Striving for Quality Care in America's Nursing Homes: Tracing the History of Nursing Homes and Noting the Effect of Recent Federal Government Initiatives to Ensure Quality Care in the Nursing Home Setting

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The health care industry has become a hot topic over the last several years. While there are many facets of this industry, one of the recently discussed segments is long-term care, more specifically, nursing homes. Listening to news reports and perusing newspapers will turn up recurring buzzwords and themes within the nursing home industry, such as: "fraud and abuse," "false claims," "managed care," "long-term care" and "quality care."

One of the major points of disagreement among legislators, health care providers and recipients of health care services is the definition of "quality care" and how "quality care" should be monitored in the
nursing home setting.\(^2\) The federal government has responded to such issues by making the nursing home industry one of the most heavily regulated industries in the United States.\(^3\) This begs the question of whether a seemingly endless amount of regulations further guarantees or ensures that quality care will be administered within the nursing home industry. The following examples demonstrate what I believe to be the inefficiency of such regulations.

First, assume that an elderly person has been a resident of a nursing home for approximately one year. The resident suffers from foot sores that go undetected by the nursing home. Several months after the problem has developed, the sores are finally discovered but they are now filled with maggots. Not wanting to trigger an investigation by the state licensing agency because of the circumstances suffered by this particular resident, the nursing home does not transfer the resident to a hospital for treatment. Instead, the resident is provided with care at the nursing home and the state-licensing agency is never notified of the conditions that the resident suffered.\(^4\)

Second, assume that a nursing home certified as a provider under both the Medicare and Medicaid programs is not in “substantial compliance” with program regulations as determined after a state

\(^2\)See generally, David R. Hoffman, The Role of the Federal Government in Ensuring Quality of Care in Long-Term Care Facilities, 6 ANNALS OF HEALTH L. 147 (1997); Symposium, When Neglect Becomes Fraud: Quality of Care and False Claims, 43 ST. LOUIS L.J. 27 (Spring 1999); Symposium, Managed Care For the Elderly: Obtaining Cost Effectiveness While Enhancing Quality, 1 QUINNIPIAC HEALTH L.J. 193 (1997); HCFA Symposium & Workshop, Improving Quality of Life For Nursing Home Residents: The Challenge & The Opportunities, Baltimore, MD (July 11-12, 1996), available at http://www.hcfa.gov/medicaid/siq/doinhb9.htm.


\(^4\)This example is taken from a report made by the General Accounting Office concerning the investigation processes of states when a compliant is filed against a nursing facility. See GAO Letter Report, Nursing Homes: Complaint Investigation Processes Often Inadequate to Protect Residents, GAO/HEHS-99-80, (Mar. 22, 1999). The report goes on to list several other instances which were suspiciously either not investigated or deemed non-serious by state surveyors, such as: (1) a resident found dead with her head trapped between the mattress and the side rail of the bed; (2) an ambulance crew member transporting a resident who notified the appropriate state agency of a resident who had dried blood in his fingernails and on his hands, sores all over his body, smelled like feces and was unable to walk or take care of himself; (3) a resident who was sent to the emergency room because her feeding tube had become dislodged and was entirely within her stomach; and (4) a resident who had received ten times the prescribed dosage of medication. Id. at p. 11-13.
survey of the facility. Several months later, the nursing home proves to the state licensing agency that it has currently fixed all problems noted in the state survey. Nonetheless, the federal government becomes directly involved in the compliance overview of the facility.

One month after the state agency certified that all alleged deficiencies were supposedly "cured," the federal government survey leads to the opposite conclusion. Because the federal survey uncovers deficiencies that allegedly still exist at the facility, the federal surveyors recommend that the nursing home be terminated from participating in the Medicare and Medicaid programs. The nursing home fights in court to block the federal government's decertification since it would potentially bankrupt the nursing home, as it relies on the government reimbursement for the care and treatment of approximately ninety percent of its residents.

The residents of the facility are consequently placed in a predicament. If the facility has to shut its doors, the residents will have to be transferred to another facility causing a potential impairment of patient function and condition. What at first looked like the facility's compliance with the rules and regulations as verified by the state surveyors, turns into a lawsuit jeopardizing the nursing home residents because the federal surveyors disagree with the facility's compliance efforts.5

5This example is based upon what transpired in Northern Health Facilities, Inc. v. U.S., 39 F. Supp. 2d 563 (D. Md. 1998). In this actual case, a nursing home was not allowed a temporary restraining order to enjoin the government from terminating its participation in the Medicare and Medicaid programs. The injunctive relief sought meant that the nursing home had to show three things. First, the court agreed that the possibility of closing the facility was a great harm to the nursing home. Second, the court found that the government agency was unable to show a likelihood of harm to the residents of the nursing home if the injunction was granted. Nonetheless, the court found that the nursing home was unable to meet the third requirement, stating that the nursing home was not likely to be successful on the merits of its claim. The effect of the court's finding was that the government did have the statutory authority to terminate the nursing home's participation in the Medicare and Medicaid programs which the nursing home could not block with an injunction because it was not likely to be successful on the merits of its claim. This is a very interesting ruling because the court also states, in dicta, that the nursing home entered into a consent order to cure the alleged deficiencies in good faith and the facility had not had appropriate time to cure those deficiencies. In Mediplex of Massachusetts, Inc. v. Shalala, 39 F. Supp. 2d 88 (D. Mass. 1999), however, a nursing home sought an injunction to prevent the federal government from decertifying the facility from the Medicare and Medicaid programs because of the absence of any present and immediate danger to the health and safety of its residents. The court here found that the lack of funding from the government programs would likely cause irreparable
In the previous scenarios, the point of disagreement turns on the issue of where the government should base its efforts to enforce quality care standards. The argument is whether the focus should be on the residents receiving poor care in the nursing home setting, or rather on the nursing home itself for administering poor quality care. In other words, does more government involvement in the regulation of the nursing home industry hinder or enhance quality care to nursing home residents?

This note will outline the nursing home industry in the context of past and present measures advocated by the federal government in its role to ensure quality care in the nursing home setting. In doing so, it will argue that the federal government will continue to be heavily involved in the nursing home industry, particularly on the issue of quality care being provided to nursing home residents. Section I will discuss current and projected statistics of the elderly population to shed light on why nursing homes are going to be an area of significant policymaking in the future. Section II will trace the history of nursing home care from its inception in the United States, focusing on the level of government involvement in quality care issues. Finally, Section III will analyze the most recent federal government initiatives in ensuring quality care in the nursing home setting and addresses possible issues for the future.6

Because of space limitations, it is not possible to also include a detailed analysis on state and private party initiatives that have also influenced policy in this area. This should not discount the importance of those separate initiatives. Generally speaking, some important initiatives by states, include: passing stringent state laws and regulations for nursing homes, performing state surveys of nursing facilities and instituting its own fines and penalties against non-compliant facilities. See, e.g., S.B. 10, North Carolina 1999-2000 Sess. (mandating stricter rules at the state level to protect nursing home residents); State To Implement Stricter Rules To Protect Safety of Rest Home Residents, 8 Health L. Rep. (BNA) at 1625-27 (Oct. 7, 1999). On the other hand, private party initiatives generally result from tort litigation. If the plaintiff obtains a favorable verdict from suing a nursing home for negligence or inadequate care, the presumed effect is that the award of damages against the facility will be a deterrent from performing such acts in the future. The negative side of having to resort to litigation is that several years may pass before a case is resolved which leaves the residents of such facility at potential risk for the type of harm alleged in the complaint.
STATISTICS OF A GRAYING AMERICAN PUBLIC

The percentage of the United States population over age sixty-five is growing at an unprecedented rate which makes nursing home care issues a ripe topic in today's society. As people age, the utilization of health care services increases. The resulting issue is whether, and to what extent, government will fund long-term care services, such as skilled nursing care.

It is a well-documented fact that Americans are living longer. Since 1900, the percentage of the United States population reaching age sixty-five and older has tripled (4.1 percent in 1900 to 12.8 percent in 1995), with the absolute number of seniors increasing nearly eleven times (from 3.1 million to 33.5 million). Indeed, as of 1997, the fastest-growing age group consists of persons who are eighty-five and older, with the second-fastest growing age group consisting of persons age one-hundred and over.

Further, the wave of "Baby Boomers" that will hit retirement age between the years of 2010 and 2030 will increase the population of Americans aged sixty-five and older by approximately thirty million. Thus, by the year 2030, the elderly population is expected to reach approximately seventy million people, a figure that is more than twice their number in 1990. This means that the population age sixty-five and older will make up nearly 20 percent of the total population of the United States by the year 2030. Health care services will have to be

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7 Long-term Care and the Challenge of an Aging America: An Overview, supra note 1.
8 Id.
10 Long-term Care and the Challenge of an Aging America: An Overview, supra note 1.
Again, the United States Bureau of the Census estimates that the projected number of Americans aged sixty-five and older in 2010 to be 39,408,000 and the projected number in 2030 to be 69,379,000, http://www.census.gov/population/projections/nation/nas/npas0610.txt and http://www.census.gov/population/projections/nation/nas/npas1530.txt.
11 Long-term Care and the Challenge of an Aging America: An Overview, supra note 1.
12 The United States Bureau of the Census estimates that the total population by the year 2030 will be 346,899,000, with people aged sixty-five and older numbering 69,379,000, http://www.census.gov/population/projections/nation/nas/npas1530.txt.
provided to this increasing segment of the population which correlates to an increase in the number of facilities to care for these individuals.

The United States has also seen an increase in the total number of nursing homes, along with the increase of residents within these homes. Looking back to 1987, there were just over 14,000 nursing homes with 1.36 million residents. In 1998, the United States had approximately 17,000 nursing homes with 1.6 million residents. This represents an increase of approximately 21 percent in the total number of nursing homes with an increase of about 15 percent in the total number of nursing home residents.

In addition, nursing home facilities in both 1987 and 1996 were about 92 percent privately owned. Looking at all nursing home facilities during this time period, about 66 percent were for-profit facilities, with about 26 percent being non-profit in 1996, as compared with 70 percent and 22 percent, respectively, in 1987. By 1998, the amount of money a nursing home resident spent for normal long-term care was more than $40,000 per year.

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14 This number is approximate because of differences in the definition of “nursing home.” The federal government most often cites the 1998 figures used above which are also the numbers most often cited in other articles. But see 1997 State Data Book On Long-Term Care Program and Market Characteristics, (May 1999), available at http://www.hcfa.gov/medicaid/97stdabk.pdf (independent study finding the number of nursing homes in the United States to be 17,628 in 1997).

15 Id.

16 Federal, state or local governments owned the remaining approximate 8 percent. See supra note 14.

17 See id.

18 Id.

19 Note that this includes the total cost incurred by the resident, much of which is paid out-of-pocket by the resident, with Medicare, Medicaid and even long-term care insurance being responsible for payment of its appropriate share. See William J. Scanlon, Future Financing of Long-Term Care, CONSUMER’S RES. MAG., 16 (Jun. 1, 1998). Please note that long-term care insurance is an important topic of discussion regarding the payment side of elder care. I do not discuss this issue here, but the following resources should be consulted if further research is desired. See Nat’l Underwriter Life & Health-Fin. Serv. Edition, Encouraging News About Long-Term Care Insurance, (Oct. 12, 1998); Symposium, Covering the Financial Risk of Long-Term Care: Responding to the Myths, 1 QUINNIPAC HEALTH L.J. 175 (1997); and Symposium, Long-Term Care Financing: Federal Policy Implications, Actions, and Options, 1 QUINNIPAC HEALTH L.J. 139 (1997).
These are staggering and astonishing figures that should evoke serious questions of how the United States will respond to this segment of the population and its increasing needs. The federal government has initially responded by recognizing that the amounts of National Health Expenditures and Gross Domestic Product designated to health care expenditures will have to increase. National Health Expenditures are projected to reach approximately $2.2 trillion, becoming 16.2 percent of the Gross Domestic Product by 2008, as compared with approximately 1.1 trillion and 13.5 percent, respectively, in 1997. From 1998 to 2008, the expected increases in National Health Expenditures are projected to be sustained to less than a 7 percent gain from the previous year which is sometimes less than one half of the total amount of increase from past years. Arguably, the government has implicitly recognized that long-term care will be an important issue in the future.

Despite unavoidable obstacles, the federal government should be actively involved in ensuring that nursing homes provide quality care to their residents. These obstacles include an increasing elderly population, the enormous amount of federal and private dollars at stake in the nursing home industry and the current number of residents receiving care from a nursing home. The extent of this involvement is what leads to substantial argument. While some level of federal government involvement is quintessential in ensuring quality care, the

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20 The awareness of the inevitable growth of the elderly population as compared with the overall population is a phenomenon that is also being recognized worldwide. See Colleen Galambos and Anita Rosen, The Aging Are Coming and They Are Us, 24 HEALTH & SOC. WORk 73 (Feb. 1, 1999) (in-depth discussion on how other nations are preparing for this burgeoning segment of the world’s population).

21 ld.


23 ld. From 1970 to 1997, the gains in the national health expenditures increased as much as 12 percent one year to as little as 4.3 percent in another year. The reason for the projected restrained growth in the NHEs include: The Balanced Budget Act of 1997, a projected increase in the uninsured fraction of the population, the continued (although smaller) impact of managed care and the effect of projected excess capacity among health providers.

24 In 1997, for each dollar spent by the federal government on NHE, 7.6 percent of that dollar went to nursing homes. See HCFA The Nation’s Health Dollar: 1997, available at http://www.hcfa.gov/stats/nhe-oact/tables/chart.htm. This does not imply that nursing homes will be as prominent in the future as they are today. However, I believe that nursing homes will continue to play an important role in the future growth of long-term care.
amount of involvement has greatly increased in the last several decades and appears to be on a pace to continue to increase in the future. To better gain an understanding of the federal government’s increased involvement in the nursing home industry, it is necessary to first understand the nursing home industry of the past.

THE HISTORY OF NURSING HOMES

Nursing homes have been operated in the United States, in one form or another, for well over two centuries. In the eighteenth century, nursing homes originated as poor relief centers. Today, nursing homes have developed into a highly sophisticated business industry.

Late 1700’s – 1820: Colonial “Outdoor Relief”

Based on the English Poor Law of 1601, early American colonists took the view that government was responsible for giving public relief only to those individuals who could not obtain support from family, friends or private charity. Relief in this time period came essentially in the form of “outdoor relief.” This was basically a localized and flexible effort, providing care for the established community residents in the homes of the colonists.

In essence, the community placed responsibility on each individual family to care for their own elderly family members. If an

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28 Id. at 18. Because early American poor relief had no separate institutional structure during this time period, the term “outdoor relief” is used to describe the type of relief centers that existed during this time period and is synonymous with the phrase “community-based.” Id. at 32.

29 Id. at 32.

30 The poor and “deviant” populations were viewed as being a problem indigenous to society. As a result, society focused on pragmatic solutions and appropriate management, as
elderly person had no family members to provide such care, the community would still make sure care was provided, usually by rotating such person's boarding between residents within the community. Basically, colonists would administer care to persons in need, but only upon the expectation that the person would in turn provide some form of task or remedy to the caregiver. The community thus placed its core moral values upon both sharing and reciprocity.

It is very difficult to obtain an accurate assessment of the quality of care administered during this time period. Records, at least those which still exist, are very scarce and do not apply uniformly to a particular rating system, since most care was an individually based effort premised upon convenience and frugality. What is known is that the government played only a small role because the culture and law of this time period placed responsibility for the care of the elderly and poor with individuals, rather than relying on extensive government involvement in their care.

1820 – 1865: From “Outdoor Relief” to Almshouses
The values of the “Outdoor Relief” period could not survive in the highly evolving America that was experiencing both demographic and economic changes. The values of society at this time preferred opposed to trying to personally change the person through reformation. CHARLES W. LIDZ ET AL., THE EROSION OF AUTONOMY IN LONG-TERM CARE 23 (1992).

31HOLSTEIN, supra note 27. It is important to note that strangers to a community fared a much worse fate. Aware that the British unloaded its unwanted population in the colonial territory, the colonists started to make distinctions between its own poor and those other “paupers” which had no connection with the community. While the colonists did allow these “paupers” to reside in the communities, it was often at the price of waiving any type of poor relief provided by the community. Id. at 19. Thus, it seems that the policy of “caring first for your own members” was being carried out by the colonists not wanting to take responsibility for “outsiders” with similar problems.

32For instance, an elderly person receiving care might be expected to perform some kind of simplified task based on the ability of that person, such as sewing or knitting. Id. at 18.

33It is important to note that the treatment of the poor in such an individualized and localized method allowed such persons to remain in the community, resulting in the poor being able to maintain their social and familial roles. CHARLES W. LIDZ ET AL., THE EROSION OF AUTONOMY IN LONG-TERM CARE 24 (1992).

34Id.

35See HOLSTEIN, supra note 27.

36Id. at 20.
"Indoor Relief," leading to deliberate social policies to place the care of
the poor and elderly under institutionalized centers. These
institutionalized centers were called poor houses, otherwise known as
almshouses.

Society during this time period held the optimistic view that
individuals could cure all that ailed society through moral guidance. This led to the decline and disappearance of social reciprocity that was
previously expected from those receiving care. However, it was still
believed that society could steer its poor individuals away from relying
purely on public and private relief. Consequently, the almshouses
were seen as a deliberately punitive environment which were supposed
to motivate persons to lead upstanding lives. Such facilities were
based on principles of order, discipline and an exacting routine. In
other words, these facilities were much more structured and formal,
unlike their colonial period counterparts.

The government was not enforcing quality care provisions in such
facilities, as the almshouse was viewed as a "motivator" to change an

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37Id. The need for labor in the newly industrialized America lessened the harsh treatment of the other "paupers," but feelings still ran deep that the communities should not be responsible for caring for these individuals.

38LIDZ, supra note 33. The first of these almshouses appeared in the more populated cities of the United States at that time, such as: New York, Boston and Philadelphia.

39This was especially prevalent in the thinking of Jacksonian Democrats who tried to explain poverty as opposed to accepting it as part of life’s natural order. As a result, poverty became equated with moral failure which could be changed from teaching the poor their moral wrongdoings. HOLSTEIN, supra note 27, at 20-21.

40Id. at 21. Because the poor were viewed as morally depraved, they were seen as not being able to offer society any benefits. Instead, the poor were seen as moral children during this time in which they were expected to obey, rather than to make a choice.

41Id. at 22. The prevailing opinion of the public at this time was that “anyone who lived a life of hard work, faith, and self-discipline could preserve health and independence to a ripe old age; the shiftless, faithless, and promiscuous, however, were doomed to premature death or a miserable old age.” LIDZ, supra note 33, at 26.

42HOLSTEIN, supra note 27, at 22. This was accomplished by regulating labor market forces which was designed to force an individual to make a choice between living in the deliberately deplorable almshouses or to accept a low wage instead. It was hoped that the individual would choose to work to earn his/her keep, as opposed to living in the purposefully objectionable conditions of the almshouses. However, the social structure of the almshouse remained quite similar to that of the traditional family. For instance, there were few staff or formal rules imposed and the able residents participated in minor daily tasks. LIDZ, supra note 33, at 25.

43LIDZ, supra note 33, at 27.
individual's way by "molding" new values into such person.\textsuperscript{44} The poor conditions of these almshouses actually resulted in the development of new facilities by individual classes of society to care for persons who were viewed as being poor by "no fault of their own."\textsuperscript{45} In a sense, people reverted back to caring for their own members of society by taking care of those deemed "worthy" enough not to be held in the same company as those who were in the almshouses purely by lack of moral choice.\textsuperscript{46} Although the intentions of the reformists were benign, their goal of rehabilitation went unfulfilled.\textsuperscript{47} The end result was the successful separation of the ill, the indigent and the criminal from the rest of society in facilities advocating the custodial aspect with little or no provisions to ensure quality.\textsuperscript{48}

1865 – 1935: Leading up to Social Security
During the period of 1865-1935, almshouse residency literally became "older" in the sense that elderly persons made up the majority of residents in such facilities. However, this contradicted the original intent of almshouses being a place for just the poor.\textsuperscript{49} The elder generation nonetheless became the mainstream resident for the almshouses at this time and the public came to accept this premise.\textsuperscript{50} By the end of the 1800's, almshouses were becoming "transformed" into public nursing institutions as a result of the aging

\textsuperscript{44}Id. at 26. Again, it was thought that "if the poor and the unemployed had to rely on themselves, they would overcome their vices and become productive members of society."

\textsuperscript{45}It was "shocking to the American culture to find that white, native-born women were ending up in these almshouses, at no fault of their own for being poor." As a result, Protestant reformers developed private homes for the aged at this time, but only admitted those individuals "deemed of appropriate caste and nativity." Minority groups also followed in this pattern by developing their own homes to get particular individuals away from the unpleasant conditions of the almshouses. HOLSTEIN, supra note 27, at 22-23.

\textsuperscript{46}Id.

\textsuperscript{47}Id.

\textsuperscript{48}LIDZ, supra note 33, at 27-28.

\textsuperscript{49}HOLSTEIN, supra note 27, at 24.

\textsuperscript{50}The author even goes as far as to say that, "ties between a dependent older population and the almshouse became ingrained in the American mind." Id. Looking at years 1830 to 1850, people over age fifty made up 18 percent of the population in northeastern almshouses. More particularly, in 1826, 61 percent of the "outdoor relief" population in Philadelphia was over 50 years of age, growing to 80 percent by 1929.
American population and the institutional advances.\textsuperscript{51} As part of this transformation, the idea of reciprocity for services rendered was dropped in favor of determining why these residents were dependent upon others during their elder years.\textsuperscript{52} The care provided in the public nursing institutions nonetheless remained less than desirable, greatly deteriorating by the end of the 1800's.\textsuperscript{53}

The decline in the quality of care provided in the public nursing institutions was obvious in American society during this time period. In fact, a new attitude developed embracing the concept that no matter how an individual lived life, everyone would eventually depend on a nursing institution in some form.\textsuperscript{54} This consequently became the main thrust behind the notion at this time that public nursing institutions were actually the best setting to care for the poor and ailing elder population.\textsuperscript{55} Nonetheless, this attitude did not discourage the use of private nursing homes, maybe even fostering its continued growth during this period.\textsuperscript{56}

Government involvement at this time was once again as non-invasive as possible.\textsuperscript{57} Federal laws mandating the level of care to be administered to public or private institution residents were still

\textsuperscript{51}Id. As the progressive reformists pushed for social reform, this thinking did not apply to the older population. Instead, reformists moved those persons still “salvageable” out of the almshouses until there was no one left except for the elder population. Part of this came from the thinking at the time that, “physicians held little hope for ameliorating the pathological conditions of old age...,” so little was done to help the elderly. People were also forced into almshouses because many private charities declined to help those elderly thought to be “non-salvageable.” Furthermore, medicine became more curative and hospitals started refusing to accept custodial patients.

\textsuperscript{52}Id. at 26. The author notes that while the aged did not, “wholly relinquish their ‘worthy’ status to this group of reformers, old age dependency seemed closely tied to profligacy in youth.”

\textsuperscript{53}The following conditions were noted as being widespread in the almshouses at the end of the nineteenth century: minimal physical care, no recreation, no attention to emotional needs, the separation of husbands and wives, as well as illness and insanity going untreated. \textit{Id.}

\textsuperscript{54}The author notes that “gone was the Victorian concept of self-willed health and independence.” \textit{Id.} at 27.

\textsuperscript{55}HOLSTEIN, supra note 27, at 27. The reformers even touted the public nursing institution as the “location of choice for the severally incapacitated aged of limited means or even competent but poor elders.”

\textsuperscript{56}The professionals thought the private institutions were the residence of choice to care for the needs of the elderly, adding nursing staffs which eventually evolved into what look like modern day nursing homes. \textit{Id.}

\textsuperscript{57}Id.
nonsistent. While society came to accept the premise that care for the elderly was a function of the nation's nursing institutions, it did not seem to accept the notion that government should be heavily involved in their day-to-day operation.


The Social Security Act changed the role of public nursing institutions, inadvertently transforming them into the modern nursing home. Before the passage of the Social Security Act, society envisioned public nursing institutions as a place of last resort, to be used only as a measure of last chance. However, the Social Security Act signified that the community was once again accepting the poor and elderly as community members. Federal government programs to reimburse only particular types of facilities for the care and treatment of qualified elderly persons inadvertently shaped these facilities into the "singularly most important source of institutional care for America's elders."

These types of federal funding schemes helped to encourage the expansion of private nursing homes, transforming the remaining public nursing institutions and almshouses into the modern day nursing home.

Quality care did not persist in these newly emerging alternatives to public nursing institutions and almshouses. Instead, the shortage of facilities caused regulators to ignore quality complaints, in the hope

\[^{58}\text{Id.}\]
\[^{59}\text{LIDZ, supra note 33, at 29. The government was not very concerned with public nursing institutions at this time based in part on the fact that the United States was entering the Great Depression, as other areas of society were obviously of greater public concern.}\]
\[^{60}\text{Id.}\]
\[^{61}\text{HOLSTEIN, supra note 27, at 29. Public facilities were viewed as the "care setting of last resort for the down-and-outer types...[serving] the poorest, but also some of the sickest, nursing home patients."}\]
\[^{62}\text{Id. The Social Security Act prohibited payment to residents of public homes, resulting in the flourishing of private nursing homes, at the demise of the public nursing institutions.}\]
\[^{63}\text{Id. As the chronically ill began to fill available bed space in hospitals, federal laws were passed to encourage the development of private, for-profit nursing homes to free-up bed space in the hospitals. For instance, homeowners who needed to supplement their income were encouraged to offer boarding to the indigent and disabled elderly. LIDZ, supra note 33, at 23. These "entrepreneurial endeavors" were viewed by the public as the "rest" or "convalescent" homes and eventually become the impetus for the modern day nursing home. The author notes "what started out as an alternative to institutionalization became an alternative form of institution." Id. at 30.}\]
that education and persuasion could be used in the long-term to persuade operators of such facilities to rectify quality deficiencies.\textsuperscript{64}

Then, in the 1940's, a push towards a more medicalized model of treatment emerged for these nursing facilities.\textsuperscript{65}

As competition between the private nursing homes grew, they began to distinguish themselves by offering more sophisticated care.\textsuperscript{66} Congress responded by passing new legislation and amending other laws to make the provision of services to the elderly more accessible and, unintentionally, more profitable.\textsuperscript{67} Nonetheless, lack of federal enforcement over nursing home services continued into the 1960's until the passage of the Medicare and Medicaid programs.\textsuperscript{68} These programs made more public money available for these institutions at the cost of meeting certain federally mandated standards.\textsuperscript{69} Few nursing facilities were able to meet the newly created hospital-like regulations.\textsuperscript{70} In response, the government developed different methods, essentially classifications, whereupon a nursing facility could still receive Medicare and Medicaid funding without technically meeting the newly created hospital-like regulations. For instance, the government created

\textsuperscript{64}\textsuperscript{LIDZ, supra note 33, at 30.}
\textsuperscript{65}\textsuperscript{Id. at 31.}
\textsuperscript{66}\textsuperscript{Id.}
\textsuperscript{67}\textsuperscript{Id. at 31-32. While I do not list every piece of legislation that contributed to this more profitable designation, the Hill-Burton Act was of great importance. In 1946, Congress passed the Hill-Burton Act to encourage hospital construction. In 1950, this Act was amended to require the licensure of nursing homes at the state level and also provided for the direct payment of health care providers. The licensure requirements had little effect upon regulating the nursing home industry because each state made its own provisions. The direct payment of health care providers, on the other hand, made a significant impact on nursing home care as providers realized that a profit could be realized for rendering treatment to the elderly.}
\textsuperscript{68}\textsuperscript{Medicare is codified at 42 U.S.C. § 1395 et seq. (1994) and can generally be called the program that cares for the elderly. Medicaid is codified at 42 U.S.C. § 1396 et seq. (1994) and can generally be classified as the program caring for the poor. The federal government administers the Medicare program, while the Medicaid program is mainly administered by each individual state government. Vast differences exist between the two different programs and the statutes should be consulted to note these differences.}
\textsuperscript{69}\textsuperscript{LIDZ, supra note 33, at 32-33. For instance, these programs resulted in further encouragement for facilities to develop more hospital-like services before the federal government would pay reimbursement for services rendered to qualifying residents.}
\textsuperscript{70}\textsuperscript{Id. at 32.}
a "substantial compliance" and an "intermediate care" designation which allowed a facility to qualify for vendor payments.\textsuperscript{71}

Congress would make further changes throughout the years leading up to 1986, but there were still no clear set of federal standards to assure quality treatment was being rendered in these nursing facilities.\textsuperscript{72} In light of the ever-changing designations, classifications and certifications of nursing facilities, federal and state funding of nursing homes through the Medicare and Medicaid programs allowed a vast amount of money to be spent for elderly care. However, it was obtained at the expense of a facility having to implement complex government regulations.\textsuperscript{73}

1987 – Present: Quality Care Emblazoned by Statutes and Regulations

By the 1980’s, publicity had spread regarding the poor quality of care within public and private nursing homes.\textsuperscript{74} Invariably, the government found itself becoming more deeply involved in the regulation of the level of care administered by nursing facilities.\textsuperscript{75} In 1987, Congress passed the Omnibus Reconciliation Act of 1987 (OBRA 87) which was sweeping legislation aimed at curing some of the quality care downfalls of nursing home facilities, as well as enacting patients' rights.\textsuperscript{76}

OBRA 87 changed the focus of standards for nursing homes enrolled in the Medicare and Medicaid programs.\textsuperscript{77} Prior to the passage of this legislation, the program participation standards focused merely on the nursing home’s ability to provide care to its residents, not on the

\textsuperscript{71}Id. at 33. This allowed facilities to maintain a favorable status, and therefore still receive federal reimbursement, while having a certain amount of time to bring such facility within full compliance with the federal standards.

\textsuperscript{72}Id. at 33-35. Again, space limitations prohibit listing every legislative and agency change that occurred during this time period. Suffice it to say that while the federal government kept amending the laws to try to provide quality-control measures, the states still had their own licensure standards that were not uniform from state to state. The result was a constant struggle to apply standards that focused on the actual delivery of services, i.e. outcome-based, as opposed to focusing only upon the ability of a facility to deliver services.

\textsuperscript{73}Id. at 35.

\textsuperscript{74}Litz, supra note 33, at 35.

\textsuperscript{75}Id.

\textsuperscript{76}Omnibus Reconciliation Act of 1987, Pub. L. No. 100-203, 101 Stat. 1330-175, 1330-179, 1330-182 (1987) (codified at 42 U.S.C. §§ 1395i-3(a)-(h) and 1396t(a)-(h) (1994)). This legislation has also been dubbed as the "Nursing Home Reform Act."

\textsuperscript{77}Litz, supra note 33, at 35.
quality of the care that was actually rendered.\textsuperscript{78} Accordingly, OBRA 87 refocused the federal program standards upon: (1) the actual delivery of care and (2) the results of such care.\textsuperscript{79}

OBRA 87 also revamped its enforcement mechanisms for sanctions in an effort to encourage facilities to remain in compliance with the new standards.\textsuperscript{80} Seeking to have a federal penalty to enforce compliance by nursing facilities, this legislation added new penalties, such as civil monetary penalties,\textsuperscript{81} the placement of a substitute manager at the nursing home, mandatory staff training on specific non-compliant issues, implementation of a correction plan and the placement of an on-site state monitor at the nursing home.\textsuperscript{82} Several years later, the government developed compliance regulations for nursing facilities which finally implemented quality care standards for nursing facilities.\textsuperscript{83}

With the passage of OBRA 87 and its subsequent regulations, the federal government has become directly involved in the provision of quality care administered by nursing facilities. While such involvement

\textsuperscript{78}This fact came to light largely through a report submitted to Congress by the Institute of Medicine. The Institute of Medicine, under contract with Department of Health and Human Services, recommended changes in the regulatory policies and procedures to ensure nursing home residents receive satisfactory care. The Institute of Medicine report suggested that the government should focus on the delivery of more "resident-orientated" nursing homes standards. See GAO Letter Report, Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards, GAO/HEHS-99-46 (Mar. 8, 1999).

\textsuperscript{79}Id.

\textsuperscript{80}Id.

\textsuperscript{81}Id. These were of particular importance to the government for establishing a measure to keep nursing facilities compliant with the new standards. By allowing the state to impose civil monetary penalties in an amount up to $10,000 per day for each non-compliance with a standard, the House Budget Committee thought that this financial incentive was the means necessary to keep the nursing homes compliant with federal rules and regulations. H.R. 391, 100\textsuperscript{th} Congress, p. 473. The means did not achieve the desired end, as nursing homes began a "yo-yo pattern of compliance" whereby facilities would avoid the penalties if the violations were corrected within a designated time period. See GAO Letter Report, Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards, GAO/HEHS-99-46 (Mar. 8, 1999).

\textsuperscript{82}Before the enactment of OBRA 87, the only sanctioning powers available to the federal government against the non-compliant nursing homes included: (1) terminating the nursing home's Medicare participating agreements, and (2) denying payment for services provided to new Medicare or Medicaid qualified residents. Id.

\textsuperscript{83}Regulations dealing with quality standards were passed in 1990, while the regulations dealing with enforcement mechanisms were not passed until 1995. See 42 C.F.R. §§ 483.1 et seq. (1995) (requirements for States and long-term care facilities) and 42 C.F.R. § 488.400 et seq. (1995) (enforcement of compliance for long-term care facilities with deficiencies).
was nearly nonexistent in colonial times, the extent of government involvement as it exists today can be seen in the following example.\textsuperscript{64}

Suppose that a person owning a nursing home wants to open that facility to the public. To open such a facility, it first must satisfy local and state concerns. This could involve matters such as local zoning requirements and meeting state licensure requirements, such as certificate of need standards.\textsuperscript{65} Assuming that state and local government concerns are fully addressed, the facility must decide if it is going to participate in federal and state programs, such as Medicare and Medicaid. If it chooses to participate in either or both programs, the facility must obtain accreditation from an appropriate agency before the federal and state governments will provide reimbursement for services under such programs.\textsuperscript{66} Participating in the government programs gives the facility a stable source of income, but this assurance is taken at the cost of accepting numerous regulations.\textsuperscript{67} In other words, this "guaranteed" government money comes at the cost of complying with additional federal and state government imposed standards.\textsuperscript{68}

Assuming all of the above requirements are met, the facility would operate under the provisions imposed by local, state and federal governments. However, these actions merely ensure that the facility can open its doors to the public and provide service. If a facility wants to continue to keep its doors open, it must receive favorable reviews from state and/or federal surveyors. Such inspections occur unannounced and the facility is checked for compliance pursuant to a list of measures drawn up by a federal government agency.\textsuperscript{69} The list

\textsuperscript{64}This discussion is not limited to the federal government; it reaches out also to state and local government involvement. Unfortunately, constraints on the length of this note prohibit elaborate discussions of state and local government involvement.

\textsuperscript{65}This of course varies depending on the state in which such facility is located. This also assumes that the state still requires a certificate-of-need finding and that a moratorium has not been placed on future establishment of such facilities.

\textsuperscript{66}Normally, this accrediting agency is the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), but this accreditation could come from other organizations recognized by the federal government.

\textsuperscript{67}An example of this includes the requirements for long-term care facilities, i.e. skilled nursing facilities, participating in the Medicare program. See 42 C.F.R. § 483.1 \textit{et seq} (1995).

\textsuperscript{68}\textit{Id.}

\textsuperscript{69}Effective January 1, 2000, JCAHO voted to do away with its twenty-four hour announced window policy in order to have more spontaneous inspections pursuant to government reports requesting more staggered and unannounced visits by surveyors. See
is long and the facility is given a rating as to whether it is in compliance with each measure. To avoid being in violation of the government-imposed standards, the facility must be in "substantial compliance" with such measures. Otherwise, the facility could be subject to penalties, such as civil monetary penalties and/or the exclusion of participation in federal and state programs.

If a facility is subject to penalty because of a violation of quality care provisions, certain procedures must be followed to effectively enforce the sanction. For instance, assume that a nursing home is not in "substantial compliance" with the measure concerning the method for providing bathing services to bed bound residents. Federal government policies grant a grace period whereby the facility could correct the non-compliance and not be subject to penalty. If the violation is not corrected within that grace period, then a state agency would bring the facility's violation to the attention of the federal agency. When the federal agency receives this information, the accused facility has an opportunity to come within compliance before a

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*Hospitals Face Random Unannounced Visits Under Amended JCAHO Survey Policy, 8 Health L. Rep. (BNA) at 1382 (Aug. 19, 1999).*

90 A deficiency can be placed in one of twelve different categories, designated A through L, with each category signifying a particular level of seriousness. As long as the nursing facility does not have a deficiency greater than a Level C, then that home is in "substantial compliance" with the standards, and therefore, is providing an acceptable level of care and not subject to sanction. A violation greater than a Level C is viewed as subjecting the nursing home residents to a more than minimal type of harm and subjects the nursing home to sanctions. State surveyors identify and categorize deficiencies which are then provided to the appropriate federal government agency. The federal agency, nonetheless, retains the authority to issue the final decision of the appropriate penalty and also holds the authority to collect any monetary penalty that is assessed. See *GAO Letter Report, Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards*, GAO/HEHS-99-46, (Mar. 8, 1999).

91 This is looking only at what I consider to be the traditional method to sanction the nursing home for such violations. The new methods will be explained in the next section of this note.

92 The federal agency has the authority to grant a grace period upon which a facility could achieve compliance, ranging from thirty to sixty days. Nonetheless, facilities with repeat severe deficiencies are not given the benefit of this grace period in the interest of protecting the residents of such facility.

stated deadline.\textsuperscript{94} If such deadline passes, then the sanction assessed by the federal agency will be mandated against the facility.\textsuperscript{95} This sanction can be appealed to federal court, but the facility maintains the burden of proof to show that the sanction is not warranted.\textsuperscript{96}

Thus, nursing facilities must comply with numerous statutes and regulations not only to open a facility, but also to keep the facility accredited to receive reimbursement from federal and state programs.\textsuperscript{97} While the federal government already has several different options available to penalize facilities, additional measures are currently being used to enforce some measure of quality care standards in the nursing home industry.\textsuperscript{98}

\section*{PAST AND CURRENT FEDERAL GOVERNMENT INITIATIVES TO SEEK QUALITY CARE IN THE NURSING HOME SETTING}

The federal government has traditionally approached the issue of quality care in nursing homes using three distinct statutory tools. First, OBRA 87 created quality care requirements for "nursing facilities" which basically extended to all nursing homes.\textsuperscript{99} OBRA 87 mandates that a nursing facility "must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement

\begin{itemize}
\item[\textsuperscript{94}]Generally speaking, the facility has fifteen to twenty days to correct the deficiency. The exception to such a notice period concerns civil monetary penalties and certain stated deficiencies. \textit{Id.}
\item[\textsuperscript{95}]With the many different approaches that could be taken to a nursing home's violation of the OBRA 87 enacted standards, it was, and still is, very confusing to determine exactly what sanction could be applicable upon the occurrence of a violation.
\item[\textsuperscript{96}]This is obviously an over-simplification of the regulation process for which a nursing home is subject when operating a facility. Of course, this process varies depending upon what type of facility is operated. Suffice it to say, however, that a vast regulatory scheme applies to nursing homes.
\item[\textsuperscript{98}]\textit{Id.}
\item[\textsuperscript{99}]A nursing facility is defined as an institution that provides skilled nursing care and related services, rehabilitation services to the injured, disabled or sick, and the health-related care and services to persons because of their mental or physical condition. While other requirements exist to qualify an institution as a nursing facility, the main provisions are embodied in 42 U.S.C. § 1396r(a) (1994).
\end{itemize}
of the quality of life of each resident." However, "quality of life" is not specifically defined in the statute which promotes differing interpretations of a facility that is not meeting quality care standards. Regardless, a nursing home's failure to meet the standard of quality care can result in:

1. termination of that facility's participation in the state program;
2. denial of payment for services rendered;
3. assessment of a civil monetary penalty for each day the nursing facility is not in compliance;
4. appointment of a temporary manager to oversee the operation of the facility; and/or
5. closure of the facility and the resulting transfer of the residents.

Second, the Social Security Act contains "quality of life" requirements specifically for skilled nursing facilities. Because skilled nursing facilities must meet certain requirements to participate in the Medicare program, the statute does not apply to every nursing facility. Requirements under this statute include: making an assessment of the resident's functional capacity; the provision of particular services to attain or maintain the highest well-being of each resident; and having the care of each resident provided under the supervision of a physician. 42 U.S.C. § 1396r(b) (1994). Note that requirements are scattered throughout this statute and I have chosen only a few for example purposes. The entire statute should be read in detail to get the full breadth of the requirements for nursing facilities.

42 U.S.C. § 1396r(h) (1994). The penalty that can be assessed depends on the severity of the noncompliance. Furthermore, the statute does not restrict any remedies that may be available under state law, thus compounding the penalty that a nursing facility could be subjected to for noncompliance. The statute even goes as far as to list specific remedies when a facility has not been in compliance for three consecutive standard surveys regarding the provision of substandard quality of care to the residents.

Skilled nursing facility refers to an institution which is primarily engaged in providing residents with (i) skilled nursing care and related services for residents who require medical or nursing care, or (ii) rehabilitation services for the rehabilitation of injured, disabled, or sick persons and is not primarily for the care and treatment of mental diseases. 42 U.S.C. § 1395i-3(a) (1994). Skilled nursing facilities must "care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident." Id. The facility is also under a three-month deadline to correct any noncompliance found. If this is not met, then the facility cannot receive payment for Medicare related services provided to any resident who is admitted to the facility after the expiration of the three-month window. See specifically 42 U.S.C. §§ 1395i-3(b)(1) (1994) and generally 42 U.S.C. § 1395i-3 (1994).
facility. Nonetheless, penalties available for a violation under this statute include:

1. terminating the facility's participation in the Medicare program;
2. denying payment for services rendered;
3. assessing civil monetary penalties up to $10,000 for each day of non-compliance; and/or
4. appointment of a temporary manager.

Third, quality care issues are addressed by specific legislation for provider violations under the Medicare and Medicaid programs. The Secretary of Health and Human Services can terminate facilities from participation in the Medicare and Medicaid programs for furnishing "items or service to patients . . . substantially in excess of the needs of such patients or of a quality which fails to meet professionally recognized standards of health care." Furthermore, in return for participation in the federal and state programs, providers themselves must assure that patient services "will be of a quality which meets professionally recognized standards of health care." Such assurances can even be found in the individual provider agreements entered into between a State and a provider of Medicaid reimbursed services. Failure to meet the provisions of the Medicare and Medicaid programs

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104 42 U.S.C. § 1395i-3(h) (1994). Again, the applicable penalty depends on the danger to the resident, i.e. whether it immediately jeopardizes the health or safety of its residents.
106 42 U.S.C. § 1320a-7(b)(6)(B) (1994). The Secretary's authority here is permissive exclusion, as opposed to a mandatory exclusion of the facility from the Medicare and Medicaid programs.
107 42 U.S.C. § 1320c-5(a)(2) (1994). See also 42 U.S.C. § 1396a(a)(30)(A) (1994) (State's Medicaid program must provide such methods and procedures that may be necessary to "assure that payments are consistent with efficiency, economy, and quality of care...").
108 See Symposium, When Neglect Becomes Fraud: Quality of Care and False Claims, 43 St. Louis L.J. 27, 38-39 (Spring 1999). The author focuses on the Missouri Medicaid Participation Agreement which provides that provider of services under the agreement agree to "comply with the Medicaid manuals, bulletins, rules, and regulations as required by the Division of Medical Services and the United States Department of Health and Human Services in the delivery of services and merchandise and in submitting claims for payment. [The provider] understands...[that he/she is] not entitled to Medicaid reimbursement if [he/she fails] to so comply...." Id. at 38.
could result in termination from participation in either (or both) programs which could have a significant impact upon the financial status of the nursing facility.\footnote{This statement is highly dependent upon the individual nursing home’s reliance upon Medicare and Medicaid funding. Some facilities rely almost exclusively upon government reimbursement, whereas some facilities do not even participate in these programs.}

As previously mentioned, OBRA 1987 has not had the effect of ensuring quality care in the nursing home setting as was hoped when the legislation was passed. Instead, additional measures have been sought by the federal and state governments, along with members of the public, to try to enforce quality care within such facilities.\footnote{Although only a few nursing homes have been labeled as “problem facilities” with reoccurring violations and deficient levels of care being administered to their residents, these facilities attract the most attention from Congress and the media regarding the argument of the need for more regulation of the nursing home industry.} The following section explains such newly applied initiatives by the federal government to combat alleged deficiencies in quality care in nursing homes.\footnote{I have compiled only the major initiatives to outline in the following section, as space limitations prohibit the listing of every current initiative and relevant cases.}

**False Claims Act**
The False Claims Act (FCA)\footnote{False Claims Act of 1863, ch. 67, 12 Stat. 696 (re-codified at 31 U.S.C. § 3729 (1994)). See also When Neglect Becomes Fraud: Quality of Care and False Claims, supra note 108 (providing a more complete discussion of the history of the FCA and its several modifications over the years).} was initially passed to combat the proliferation of fraudulent claims submitted for items provided to the government during the Civil War.\footnote{These items were at best second-rate or entirely worthless. U.S. v. McNinch, 356 U.S. 595, 599 (1958).} This legislation has since expanded to areas beyond the scope of the military to its more recent application to health care providers.\footnote{See When Neglect Becomes Fraud: Quality of Care and False Claims, supra note 108, at 28.} The impact that the FCA could have as a significant weapon in the federal government’s “war” against health care fraud and abuse should not be taken lightly because of the potential for enormous penalties.\footnote{Id. The FCA has been argued as a special message from government prosecutors to health care providers that, “(1) quality of care has been and remains a necessary prerequisite for reimbursement under government programs and (2) quality of care cannot be sacrificed for the sake of profits.”}
The penalties are two-fold. First, treble damages can be assessed for any false claims submitted to the government. Second, a penalty of $5,000 to $10,000 can be assessed for each false claim submitted to the government. As a result, the potential amount of penalties when submitting claims for services provided under the Medicare and Medicaid programs accumulates at an alarming rate.

Furthermore, any person with the appropriate knowledge can file a false claims lawsuit under a qui tam provision of the FCA, called a “whistle-blower” lawsuit. A “whistle-blower” is one who has knowledge of the submission of a false claim and can file a lawsuit on behalf of the federal government. The “whistle-blower” is given a financial incentive by being able to collect up to 30 percent of the proceeds as a result of the lawsuit. Therefore, the nursing facility must be aware that the threat of lawsuit may come from the federal government or any individual with knowledge of false claims being submitted to the government for payment.

However, the government or the “whistle-blower” carries the burden of proof, which requires a showing that: (1) the defendant presented or caused to be presented a claim, (2) that was false or fraudulent, (3) the acts were performed “knowingly,” and (4) it caused damages. Even though it may be difficult for the government to prove each and every factor, this is a fact that has remained unseen in the false claims lawsuits filed against nursing homes as such a case has yet to reach the conclusion of a full trial.
The FCA has been used against nursing homes to argue that a claim for reimbursement is actually a false claim when the services provided to a resident are sub-standard or sub-par quality care concerns.\(^{124}\) Essentially, the government argues it pays for quality care services for residents who qualify for Medicare and Medicaid.\(^ {125}\) Thus, if the care received by such a resident does not meet the quality care standards, the submission of a claim for reimbursement for those services is a false claim and subjects the nursing facility to potential penalties.\(^ {126}\)

The FCA, as used against nursing homes, has received recent attention as a result of two separately filed cases by the federal government.\(^ {127}\) In *U.S. v. GMS Management-Tucker, Inc.*, a resident of the Tucker nursing facility was transported to a local hospital for...

\(^{124}\)Id.

\(^{125}\)As discussed *infra* in Section II.

\(^{126}\)To establish a valid case against a nursing home for quality care violations, the government must show: (1) the "provider" of services failed to provide the requisite quality care to its Medicare or Medicaid patients, and (2) when such "provider" submits its request to Medicare or Medicaid for reimbursement, the "provider" is at the very least implicitly certifying that it has complied with the applicable standards of care. See *When Neglect Becomes Fraud: Quality of Care and False Claims*, supra note 108, at 36.

\(^{127}\)There are several other cases worth mentioning here. In *United States v. Philadelphia*, No. 98-4253, (E.D. Pa. Aug. 14, 1998), a nursing home accused of violating the FCA and depriving residents of their civil rights settled such allegations by agreeing to pay a $50,000 penalty, as well as implementing several detailed policies ensuring patient’s rights and adequate care. See *Nursing Home Settles Quality Care Case*, 7 Health L. Rep. (BNA) at 1495 (Sept. 24, 1998) (noting that this was the third time that the government used the FCA to address inadequate quality care received by nursing home residents). In addition, another Philadelphia area nursing home settled allegations of FCA violations for failing to provide adequate care to its residents. The nursing home agreed to pay a civil monetary penalty of $195,000 and to implement weight monitoring and wound care protocols in exchange for HCFA dropping its appeal of current and potential civil and administrative penalties. See *Nursing Home Settles FCA Claims on Inadequate Care*, 8 Health L. Rep. (BNA) at 858-59 (May 27, 1999). In *United States ex rel. Todarello v. Beverly Enterprises Inc.*, No. C96-2697 (N.D. Cal. plea entered Feb. 3, 2000), one of the nation’s largest nursing home chains settled all criminal and civil allegations filed by a former manager in a qui tam lawsuit by agreeing to pay the federal government $170,000,000 in civil penalties, $5,000,000 in criminal fines and divesting itself of ten nursing homes. See *Beverly Enterprises Agrees To Pay $175 Million, Agree to Exclusions*, 8 Health L. Rep. (BNA) at 1412 (Aug. 26, 1999). In *United States v. Mercy Douglas Human Services Corp.*, No. 00-CV-3471 (E.D. Pa. Consent orders filed Jul. 10, 2000), the owner of two Philadelphia nursing homes agreed to pay $160,000, hired an outside firm to manage the facilities and took steps to ensure the provision of “adequate care” for the facility residents in order to settle FCA charges and civil penalties imposed by HCFA regarding allegations of care deficiencies. See *Nursing Homes to Pay $160,000, Improve Care to Settle Quality Charges*, 4 Health Care Fraud Rep. (BNA) at 542-43 (Jul. 26, 2000).
The staff at this hospital was so upset with the condition of the patient that it contacted local officials, resulting in the investigation of the facility by the Pennsylvania State Department of Health. The federal government filed suit against the nursing home owners and the managing entity alleging that the nursing home residents' nutritional needs and wounds were not properly treated. The submission of claims to the Medicare and Medicaid programs for the services provided to the residents were therefore alleged to be false claims.

Almost immediately after suit was filed, the defendants settled the case. The government received damages of $25,000 and $575,000 from the nursing home operator and its owner, respectively. Furthermore, defendants were required to enter into separate consent orders requiring each one to improve its manner of treating nutritional and wound care services. Rather than face the severity of penalties under the FCA, the nursing facility and its management partner decided to settle the claims.

In U.S. v. Chester Care Center, the federal government claimed the defendant nursing home submitted false claims to Medicare and Medicaid arising from the alleged inadequate services provided to its residents. The government alleged that the defendant's provision of care was inadequate in the following areas of treatment: nutrition, nursing care to residents with diabetes, monitoring of water

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129 Expanding on the alleged inadequate care issues, one resident of the Tucker facility had twenty-six "decubitus ulcers or pressure ulcers" with almost every one in the most severe stage. In addition, he had a "gangrenous left leg and all five toes on one foot were...in the process of falling off" and was "dehydrated, malnourished, severely anemic, and his eyes were infected." David R. Hoffman, The Role of the Federal Government in Ensuring Quality of Care in Long-Term Care Facilities, 6 ANNALS HEALTH L. 147, 152-53 (1997).
130 Id. at 148. The suit also included charges of inadequate care provided to two additional residents of Tucker. These residents suffered from "malnutrition and exhibited severe skin breakdown as evidenced by multiple decubitus ulcers." Id. at 153.
131 Id. at 148.
132 Id.
133 The purpose of the consent orders was not only to provide remedy for the treatment of the three residents listed in the complaint, but also to bind Tucker to provide state-of-the-art nutrition and wound care in every one of its nursing facilities. Id. at 154.
134 Hoffman, supra note 129, at 154.
temperatures, wound care and staffing. In exchange for disallowing the consent order to be used as evidence of liability in any other proceeding and for an agreed upon penalty, the defendant nursing home agreed to pay a structured settlement amount of $500,000 total for the alleged FCA violations and for a federal agency's imposition of civil monetary penalties. Instead of facing the full realm of potential penalties available under the FCA and the federal agency, the nursing home "voluntarily" chose to enter the consent agreement in order to have just one established monetary penalty and a chance to improve its provision of services to its residents while still receiving Medicare reimbursement.

In theory, the government's use of the FCA against claims submitted by nursing homes alleging inadequate care should make the nursing homes more accountable for claims submitted to the government by: (1) improving the provision of its services to be in compliance with the quality care standards, and (2) submitting only claims for reimbursement in which quality care was rendered. In reality, it has yet to be seen whether this is true. Unfortunately, the government has yet to test its argument in a full blown trial, as all the cases have reached settlements, either before going to trial or during trial. It can only be speculated what outcome would occur if a verdict would be reached in a false claims lawsuit against a nursing facility.

At best, it can be argued that the government's use of the FCA at the present time has been mainly a threat of potential financial devastation to a facility. Arguably, the threat of financial devastation

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136 Id. at *2.
137 Id. at *3.
138 Many of the same provisions of the consent order of the Tucker case were also incorporated here. These provisions include: the nursing home giving its assurance of full compliance with the provisions of the Nursing Home Reform Act at 42 U.S.C. §§ 1395-1396 et seq., and all regulations and guidelines associated with these statutes; ensuring staff members provide residents with appropriate basic care services that meet the resident's individual needs; and ensuring residents receive adequate and appropriate nursing care. Id. at *6, *10, *19.
139 Again, this statement is based upon legal research of caselaw as of March 2000.
140 As stated by Mr. Patric Hooper, who specializes in health care litigation, "[i]f you are sitting across from a U.S. attorney in a settlement conference, you may feel powerless; but in a court, the government has the burden of proof, and that makes a very big difference." Patric Hooper, Courts Increasingly Important in Resolving Enforcement Allegations, Health Law Expert, 5 No. 13 CAL. HEALTH L. MONITOR 2 (Jul. 7, 1997). See also Michael M. Mustokoff, et al., The Government's Use of the Civil False Claims Act to Enforce Standards of Quality of...
does not assure the provision of quality care. Instead, the FCA only provides leverage for the government to recoup money in its current thrust under health care fraud and abuse initiatives.\textsuperscript{141} Challenging the government in a false claims action may cost hundreds of thousands of dollars, and the facility may still be liable for paying out sanctions and civil monetary penalties. Instead of facing the huge fines and other severe penalties, some facilities may find it easier to settle with the government than to possibly jeopardize their financial status.\textsuperscript{142}

Furthermore, attention should be given to the residents of a facility bankrupted by FCA sanctions or other penalties. While closing the doors of a facility providing "inferior" services is beneficial to the residents, bankrupting that facility and the consequential damage that could occur from transferring the residents may not be the appropriate ends to justify the means.\textsuperscript{143}

Nonetheless, the government's use of the FCA should be taken very seriously by nursing facilities because of the potentially immense monetary penalties.\textsuperscript{144} As stated by an Assistant United States Attorney for the Eastern District of Pennsylvania, "[t]he use of the False Claims Act is another weapon available to the government to combat inappropriate behavior, and it will be pointed at those who choose profits over good care, neglect over concern, and greed over


\textsuperscript{142}For instance, reasonable minds could very easily differ over the interpretation of Medicare manual provisions and Medicare guidelines. While every over-payment is not a false claim, it may be in the financial interests of a facility to settle the matter out-of-court instead of risking civil monetary penalties and termination from participating in the Medicare and Medicaid programs.

\textsuperscript{143}Potential harm to residents, referred to as "transfer trauma," can occur when a resident is transferred to a new, unfamiliar environment. The forced transfer of a nursing home arguably creates a "great risk of emotional trauma and impairment of patient function and condition." Northern Health Facilities, Inc. v. United States, 39 F. Supp. 2d 563, 564 (D. Md. 1998).

\textsuperscript{144}The Department of Justice's use of the FCA is a powerful enforcement tool because of its damages and penalties. The GAO, however, recommended that the Department of Justice should take additional steps to improve its oversight of its national health care initiatives, including its efforts to implement the FCA guidance program. See GAO/HEHS-99-170 \textit{Medicare Fraud and Abuse: DOJ's Implementation of False Claims Act Guidance in National Initiatives Varies} 1 (August 1999).
compassion when caring for nursing home residents." These might be harsh words, but they appear to address the current trend of the federal government in combating nursing home abuse.

Preventing Fraud and Abuse in the Nursing Home Setting
Protecting the integrity of government health care programs is an ongoing concern for the federal government. With an estimated $1,228.2 billion to be spent by private and government sources on National Health Expenditures in 1999 alone, it is without doubt that the government is genuinely concerned with preventing the exploitation of government dollars spent on health care services. While fraud and abuse prevention measures apply across the full spectrum of health care services, particular attention is noteworthy of the efforts of four federal agencies in their fight to curb violations in the nursing home setting.

The administration of nursing home oversight is handled by the Department of Health and Human Services (HHS) and its subdivision agency Health Care Financing Administration (HCFA). Both HHS

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145 This is merely the opinion of the attorney which does not represent the official policy of the United States Department of Justice. Hoffman, supra note 129, at 156. Still, I argue that this seems to be the "battle-cry" of the federal government when going after nursing homes for alleged quality care violations.
146 Former United States Attorney General Janet Reno stated that combating health care fraud is one of the Justice Department's highest priorities. See Health Care Fraud Is High Priority For Justice, Attorney General Claims, 7 MEDICARE REPORT (BNA) 27 (Jun. 14, 1996).
148 The Department of Justice estimated that the total amount of Medicare overpayments in Fiscal Year 1998 was $12.6 billion, or 7.1 percent of Medicare's total fee-for-service spending. However, this amount is almost half of that from the previous year. In 1997, it was estimated at $20.3 billion, or 11 percent of Medicare spending. The 1996 figures estimated that Medicare made overpayments in the amount of $23.2 billion, or 14 percent of Medicare spending. See DOJ Health Care Fraud Report Fiscal Year 1998, available at http://www.usdoj.gov/dag/health98.htm.
149 Please also note that a task force formed in 1999 called the National Health Care Fraud and Abuse Task Force has made nursing homes one of its top priorities. This new task force has major goals which include: (1) fighting nursing home fraud and (2) increasing the number of exclusions of dishonest providers from federal health care programs. The task force is comprised of officials from federal, state and local levels in order to better coordinate health care fraud investigations and the sharing of information between the different groups. See New Fraud Task Force Sets Goals, 8 Health L. Rev. (BNA) at 686-87 (Apr. 29, 1999).
and HCFA are instrumental in forming the policies and regulations that nursing homes must follow.\footnote{Id.}{151}

A significant effort of HCFA is to control fraud and abuse by preventing the exploitation of the Medicare and Medicaid programs.\footnote{Id.}{152} Because many nursing homes depend on funds coming from either or both of these programs, the concern to protect government payments is well understood.\footnote{Id.}{153} Accordingly, HCFA has implemented many policies to prevent financial abuses within the nursing home industry over the years, whether supporting specific legislation, performing investigations or publishing reports.\footnote{Id.}{154} The following are some of HCFA’s significant initiatives over the last few years which have the potential to have an important effect on the nursing home industry:

- HCFA changed the civil monetary penalty methods that can be assessed against nursing homes to prevent a “yo-yo pattern of compliance.” Effective May 17, 1999, HCFA or a state can impose a single civil money penalty not to exceed $10,000 for each “instance” of a nursing home’s non-compliance.\footnote{See 64 Fed. Reg. 13354-62 (March 18, 1999) (codified at 42 C.F.R. § 488.402 et seq.).}{155}

- HCFA developed a Comprehensive Plan for Medicare and Medicaid Program Integrity which lists the steps to be taken by the agency to toughen enforcement of nursing home safety and quality regulations. For example, HCFA sought measures to strengthen its ability to sanction nursing homes guilty of causing harm to residents, to strengthen federal oversight of state inspections, to combat resident abuse and to prosecute egregious violators.\footnote{As reported in this plan, prior Medicare and Medicaid anti-fraud activities conducted in 1997 alone resulted in a total savings to the federal government of over $7.5 billion. See}{156}
• HCFA developed an education campaign to have nursing home residents more involved with the prevention of abuse and neglect.\textsuperscript{157}

• HCFA earmarked $4 million from its 1999 budget for the newly announced initiative of adding new enforcement tools and strengthening federal oversight of nursing home quality and safety standards.\textsuperscript{158}

• Congress provided HCFA an additional $17 million, for a total of $171 million, for state survey and certification activities to increase oversight of nursing homes.\textsuperscript{159}

• HCFA and the Department of Justice are both working together towards developing guidelines for referring cases for prosecution involving "egregious" nursing home violations.\textsuperscript{160}

• HCFA is developing additional standards for improving state investigations of complaints regarding nursing home care.\textsuperscript{161}


\textsuperscript{158}See HCFA Fact Sheet, Assuring the Quality of Nursing Home Care, (Feb. 1999).

\textsuperscript{159}See Bulk of HHS Funding Goes To HCFA, 7 Health L. Rep. (BNA) at 1760 (Nov. 5, 1998).

\textsuperscript{160}See HCFA, DOJ Develop Plan For Prosecuting Nursing Home Violations, Report Says, 8 Health L. Rep. (BNA) at 17 (Jan. 7, 1999) (the report is HCFA Nursing Home Initiative Update #4 which HCFA classifies as a "memorandum of understanding").

STRIVING FOR QUALITY CARE IN NURSING HOMES

- HCFA is expanding the previous rules on how a nursing home facility can be given an immediate fine, subjecting nursing homes having "isolated incidents of physical harm to patients" to an immediate fine of up to $10,000 per instance of abuse.¹⁶²

In short, HCFA is pushing for increased scrutiny of the nursing home industry at the federal, state and local levels. By disseminating more information to the general public, HCFA hopes to expedite the process to expose any abuses or noncompliance actions of nursing homes.¹⁶³ HCFA also wants individual states to become more involved in the increasing pattern of scrutiny by prohibiting noncompliant nursing homes to "slip through the cracks".¹⁶⁴ Advocating for tougher penalties and stricter compliance measures, this agency hopes to enforce better quality care for nursing home residents.¹⁶⁵

Next, HHS also has oversight of the nursing home industry through its control over HCFA. While HCFA deals more directly with the nursing home industry on a day-to-day basis, HHS can still have its presence felt by promoting its own initiatives, especially those directed by the Office of Inspector General (OIG).¹⁶⁶ The OIG affects the nursing home industry with its issuance of Special Fraud Alerts, investigations of the industry and implementation of policy.¹⁶⁷ The following is a compiled list of such measures which have the potential to have a significant impact upon the nursing home industry:

- Special Fraud Alert issued in 1998 regarding the possibility of improper arrangements between a

¹⁶³Id. at 2015.
¹⁶⁴Id.
¹⁶⁵Id.
¹⁶⁶The OIG works to combat fraud, abuse and waste within HHS's programs through a nationwide program of audits, investigations and inspections. See OIG Special Facilities Fraud Alert: Publication of Fraud and Abuse in the Provision of Services in Nursing Facilities, 61 Fed. Reg. 30,623 (June 17, 1996).
¹⁶⁷Id.
hospice and a nursing home for services provided to a hospice patient in a nursing home setting.168

- Special Fraud Alert issued in 1996 listing certain practices identified in the nursing home industry that are suspect of violating the fraud and abuse statute, subjecting the sender of the reimbursement claim to penalty for submission of a false claim to Medicare.169

- Special Fraud Alert issued in 1995 warning against schemes regarding inappropriate business dealings between medical suppliers and nursing homes because of the potential for inappropriate claims submitted for reimbursement by such suppliers.170

- The development of a Compliance Program to help nursing homes design effective voluntary programs to prevent fraud, waste and abuse in health care programs.171

- A survey of the abuse complaint systems of 11 large states which revealed the existence of serious quality care problems for some of the nursing homes in those states.172

169 See OIG Special Facilities Fraud Alert: Publication of Fraud and Abuse in the Provision of Services in Nursing Facilities, 61 Fed. Reg. 30623 (June 17, 1996). The Special Fraud Alert identified common schemes that entailed submitting claims for services that were not rendered to nursing home residents and falsifying claims to circumvent coverage limitations on medical specialties.
172 The data was compiled to understand the current conditions in nursing homes. However, the overall seriousness of the situation was inconclusive because the states applied different meanings to define the levels of severity of the patient abuse. The OIG plans to conduct a follow-up to this report after HCFA implements its program for improved complaint
The OIG reported that the Administration on Aging should be more aggressive on health care fraud.\textsuperscript{173}

The development of a long-term agenda to continue improvements in nursing home care that will take place in a three stage approach: immediate action, research and evaluation and continued progress measurement.\textsuperscript{174}

The main point to be gathered from the actions of HHS, in particular the OIG, is that other government agencies are concentrating their efforts on curing fraud and abuse within the nursing home industry.\textsuperscript{175} It too can perform special studies which may result in the passage of further regulations.\textsuperscript{176} In its efforts to protect the integrity of HHS programs, nursing homes should expect the scrutiny to continue. Because HHS is normally proactive in its efforts to disseminate information that warns of practices that are considered "suspect" by the agency, nursing homes should have the opportunity to also be proactive in their compliance efforts. Accordingly, the actions of HHS should

\begin{itemize}
  \item Former HHS Inspector General June Brown told BNA representatives that the OIG "plans to use the exclusion authority more often, particularly in egregious cases, to 'jar the industry' into paying attention to quality issues and protecting Medicare and Medicaid." See \textit{Officials Warn of Nursing Home Crackdown}, 7 Health L. Rep. (BNA) at 1711-12 (Oct. 29, 1998). In addition, the HHS budget for fiscal year 2001 includes 70.8 million dollars which is specifically designated for expanding implementation of former President Clinton's quality focused Nursing Home Initiative announced in July 1998, showing that serious dollars are being spent to "cure" fraud occurring within the nursing home industry. See \textit{HHS Budget Includes Fraud Provisions On Contractors, Nursing Homes, Waste}, Health L. Rep. (BNA), Vol. 9 No. 6, at 199 (Feb. 10, 2000) (original HHS budget available on the world wide web at http://www.hhs.gov/asmb/budget/fy2001/html).
  \item Officials Warn of Nursing Home Crackdown, 7 Health L. Rep. (BNA) at 1711-12 (Oct. 29, 1998).
\end{itemize}
serve as a clear warning of the type of actions that the agency will tolerate, and more importantly, the practices it deems as suspect of violating the law.

The Department of Justice (DOJ) also plays a contributing role in the fight against health care fraud. The DOJ has developed a program which focuses first on enforcement efforts, including criminal and civil tools. The second part of the program looks towards deterrence and prevention by encouraging public education and compliance initiatives.

The main effect of the DOJ’s efforts can be seen in the number of settlements it has generated and the amount of dollars recovered through criminal fines, civil settlements and judgments in health care fraud matters. Looking at fiscal year 1998, the total amount of money collected by the DOJ for criminal fines, civil settlements and judgments was an estimated $480 million. On the criminal side of the prosecutions, the total amount of criminal health care fraud matters investigated increased 23 percent with prosecutions increasing 14 percent. However, civil health care fraud matters, resulting mainly from qui tam actions, did not have a similar pattern of increase in 1998. Instead, the number of cases pending dropped by 14 percent, but the number of civil health care cases filed did increase by 17 percent. Nevertheless, the DOJ collected $300.4 million in fiscal year 1998 from civil health care fraud matters.

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178 Id.
179 Id. Arguably, deterrence is also an implied goal of the DOJ, but such efforts would not be reflected by the money recovered through DOJ settlements.
181 Id. In 1998, the DOJ investigated 1,866 matters against 2,986 defendants, as compared to 1,517 and 2,479, respectively, from fiscal year 1997, and 1,346 and 2,151, respectively, from fiscal year 1996.
182 Id. As noted in the report, this was mainly due to the end of the DRG National Project.
183 Id. In fiscal year 1998, there were 3,471 matters pending with 107 civil health care fraud cases actually filed. The figures from previous years were 4,010 and 89, respectively, in 1997, and 2,488 and 90, respectively, in 1996.
184 Id. Note that this is a decrease of 33 percent from the amount collected in fiscal year 1997 which was $989.7 million. The decrease can be explained by the settlement of three abnormally large cases in 1997 that greatly inflated the totals.
In fiscal year 1999, the total amount of money collected by the DOJ for criminal fines, civil settlements and judgments was an estimated $524 million.\textsuperscript{185} On the criminal side of the prosecutions, the number of criminal cases filed increased by 16.3 percent, with the total number of criminal cases pending in the United States Attorney’s Office increasing by 6.9 percent, as compared with the previous fiscal year.\textsuperscript{186} Turning to the civil side of the prosecutions, the number of civil cases filed decreased by almost 18 percent while the total number of civil cases pending decreased by almost 53 percent.\textsuperscript{187}

Finally, in fiscal year 2000, the total amount of money collected by the DOJ for criminal fines, civil settlements and judgments was an estimated $1.2 billion.\textsuperscript{188} Looking only at the criminal matters, the number of criminal cases filed in this fiscal year increased 23 percent, with the total number of criminal cases pending in the United States Attorney’s Office decreasing by 2.7 percent.\textsuperscript{189} Focusing only on the civil matters, the number of civil cases filed increased by 256 percent while the total number of civil cases pending decreased by 14 percent.\textsuperscript{190}

These figures should be of great interest to nursing home owners and operators because government efforts to prevent abuse translate into significant settlements being negotiated as a result of the threat of legal action. The threat can be the imposition of civil monetary penalties and/or treble damages, both having the potential of substantial penalties. It appears that the DOJ is using whatever means possible to

\textsuperscript{186}Id. In fiscal year 1999, 371 criminal cases were filed which involved 506 defendants. Furthermore, the United States Attorney’s Office had 1,994 criminal cases pending which involved 3,158 defendants.
\textsuperscript{187}Id. The total amount of civil cases filed in fiscal year 1999 was 91 while 2,278 civil cases were pending with the United States Attorney’s Office.
\textsuperscript{189}Id. The total amount of criminal cases filed in fiscal year 2000 was 457 which involved 668 defendants. The number of criminal cases pending in the United States Attorney’s Office for fiscal year 2000 was 1,939.
\textsuperscript{190}Id. The total amount of civil cases filed in fiscal year 2000 was 233 while 1,995 civil cases were pending with the United States Attorney’s Office.
collect money that it believes was wrongfully paid out under federal and state programs.191

Finally, the General Accounting Office (GAO) plays a role in keeping the government well-informed of the trends and practices within the nursing home industry. As the “investigative arm” of Congress, the GAO performs examinations of matters relating to the receipt and disbursement of public funds.192 By “following the federal dollar,” the GAO assists Congress and federal agencies by performing financial audits, making public policy analysis, evaluating the effectiveness of federal programs and conducting many other functions.193 While such findings and recommendations are not required to be implemented, many of the suggestions of the GAO do find their way into the policies and initiatives addressed by federal agencies. This is evident in the following GAO reports which involve the nursing home industry in some way:

- GAO findings in January 1996 of rampant fraud and abuse related to the services and supplies provided to nursing facility patients.194

- As early as 1997, the GAO was requested to investigate the efforts to combat fraud and abuse in the nursing home industry. Noting that “some unscrupulous providers of supplies and services have used the nursing facility setting as a target of

191 I argue that the DOJ has seen what a potential moneymaker health care fraud litigation can be and that more measures or lawsuits can be expected from the DOJ in order to continue to reap such large amounts of money. Indeed, during the first-ever national conference on nursing home fraud and abuse, Deputy Attorney General Eric Holder stated that one of DOJ’s highest priorities within the health care fraud program is to combat nursing home abuse, especially when resident safety is threatened. See Officials Warn of Nursing Home Crackdown, 7 Health L. Rep. (BNA) at 1711-12 (Oct. 29, 1998). In addition, research performed at the direction of the DOJ was very skeptical of the progress made in the highly publicized fight against unscrupulous health care providers and companies. See DOJ Criticizes Fraud Crackdown, 8 Health L. Rep. (BNA) at 229-30 (Feb. 11, 1999).
193 Id.
194 See GAO/HEHS-96-18, Providers Target Medicare Patients in Nursing Facilities (1996). More than likely, this report led to the OIG’s issuance of the Special Fraud Alert concerning the provision of services in nursing facilities, issued June 17, 1996. See OIG Special Facilities Fraud Alert, supra note 169.
opportunity,” the implementation of fraud and abuse measures were still too new for the GAO to be able to obtain an accurate assessment of their effect.\textsuperscript{195}

- GAO's review of HCFA's program safeguard activities to protect the integrity of the Medicare program in August 1999 revealed that it was premature to quantify the effects such programs have had on controlling Medicare fraud and abuse.\textsuperscript{196}

- GAO reported in March 1999 that while HCFA has attempted to improve oversight of nursing homes, more provisions were necessary to enforce federal quality standards amongst all nursing homes.\textsuperscript{197}

- GAO stated in June 1999 that the current efforts of HCFA to ensure quality care provided by nursing homes is going to require a continuing effort by HCFA for the commitment and oversight of the nursing home industry.\textsuperscript{198}

Many of the GAO's suggestions and recommendations are taken seriously and usually adopted by federal agencies. For instance, HCFA has implemented several key recommendations by the GAO, such as:

\textsuperscript{195}See GAO/T-HEHS-97-114, Too Early to Assess New Efforts to Control Fraud and Abuse (1997).

\textsuperscript{196}The nursing home industry can count on HCFA's efforts being continued into the future because there is no data currently available which gives an accurate assessment of the effects of HCFA's current efforts. Until such efforts can be shown to be fruitless or ineffective, I argue that HCFA is going to continue its current fight against fraud and abuse in the nursing home industry. See GAO/HEHS-99-165, Program Safeguard Activities Expand, But Results Difficult to Measure (1999).

\textsuperscript{197}The GAO noted that HCFA still needed to concentrate on the following areas: reducing the backlog of civil monetary penalties, reinforcing measures to make termination from a program a deterrent, requiring that states must refer all homes with deficiencies that contribute to resident deaths to HCFA for appropriate sanction and improving HCFA's management information system. See GAO/HEHS-99-46, Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards (1999).

increased civil monetary penalty enforcement, staggering of state inspections of nursing homes and reducing the backlog of nursing home cases pending before the HHS Departmental Appeals Board. Again, nursing homes can continue to expect more scrutiny, as the focus towards quality care seems well in place for the next several years and will probably be well-documented through GAO reports.

Special Committee on Aging and the Administration on Aging
The government can also take action to make the public aware of particular society problems through the appointment of a special committee or even the creation of a special agency to resolve particularly identified problems. The efforts of a special committee created to combat the problems associated with the elderly are worth noting, in addition to the efforts of Senator Charles Grassley.

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200 As mentioned previously, JCAHO has changed its survey procedures, as suggested by HCFA and after the issuance of OIG reports criticizing the current hospital monitoring system. A GAO report noted that the backlog of cases was further hampering HCFA's efforts to ensure quality care in the nursing home setting. See GAO/T-HEHS-99-89, Stronger Complaint and Enforcement Practices Needed to Better Assure Adequate Care, (1999). Since the report has been issued, Congress passed a bill that appropriated funds to help the HHS with its current backlog of hearings. See HHS Appeals Board Will Use $1.4 Million For More Judges to Reduce Case Backlog, 8 Health L. Rep. (BNA) at 946 (Jun. 10, 1999).

201 I argue that the GAO is suggesting quality care issues in the nursing home industry are not going to lose any momentum in the near future and that it will be necessary for the GAO to revisit this problem time and time again to make sure that compliance and quality care goals are met.

202 A less influential, but still an important federal agency advocating elderly concerns, is the Administration on Aging (AoA). Created under the Older Americans Act of 1965, the AoA was developed to respond to the needs of the growing elder population. Being the focal point and advocacy agency for elderly concerns, the AoA seeks to make all departments of government and the general public aware of the needs of the elderly and the benefits this elder population can provide to our society. Accordingly, the AoA is mainly concentrated on working jointly with States to develop programs which help elder citizens to remain functioning members of society. The AoA is further involved with research programs which collect information about the "status and needs of various subgroups of elderly which is used to plan services and opportunities that will assist them." A direct result of some of this research was the implementation of successful demonstration programs, leading towards the creation of nationwide programs, such as: Nutrition Program for the Elderly, the nationwide network of Area Agencies on Aging and the Elder Abuse Prevention Program. See AoA Website, at http://www.aoa.dhhs.gov. However, the direct policy of the AoA has yet to effectively attack
The Senate Special Committee on Aging (Committee) was first created in 1961 as a temporary committee and given permanent status in 1977. Although it has no legislative authority, the Committee studies issues, conducts oversight of programs and investigates reports of fraud and waste. In particular, the Committee is dedicated to studying matters affecting older people. It is through these "studies" that the Committee has established itself as very influential on the development of policy involving elder citizens.

Since its creation, the Committee has been a focal point for Senate debate concerning elderly policy. Before Medicare was in effect, the Committee was researching health insurance coverage issues for the elder American population. Once Medicare was in place, the Committee reviewed the performance of the program on an almost annual basis. It has continued this oversight initiative of the administration of programs that concern elder citizens, such as Social Security and Medicare. More recently, the Committee has campaigned against fraud which targets both the elder population and the Federal programs on which the elderly rely. The Committee has therefore brought to light major issues resulting in specific policy changes for the elder population.

the quality care concerns in the nursing home setting. While it is nonetheless concerned about such an issue, its lack of current policy and/or initiatives makes this agency seemingly uninvolved with shaping such future concerns regarding quality care in nursing homes. See IG Says AoA Should Be More Aggressive, 8 Health L. Rep. (BNA) at 1412 (Aug. 26, 1999). Nonetheless, it should be at least noted that this is another government agency that could address quality care issues for nursing homes in the future.

204See Special Committee on Aging Website, at http://aging.senate.gov.
205Id.
206As stated in its mission statement, "It shall be the duty of the Special Committee on Aging to conduct a continuing study on any and all matters pertaining to problems and opportunities of older people, including, but not limited to, problems and opportunities of maintaining health, of assuring adequate income, of finding employment, of engaging in productive and rewarding activity, of securing proper housing, and, when necessary, of obtaining care or assistance."
207Id.
208Id.
209See Special Committee on Aging Website, at http://aging.senate.gov.
210Id.
211Id.
212Id. Some examples of Committee Chairmen researching and revealing pertinent elderly issues are: Senator Frank Moss regarding unacceptable conditions in nursing homes, Senator John Heinz reviewing Medicare's Prospective Payment System as to whether the system promulgated Medicare beneficiaries to be discharged "quicker and sicker," Senator
Under the lead of former Committee Chairman Senator Charles Grassley, the Committee kept the public very informed of the problems within the nursing home industry through press releases and other media forums. In 1998, the Committee conducted a hearing which brought to light a very disturbing pattern of nursing home noncompliance and blatant inadequate care of nursing home residents. The GAO provided recommendations to cure the defects, but the Committee’s charge to cure such wrongful conditions has persisted to implement even further measures.

On June 30, 1999, the Committee held another hearing to follow up on the efforts of the federal government to resolve the previously highlighted conditions in nursing facilities. The Committee once

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Melchor restoring the right to file suit for individuals barred under the age discrimination in employment’s statute of limitations, Senator Pryor’s investigation of the pricing schemes of pharmaceutical companies for prescription drugs, Senator Cohen pushing through major health care anti-fraud legislation, and more recently, Senator Grassley fighting for better conditions in long-term care treatment.

Senator Grassley is a Republican representing the State of Iowa and is a major factor in the push for changes in the nursing home industry. See Special Committee on Aging Website, at http://aging.senate.gov and Senator Grassley’s Website, at http://www.senate.gov/-grassley/.

The GAO was directed to perform the study at the request of Senator Grassley after alleged deficient conditions in California nursing homes were brought to his attention. See GAO/T-HEHS-98-219, California Nursing Homes: Federal and State Oversight Inadequate to Protect Residents in Homes With Serious Care Violations, (1998) and GAO/HEHS-98-202, Care Problems Persist Despite Federal and State Oversight, (1998).


See Special Committee on Aging Hearing, The Nursing Home Initiative: Results at Year One, (Jun. 30, 1999), available at http://aging.senate.gov/hr35.htm. This was the third of a series of such scheduled hearings proposed by the Committee on the nursing home quality of care issue. The second hearing was held on March 22, 1999, and found that while improvements in nursing homes had been found, there was still a long way to go to ensure that compliance was maintained by nursing homes. See Special Committee on Aging Hearing,
again brought to light problems that existed in the industry and further attacked the efforts of federal agencies to cure those problems.\textsuperscript{217}

In short, the Committee has been instrumental in making Congress and the public aware of quality care deficiencies that exist in certain nursing facilities. If the Committee continues to have an aggressive advocate for elders' rights at its helm, the attack for ensuring quality care is rendered in nursing homes does not seem to be disappearing anytime soon. Instead, it seems that this topic will continue well into the future if the thrust of Senator Grassley's former leadership of the Committee is to continue to fuel the fires for change.\textsuperscript{218}

Miscellaneous Initiatives Affecting Nursing Home Policy
While there are many other events and initiatives that impact nursing homes, they are too numerous to list in this note. However, the following section lists several more current initiatives that affect the nursing home industry in some significant fashion and deserve adequate consideration.

Curbing Rising Health Care Costs
Partially out of concern for controlling increasing health care costs, Congress passed the Balanced Budget Act of 1997.\textsuperscript{219} This legislation affects the nursing home industry by changing the reimbursement

\textsuperscript{217}More importantly, both Congress and former President Clinton agreed that something had to be done to cure such "problem homes," in addition to making sure that effective measures were taken against such facilities See Special Committee on Aging, Hearing, The Nursing Home Initiative Results at Year One (Jun. 30, 1999), available at http://aging.senate.gov/hr35.htm.

\textsuperscript{218}I suggest that Senator Grassley, or his replacement on the Committee, will continue this fight against noncompliant nursing homes until the reports of egregious nursing home practices no longer exist. See, for example, IG Calls For Criminal Background Checks, Grassley Skeptical HCFA Up to the Task, 7 Health L. Rep. (BNA) at 1456-57 (Sept. 17, 1993); HCFA Sends Grassley Progress Report on Improving Care in California Care, 7 Health L. Rep. (BNA) at 1600 (Oct. 8, 1998); HHS Needs More Money, 8 Health L. Rep. (BNA) at 395-96 (Mar. 11, 1999); HCFA Tells States to Prepare For Possible Nursing Home Closures, 8 Health L. Rep. (BNA) at 788-89 (May 13, 1999); Senators, GAO Laud HCFA Reforms of SNF's But Note Initiative's Slow Implementation, 8 Health L. Rep. (BNA) at 1109-11 (Jul 8, 1999); and Grassley To Meet With HHS Officials, 9 Health L. Rep. (BNA) at 203 (Feb. 10, 2000).

method that skilled nursing facilities would receive from the federal programs. Instead of the traditional payment based on the services administered to the patient, the new prospective payment system gives the skilled nursing facility a per-diem payment for every patient in need of Medicare services.220

Skilled nursing facilities will now have to provide the same services under the federal programs, but will have to accept a lower amount of total reimbursement if the facility falls within the area slated for the lower per-diem rate.221 In theory, the government hopes that skilled nursing facilities will become more efficient in its provision of services because the per-diem payment dictates efficiency at the cost of losing profits.222 The flip-side to the government's intentions is that skilled nursing facilities are having to provide services for less money, potentially placing the resident in danger because the facility can no longer afford to provide particular services. For example, since ancillary services were separately billable to Medicare, the incentive to provide such services is no longer present.223

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220 See 42 U.S.C. § 1395yy (1994). The payment covers all ancillary services administered to the patient, including any physical and speech therapy. This is important because such ancillary services used to be billed separately and now such services will have to be provided in an environment that calls for less total reimbursement. The new payment system is to be phased-in over a three-year timetable, starting July 1, 1998. For 1998, a blended rate of 25 percent of the new prospective payment system and 75 percent of the old payment system will be used. In 1999, this blended rate changes to 50 percent and 50 percent, moving to 75 percent and 25 percent, respectively, in the year 2000. Finally, in 2001, the new prospective payment system rate will be fully in place. This phase-in period is very important because it gives nursing facilities the opportunity to adjust to the new reimbursement system. More importantly, it gives the facilities the flexibility to experiment with the provision of services to develop a method that will provide the most economical and efficient system.

221 Id.

222 The prospective payment system was designed to "ensure better patient care by relating payments to the condition of the patient, recognizing that some need more services of more expensive care than others, rather than a set amount per patient." See HCFA Press Release, HCFA Announces New Medicare Payment Rate For Nursing Homes, (Jul. 30, 1999), available at http://www.hcfa.gov/news/pr1999/pr99730b.htm.

223 It has been argued that this prospective payment system for nursing homes will have three potential negative consequences: (1) it will increase the facility's incentive to increase the length of stay of a patient, (2) the facility may adopt selective admission criteria in order to "weed out" the residents who would be "non-profitable" by requiring a total amount of services that would exceed the per-diem amount, and (3) encouraging the use of lesser qualified, lower paid individuals to provide patient care, called the "downward shifting of care providers". See Symposium, Recent Developments in Long-Term Care Law and Litigation, 20 WHITTIER L. REV. 325 (Winter 1998).
However, this potential negative side has yet to be seen in skilled nursing facilities. In fact, the reports and studies thus far have shown that the new prospective payment system has had a positive effect on most nursing facilities.\(^{224}\) In one example, the changes were openly accepted. One of the largest for-profit nursing home chains, Beverly Industries, welcomed the revised reimbursement system from Medicare because its facilities had been preparing for this measure by "drastically slashing operating costs and making its operations more efficient."\(^{225}\) The smaller nursing homes, not surprisingly, have not welcomed this payment system because they are unable to adapt as easily to such drastic reimbursement changes.\(^{226}\) As a result, these smaller nursing facilities may not be able to compete in the realm of the newly implemented prospective payment system embraced by the federal government.\(^{227}\)

The full effects of the new prospective payment system will be better assessed in the future. For now, it seems that most nursing homes have been able to adjust to the inevitable cutbacks on reimbursement.\(^{228}\)

More notably, the effects of containing health care costs have also been seen in the reform of Medicaid reimbursement. In particular, states have been experimenting with a managed care-based system of services that again lowers the total amount of reimbursement received by nursing facilities for residents qualifying for Medicaid services.\(^{229}\)

\(^{224}\)See OIG Report, Early Effects of the Prospective Payment System on Access to Skilled Nursing Facilities, OEI-02-99-00400 (Aug. 1999), available at http://www.dhhs.gov/progorg/oei/reports/oei-02-99-00400.htm (OIG interviewed hospital discharge planners which revealed that no serious problems exist in placing Medicare patients in nursing homes but careful monitoring will be necessary); and OIG Report, Early Effects of the Prospective Payment System on Access to Skilled Nursing Facilities: Nursing Home Administrators' Perspective, OEI-02-99-00401 (Oct. 1999), available at http://www.dhhs.gov/progorg/oei/reports/oei-02-00-00401.htm (OIG interviewed a sample of nursing home administrators and found that access to skilled care is not a problem because nursing homes were changing their admission practices; however, continued monitoring will be necessary).\(^{225}\)See John Haman, Medicare Changes Excite Beverly; Small Nursing Homes Qua!c, 16 ARK. BUS. 1 (Jan. 25, 1999).\(^{226}\)Id.\(^{227}\)Id.\(^{228}\)In fact, HCFA announced that it was going to increase Medicare payment rates to skilled nursing facilities by 2.1 percent for fiscal year 2000, to account for increases in the cost of covered care and changes in the geographic variation in wage levels.\(^{229}\)See Haman, supra note 225.
This new reimbursement system, which is based on per-diem as opposed to per-service, has resulted in some nursing facilities withdrawing from certain markets because they can no longer afford to provide services to those Medicaid-qualified residents.\textsuperscript{230}

As a result of several nursing homes voluntarily pulling out of participation in a state Medicaid program, Congress passed legislation specifically aimed to protect those Medicaid-qualified residents who suddenly found themselves without a caretaker.\textsuperscript{231} The Nursing Home Resident Protection Amendments of 1999\textsuperscript{232} places restrictions on the transfers or discharges of Medicaid-qualified nursing home residents when a nursing facility decides to voluntarily withdraw from the Medicaid program.\textsuperscript{233} If a Medicaid-qualified resident is residing in the nursing facility on the day before the facility’s effective date of withdrawal from the Medicaid program, such facility is prohibited from transferring or discharging the resident purely on this basis.\textsuperscript{234} For those Medicaid-qualified residents seeking residency after the facility’s decision to voluntarily withdraw from the Medicaid program, the facility must provide both written and oral notice that it is not participating in the Medicaid program.\textsuperscript{235}

The effect of the legislation is that nursing facilities will have to reevaluate a decision to voluntarily withdraw from participation in Medicaid.\textsuperscript{236} Financially, it makes sense to have residents that can generate money by providing services that require higher reimbursement rates. However, Congress has stepped in to protect residents from this alleged “improper eviction” on the basis of purely financial concerns.\textsuperscript{237}

\begin{footnotes}
\item[230] Id.
\item[231] Id.
\item[233] Id.
\item[235] Id.
\item[236] See Haman, supra note 225.
\item[237] As stated by former Senate Finance Committee Chairman William V. Roth Jr., “[t]his law will go a long way toward assuring residents and their families that they will continue to receive quality nursing home care without fear of inappropriate eviction.” (as reported in Medicare/Medicaid Compliance Library – Reimbursement Alert, available at http://www.bna.com/Medicare/mmraarchive.mmr03309.htm).
\end{footnotes}
Involvement of the Institute of Medicine, Again
The Institute of Medicine, which was instrumental in forming the policies embraced by OBRA 87, has been hired once again by the federal government to perform another investigation of quality care issues in the long-term care setting. Noting that many changes have occurred since its initial 1986 report, this study examines the "full range of long-term care settings and services, including nursing homes, assisted living facilities and community-based home health care." Even though this report will be more comprehensive, it is necessary in order to answer very serious questions concerning the future of long-term care needs for our older population. For instance, the study will focus on the demographic, health and other characteristics of individuals requiring long-term care and how they are changing. With the extent of changes implemented as a result of the Institute of Medicine's previous report on quality care issues, it is possible that similar sweeping changes may result from this current study as well.

238 The Institute of Medicine was hired by the federal government in 1986 to study the quality care issues in nursing homes by suggesting federal legislation which could cure the problems within the industry. The more specific function to be performed by the Institute of Medicine in its current study is the examination of the "means for assessing, overseeing and improving the quality of long-term care in different settings and the practical and policy challenges of achieving a consistent quality of care regardless of the site of care." An important difference is that this study will be much broader than the 1986 study in that the current study looks at long-term care in a general scope with recommended solutions to include measures that are not limited to legislative suggestions. See Institute of Medicine Website, Continuing To Improve Quality in Long-Term Care, Project No. HCSX-H-97-02-A, at http://www.nas.edu/IOM/IOMHome.nsf.

239 Id.

240 Id. Other questions that the study seeks to answer are: "(1) What are the roles of the various long-term care settings in community health care systems, and how do they relate to other components of community care systems? (2) What are the strengths and limitations of existing methods and tools to measure, oversee, and improve quality of care and outcomes in nursing homes and other long-term care settings? (3) How can these methods and tools be improved to promote better quality of care and other outcomes regardless of setting? (4) What is known about the current quality of long-term care in different settings and the extent to which care has improved or deteriorated in the last ten-to-fifteen years? (5) What is known about the impact of long-term regulation, especially the Nursing Home Reform Act of 1987, on such matters as: the use of physical and chemical restraints; advance care planning; provision of adequate nutrition; identification of substandard facilities or programs; and public access to information on quality of care?"

Please note that the initial duration of this project was originally scheduled for only eighteen months, placing the initial deadline of this project sometime in May of 1999.
Increased Public Awareness
The "strength" of the elder population as a separate segment of society is actively increasing, as advocates for senior's rights continue to make the public aware of the elder's needs and benefits to society. This trend for public awareness can also be seen with the government's campaign to have the public more involved in the fight against health care fraud and abuse. As more Americans grow older and become a larger segment of the total population, it should be expected that advocacy and awareness efforts will continue in the new millennium.

CONCLUSION

It appears that the nursing home industry will continue to be a target for more government scrutiny regarding the provision of quality care within the realm of nursing homes. So long as quality care within the nursing home industry remains a hot topic in today's aging society, the push for more quality-based governmental initiatives will occur at the federal level and even at the state level. Therefore, nursing homes should prepare themselves for the imminent passage and implementation of more governmental initiatives and policies aimed specifically at quality care assurance in an already heavily regulated industry.

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report itself, however, was not completed and made available to the public until 2000. The report is available at http://www.nap.edu/books/0309064988/html/.

242 For instance, a visit to the HHS webpage reveals numerous resources to report health care fraud to the government, at http://www.dhhs.gov/oei/outreach.outreach.htm. It also lists the joint efforts of several different agencies and organizations, such as the anti-fraud campaign between HHS, DOJ and the American Association of Retired Persons. Id.
APPENDIX A

RESEARCHING NURSING HOMES


- HCFA has a webpage to compare the nursing home inspection survey of every Medicare and Medicaid certified facility. http://www.medicare.gov/nursing/home.asp.


- NURSING HOME ABUSE AND NEGLECT INFORMATION CENTER. A website maintained by The Bauman & Rasor Group, Inc., to provide consumers with important information on nursing home abuse and neglect. http://www.nursinghomeabuse.com.

- Medicare maintains its own nursing home webpage which is a good place to start when looking for general information about choosing a nursing home. http://www.Medicare.gov/nursing.html.

METHODS TO REPORT FRAUD AND ABUSE

- HHS has a great comprehensive webpage which lists many different reporting methods and fraud resources. http://www.dhhs.gov/progorg/oei/outreach/outreach.html.

The Special Committee on Aging maintains a Fraud Hotline through which individuals can report problems over the internet and the agency will further investigate such claims. http://aging.senate.gov/fraudhl.htm.


GOVERNMENT AGENCIES INVOLVED IN NURSING HOME QUALITY CARE ISSUES

HCFA. Overseer of the Medicare and Medicaid programs. This is a great resource for research of long-term care policy and initiatives currently being sought by the federal government. http://www.hcfa.gov.

SPECIAL COMMITTEE ON AGING. Senate Committee that has forced much talk about quality care issues. Lists current and past initiatives of the Committee and is a great resource. http://aging.senate.gov.

ADMINISTRATION ON AGING. Good resource to obtain information of the current elder issues being reviewed by the federal government. http://www.aoa.dhhs.gov.

HHS. Has oversight over HCFA and gets involved with the nursing homes issues through the actions of the OIG. http://www.hhs.gov.
INDEPENDENT ORGANIZATIONS INVOLVED WITH NURSING HOMES

- **AARP.** A great resource for individuals to gather information regarding elder issues, such as long-term care. http://www.aarp.org.


- **AMERICAN HEALTH CARE ASSOCIATION (AHCA).** This is a federation of fifty state health organizations which represent about 12,000 non-profit and for-profit long-term care facilities. Lists great statistics and policy concerns involving the future of long-term care. http://www.ahca.org.

- **THE INSTITUTE OF MEDICINE.** Has general information available to follow the progress of Project Number HCSX-H-97-02-A regarding the current study of “Improving the Quality in Long-Term Care.” http://www4.nas.edu/webcr.nsf/ProjectScopeDisplay/HCSX-H-97-02-A.

- **NATIONAL INSTITUTES OF HEALTH.** This is an agency under the HHS which performs research to uncover new knowledge leading for the better health of the population. Part of this research involves studying the effects of aging. http://www.nih.gov.

- **AMERICAN COLLEGE OF HEALTHCARE EXECUTIVES.** The professional membership society for healthcare executives seeking to be the provider of knowledge, skills, and values to assist healthcare executive
leaders in improving the health status of society.  

- **ABA COMMISSION ON LEGAL PROBLEMS OF THE ELDERLY.** This organization is dedicated to examining the law-related concerns of the elderly by exploring the issues surrounding long-term care.  

- **NATIONAL SENIOR CITIZENS LAW CENTER.** Deals with low-income elderly individuals, with particular emphasis on women and racial and ethnic minorities. Has some pertinent information, but overall not a great resource.  