACT COMMISSION (October, 1975) at 24.

[86] Statement by Commissioner of Health Finley, April 16, 1975 *Hearing,* at 10x.

forwards the survey results and a certification recommendation to the Department of Institutions and Agencies.[87] I & A makes the certification decision for Medicaid participation unless a waiver of Life Safety Code requirements has been requested, in which case HEW finally decides on certification.[88]

Standards

The Department of Health has promulgated one set of standards for licensing skilled nursing facilities[89] and another set of standards for licensing intermediate care facilities.[90] One of the most important aspects of each set of standards is the detail with which nursing services are regulated.

For example, State standards for skilled nursing facilities require a minimum of 2.75 hours of nursing home care for each patient.[91] Further, each SNF must have at least two nursing personnel on duty at all times in case of fire or other emergency.[92] There must be no less than one registered nurse on the day tour of duty, seven days a week[93] and the SNF must have a ratio of registered nurse hours to auxiliary nursing hours of one to five, with 25% credit for licensed practical nurse hours.[94] Finally, professional and licensed nursing personnel must be distributed on each tour of duty to insure that the required quality of care is provided[95] and the amount of nursing time provided for direct patient care must be limited to nursing duties.[96]

State standards for intermediate care facility nursing services are also extremely detailed and in many respects parallel, on lower levels, the SNF standards. For ICF "A" care, the facility must provide in each 24 hour period, seven days a week, a minimum of 2.5 hours of direct care for each patient-resident;[97] registered nurses must be on duty 8 hours a day, seven days a week;[98] there

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87 *Id.*, at 12x.

88 *Id.*, at 12x.

89 N.J.A.C. 8:30. *See also,* note 16 *supra.*

90 N.J.A.C. 8:37. *See also,* note 16 *supra.*

91 N.J.A.C. 8:30-5.1 (a) (1).

92 N.J.A.C. 8:30-5.1 does not include this requirement. Instead, it is found in the Manual of Standards for Nursing Homes (SNF), published by DOH, § 5 at 1.

93 N.J.A.C. 8:30-5.1 (a) (4).

94 *Id.* 8:30-5.1 (a) (2).

95 *Id.* 8:30-5.1 (a) (5).

96 *Id.* 8:30-5.1 (a) (6).

97 *Id.* 8:37-6.1 (b).

98 *Id.*

must be a ratio of registered nurses to other staff of 1 to 5, with 25% credit for licensed practical nurses;[99] and on each 8 hour shift there must be at least one licensed practical nurse and one nurse's aide on duty.[100]

For ICF "B" care the facility must provide a minimum of 1.25 hours of direct care in each 24 hour period, seven days a week, for each resident;[101] there must be a licensed practical nurse and at least one nurse's aide on duty on each 8 hour shift, 24 hours a day, seven days a week;[102] and in every facility there must be a sufficient number of licensed practical nurses on duty to provide 20% of the minimum required hours of care in each 24 hour period.[103]

From the foregoing, it is easy to appreciate the complexity involved in the evaluation of a facility. The possibilities for confusion are increased when one considers that every ICF provides both level A and level B care, and many facilities are licensed to provide both skilled nursing and intermediate care.[104] In addition, under the new "mixed bed" policy, facilities are not required to separate patients according to the level of care which they are receiving.[105]

Where a nursing home participates in Medicaid or Medicare another "layer" of standards is added to the evaluation process: skilled nursing facility conditions for participation in Medicaid and Medicare and intermediate care facility conditions for participation in Medicaid. While the Federal standards are similar in many respects to the State standards, they are not identical. There are some areas in which Federal regulations are more stringent[106] or cover areas not the subject of State regulations.[107]

However, the State standards for nursing services mentioned above are notably more stringent than corresponding Federal standards. For SNF care, federal regulations require that the facility provide 24 hour service by licensed nurses, including the

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99 *Id.*

100 *Id.*

101 *Id.*

102 *Id.*

103 *Id.*

104 Figures supplied by the Bureau of Long Term Care of HEW indicate that as of November 1975, of the 231 nursing homes in New Jersey which participate in Medicare and Medicaid or Medicaid alone, 205 were certified to provide both SNF and ICF care.

105 Statement by Commissioner of Health Finley, April 16, 1975 *Hearing*, at 3x.

106 *See, e.g.*, 20 C.F.R. 405.1123.

107 *See, e.g.*, 20 C.F.R. 405.1122, 20 C.F.R. 405.1137.

services of a registered nurse at least during the day tour of duty seven days a week.[108] Further than this there is only the mandate that there be a "sufficient number of qualified nursing personnel to meet the total nursing needs of all patients".[109] In the same area of nursing services ICF conditions for participation require only that "nursing services, including restorative nursing, are provided in accordance with the needs of the patient".[110]

It is evident that State standards are geared to a careful monitoring of nursing hours to patient census, an objective which is lacking under Federal regulations.[111] In general it should be observed that while the highly detailed State standards contribute to the inherent complexity of nursing home regulation, these detailed standards, if properly enforced, lead to a better quality of patient care than that envisaged by the very general and somewhat vague Federal standards.[112]

B. The Administrative Responsibilities of the Department of Institutions and Agencies

Unlike the Department of Health, the Department of Institutions and Agencies is involved in the regulation of only those nursing homes which accept Medicaid-reimbursed patients. While it regulates these homes chiefly through the activities of the Division of Medical Assistance and Health Services (DMAHS),[113] it also coordinates and oversees the Nursing Home related activities of the local county welfare boards through the Division of Youth and Family Services (DYFS)[114] and the Division of Public Welfare (DPW).[115]

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108 20 C.F.R. 405.1124.

109 *Id.*

110 45 C.F.R. 249.12 (a) (9) (v).

111 HEW's failure to promulgate such minimum nurse-patient ratios has been criticized by the Moss Subcommittee on Long Term Care as resulting in situations where an inordinate amount of care is provided by unlicensed aides and orderlies. Moss INTRODUCTORY REPORT, note 3, *supra* at 49.

112 For a discussion of Federal Medicare and Medicaid regulations as related to New York State licensure regulations, *see, Report of the New York State Moreland Act Commission,* (October, 1975) at 29-38. The Moreland Commission noted that while the New York State regulations were in some areas stronger than federal regulations, the State Health Department had failed to develop effective enforcement policies and procedures to take advantage of its "significant incremental standard setting powers." *Id.*, at 29.

113 N.J. STAT. ANN. § 30:4D-1 (1968).

114 *Id.* § 30:4C-2 (1974).

115 *Id.* § 30:4B-1 (1967).

Division of Medical Assistance and Health Services

The DMAHS is charged with the responsibility of administering the Medicaid program.[116] However, as the discussion of the Department of Health's nursing home regulatory activities has pointed out, much of the most important regulation of Medicaid-reimbursed nursing homes is the responsibility of that Department. DMAHS does, however, conduct two large regulatory[117] programs: the cost study program and the medical and utilization review program.

Cost Study

Nursing homes are reimbursed by the Medicaid program on the basis of a cost study[118] which must be submitted annually by each facility and which delineates the prior year's costs upon which the

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116 *Id.* § 30:4D–4 (1968).

117 I & A, however, does not consider these to be "regulatory" in nature. *See*, testimony of I & A Commissioner Klein, April 16, 1975 *Hearings* at 30:

> With regard to nursing homes our primary goal is to purchase services as needed, and as appropriate, for people who need long term care. The division is not designed to be a regulatory agency although, to reasonably discharge its public responsibility, the Division does exercise some regulatory functions in connection with nursing homes.

118 A copy of the 1975 Cost Study is included in May 2, 1975 *Hearings* at p. 40x. The most important aspects of the reimbursement of New Jersey's nursing homes, as revealed by the Cost Study are:

—The per patient per day rate paid by Medicaid for each level of care may not exceed the lowest daily semi-private room rate charged to private patients.

—If a nursing home has operated at less than 80% capacity for the previous year, the home's variable costs will be adjusted to reflect an 80% capacity for that year. This is done to prevent abnormally high per diem cost figures caused by under-utilization of the facility.

—An inflation factor is set annually, and is added to the appropriate variable costs in the study. However, the resultant rate is still subject to the administrative ceiling.

—Only straight line depreciation is allowed in the cost study; no accelerated depreciation is permitted. Also, depreciation may not be computed on appraisal value.

—An imputed rental option is available to be used in place of actual depreciation, thus providing a bonus to operators of older properties who own their properties outright or subject to a small mortgage. This imputed rental is supposed to deter sale and leaseback arrangements by these owners.

[*See*, Testimony of Michael Siavage, Counsel, State Commission of Investigation, May 2, 1975 *Hearing* at 42a for a criticism of this practice.]

—The cost of social services and salaries for social workers and social work consultants are not permitted to be included in the cost study.

—There is no profit figure included in the cost study.

—No uniform accounting system or uniform fiscal year is required to be used by the nursing homes for purposes of the cost study. Also, a yearly audit by a certified public accountant is not required, rather a yearly review by an independent public accountant is the requirement.

facility's reimbursement rates for the following year are based.[119] Once a facility submits its yearly cost study, the Division of Audit of I & A does not review it in any depth until an audit is performed.[120] In this audit the audit personnel go out into the facility and examine at length the facility's records in order to determine the accuracy of the cost study and the correctness of the State's reimbursement based upon that cost study.[121] Currently, approximately 20% of Medicaid-reimbursed homes have not yet been given a per diem audit.[122]

Utilization and Medical Review

Utilization review is a federally-mandated cost-control procedure in which admissions to nursing homes, the duration of patient stays in nursing homes and the type and frequency of professional services furnished within the homes are monitored.[123] Medical review is an analysis of the quality of the professional care delivered in a nursing home.[124] Federal medical review regulations include a requirement for the periodic on-site state-conducted inspection of nursing homes[125] and for the individual contact of each recipient of public medical assistance during this inspection to review the recipient's condition through personal observation and inspection

—Ceilings are placed on the salaries allowed to be paid to the nursing home administrator. These ceiling figures increase with the size of the home.

—Legal expenses are allowed to be included in the cost study, but legal expenses incurred in the defense of a criminal or civil suit brought by a governmental agency may only be included upon order of the court.

119 However, the reimbursement rate is subject to an administrative ceiling. *See*, May 2, 1975 *Hearing* at 15x.

120 The Star Ledger (Newark, N.J.), June 25, 1976, § 1 at 20, col. 4-8, reports that an Office of Fiscal Affairs audit of DMAHS concluded that these nursing home audits were being performed too infrequently, due to understaffing.

121 As a condition of the provider agreement, a nursing home must allow state personnel access to all financial records. May 2, 1975 *Hearing* at 37x.

122 Testimony of Gerald Reilly, April 16, 1975 *Hearings* at 41.

123 45 C.F.R. 250.20 (a) (1) (1974).

124 45 C.F.R. 250.23 (a) (1) (1974). Actually, federal regulations assign this term only to this review as it applies to SNF's; independent professional review is the term for this procedure as it applies to ICF's. 45 C.F.R. 250.24 (a) (1975). The major difference between these two operations is that medical review in SNF's must be performed by a physician. 45 C.F.R. 250.23 (a) (2) (ii) (1974). Because the New Jersey procedure does not differentiate between these types of homes and because a physician leads all medical review teams (though the physicians do not see each patient) the term "medical review" is used here to refer to the review of both SNF and ICF patients, although citation will be made to both medical review and independent professional review regulations.

125 45 C.F.R. 250.23 (a) (2) and (a) (3) (iii) (1974; 45 C.F.R. 250.24 (a) (2) and (a) (3) (iii) (1975).

of the nursing home's medical records.[126] Although both medical review and utilization review are required by federal regulation, the methods by which a state program may meet these requirements are varied. Federal regulations allow them to be coordinated into a single program, provided that the on-site inspection requirement is met.[127] This is the procedure followed in New Jersey.

The Bureau of Long Term Care (BLTC) of DMAHS, administers the coordinated utilization and medical review program[128] utilizing a staff of over 12 consulting physicians, 48 nurses and 22 social workers.[129] The system has three basic components: 1) the admission and the duration-of-stay assessment; 2) the medical review team conference; and 3) the periodic on-site inspection.[130] The admission assessment must be made by a Medicaid staff nurse prior to the admission of each Medicaid recipient to a nursing home.[131] If the patient is being admitted from a hospital, however, the admission assessment may be made within 30 days of patient admission to the nursing home.[132] The duration-of-stay assessments are made at periodic intervals after the patient has been admitted to evaluate the care which the patient has received in the home[133] (a medical review goal) and to determine whether or not the patient requires the level of nursing care currently being received[134] (a utilization review goal). These admission and duration-of-stay assessments form the backbone of New Jersey's utilization and medical review procedure. During these assessments the nurse fills out an elaborate assessment form[135] on which

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126 45 C.F.R. 250.23 (a) (3) (v) (1974); and 45 C.F.R. 250.24 (a) (3) (v) (1975).

127 C.F.R. 250.23 (b) (1974); and 45 C.F.R. 250.24 (b) and (c) (1975).

128 The authorization for the DMAHS to administer this program is found in N.J.A.C. 10:45-1.12.

129 Testimony of Gerald Reilly, April 16, 1975 *Hearings* at 32.

130 Division of Medical Assistance and Health Services, New Jersey Department of Institutions and Agencies, Inter-Bureau Procedural Directive: *Procedure for Periodic Medical Review and Medical Inspection in SNF (and ICF's) in the N.J. Medical Assistance and Health Services Program* (Oct. 15, 1973) [hereinafter cited as *Procedure*] outlines this procedure.

131 *Id.* at 2.

132 *See,* Division of Medical Assistance and Health Services, New Jersey Department of Institutions and Agencies, Guidelines for Completing Form MCNH 4 and 5 (Revised 1973) at 3.

133 *Procedure,* note 130 *supra* at 2.

134 *Id.*

135 Division of Medical Assistance and Health Services, New Jersey Department of Institutions and Agencies, Form MCNH 4 and 5 (Rev. September 1973), at 1-12. [Hereinafter referred to as Form MCNH 4 and 5.]

are recorded impressions of the care the patient has received and the care believed to be needed by the patient. This information forms the basis for all decisions made in the medical review team conference as to the appropriateness of the patient's placement in the nursing home, as well as to all conclusions regarding the quality of care received by the patient in the nursing home assessed. [136]

In addition, the information gathered in these assessments creates the basis for a yearly utilization and medical review rating of the facility. The information included on the assessment form is summarized into 24 "quality-of-care" categories for the purposes of this yearly review. In conjunction with each patient assessment the nursing home is ranked satisfactory or unsatisfactory in each category to provide a profile of the quality of the care received by that patient.[137] At the time of a nursing home's yearly periodic on-site inspection these summary conclusions are collated to provide a general profile of the quality of care delivered by the facility in that year.[138] If in any of the 24 quality-of-care categories a facility has received unsatisfactory ratings in 25% of the assessments for the prior year, that category of care is rated unsatisfactory for the year.[139] This profile is presented to the facility during the yearly periodic on-site medical review team visit.[140] The facility must respond to any unsatisfactory ratings by preparing a formal plan of correction. This plan of correction is monitored by a local medical assistance unit and the facility may be revisited by the medical review team to observe the remedial efforts of the facility.[141] If a plan of correction is not implemented, remedies available to the State are: 1) termination of patient placement within a facility; 2) decertification of the facility from the Medicaid program and 3) recommendation of revocation of the facility's license by the Department of Health.[142]

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136 *Procedure,* note 130 *supra* at 2. The decisions are documented on Form MCNH 4 and 5 at 13, 14.

137 *Procedure,* note 130 *supra* at 2; form MCNH 4 and 5 at 15 and 16.

138 *Procedure,* note 130 *supra* at 3; the facility's quality-of-care summary is prepared on New Jersey Department of Institutions and Agencies, Division of Medical Assistance Health Service Form MCNH 51 (August 1973).

139 *Procedure,* note 130 *supra* at 3.

140 *Id.* at 4.

141 *Id.* at 3.

142 For a discussion and criticism of these and other remedies *see,* Report of the Public Advocate, May 2, 1975 *Hearing,* at lx-33x.

The County Welfare Boards

The 21 local county welfare boards are a potentially important, but much ignored component of the state regulatory presence in New Jersey's nursing homes. Each board is organized into two distinct administrative units: 1) an income maintenance unit, which is responsible for the determination of certain clients' eligibility for the medicaid program and for the initiation of procedures for placement in nursing homes; and 2) a social service unit, which is responsible for the preparation of social studies at the time of patient placement, for visiting all Medicaid recipients in nursing homes at periodic intervals, and for performing various types of social services on an individual patient-need basis.[143] Because there is no uniform centralized welfare administrative structure in New Jersey, the activities of the various county welfare boards regarding the nursing home population within their control differ from county to county.[144] However, the Division of Public Welfare of I & A is responsible for the state-wide coordination of the income maintenance units of the local county welfare board[145] and the Division of Youth and Family Services of I & A is responsible for the coordination of the social service unit functions of the local boards.[146]

PART II: THE STRUCTURAL REFORM OF NURSING HOME REGULATION IN NEW JERSEY

There are two major structural problems with the current New Jersey nursing home regulatory scheme: 1) its structure, as outlined in the Health Care Facilities Planning Act and Medical Assistance and Health Services Act, is ambiguous and 2) there is at least a partial duplication of effort and lack of coordination as to the results of the inspection procedures conducted by the DOH and I & A.

The Medicaid program began functioning in New Jersey on January 1, 1970, a creation of the New Jersey Medical Assistance and Health Services Act.[147] The administrative structure outlined

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143 Division of Public Welfare, New Jersey Department of Institutions and Agencies, Public Assistance Manual, Ch. 7000, § 7450 (April, 1975).

144 *See generally, Id.* at Ch. 3500.

145 N.J. STAT. ANN. § 30:4B–1 (1968; *see generally*, N.J.A.C. 10:81, especially 10:81–3.2 and 3.3.

146 N.J. STAT. ANN. § 30:46–2 (1968); *See generally*, N.J.A.C. 10:123, especially 10:123–1.2.

147 N.J. STAT. ANN. § 30:45–1 (1968).

in this act was altered by the passage of the Health Care Facilities Planning Act of May 10, 1971,[148] the partial purpose of which was to "... (transfer) certain powers and duties from the Department of Institutions and Agencies to the Department of Health..."[149] The ambiguity of the words "certain powers and duties" has created interpretive problems, however, as to which specific powers and duties the legislature intended to transfer to the Department of Health.[150] For example, Sections 1[151] and 19[152] of the Act can be expansively interpreted as having relieved the Department of

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148 *Id.* § 26:2H–1 (Supp. 1975-76).

149 *Id.* § 2H–1 (Supp. 1975-76).

150 *Id.* § 26:2H–1, 19, 20, 21 (Supp. 1975-76) deal with this transfer.

151 N.J. STAT. ANN. § 26:2H–1 (Supp. 1975-76) reads:

> It is hereby declared to be the public policy of the State that hospital and related health care services of the highest quality, of demonstrated need, efficiently provided and properly utilized at a reasonable cost are of vital concern to the public health. In order to provide for the protection and promotion of the health of the inhabitants of the State, the State Department of Health, which has been designed as the sole agency in this State for comprehensive health planning under the "Comprehensive Health Planning and Public Health Services Amendments of 1966" (Federal Law 89-749), as amended and supplemented, shall have the central, comprehensive responsibility for the development and administration of the State's policy with respect to health planning, hospital and related health care services, and all public and private institutions, whether State, county, municipal, incorporated or not incorporated, serving principally as boarding, nursing or maternity homes or other homes for the sheltered care of adult persons or as facilities for the prevention, diagnosis, or treatment of human disease, pain, injury, deformity or physical condition, shall be subject to the provisions of this act.

152 N.J. STAT. ANN. § 26:2H–19 (Supp. 1975-76) reads:

> All of the functions, powers and duties of the State Board of Control, the Commissioner of Institutions and Agencies and the Department of Institutions and Agencies and its Hospital Licensing Board related to administration of laws governing and concerning boarding homes for the sheltered, care of children and adult persons, private mental hospitals, convalescent homes, private nursing homes and private hospitals, and relating to the planning, construction and licensing of health care facilities as defined in this act and the power to receive, allocate, expend and authorize the expenditure of Federal moneys available for health care facility construction and renovation are hereby transferred and assigned to, assumed by and devolved upon the State Department of Health. To effectuate such transfer there shall also be transferred such officers and employees as are necessary, all appropriations or reappropriations, to the extent of remaining unexpended or unencumbered balances thereof, whether allocated or unallocated and whether obligated or unobligated, and all necessary books, papers, records and property. All rules, regulations, acts, determinations and decisions in force at the time of such transfer and proceedings or other such matters undertaken or commenced by or before the Department of Institutions and Agencies or the Hospital Licensing Board pertaining to the planning, construction, licensing and operation of such health care facilities, and the administration of Federal moneys for health care facility construction, and renovation pending at the time of such transfer, shall continue in force and effect until duly modified, abrogated or completed by the Department of Health.

Institutions and Agencies of the responsibility of administering the Medicaid program in its entirety, or at least as it applies to nursing homes. [153]

The New Jersey Attorney General's Office has issued a formal opinion[154] which highlights the interpretive problems created by the drafting of the Health Care Facilities Planning Act, and indicates the need for the legislative restructuring of the New Jersey nursing home regulatory system. The opinion addresses the question of whether the legislature has authorized the Commissioner of Institutions and Agencies or the Commissioner of Health care facilities to set reimbursement rates for the Medicaid program.[155] It points out that although the Health Care Facilities Planning Act empowered the Commissioner of Health to establish the rates

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153 These two sections, which place within the State Department of Health the "central, comprehensive responsibility for the . . . administration of the State policy with respect to . . . health care services" ("health care services" being defined in § 2 (b) of the Act to include care provided in both skilled nursing and intermediate care facilities) and which transfer to the Department of Health "All of the functions, powers and duties of . . . the Department of Institutions and Agencies . . . related to administraion of laws governing . . . private nursing homes", can be interpreted as having relieved the Department of Institutions and Agencies of the responsibility of administering the Medicaid program in its entirety, or at least as the program applies to nursing homes.

The argument that the Health Care Facilities Planning Act effectively transferred the Department of Institutions and Agencies' responsibility over Medicaid to the Department of Health is bolstered by § 18 (b), 5 (a), and 5 (b) of the Act. The two chief regulatory devices used by DMAHS to monitor the nursing homes are the cost study and audit procedure and the utilization and medical review procedure. § 18 (b), 5 (a) and 5 (b) of the Health Care Facility Planning Act can be read to have transferred both of these procedures to the Department of Health § 18 (b) states:

> . . . payment by government agencies for health care services provided by a health care facility shall be at rates established by the commissioner (of Health), based on elements of costs approved by him.

This section may be interpreted as transferring the cost study and auditing responsibilities to DOH, although this interpretation has recently been rejected by the New Jersey Attorney General (*see* notes 160-167, *infra*). Also, the Health Care Facilities Planning Act can be seen to have transferred responsibility for the conducting of medical and utilization review in nursing homes. § 5 (a) of the Act reads, "The Commissioner (of Health) . . . shall have the power . . . to conduct periodic inspections of such (health care) facilities with respect to the fitness and adequacy of . . . personnel . . ."; § 5 (b) of the Act empowers the Commissioner of Health to:

> adopt and amend rules and regulations . . . to effectuate the provisions and purposes of this act, including but not limited to: (1) the establishment of requirements for a uniform State-wide system of reports and audits relating to quality of health care provided, health care facility utilization and cost; . . .

§ 5 (a) can be interpreted as giving the Department of Health the responsibility to perform the medical reviews, while § 5 (b) at least empowers the Department of Health to set up procedures, regulations and forms for the utilization reviews.

154 New Jersey Department of Law and Public Safety, Opinion of the Attorney General #8—1976, (Feb. 27, 1976).

155 *Id.* at 1.

at which government agencies will pay for health care services provided by a health care facility,[156] the legislature did not repeal the prior grant of this authority to the Commissioner of Institutions and Agencies in the New Jersey Medical Assistance and Health Services Act.[157] Based upon this lack of an express repeal and upon rules of statutory interpretation,[158] the opinion concludes that the authority to set reimbursement rates for the Medicaid program's health care facilities remains with the Commissioner of Institutions and Agencies.[159]

This results in a situation in which the Commissioner of Health has the power to establish reimbursement rates for hospitals and nursing homes paid by Blue Cross[160] (and Medicare),[161] but does not have the same power to set Medicaid reimbursement rates, which must be established under the "authority" of the Commissioner of Institutions and Agencies.[162]

There has been much discussion concerning the lack of a clear, coordinated administrative structure for regulating nursing homes in New Jersey. Without further legislative clarification of the responsibilities of the Department of Health and the Department of Institutions and Agencies concerning nursing homes there is no reason to believe that this confused situation will not continue, since it is based at least in part on the ambiguities and conflicts inherent in the New Jersey Medical Assistance and Health Services Act and the Health Care Facilities Planning Act.

The overlapping of responsibilities between the utilization and medical review procedure of I & A and the licensure and inspection

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156 *Id.* at 2.

157 *Id.* at 3.

158 *Id.* at 3:

> The general rule is that when two statutes deal with the same subject, one in specific and concrete terms and the other in a more general manner, the specific statute will supersede the general and govern a given situation. 2A Sutherland, *Statutory Construction*, § 51.05 (4th Ed. 1973). The Supreme Court of New Jersey has consistently applied this doctrine whenever it is necessary to discern probable legislative intent. *See, e.g., W. Kingsley v. Wes Outdoor Advertising Co.*, 55 N.J. 336, 339 (1970); *State, by Highway Com'r v. Dilley*, 48 N.J. 383, 387 (1967). In the present circumstance, the specific and comprehensive manner with which the Legislature addressed the issue of Medicaid reimbursement leads one to conclude that the Commissioner of Institutions and Agencies possesses exclusive jurisdiction to establish and determine the reasonableness of reimbursement rates.

159 *Id.* at 4.

160 New Jersey Department of Law and Public Safety, Opinion of the Attorney General #12–1975 (April 30, 1975). This authority is exercised in conjunction with the Commissioner of Insurance.

161 Medicare rates are based upon the Blue Cross rates.

procedure of the DOH exemplifies the lack of sufficient coordination between these agencies and the need for a more unified administrative structure for the entire nursing home area.

Both the DOH, in its licensure and certification inspections, and I & A in its medical and utilization review procedure, conduct extensive monitoring activities in New Jersey's nursing homes. This is not in itself objectionable, for the two agencies assess, at least in part, different aspects of nursing home care. DOH performs the more broadly-based review, assessing every aspect of a home's performance, while the utilization and medical review procedure is much more narrowly focused and concentrates predominantly on the professional health care services delivered in the homes. However, both of these inspection procedures are autonomous, do not rely upon or effectively coordinate with each other, and thus create unnecessary and wasteful conflicts.[163] For example, among the items included on the Department of Health's inspection survey form to be assessed is the nursing home's utilization review program.[164] However, as has been explained above,[165] this function is performed for Medicaid purposes by the Bureau of Long Term Care of I & A, not the nursing home. Also, during the licensure and certification inspection the DOH attempts to assess the quality of professional care delivered in a nursing home.[166] The DOH bases this asessment on a selective sampling of the facility's records. Instead, the Department should rely for

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162 The Star Ledger (Newark, N.J.) March 7, 1976 § 1 at 26, col. 5-8 reports the reaction of the Commissioners of DOH and I & A to the Attorney General's Formal Opinion #8 (1976). Although the opinion declared that the Commissioner of I & A has the "exclusive authority" to establish Medicaid reimbursement rates, the DOH will begin to perform this function for the Commissioner of I & A beginning in July of 1977. "Institutions and Agency *(sic)* Commissioner Ann Klein agrees in that the Health Department is the most appropriate rate-setting agency and has agreed to use the rates (Commissioner of Health) Finley determines are adequate...." However, the agreement" outlined in this article does not result in what the Legislature contemplated in the Health Care Facilities Planning Act, because the Commissioner of I & A still has a "veto power" over the rate set by the Commissioner of DOH, by virtue of its continued final authority in the setting of Medicaid provider rates. This "authority" was exercised, the article points out, in August of 1975 to reduce provider fees due to a deficit in the Medicare budget, and will continue to be available to the Commissioner of I & A under the current interpretation of the Health Care Facilities Planning Act as articulated in Formal Opinion #8.

163 REPORT OF GOVERNOR'S CABINET COMMITTEE ON MEDICAID REIMBURSEMENT FOR NURSING HOME CARE (November 13, 1975) [hereinafter cited as REPORT OF GOVERNOR'S COMMITTEE] at 43, however, reports progress in interdepartmental coordination.

164 20 C.F.R. 405.1137 (1975).

165 *See* notes 123-142 *supra* and accompanying text.

166 20 C.F.R. 405.1123 and 405.1124 (1974) (SNF); 45 C.F.R. 249.12(a) (9) (1974) (ICF).

licensure purposes on the conclusions of the more elaborate and extensive medical review procedure conducted by the Bureau of Long Term Care of I & A.

Apart from the increased costs which must arise from such duplication of effort, the greatest problem caused by this duplication occurs when the findings of one agency's inspection conflicts with the other agency's conclusions.[167] When this happens, the conclusions of the one inspection are in effect neutralized by the conflicting conclusions of the other. This results not only in nursing homes perhaps being absolved from making changes that at least one agency believes necessary, but also in the engendering of a rather cynical attitude on the part of the nursing homes concerning the results of all such inspections and of the activity of State regulation in general.[168]

If the two inspection procedures of DOH and I & A were fully coordinated, with each agency assessing only those aspects in which its competence is clear, and with only one coordinated inspection report being issued to the nursing homes, a more efficient and effective assessment procedure could result.

Solution: Removal of Medicaid to DOH

A more coherent and efficient nursing home regulatory apparatus could be attained in New Jersey if the responsibility for the Medicaid program were removed from the Department of Institutions and Agencies and placed in the Department of Health. This would be accomplished by the transfer of the Division of Medical Assistance and Health Services to the Department of Health and the denomination of the Department of Health as the "single state agency" for the Medicaid program. Several reasons compel this conclusion: 1) The denomination of the DOH as a single state Medicaid agency is the only way under current federal regulations that the most important of the nursing home regulatory activities of the Medicaid program can be placed within the responsibility of a single administrative agency. 2) The ambiguities inherent in the

[167] In REPORT OF THE NEW YORK STATE MORELAND ACT COMMISSION (October, 1975) REGULATING NURSING HOME CARE: THE PAPER TIGERS, at 86 are the results of an empirical study designed to investigate whether that State's Medicaid period medical review procedure and its inspection survey procedure provide similar conclusions as to the adequacy of care rendered in that State's SNF's. The study concluded: "The analysis has shown there is little correlation between the two systems, but not necessarily that either or both are inaccurate or ineffective . . ." (at 108). A similar structure exists in New Jersey. Therefore, similar conclusions may be drawn.

[168] *See generally*, testimony of William R. Martin, June 24, 1975 *Hearings* at 3-56. As to the conflict between DOH and I & A inspections, *see*, p. 47.

Health Care Facilities Planning Act, as it intersects with the Medical Assistance and Health Services Act, can be resolved in a way most compatible with what appears to be the intent of the Health Care Facilities Planning Act by this proposed transfer. 3) The current licensure inspection procedures of the DOH could be more effectively coordinated with the utilization and medical review procedures of I & A, if both programs were the responsibility of the DOH. 4) The transfer of Medicaid from I & A to DOH hopefully would result in a more pronounced emphasis on the public health aspects of the program and in an even greater emphasis on the delivery of quality health care in New Jersey's nursing homes.

The placement of the Medicaid program in the DOH and that Department's denomination as the Medicaid "single state agency" is the simplest method under current federal law to achieve a unified nursing home administrative structure in New Jersey. Federal regulations, as discussed in Part I, require that no matter where the "single state agency" is placed the state health agency must license Medicaid-reimbursed nursing homes and recommend them for certification to the "single state agency". Thus, DOH, as the State health agency, must always be substantially involved in the administration of Medicaid reimbursed nursing homes because of its licensure responsibility. However, even if I & A were not currently designed as the Medicaid "single state agency", the only Medicaid function federal regulations would require to be placed within its responsibility would be eligibility determination, which is currently being performed by the county welfare boards and supervised by I & A. Thus, while federal regulations require the participation of both agencies in the administration of Medicaid,[169] the DOH's mandated licensure role is much more crucial to the delivery of quality nursing home care than I & A's required role of eligibility determination. Because DOH is required under Federal law to perform such an extensive role in the regulation of nursing homes, it is only through its denomination as the Medicaid "single state agency" that a unified nursing home administrative structure is possible.

The transfer of Medicaid to the DOH would eliminate existing ambiguities in the nursing home regulatory structure created by the Health Care Facilities Planning Act. The current

[169] This requirement can be seen as a product of the dual nature of the Medicare program. It is both a public health program and a welfare program. The mandated DOH role reflects the public health aspects of Medicaid, while the mandated I & A role reflects the welfare aspects of the program.

situation of I & A having, for example, "authority" over DOH in the rate setting area even though the Health Care Facilities Planning Act delegates that authority to the DOH would be remedied. Also, DOH would have the primary authority for rate setting in the Medicaid area that it now has in the private insurance rate-setting area, if it were denominated the state Medicaid agency. Additionally, this proposed move of the Medicaid program to the DOH may be seen as the final logical step in a procedure begun by the Health Care Facilities Planning Act, but imperfectly realized in that Act, of placing in the DOH the primary responsibility for all of New Jersey's health-related regulatory activities.[170]

Currently the DOH has a full scale inspection program for nursing homes as a part of its licensure and certification programs, and I & A has another full-scale inspection program in its utilization and medical review procedure. Although these programs have different emphases and capabilities for assessing different aspects of a nursing home's performance, the state's assessment capability would be improved if they were effectively coordinated. Each inspection procedure would benefit from this coordination. The DOH's inspection procedure would benefit from reliance upon the medical and utilization review procedure's patient quality care assessments, since the Bureau of Long Term Care personnel are more familiar with this aspect of nursing home care due to their more frequent presence in the homes and their singular concern for the assessment of patient care in the medical and utilization review procedure.[171] Also, the medical and utilization review program should be improved by coordination with DOH's standard-setting capability, since the medical and utilization review program currently utilizes its own criteria for patient care rather than criteria developed by the DOH and promulgated as standards.[172] In addition, the patient would benefit from the fuller coordination possible under a uniformly administered inspection capability. For example, a proper coordination of the two inspection procedures could link the results of both inspections so that a nursing home could not receive a license to operate or a certificate for Medicaid participation unless the periodic medical review rated the facility as "satisfactory" or unless a facility initially rated

170 Testimony of Sen. Dumont, April 16, 1975 *Hearings* at 9, 10 corroborates this interpretation.

171 The number of personnel involved with utilization and medical review procedure demonstrates the greater capacity of this procedure to assess patient care. *See* note 129 *supra*. *Cf.* Testimony of DOH Commissioner of Health Finley, April 16, 1975 *Hearings*, at 18, 19, as to the staffing of the inspection teams.

172 MCNH Form 4-5 embodies these standards.

"unsatisfactory" completed implementation of its plan of correction within a short specified period of time.[173]

There are currently three sources of nursing home regulation in New Jersey: 1) licensure standards, 2) Medicare regulations and 3) Medicaid regulations. Of these three areas of nursing home regulation, the State regulation of the first two is the sole responsibility of DOH, while I & A is only responsible for the regulation of Medicaid-recipient nursing homes. This results in an administrative segregation of homes which accept Medicaid-reimbursed patients, since nursing homes which accept only private patients or only private and Medicare-reimbursed patients are regulated exclusively by DOH. Administrative segregation such as this cannot help but emphasize the public welfare component of the Medicaid program at the expense of the public health component of that program. By removing the Medicaid program from I & A and by placing it in DOH, the predominantly public health organization of DOH would, hopefully, reverse this emphasis.

While the transfer of the administrative responsibility for the Medicaid program from I & A to DOH would solve many problems currently perceived in the nursing home regulatory structure, this proposed transfer may be objected to as too drastic a solution to problems which may be remedied in other ways. Such less drastic solutions could include the imposition of a more effective coordinative capability upon the current nursing home regulatory structure[174] or the transfer of only some of the I & A Medicaid administrative activities to the DOH while retaining others in I & A.[175] However, increased coordinative activities between DOH and I & A would be time consuming for the administrative personnel involved and would preserve the inefficiencies inherent in the current administrative structure, as would the transfer of such individual programs. The current complications in the New Jersey nursing home administrative structure are a product of reform attempts such as these.[176]

Only the complete transfer of the responsibility for the Medicaid program from I & A to DOH, by the denomination of DOH as the Medicaid single state agency, will effectively remedy the structural problems in New Jersey's current nursing home regulatory system.

173 For current coordination efforts between the procedures, *see* REPORT OF GOVERNOR'S COMMITTEE, note 168 *supra*.

174 This is currently the policy being recommended in the REPORT OF GOVERNOR'S COMMITTEE, note 168 *supra*.

175 For example, the Bureau of Long Term Care which performs utilization and medical review could be transferred from I & A to DOH and with this transfer the State's inspection procedures could be coordinated.

176 The Health Care Facility Planning Act can be seen as such an attempt.

PART III: THE ROLE OF THE NURSING HOME CONSUMER

Legislation reforming nursing home regulation in New Jersey should focus greater attention on the nursing home patient—as well as his family and the public at large—as "consumers" of the health care delivery system. While the controls on nursing home abuses outlined above which now exist in the law are many and have the potential to become more effective through greater coordination, the nursing home consumer represents a potential control which should not be ignored. The goal of all nursing home reform is to improve the quality of patient care and to curb abuses which directly or indirectly affect the daily existence of the elderly in nursing homes. At present, the patient and the patient's family may be most in a position to know about specific abuses, but least in a position to do anything to improve the situation.

The consumer now has several means of access to state regulatory machinery. He or she may register a complaint with or seek information from the State Ombudsman for the Aged within the Department of Community Affairs,[177] and a complaint to state officials may initiate a surveillance inspection by DOH.[178] Both the annual inspections of DOH and the periodic medical review inspections of I & A provide some contact with the patients in nursing homes.[179] And, as discussed below, both state and federal regulations allow limited public access to inspection results.

However, when considered in the light of the medical and psychological condition of the nursing home patient and the harsh realities of his surroundings, the above-mentioned contacts are too inade-

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[177] In 1975, under a one year grant from HEW, New Jersey established the position of Nursing Home Ombudsman for the Elderly within the Division on Aging of the Department of Community Affairs. The duties of the ombudsman include investigating complaints from nursing home patients, and their relatives and friends which are received in the mail or via the senior citizen "hot line". Sunday Star Ledger (Newark, N.J.), Aug. 24, 1975, § 1, at 60, col. 1, and N.Y. Times, Sept. 22, 1975, New Jersey section at —, col. 1.

The New Jersey Association of Health Care Facilities has begun a program called "cool line" by which member facilities post notices on their premises encouraging patients to discuss any complaints which they might have with the administration. If the complaints are not then resolved the patient may call the Association via the special "cool line". April 16, 1975 *Hearing* at 61A.

The New Jersey Nursing Home Study Commission has recommended legislation to establish a permanent Division of Nursing Home Ombudsman in the Department of the Public Advocate. INTERIM REPORT OF THE NEW JERSEY NURSING HOME STUDY COMMISSION, at 9. *See also*, Statement of Herbert Semmel, May 2, 1975 *Hearing* at 90x, supporting a broad ombudsman concept.

[178] Testimony of Commissioner of Health Finley, April 16, 1975 *Hearing* at 19, and 4x.

[179] *Id.* at 25; Testimony of Gerald Reilly, *id.* at 33.

quate to be of any real value. The nursing home patient is uniquely dependent on the nursing home to provide for some or all of his most basic needs. He or she may be confined to bed or to a wheelchair and may not have any contacts outside of the nursing home.[180] Because of this dependence, the patient may feel that any protest could bring about retaliation.[181] If the patient has relatives, they too might be reluctant to complain, fearing that the patient may be abused, neglected or discharged as a result.[182]

The inadequacies of the current means available for consumer pressure are, ironically, the result of the complex and cumbersome federal and state machinery set up to monitor patient care and prevent patient abuse.[183] It is more than likely that the patient or his family may be unaware of the many standards with which a nursing home must comply in order to be licensed or certified for participation in Medicaid/Medicare.[184] The continued operation of a facility which is obviously sub-standard due to problems in the

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180 The position of the patient in nursing homes is described in a report prepared by the Health Law Project, University of Pennsylvania Law School in conjunction with the National Health Law Program, University of California School of Law, The Nursing Home Vol. 4, Materials on Health Law, revised edition (1972, not published) [hereinafter cited as Materials on Health Law] at 205:

> For many old people simply going into a nursing home means a big loss of independence and self-identity. This loss is often made worse by the set up and operation of the nursing home itself. . . . The nursing home patient, like the sick person in a hospital, is encouraged to be passive and dependent on the institution in order to receive proper care.
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> Nursing home patients are living in total institutions—their entire environment, their entire lives are controlled by the staff and administration while both awake and asleep.

181 The most subtle forms of pressure can be applied to patients who incur the displeasure of any nursing home personnel, from administration to orderly. A patient requiring feeding can be fed just a little too quickly, turning mealtimes into a horror. A patient needing assistance in reaching the bathroom or turning in bed can be ignored. And, of course, there exists the more direct physical abuse found by the Senate Committee on Aging.

Statement of Herbert Semmel May 2, 1975 *Hearing* at 89x. For a discussion of retaliatory discharge from nursing homes and the denial of Medicaid services *see*, Materials on Health Law, *id.*, at 191-196.

182 Statement of Herbert Semmel, May 2, 1975 *Hearing* at 89x.

183 *See generally*, discussion at notes 89-112 *supra* and accompanying text.

184 The Moss Subcommittee on Long Term Care has observed that "the average consumer has no idea what his money is buying. There are few commodities on the market that are more of a 'blind item' than nursing home care." *Moss Supp. Paper I*, note 3 *supra* at 219. The Subcommittee attributes this lack of knowledge in part to the rapid growth of the nursing home industry, which is "still taking shape but in response to rapidly changing circumstances." *Id.*

existing mechanisms for enforcement[185] may reinforce or perpetuate a belief that "nothing can be done".

While the causes of the problem of inadequate consumer input are undoubtedly many, there do exist possibilities for improvement through legislation. This legislation could include the following: 1) a requirement for the conspicuous disclosure of inspection reports and/or establishment of a rating system for the evaluation of nursing homes, along with a requirement that such ratings be posted conspicuously within the facility; 2) enactment of a patient "bill of rights" which would clarify the rights afforded to the patient, including the right to complain about conditions in the nursing home and the right to be free from retaliation for so doing.

Conspicuous Disclosure

At the present time, the consumer has very limited access to information concerning how each nursing home has fared in its evaluation by the state. Under both the Medicare and the Medicaid laws, the Department of Health is required to make public "in readily available form and place" the pertinent findings of each nursing home annual survey within 90 days following the completion of such survey.[186] Under Medicaid regulations, statements listing deficiencies which are found during the survey are to be made "readily available for inspection and copying" in the local public assistance office and the district office of the Social Security Administration serving the area in which the provider (nursing home) is located.[187] These same regulations require that the actual survey reports and accurate and current ownership information for each facility participating in Medicaid be retained by the surveying agency (DOH) and made available upon request.[188] Department of Health regulations allow for public review of health facility inspection reports completed after September 28, 1972.[189] This regulation pertains to the reports of *all* licensed nursing homes, including those which do not participate in Medicaid or Medicare. However, anyone desiring a copy of a report must make a request in writing to the Department of Health.[190]

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185 *See* discussion at note 61, *supra.*

186 42 U.S.C.A. § 1395aa (a) (1974), 42 U.S.C.A. § 1396a (a) (36) (1974).

187 45 C.F.R. 250.70 (a) (2) (1974).

188 45 C.F.R. 250.70 (2) (3) (1974).

189 N.J.A.C. 8:30-13.1.

190 *Id.*

The assumption behind the State and Federal regulations is that the patient and the public will be aware of the right to such information and will actively seek it out, either by going to the public assistance or Social Security offices or by writing to the Department of Health. This hardly constitutes "ready availability" and, as might be expected, the consumer has not benefited from these limited mechanisms for disclosure.[191] These obstacles which now confront the consumer who wishes more information about a particular facility could be remedied, on the most fundamental level, by legislation requiring all nursing homes to post conspicuously on their premises copies of inspection reports listing deficiencies found during the annual inspection and any follow-up inspection conducted by the Department of Health.[192]

Rating Systems

In addition to or in place of a requirement to conspicuously post inspection reports, legislation establishing a rating system for the evaluation of nursing homes could also benefit the consumer. Rating systems have been widely recommended, both as aids to

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191 Statement of Herbert Semmel of the Center for Law and Social Policy, May 2, 1975 *Hearing* included the following criticisms of the disclosure mechanisms of the Medicaid regulations:

> Only a miniscule number of people know of the availability of inspection reports to the public. Our information and experience is that only the most persistent inquirer actually gets to see the reports. It is hard to imagine a sick, elderly person about to enter a nursing home being able to go to a Social Security Office to examine inspection reports, nor are their relatives or friends likely to do so.

192 The National Senior Citizens Council in its statement at the May 2, 1975 *Hearings* at 91x supported such a requirement as well as a requirement that nursing homes provide copies of all such reports to all patients and to "every potential patient or any other person to whom promotional literature is provided by the nursing home". Furthermore, the Council recommended that nursing homes be required to send copies of inspection reports to every physician who refers a patient to the nursing home and to the current attending physician of every patient in the nursing home. *Id.* at 91x-92x. Significantly, it was observed by the N.S.C.C. that the current disclosure provisions discouraged even physicians from attempting to get information about a facility. *Id.* The INTERIM REPORT OF THE NEW JERSEY NURSING HOME STUDY COMMISSION has recommended a requirement for conspicuous posting, along with 1) a requirement that the nursing home provide free access to other pertinent documents, and 2) enactment of a rating system. *See* INTERIM REPORT OF THE NEW JERSEY NURSING HOME STUDY COMMISSION at 9. New York has recently enacted legislation under which every nursing home must keep available for public inspection copies of all inspection reports for 10 years from their date of issue. N.Y. PUBLIC HEALTH LAW § 2805-e (1) (McKinney 1975-1976).

the consumer[193] and as more efficient and logical mechanisms to penalize a noncomplying facility.[194]

Nursing homes by their very nature must provide many different kinds of services and, as such, the multitude of standards which exist to regulate these services are necessarily highly complex and wide-ranging. Nevertheless, within the various categories of nursing home standards (i.e. SNF, ICF "A", ICF "B", participating, non-participating), there are some standards which, when violated, present more serious consequences than others, and more directly affect the health or safety of the patients. Among the deficiencies which frequently occur in New Jersey nursing homes, the Department of Health classifies the following as more serious:

1. *Nursing services*—insufficient nursing coverage for the patient care (the most frequent of all deficiencies).
2. *Pharmacy*—"stop order" policies for continuance, discontinuance or modification of medications not observed by attending physicians.
3. *Dietary and Housekeeping*—patient special diets not observed.
4. *Physician Services*—physician visits to patients not occurring within required time limit.
5. *Physical Plant and Life Safety Code*—inadequate fire resistivity of the building structure; inadquate fire alarm system; inadequate smoke barrier compartmentalization of facility; lack of nurse call system.[195]

The salient features of a nursing home rating system can be seen from an examination of the systems which have been established by

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193 *See* Ralph Nader's Study Group Report on Nursing Homes: OLD AGE, THE LAST SEGREGATION (1971) at 158; *Nursing Home Care in the United States: Failure in Public Policy, Moss Supp. Paper* No. 6, note 3 *supra* at 613; INTERIM REPORT OF THE NEW JERSEY NURSING HOME STUDY COMMISSION, at 9. In 1975, Senator Frank E. Moss introduced S. 1568 which would require the Secretary of HEW to establish a rating system for nursing homes participating in Medicaid or Medicare as a guide to consumers. 212 *Cong. Rec.* at 4 and 10 (daily ed. April 29, 1975).

194 *See*, REPORT OF THE GOVERNOR'S CABINET COMMITTEE ON MEDICAID REIMBURSEMENT FOR NURSING HOME CARE, No. 13, 1975, 15-18, 43; Statement of the Health Law Project at the Department of Public Welfare Hearings on Non-Public Nursing Home Reimbursement Rate Increases, Sept. 27, 1971, reprinted in Materials on Health Law, note 184 *supra*, at 132-134; Statement of Commissioner of Health Finley, April 16, 1975 *Hearing* at 9x-10x; Proposal Prepared by the Department of the Public Advocate of New Jersey and the Center for Law and Social Policy on Behalf of the National Council of Senior Citizens, *Effective Enforcement of Patient Care Standards in New Jersey Nursing Homes*, included in May 2, 1975 *Hearing* at 5x.

195 Statement of Commissioner of Health Finley, April 16, 1975 *Hearing* at 6x-7x, and testimony, *id.* at 20-21.

legislation in New York and California. The California legislation provides for a rating of deficiencies found in a facility upon inspection or investigation,[196] and authorizes the issuance of citations classified according to the nature of the deficiency or violation.[197]

Class "A" violations are defined as those

> "which the state department determines present an imminent danger to the patients or guests of the long-term health care facility or a substantial probability that death or physical harm would result therefrom".[198]

Class "B" violations are defined as

> "violations which the state department determines have a direct or immediate relationship to the health, safety or security of long-term health care facility patients other than class "A" violations".[199]

The director of the Health Department is given the authority to promulgate regulations which specify the criteria for and the specific acts which constitute class "A" and class "B" violations,[200] and in addition also to establish procedures for the

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196 CALIF. HEALTH AND SAFETY CODE § 1423 (West 1973).

197 *Id.* For a discussion of the merits of a citation system of enforcement relative to the procedure for license revocation and decertification, *see* R. Mayers, Cal. Atty. Gen. Special Study of Problems of the Aged (1973) at 17-20.

198 CALIF. HEALTH AND SAFETY CODE § 1424 (West 1973).

199 *Id.*

200 *Id.* § 1426 (West 1973). Regulations promulgated pursuant to this section include *inter alia,* the following situations which may constitute Class A violations:

1) physical abuse of patients that results in a patient's death or serious physical harm;
2) lack of an adequate emergency call system from patient to staff;
3) failure to notify the attending physician of any significant change in a patient's condition;
4) failure to administer medications and treatments as prescribed and recorded in patient's records;
5) administration of medications by unauthorized persons.

22 CAL. ADM. CODE §§ 72703, 73703. While all of the above, with the exception of No. 2, may also be classified as "Class B" violations, the following are examples of violations which are listed only as giving rise to Class B violations:

1) failure to employ nursing service personnel in the number and with the qualifications determined by the Department to provide the necessary services for those patients admitted for care;
2) failure to maintain adequate licensed nurse coverage;
3) failure to provide therapeutic diets as prescribed by the attending physician and without proper supervision and/or consultation from the dietician;
4) unauthorized use of restraint or seclusion.

22 CAL. ADM. CODE §§ 72707, 73707.

issuance of notices for violations which bear only a "minimal relationship to safety or health".[201]

This system of rating violations is tied into both the enforcement area and the consumer area. First, as a tool for more flexible enforcement, the rating procedure allows for the gradation of civil penalties.[202] Second, consumer interests are benefited through the requirement that all final uncorrected class "A" citations be posted in the facility in "plain view of the patients in the long-term health care facility, persons visiting those patients, and persons who inquire about placement in the facility".[203] Further the nursing home must keep citations for both classes of violations available for inspection "by any member of the public who so requests",[204] and the nursing home must conspicuously post a notice that citations for all final uncorrected violations will be so available for inspection.[205]

The New York legislation, on the other hand, provides for the rating of the entire facility, based on uniform criteria promulgated by the Commissioner of Health.[206] These criteria are to include not only "a detailed listing of the types, and degree of severity or unacceptability, of deficiencies which inspections might indicate",[207] but also "areas of care and performance in which residential health care facilities notably and significantly exceed minimum standards".[208] The resultant rating system must include at least five specific rating categories,[209] and the nursing home must conspicuously post the rating it receives.[210]

As it is a system for the overall judging of a nursing home, the New York system could be of great value to the consumer who needs a simple standard by which to evaluate a nursing home. On the other hand, this type of rating system might run the risk of oversimplifying the complexities involved to the detriment of

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201 CALIF. HEALTH AND SAFETY CODE § 1427 (West 1973).

202 *Id.* § 1424 (West 1973).

203 *Id.* § 1429 (West 1973).

204 *Id.*

205 *Id.*

206 N.Y. PUBLIC HEALTH LAW § 2803-1 (c) (McKinney 1975-1976 Supp.).

207 *Id.*

208 *Id.*

209 *Id.* Those nursing homes which receive a rating in the lowest category may be required as a condition for continued operation, to obtain financial security to ensure that future obligations will be met. N.Y. PUBLIC HEALTH LAW § 2809 (McKinney 1975-1976 Supp.).

210 N.Y. PUBLIC HEALTH LAW § 2803-1 (c) (McKinney 1975-1976 Supp.).

either the patient who relies on the rating, or the nursing home which is sub-standard in one area, but superior in another. It is obviously a very difficult task to weigh the many different areas of standards and arrive at one determination concerning the performance of the nursing home.

From the standpoint of the consumer it can be said that a rating system either of particular deficiencies or of an entire facility, or a requirement for conspicuous disclosure of inspection results would bring a greater visibility to the subject of quality of health care. Ideally, such information could be used by a consumer in determining which nursing home to enter. However, given the shortage of nursing home beds[211] there may be no real "choice" involved. The real benefit would be in providing the consumer with the tools for judging a facility once patient placement has been made. A rating system would also have the added benefit of providing the consumer with a more accurate view of how effectively the Department of Health is "policing" the nursing home.

The Patient Bill of Rights

Another, more direct, means by which legislation could increase the potential for consumer input would be enactment of a patient "bill of rights". A model for such legislation can be found in current federal regulations which require that every skilled nursing facility participating in Medicare or Medicaid establish a statement of patient rights and written policies and procedures to implement those rights.[212] The nursing home must ensure that each patient has at least the following rights, which are generally reflective of the type of abuses to which patients have been subject:

1) Full information concerning services available in the facility;
2) full information as to medical condition and the opportunity to participate in planning of medical treatment;
3) control of personal financial affairs or a quarterly accounting where that authority has been delegated to the nursing home;

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211 REPORT OF GOVERNOR'S CABINET COMMITTEE ON MEDICAID REIMBURSEMENT FOR NURSING HOME CARE, (Nov. 13, 1975) at 9 states that there were 1300 elderly Medicaid patients awaiting placement in nursing homes. This was attributed not only to a shortage of beds but also to Medicaid reimbursement below reported cost.

212 20 C.F.R. 205.1121 (k) (1974). Federal regulations governing intermediate care facilities participating in Medicaid were recently amended to extend similar rights to ICF patients or residents. *See*, 41 Fed. Reg. 12883 (1976).

4) freedom from mental and physical abuse and freedom from chemical and physical restraints except as authorized in writing by a physician for a specified and limited period of time, or when necessary to protect the patient from injury to himself or to others;
5) confidential treatment of personal and medical records;
6) treatment with "consideration, respect, and full recognition of his dignity and individuality";
7) elimination of services performed solely for the facility that are not included for therapeutic purposes in the patient's plan of care;
8) freedom to associate and communicate with persons of his choice, to send and receive mail unopened, and to meet with and participate in social, religious and community groups at his discretion;
9) retention of personal clothing and possessions;
10) privacy for visits by his or her spouse, if married, and, if both are patients in the facility, permission to share a room.[213]

In addition, the patient is to be "encouraged and assisted to exercise his rights as a patient and as a citizen" and therefore has the right to voice grievances and suggest changes in policies and services to the facility staff outside representatives of his own choosing "free from restraint, interference, coercion, discrimination, or reprisal".[214] These regulations also prohibit the transfer or discharge of a patient except for medical reason, for his own welfare or that of other patients, or for nonpayment for his stay.[215] These prohibitions against reprisal or discharge are obviously crucial to the full protection of the rights enumerated above.

Another important feature of these regulations is that each patient must be fully informed of his rights and of all rules and regulations which govern patient conduct and responsibilities and he must be so informed prior to or at the time of admission and during his stay. Further, the nursing home must make the written policies and procedures implementing these policies available to patients, guardians, next of kin, sponsoring agencies, representative payees and the public.[216]

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[213] 20 C.F.R. 205.1121 (k) (1974).

[214] *Id.* at § 5.

[215] *Id.* at § 4.

[216] *Id.* at § 1.

Enactment of a state "bill of rights" for nursing home patients similar to the extensive rights afforded by the federal regulations would, as suggested in the Interim Report of the New Jersey Nursing Home Study Commission,[217] extend these rights to all patients in all New Jersey nursing homes. A few of the rights found in the federal regulations already exist in various state regulations.[218] However it would be more beneficial to the consumer to have his rights clearly delineated in the law, with provision for adequate disclosure of those rights and of all pertinent regulations, provisions for redress upon their violation, and protection from retaliation for pursuing such redress.

Proper functioning of the regulatory machinery must take into account the rights of those it purports to protect. If New Jersey's nursing home population had access to such relevant data as survey reports or ratings they would be able to supplement the bureaucratic regulatory system, and, at the same time, more knowledgeably protect the rights they would derive from a bill of rights.

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217 INTERIM REPORT OF NEW JERSEY NURSING HOME STUDY COMMISSION, at 13. A "Bill of Rights" for nursing home patients, S. 944, introduced by Senator Fay, has passed the New Jersey Senate and is currently awaiting action by the Assembly. *See*, The Star Ledger (Newark, N.J.) Tues., June 22, 1976, p. 18, col. 3.

For examples of patients' Bills of Rights enacted in other States, *see*, MINN. STAT. ANN. § 144.651 (1975-1976 Supp.), and N.Y. PUBLIC HEALTH LAW § 2803-C (McKinney 1975-1976). New York legislation provides, in addition, that a nursing home is directly liable to any of its patients for the deprivation of "any right or benefit created or established for the well-being of the patient by the terms of any contract, by any state statute, code, rule or regulation or by any applicable federal statute, code, rule or regulation," where such deprivation has resulted in injury to the patient. N.Y. PUBLIC HEALTH LAW § 2801-d (McKinney 1975-1976). The nursing home may be assessed compensatory and punitive damages, and such damages which are recovered by a patient are not to be used in determining that patient's eligibility for medical assistance. *Id.* Furthermore, the patient's right to pursue this remedy cannot be waived orally or in writing, and is in addition to "any other type of relief permitted by law". *Id.* Finally, the law also provides that the nursing home may not discriminate against the patient who brings an action or against any patient or employee who gives or provides testimony or other evidence in the action. *Id.*

Another type of protective legislation has been enacted in California. That state prohibits a nursing home from discriminating or retaliating against any patient or employee because that patient or employee or any other person has initiated or participated in certain specified actions against the nursing home. CALIF. HEALTH AND SAFETY CODE § 1432 (West 1973). Any nursing home which violates this provision is subject to a civil penalty of no more than $500. *Id.* Further, any attempt to discharge or any discriminatory treatment of a patient by whom or for whom a complaint has been submitted or who institutes an action against the facility creates a rebuttable presumption that such action was taken in retaliation. *Id.* This type of protection of nursing home patients from retaliatory discharge is similar to the protection from eviction afforded tenants in New Jersey under the Landlord and Tenant Reprisal Law. (N.J. STAT. ANN. 2A:42–10.10-10.12 (1970)).

218 *See e.g.*, N.J.A.C. 8:30–5.3 (a) (6), 8:30–8.4, 8:30–Appendix G (SNF); Manual of Standards, Chapter III, 303-306 and Chapter XIV (ICF).

Conclusion

Obviously, the subject of Nursing Homes is a vast one. While the areas of suggested reform discussed here are extremely complex in themselves, they represent only a small portion of the problems that one encounters in this field. Problems such as reimbursement of providers, ownership disclosure as a means of preventing fraud, and alternatives to institutionalization of the aged deserve thoughtful investigation with a view to their solutions. Both Federal and State regulatory machinery have contributed to the creation and entrenchment of these problems. It is hoped that this article, by illuminating the structural background of nursing home regulation, will serve as both a catalyst for reform and an outline for its implementation.