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Using What We Have: How Existing Legal Authorities Can Help Fix America's Nursing Home Crisis

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USING WHAT WE HAVE: HOW EXISTING LEGAL
AUTHORITIES CAN HELP FIX AMERICA'S NURSING HOME
CRISIS

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ABSTRACT

The COVID-19 pandemic exposed systemic quality-of-care problems in American nursing homes as well as the deadly consequences of a regulatory system that has enabled nursing homes to divert funds needed for care to profit. Policy experts have responded by urging regulators to improve nursing-home oversight practices and by calling for new regulatory and statutory authority to increase accountability. These calls, however, have been met with sharp political headwinds. This Article suggests a path around the political impasse. Specifically, it identifies and explores four opportunities to leverage existing statutory schemes to create stronger incentives for nursing homes to provide high-quality care. It then explores how politics, administrative complexity, and ageism have come together

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to prevent this existing authority from being used to its full potential. It concludes by situating the current regulatory failure to hold nursing homes accountable in the context of a larger discussion about the costs of federalism in the health care arena.

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INTRODUCTION

The COVID-19 pandemic exposed the serious quality-of-care problems experienced by nursing home residents in the United States. During the pandemic's early months, the American media published story after story about spiraling death rates in nursing homes, isolated residents, and overburdened staff struggling to care for too many people with too little help. The stories were gut-wrenching. The Associated Press reported: "Nursing home watchdogs are being flooded with reports of residents kept in soiled diapers so long their skin peeled off, left with bedsores that cut to the bone, and allowed to wither away in starvation or thirst."¹ After following up on an anonymous tip, NBC News reported finding bodies of dead nursing home residents piling up in a holding room in a New Jersey nursing home.² Indeed, the situation in the country's nursing homes was so dire that Doctors Without Borders, accustomed to working in war zones, announced that it had sent its workers into American nursing homes to teach basic infection-control procedures.³

While the pandemic may be receding and media attention fading, the approximately 1.2 million Americans who reside in nursing homes remain at risk of poor care and neglect.⁴ So, too, do the nearly 70% of Americans who will need long-term care at some point in

1. Matt Sedensky & Bernard Condon, *Not Just COVID: Nursing Home Neglect Deaths Surge in Shadows*, AP NEWS (Nov. 19, 2020), <https://apnews.com/article/nursing-homes-neglect-death-surge-3b74a2202140c5a6b5cf05cdf0ea4f32> [<https://perma.cc/XTL4-9CGA>].

2. Ben Kessler, *17 Bodies Crowded into Tiny Morgue Found at New Jersey Nursing Home*, NBC NEWS (Apr. 16, 2020), <https://www.nbcnews.com/news/us-news/17-bodies-crowded-tiny-morgue-found-new-jersey-nursing-home-n1185121> [<https://perma.cc/4B5X-DR86>].

3. See *COVID-19: More Nursing Home Staff Need Training to Prevent Spread of Infection*, DRS. WITHOUT BORDERS (Nov. 24, 2020), <https://www.doctorswithoutborders.org/latest/covid-19-more-nursing-home-staff-need-training-prevent-spread-infection> [<https://perma.cc/NR2F-EDEK>] ("The essential workers who clean, cook, and do laundry for the residents of nursing homes in the United States play a critical role in stopping the spread of COVID-19," but "rarely get the infection prevention and control ... training they need to protect themselves and the vulnerable people they assist day in and day out.").

4. See *Nursing Homes*, DEP'T HEALTH & HUM. SERVS., <https://oig.hhs.gov/reports-and-publications/featured-topics/nursing-homes/> [<https://perma.cc/R8QX-UTQ6>] (last updated Sept. 23, 2023).

their lives.⁵ This is because the COVID-19 pandemic did not create a nursing home crisis: rather, it only amplified already existing problems.⁶

Despite the attention that the pandemic brought to the plight of nursing home residents, remedying the situation has proven difficult. Indeed, at the outset of the pandemic, the Trump Administration responded by relaxing regulatory requirements for nursing homes,⁷ and most states responded by granting their owners and operators immunity from liability.⁸ In March 2021, in connection with his State of the Union Address, President Biden proposed new regulations to improve nursing home quality and called for Congress to provide the federal government with additional authority to regulate nursing homes.⁹ However, this call for action was met with robust opposition by nursing home owners and operators, and to date, it remains unclear to what extent they will be unimplemented.¹⁰

In this Article, we propose circumventing the challenging politics of nursing home reform.¹¹ Specifically, we show how the federal and

5. *How Much Care Will You Need?*, LONGTERMCARE.GOV, (Feb. 18, 2020), <https://acli.gov/ltc/basic-needs/how-much-care-will-you-need> [<https://perma.cc/SA3R-V6GS>].

6. Manatt, Phelps & Phillips, LLP, *Recommendations to Strengthen the Resilience of New Jersey's Nursing Homes in the Wake of COVID-19*, NEWJERSEY.GOV 12 (June 2, 2020), <https://www.documentcloud.org/documents/6935644-Manatt-Report> [<https://perma.cc/6EM5-H2R8>] (observing, among other things, that “[n]ursing homes were largely underprepared for the threat of a widespread infection and under-resourced due to long-standing shortages or low staffing ratios”).

7. Nina A. Kohn, *Nursing Homes, COVID-19, and the Consequences of Regulatory Failure*, 110 GEO. L.J. ONLINE 1, 9 (2021) (describing this response).

8. See Nina A. Kohn & Jessica L. Roberts, *Nursing Homes Need Increased Staffing, Not Legal Immunity*, THE HILL (May 23, 2020, 11:00 AM), <https://thehill.com/opinion/healthcare/499286-nursing-homes-need-increased-staffing-not-legal-immunity/> [<https://perma.cc/FM7U-PSJ8>] (describing and critiquing state policies granting immunity to nursing home operators and owners amid the pandemic).

9. *Fact Sheet: Protecting Seniors by Improving Safety and Quality of Care in the Nation's Nursing Homes*, THE WHITE HOUSE (Feb. 28, 2022), <https://www.whitehouse.gov/briefing-room/statements-releases/2022/02/28/fact-sheet-protecting-seniors-and-people-with-disabilities-by-improving-safety-and-quality-of-care-in-the-nations-nursing-homes/> [<https://perma.cc/AR5Z-Z66K>] [hereinafter *Protecting Seniors*].

10. See *Fact Sheet: Biden-Harris Administration Announces New Steps to Improve Quality of Nursing Homes*, THE WHITE HOUSE (Oct. 21, 2022), <https://www.whitehouse.gov/briefing-room/statements-releases/2022/10/21/fact-sheet-biden-harris-administration-announces-new-steps-to-improve-quality-of-nursing-homes/> [<https://perma.cc/AUE4-X766>] [hereinafter *Biden-Harris Administration Announces New Steps*].

11. See Hoag Levins, *The Policy and Politics of Long-Term Care: Latest Views on Reform*,

state governments can leverage existing statutory and regulatory authority to improve nursing home quality of care. In the wake of the pandemic, policy experts and scholars have written about the problems in nursing homes. They have urged regulators to do a better job overseeing the industry, implored policymakers to devote additional resources to nursing homes, and called for new regulatory and statutory authority to increase accountability.¹² This Article takes a different approach, examining instead how *existing* regulatory schemes, and the resources already devoted to them, could be leveraged in new ways to improve performance. In doing so, it connects recommendations for improving nursing home care offered by social scientists and health care providers to specific legal mechanisms that could be used to effectuate those recommendations.

After exploring the ways that existing legal authority could be used to incentivize better care, this Article considers the political and social forces that prevent that authority from being used to full effect. It argues that this breakdown can be explained by a combination of (1) politics, which reward attention-grabbing legislation over simple administrative solutions; (2) ageism, which enables the suffering of older adults to be tolerated; and (3) administrative

LEONARD DAVIS INST. OF HEALTH ECON. (June 27, 2022), <https://ldi.upenn.edu/our-work/research-updates/the-policy-and-politics-of-long-term-care-latest-views-on-reform/> [<https://perma.cc/96XY-ZVEA>]; Matt Sedensky, *Major Report Says Nursing Home Care, Funding System Needs Overhaul*, PBS (Apr. 6, 2022, 6:09 PM), <https://www.pbs.org/newshour/health/major-report-says-nursing-home-care-funding-system-needs-overhaul> [<https://perma.cc/3KDD-724P>].

12. See, e.g., Rachel M. Werner, Allison K. Hoffman & Norma B. Coe, *Long-Term Care Policy after COVID-19—Solving the Nursing Home Crisis*, 383 *NEW ENG. J. MED.* 903, 904-05 (2020) (arguing that new funding and new regulation is needed to “save[]” nursing homes); Rachel M. Werner, R. Tamara Konetzka, David C. Grabowski & David G. Stevenson, *Reforming Nursing Home Financing, Payment, and Oversight*, 386 *NEW ENG. J. MED.* 1869, 1870 (2022) (calling for reform in the form of increased funding for facilities and changes to payment structures); Charlene Harrington, Anne Montgomery, Terris King, David C. Grabowski & Michael Wasserman, *These Administrative Actions Would Improve Nursing Home Ownership and Financial Transparency in the Post COVID-19 Period*, *HEALTH AFFS.* (Feb. 11, 2021), <https://www.healthaffairs.org/doi/10.1377/forefront.20210208.597573/> [<https://perma.cc/LU9A-XN3S>] (urging the adoption of new regulations to enable greater federal oversight of nursing home owners); Deborah Gastfreund Schuss, *COVID-19’s Deadly Lesson: Time to Revamp Long-Term Care*, *HEALTH AFFS.* (Nov. 17, 2020), <https://www.healthaffairs.org/doi/10.1377/forefront.20201110.707118/> [<https://perma.cc/ZSR9-WYNM>] (advocating for a shift in funding to prioritize smaller care facilities); see also *infra* Part I.C.

complexity, which favors industry insiders. It then adds its voice to the growing chorus of scholars critiquing federalism in health care, explaining how the failure to hold nursing homes accountable for poor care is, in part, a symptom of role confusion and complexity occasioned by overlapping federal and state authority.

This Article comes at a critical time. The number of people who need nursing home care is likely to skyrocket in coming decades. The majority of nursing home residents are at least eighty-five years old,¹³ and the number of Americans who are at least eighty-five is expected to more than double between 2019 and 2040.¹⁴

This Article proceeds in six parts. Part I provides an overview of the quality-of-care problems that plague American nursing homes. Parts II through V identify and discuss four types of existing authority that could be used to drive higher quality care: the federal government's nursing home certification authority, federal and state governments' authority to impose inspection-related penalties on nursing homes, state licensure schemes for nursing homes, and a federal mortgage insurance program that provides a valuable subsidy to nursing homes. As part of this, it presents systematic original empirical research on the specific provisions and effects of certain of these authorities. Part V examines the political and social forces that have prevented this authority from being leveraged effectively and situates them in the larger discussion of federalism in the health care arena. Part VI briefly concludes.

I. AMERICA'S NURSING HOME CRISIS

Nursing homes are heavily regulated entities. At the federal level, nursing homes¹⁵ are subject to the Nursing Home Reform Act of

13. Christine Caffrey, Manisha Sengupta & Amanuel Melekin, *Residential Care Community Resident Characteristics: United States, 2018*, CTRS. FOR DISEASE CONTROL & PREVENTION 1-2 (2021), <https://www.cdc.gov/nchs/products/databriefs/db404.htm> [<https://perma.cc/3P59-8FML>].

14. *2020 Profile of Older Americans*, ADMIN. FOR CMTY. LIVING 5 (May 2021), <https://www.cdc.gov/nchs/products/databriefs/db404.htm> https://acl.gov/sites/default/files/aging%20and%20Disability%20In%20America/2020Profileolderamericans.final_.pdf [<https://perma.cc/4NAW-4J6Y>].

15. Although "nursing home" is the commonly used term for a long-term care facility, the Nursing Home Reform Act of 1987 distinguishes between a "skilled nursing facility," 42 U.S.C. § 1395i-3(a), and a "nursing facility," *id.* § 1396r(a). The former refers to facilities that

1987 (NHRA) and its implementing regulations.¹⁶ The NHRA grants nursing home residents extensive rights¹⁷ and creates minimum standards of care¹⁸ for providers that accept Medicaid or Medicare funds.¹⁹ At the state level, nursing homes are subject to state public health laws as well as to licensure schemes.²⁰ Not only must many of the care providers working in nursing homes be licensed, but the facilities themselves are subject to state licensure requirements.²¹ Unfortunately, as this Part shows, inadequate care is common in America's nursing homes despite the expansive regulatory scheme designed to protect residents, and certain nursing home ownership structures appear to exacerbate the problem.

A. Systemic Quality-of-Care Problems

Under the NHRA, nursing homes are required to provide the services residents need to maintain their highest practicable physical and mental well-being,²² and nursing home residents have extensive rights related to quality of life²³ and quality of care.²⁴ Unfortunately, many nursing home residents do not receive the care to which they are legally entitled.

Nursing home inspection reports (discussed at length in Part II) provide ample evidence of neglect. A search of recent inspection reports for the term “maggots,” for example, reveals scores of cases in

provide long-term critical or life-threatening care under the Medicare program, whereas the latter includes facilities that provide institutional daily assisted living care under the Medicaid program. For simplicity, we use the term “nursing home” to reference both skilled nursing facilities and nursing facilities.

16. 42 U.S.C. §§ 1395i-3, 1396r.

17. *See id.* §§ 1395i-3(c), 1396r(c).

18. *See id.* §§ 1395i-3(b), 1396r(b).

19. In the United States, 96% of all nursing homes fall into this category. *See* David C. Grabowski, A. James O'Malley, Christopher C. Afendulis, Daryl J. Caudry, Amy Elliott & Sheryl Zimmerman, *Culture Change and Nursing Home Quality of Care*, 54 GERONTOLOGIST S35, S38 (2014); *see also* CHRISTI A. GRIMM, CMS SHOULD TAKE FURTHER ACTION TO ADDRESS STATES WITH POOR PERFORMANCE IN CONDUCTING NURSING HOME SURVEYS (2022).

20. *See* NINA A. KOHN, ELDER LAW: PRACTICE, POLICY, & PROBLEMS 399 (2d ed. 2019).

21. *See id.*

22. 42 U.S.C. §§ 1395i-3(d)(1)(A), 1396r(b)(2) (requiring nursing homes to provide “services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident”).

23. 42 C.F.R. § 483.24 (2023).

24. *Id.* § 483.25.

which residents were discovered with such poor hygiene that their skin was infested with the creatures.²⁵ This neglect is not just painful and degrading; it can be lethal. For example, Donald Wallace, an Alabama nursing home resident, died in November 2020 with an untreated urinary infection and *E. coli* stemming from poor hygiene, conditions that indicate neglect and improper care.²⁶ He had likely choked to death on his food, as he needed help eating.²⁷

Evidence of poor care goes well beyond incident reports and news stories. Data maintained by the federal government²⁸ show that many nursing home residents experience health conditions associated with poor-quality care, including new or worsening pressure ulcers, bladder and bowel incontinence, and depression.²⁹ For example, although nursing homes are supposed to provide the care needed to help heal wounds such as pressure ulcers,³⁰ it is not uncommon for residents' pressure ulcers to worsen and for them to develop new ones while in the nursing home.³¹ Similarly, the

25. This can readily be done through ProPublica's "Nursing Home Inspect" website. See Lena V. Groeger, Charles Ornstein & Ruth Talbot, *Nursing Home Inspect*, PROPUBLICA, <https://projects.propublica.org/nursing-homes/> [<https://perma.cc/G5ZN-KEG9>] (last updated Sept. 23, 2023) [hereinafter PROPUBLICA].

26. Sedensky & Condon, *supra* note 1.

27. *Id.*

28. *MDS 3.0 Frequency Report*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Dec. 1, 2021, 7:02 PM), <https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Minimum-Data-Set-3-0-Public-Reports/Minimum-Data-Set-3-0-Frequency-Report> [<https://perma.cc/NMY9-Q6BP>] [hereinafter *MDS 3.0 Frequency Report*]. The self-reported data from nursing homes are collectively referred to as the Minimum Data Set and consist of patient-level assessments that are conducted at least every ninety-two days.

29. See Nicholas G. Castle & Jamie C. Ferguson, *What Is Nursing Home Quality and How Is It Measured?*, 50 GERONTOLOGIST 426, 428 (2010) (discussing how depression, incontinence, and pressure ulcers are used as indicators of quality of care by nursing home regulators).

30. Courtney H. Lyder & Elizabeth A. Ayello, *Pressure Ulcers: A Patient Safety Issue*, in PATIENT SAFETY AND QUALITY: AN EVIDENCE-BASED HANDBOOK FOR NURSES (Ronda G. Hughes ed., 2008) (discussing how, with proper care, pressure ulcers are manageable and preventable).

31. To identify the extent of worsening pressure ulcers, we looked at federal survey data. See *MDS 3.0 Frequency Report*, *supra* note 28. Using the most recent available data (those from the third quarter of 2019), we calculated that there were 508 pressure ulcers on nursing home residents that were not present or were at a lesser stage on prior assessment. These were 5.18% of 6,106 Stage 2 ulcers, 2.15% of 6,105 Stage 3 ulcers, and 1.00% of 6,103 Stage 4 ulcers that worsened or developed in care. These numbers likely represent only a portion of the actual number of worsening pressure ulcers. See Zihan Chen, Lauren J. Gleason & Prachi Sanghavi, *Accuracy of Pressure Ulcer Events in US Nursing Home Ratings*, 60 MED. CARE 775, 778-82 (2022) (concluding, in a study that validated Minimum Data Set data

majority of nursing home residents have frequent or constant urinary incontinence, and the same is true for bowel incontinence.³² Although residents may enter a facility with incontinence, continued incontinence can denote a lack of staff and financial resources to provide residents with sufficient toileting assistance.³³ In addition, the majority of residents have an active depression diagnosis, and roughly half receive daily antidepressants.³⁴ In fact, the prevalence of depression among nursing home residents is three to five times higher than in older adults who live outside these communities.³⁵

Federal data also indicate that residents experience high rates of preventable infection, including lethal infection. Insufficient infection control has been an issue in nursing homes since before the COVID-19 pandemic. Between 2013 and 2017, 82% of nursing homes surveyed by the Centers for Medicare and Medicaid Services (CMS), an entity within the federal Department of Health and Human Services (HHS), had an infection prevention and control

against hospital admissions data from 2011 through 2017, that nursing homes substantially underreport pressure ulcers).

32. To determine frequency, we reviewed the most recent available data (those from the third quarter of 2022), which indicated that approximately 56% of residents had frequent or constant urinary incontinence and approximately 58% had frequent or constant bowel incontinence. *See MDS 3.0 Frequency Report, supra* note 28.

33. Felix W. Leung & John F. Schnelle, *Urinary and Fecal Incontinence in Nursing Home Residents*, 37 *GASTROENTEROL CLINICS N. AM.* 697 (2008) (discussing the relationship between incontinence and insufficient assistance).

34. To determine rates of depression and antidepressant use, we reviewed the most recent available data (those from the third quarter of 2022), which indicated that approximately 52% of residents had an active depression diagnosis, and approximately 47% had received an antidepressant in seven of the past seven days. *See MDS 3.0 Frequency Report, supra* note 28. Importantly, high rates of depression preceded the pandemic. In the third quarter of 2019, approximately 49% of residents had an active depression diagnosis, and approximately 48% received an antidepressant in seven of the past seven days.

35. Yue Li, Xueya Cai, Charlene Harrington, Michael Hasselberg, Yeates Conwell, Xi Cen & Helena Temkin-Greener, *Racial and Ethnic Differences in the Prevalence of Depressive Symptoms Among U.S. Nursing Home Residents*, 31 *J. AGING SOC. POLY* 30, 31 (2019) (“The estimated rates of diagnosed depression among nursing home residents are higher than the estimated rates for elderly persons living in the community, which generally range between 5% and 10%. The elevated burden of depression among nursing home residents is further complicated by their severe physical and cognitive impairments, their complex clinical and nursing care needs, and the inability of many nursing homes to provide adequate psychiatric services.”); Neval L. Crogan & Bronwynne C. Evans, *Quality Improvement in Nursing Homes: Identifying Depressed Residents Is Critical to Improving Quality of Life*, 13 *ARIZ. GERIATRICS SOC’Y J.* 15 (2008).

deficiency.³⁶ Even prior to the pandemic, infections were a primary cause of death and hospitalization among nursing home residents, leading to an estimated 380,000 resident deaths each year.³⁷ The pandemic dramatically increased the consequences of insufficient infection control in nursing homes. By February 2022, over 200,000 nursing home residents and staff members had died from the virus, making up nearly a quarter of total COVID-19 deaths in the United States.³⁸ Infection control problems continue to persist years into the pandemic. Indeed, in September 2022, the Government Accountability Office implored CMS to strengthen oversight of infection prevention and control in nursing homes after finding an increase in the severity of infection control problems since the onset of the pandemic.³⁹

Problems with nursing homes are also evident from rampant non-compliance with minimum quality-of-care requirements. Routine inspections of nursing homes, on average, uncover six to seven violations of federal law designed to protect nursing home residents.⁴⁰

A key factor in poor care is inadequate staffing. Staffing levels, and particularly the ratio of registered nurses to residents, are an important predictor of quality of care in nursing homes.⁴¹ As one resident explained:

36. U.S. GOV'T ACCOUNTABILITY OFF., GAO-20-576R, INFECTION CONTROL DEFICIENCIES WERE WIDESPREAD AND PERSISTENT IN NURSING HOMES PRIOR TO COVID-19 PANDEMIC 4 (May 20, 2020), <https://www.gao.gov/assets/gao-20-576r.pdf> [<https://perma.cc/A47R-MZBG>].

37. DEP'T OF HEALTH & HUM. SERVS., NATIONAL ACTION PLAN TO PREVENT HEALTH CARE-ASSOCIATED INFECTIONS: ROAD MAP TO ELIMINATION 195 (2013), <https://health.gov/sites/default/files/2019-09/hai-action-plan-ltcf.pdf> [<https://perma.cc/TCS5-4XRH>].

38. Priya Chidambaram, *Over 200,000 Residents and Staff in Long-Term Care Facilities Have Died from COVID-19*, KAISER FAM. FOUND. (Feb. 3, 2022), <https://www.kff.org/policy-watch/over-200000-residents-and-staff-in-long-term-care-facilities-have-died-from-covid-19/> [<https://perma.cc/K6S7-G7ZX>].

39. U.S. GOV'T ACCOUNTABILITY OFF., GAO-22-105133, COVID-19 IN NURSING HOMES: CMS NEEDS TO CONTINUE TO STRENGTHEN OVERSIGHT OF INFECTION PREVENTION AND CONTROL 15-16, 33 (2022), <https://www.gao.gov/assets/730/722659.pdf> [<https://perma.cc/T396-N83W>] (calling for stronger oversight and finding that although infection prevention and control deficiencies noted by state surveyors before and during the pandemic were similar in quantity, they increased in severity).

40. CTRS. FOR MEDICARE & MEDICAID SERVS., SPECIAL FOCUS FACILITY (“SFF”) PROGRAM 1 (2023).

41. Kohn, *supra* note 7, at 5-6.

If the staffing levels are too short ... you don't get cleaned or changed which leaves you susceptible to all kinds of sicknesses ... which is supposed to be counterintuitive to how you're supposed to live in a nursing home. You're not supposed to get sicker here because of low staffing.⁴²

Even before the COVID-19 pandemic, many nursing homes lacked sufficient staff to meet residents' basic needs, but the pandemic exacerbated nursing homes' understaffing problem as it caused an exodus of workers from long-term care institutions.⁴³ Today, staffing shortages create a vicious cycle, with direct care staff exiting the nursing home industry not only because of low pay and limited benefits, but also because of the dangerous working conditions and burnout caused by working in understaffed conditions.⁴⁴

Overall, the combined result of these problems is that nursing home residents suffer from preventable harm at concerning rates. A study by the HHS Inspector General found that 22% of Medicare beneficiaries experienced adverse events, defined as "harm to a patient or resident as a result of medical care,"⁴⁵ during their stays at post-acute care skilled nursing facilities. Importantly, 59% of these adverse events were clearly or likely preventable.⁴⁶ Much of the preventable harm was attributed to "substandard treatment, inadequate resident monitoring, and failure or delay of necessary care."⁴⁷ Among preventable events, 37% involved inadequate

42. Nat'l Consumer Voice for Quality Long-Term Care, *Maurice from Maryland on Low Nursing Home Staff Leading to Not Getting Undergarments Changed*, YOUTUBE (Mar. 16, 2022), <https://www.youtube.com/watch?v=tgWUyyp0NmE> [<https://perma.cc/PZY3-8VQH>] (clip from a series of interviews that National Consumer Voice conducted with nursing home residents to provide insight into how understaffing impacts their daily lives).

43. See U.S. BUREAU OF LAB. STAT., *All Employees, Nursing and Residential Care Facilities*, <https://fred.stlouisfed.org/series/CEU6562300001> [<https://perma.cc/BYH3-5TMD>] (reporting that between 2020 and 2022, 420,000 employees left nursing home and residential care facilities).

44. See Emily Paulin, *Inside the 'Staffing Apocalypse' Devastating U.S. Nursing Homes*, AARP (June 9, 2022), <https://www.aarp.org/caregiving/health/info-2022/labor-shortage-nursing-homes.html> [<https://perma.cc/8BWP-L9AN>].

45. DANIEL R. LEVINSON, *ADVERSE EVENTS IN SKILLED NURSING FACILITIES: NATIONAL INCIDENCE AMONG MEDICARE BENEFICIARIES 2*, 17 (2014), <https://oig.hhs.gov/oei/reports/oei-06-11-00370.pdf> [<https://perma.cc/7CZY-VWV2>].

46. *Id.* at 22.

47. *Id.* at 24.

resident monitoring, and 25% involved failure to provide necessary treatments, both of which clearly denote poor quality of care.⁴⁸

B. Relationship Between Quality and Ownership

There are approximately 15,500 nursing homes in the country.⁴⁹ The bulk of these—approximately 70%—are owned by for-profit corporations, with the remainder owned by non-profit (24%) and government (7%) entities.⁵⁰ Most nursing homes (58%) are owned and operated by corporate chains,⁵¹ with private-equity firms owning approximately 11%.⁵² Notably, patterns of ownership vary geographically, with states in the southern and western United States having higher shares of for-profit facilities.⁵³

Ownership structure has been found to be a predictor of quality of care. Ownership by “large-sized and medium-sized” for-profit chains is correlated with reduced quality of care.⁵⁴ Private-equity ownership also impacts quality. After acquiring homes, private-equity firms typically aim to make the businesses more valuable and quickly sell them at a profit.⁵⁵ This focus on short-term profits has been criticized and may lead to poorer patient outcomes.⁵⁶ One

48. *Id.* Additionally, 79% of the adverse events resulted in prolonged nursing home stays, transfers to a different facility, or hospitalization; 14% required intervention to sustain the resident’s life; and 6% contributed to or resulted in the resident’s death. *Id.* at 17.

49. CTRS. FOR DISEASE CONTROL & PREVENTION, *Nursing Home Care*, <https://www.cdc.gov/nchs/fastats/nursing-home-care.htm> [<https://perma.cc/JUW8-Z2NR>].

50. Harrington et al., *supra* note 12.

51. *Id.*

52. *Id.*

53. CHARLENE HARRINGTON, HELEN CARRILLO, RACHEL GARFIELD, MARYBETH MUSUMECI & ELLEN SQUIRES, *NURSING FACILITIES, STAFFING, RESIDENTS AND FACILITY DEFICIENCIES, 2009 THROUGH 2016*, at 2 (2018).

54. Kai You, Yue Li, Orna Intrator, David Stevenson, Richard Hirth, David Grabowski & Jane Banaszak-Holl, *Do Nursing Home Chain Size and Proprietary Status Affect Experiences with Care?*, 54 *MED. CARE* 229, 233 (2016) (examining the relationship between ownership, chain size, and proprietary status with quality ratings provided by residents’ family members).

55. See James Chen, *Private Equity Explained with Examples and Ways to Invest*, *INVESTOPEDIA* (Mar. 31, 2023), <https://www.investopedia.com/terms/p/privateequity.asp> [<https://perma.cc/8B6V-Y8L8>].

56. Robert Tyler Braun, Hye-Young Jung, Lawrence P. Casalino, Zachary Myslinski & Mark Aaron Unruh, *Association of Private Equity Investment in US Nursing Homes with the Quality and Cost of Care for Long-Stay Residents*, *JAMA HEALTH F.* (Nov. 19, 2021), <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2786442> [<https://perma.cc/>]

study found that private-equity ownership is associated with a 10% increase in short-term mortality for Medicare patients as well as various indicators of low-quality care: increased use of antipsychotic medication, declines in mobility, and increases in pain intensity.⁵⁷ In addition, in for-profit facilities, larger profits are associated with more deficiencies and more serious deficiencies.⁵⁸

The link between ownership model and quality of care is especially concerning because ownership of nursing homes by private investment entities is growing. Private-equity ownership of nursing homes has exploded since the early 2000s.⁵⁹ More recently, real estate investment trusts (REITs), have begun playing a significant role in the market. New research shows that REIT ownership is associated with a significant decrease in staffing levels of registered nurses in nursing homes⁶⁰—a troubling development as registered nurse levels are critical predictors of nursing home quality.⁶¹

8YJM-D3GN].

57. Atul Gupta, Sabrina T. Howell, Constantine Yannelis & Abhinav Gupta, *Does Private Investment in Healthcare Benefit Patients? Evidence from Nursing Homes* 3-4 (Becker Friedman Inst. for Econ., Working Paper No. 2021-20, 2021) (noting that reduced nursing staff may explain these differences); Hye-Young Jung, Lawrence Casalino, Mark Unruh & Robert Tyler Braun, *Private Equity Ownership of Nursing Homes Linked to Lower Quality of Care, Higher Medicare Costs*, WEILL CORNELL MED. NEWSROOM (Nov. 19, 2021), <https://news.weill.cornell.edu/news/2021/11/private-equity-ownership-of-nursing-homes-linked-to-lower-quality-of-care-higher> [<https://perma.cc/4FFR-XMYH>]; Braun et al., *supra* note 56.

58. Ciaran O'Neill, Charlene Harrington, Martin Kitchener & Debera Saliba, *Quality of Care in Nursing Homes: An Analysis of Relationships Among Profit, Quality, and Ownership*, 41 MED. CARE 1318, 1318 (2003) (“[C]ontrolling for resident, facility, and market characteristics, profits located within the highest 14% of the proprietary sector’s profit distribution were associated with significantly more total deficiencies and serious deficiencies.”).

59. This is part of a broader trend of growing private-equity investment in health care. See Eileen Appelbaum & Rosemary Batt, *Private Equity Buyouts in Healthcare: Who Wins, Who Loses?*, INST. FOR NEW ECON. THINKING 14-15 (Mar. 2020), https://www.ineteconomics.org/uploads/papers/WP_118-Appelbaum-and-Batt-2-rb-Clean.pdf [<https://perma.cc/Z6BX-EF2Z>] (reporting that private-equity capital investment in the health care sector ballooned from approximately \$5 billion in 2000 to approximately \$100 billion in 2018).

60. Robert Tyler Braun, Dunc Williams, David G. Stevenson, Lawrence P. Casalino, Hye-Young Jung, Rahul Fernandez & Mark A. Unruh, *The Role of Real Estate Investment Trusts in Staffing US Nursing Homes*, 42 HEALTH AFFS. 207, 213-14 (2023), <https://www.healthaffairs.org/doi/10.1377/hlthaff.2023.00278> [<https://perma.cc/8YJM-D3GN>].

61. Nina A. Kohn & Aliza Seidenfeld, *Time for a Federal Nursing Home Staffing Standard?: What Twenty-Five Years of Research Reveals* (unpublished manuscript) (on file with authors) (reviewing the literature on the impact of registered nurse staffing levels on nursing home quality of care).

C. Current Reform Efforts

In response to the problems in nursing homes made visible by the pandemic, the past several years have seen new calls for reforming nursing home practice and policy.

At the federal level, there have been three major calls for reform. First, in September 2020, the Coronavirus Commission on Safety and Quality in Nursing Homes, an independent group of experts appointed by the Trump Administration, called for “payment reform” to encourage better practices, but stopped short of specifying what this reform would involve other than additional funding.⁶²

Second, in February 2022, President Biden, expressing concern about the role of private equity and profiteering in the nursing home industry, proposed a series of reforms designed to increase accountability for nursing homes and encourage higher quality care.⁶³ Some of these reforms simply called for new practices using existing authority.⁶⁴ However, President Biden also proposed new regulations to create minimum staffing requirements and called for Congress to act by appropriating additional funds for nursing home inspections and giving the federal government authority to impose “minimum corporate competency” requirements for nursing home owners and operators.⁶⁵

Third, and most comprehensively, in October 2022, the National Academies of Sciences, Engineering, and Medicine issued a more than 600-page report laying out a series of recommendations for improving nursing home care in the United States.⁶⁶ As part of the report, the Academies determined that the current nursing home quality assurance system is inadequate and concluded that the

62. CORONAVIRUS COMM’N ON SAFETY AND QUALITY IN NURSING HOMES, COMMISSION FINAL REPORT 66-67 (2020), <https://edit.cms.gov/files/document/covid-final-nh-commission-report.pdf> [<https://perma.cc/8UKT-26DA>]; see also JUST. IN AGING, *Imbalanced Commission Report Does Not Do Enough to Make Nursing Homes Responsible for Resident Safety and Quality of Life* 2 (Sept. 18, 2020), <https://justiceinaging.org/wp-content/uploads/2020/09/Comments-on-NH-Revision.pdf> [<https://perma.cc/439C-F9WZ>] (criticizing the report for its “failure to address enforcement of federal quality of care standards”).

63. *Protecting Seniors*, *supra* note 9.

64. *Id.*

65. *Id.*

66. NAT’L ACADS. OF SCIS., ENG’G, & MED., *THE NATIONAL IMPERATIVE TO IMPROVE NURSING HOME QUALITY: HONORING OUR COMMITMENT TO RESIDENTS, FAMILIES, AND STAFF* (2022).

“regulatory model needs significant improvement.”⁶⁷ They stopped short, however, of explaining what regulatory changes are needed or clarifying whether the needed changes required different practices or new legal authority.⁶⁸

Despite these calls for reform and a growing body of research indicating a need for greater accountability for nursing homes,⁶⁹ legislative reforms have been met with little success. For example, in 2021, Senators Ron Wyden and Bob Casey introduced the Nursing Home Improvement and Accountability Act, which would have increased Medicaid funding and expanded the requirements of the NHRA by, among other things, requiring facilities to (i) have a registered nurse on duty at all times; (ii) employ a full-time infection control specialist; and (iii) report staffing levels more accurately.⁷⁰ This statute has been met with industry opposition, and passage seems highly unlikely.⁷¹

Legislation has been somewhat more successful at the state level. Some states have adopted new standards for nursing homes, pertaining to matters like minimum staffing levels and spending on direct care staff.⁷² However, many states have not acted, and some have actually loosened requirements on nursing homes.⁷³

Proposed regulatory reforms have also met with fierce opposition. Most notably, the industry has strongly opposed minimum staffing requirements.⁷⁴ Perhaps not surprisingly then, proposed minimum

67. *Id.* at 17.

68. *Id.*

69. See Robert G. Kramer, *Fixing Nursing Homes: A Fleeting Opportunity*, HEALTH AFFS. (Apr. 13, 2021), <https://www.healthaffairs.org/doi/10.1377/forefront.20210407.717832> [<https://perma.cc/A5FH-PLAV>].

70. Nursing Home Improvement and Accountability Act, S. 2694, 117th Cong. (2021).

71. See Statement on the Nursing Home Improvement and Accountability Act, AM. HEALTH CARE ASS'N & NAT'L CTR. FOR ASSISTED LIVING (Aug. 10, 2021), <https://www.ahcancal.org/News-and-Communications/Press-Releases/Pages/AHCANCAL-Issues-Statement-on-the-Nursing-Home-Improvement-and-Accountability-Act.aspx> [<https://perma.cc/B2E4-MYPZ>]; Howard Gleckman, *Hill Democrats Offer Nursing Homes More Money, But Demand Reforms In Return*, FORBES (Aug. 11, 2021), <https://www.forbes.com/sites/howardgleckman/2021/08/11/hill-democrats-offer-nursing-homes-more-money-but-demand-reforms-in-return/?sh=20837d5a204c> [<https://perma.cc/9WG5-HZW3>].

72. Kohn, *supra* note 7, at 14-16.

73. *Id.* at 9-10.

74. Amy Stulick, *Cautionary Tale: Staffing Mandate Collides with Nursing Home Labor Crisis and Referral Bottleneck*, SKILLED NURSING NEWS (Jan. 27, 2023), <https://skillednursingnews.com/2023/01/cautionary-tale-staffing-mandate-collides-with-nursing-home-labor->

staffing requirements published by CMS in September 2023⁷⁵ were a far cry from the robust requirements advocates for nursing home residents had sought.⁷⁶ CMS not only proposed requiring substantially lower levels of direct care staff than prior studies had suggested were necessary to meet residents' needs, but also proposed allowing many facilities to obtain waivers that would permit them not to comply with the new requirements.⁷⁷

In this political environment, quality-improvement options that do not require new statutory or regulatory authority would thus be extremely valuable. Accordingly, in the next four parts, we identify four opportunities for using existing legal authority in new ways to improve the quality of care in nursing homes.

II. CERTIFICATION AS A LEVER

To be eligible for Medicare or Medicaid payments, nursing homes must be “certified” as being in compliance with federal regulations.⁷⁸ Certification is critical for nursing homes because Medicare and Medicaid funds comprise the substantial majority of their income.⁷⁹ In this Part, we describe the current certification process and demonstrate how—using existing statutory authority—this process could more strongly incentivize nursing home owners and operators to provide residents with high-quality care. Specifically, this Part shows how HHS could use the certification process to steer public funds away from nursing homes owned or operated by entities with a history of abuse and neglect.

crisis-and-referral-bottleneck [<https://perma.cc/V4DB-XTBD>].

75. See Ctrs. for Medicare & Medicaid Servs., *Proposed Rule: Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting* (Sept. 22, 2023), <https://www.federalregister.gov/documents/2023/06/2023-18781/medicare-and-medicare-programs-minimum-staffing-standards-for-long-term-care-facilities-and-medicare> [<https://perma.cc/8WRY-BXY5>].

76. Nina A. Kohn, Charlene Harrington & Lori Smetanka, *Biden's Nursing Home Staffing Requirements Are Dangerously Inadequate*, THE HILL (Sept. 22, 2023), <https://thehill.com/opinion/healthcare/4214467-bidens-nursing-home-staffing-requirements-are-dangerously-inadequate> [<https://perma.cc/PLG6-4N47>] (discussing concerns with the proposed regulations).

77. *Id.*

78. The relevant regulations are found in 42 C.F.R. § 483, Subpart B (2023).

79. See HARRINGTON ET AL., *supra* note 53, at 8-9.

A. *The Current Certification Process*

Under the NHRA, the HHS Secretary is responsible for determining which nursing homes are eligible for Medicare and Medicaid payments and certifying those which are indeed eligible.⁸⁰ Facilities are not eligible unless they are in “substantial compliance” with federal regulations that establish minimum facility requirements and grant residents extensive rights.⁸¹ The Secretary has delegated this authority to CMS, which, in turn, has largely delegated to the states the responsibility for certifying compliance or non-compliance.⁸²

To ensure that facilities are not certified unless they are capable of meeting these requirements, the Secretary is directed to establish criteria for certification to ensure that a nursing home is “administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.”⁸³ These criteria must consider, among other things, the nursing homes’ “governing body and management.”⁸⁴

Yet, current regulations implementing this authority do not spell out what a facility must do to satisfy this vigorous statutory mandate. Instead, they establish just two conditions related to ownership or management. First, facilities must disclose identifying information (for example, name, birthdate, address, and tax identification number) of any individual or corporation with an ownership or control interest.⁸⁵ Second, facilities must have a quality

80. 42 C.F.R. § 483.10 (2023).

81. *Id.*

82. CMS retains responsibility for certifying state-owned facilities. CTRS. FOR MEDICARE & MEDICAID SERVS., STATE OPERATIONS MANUAL CHAPTER 7—SURVEY AND ENFORCEMENT PROCESS FOR SKILLED NURSING FACILITIES AND NURSING FACILITIES, § 7300.2 (2023) [hereinafter STATE OPERATIONS MANUAL CHAPTER 7].

83. 42 U.S.C. §§ 1395i-3(d)(1)(A), 1396r(d)(1)(A). The associated regulations further elaborate on the requirements for nursing homes. *See id.* §§ 1395i-3(f)(5), 1396r(f)(5). The language is the same across the two statutory provisions except the word “skilled” is added in § 1395i-3(f)(5)(B).

84. *Id.* §§ 1395i-3(f)(5)(A), 1396r(f)(5)(A).

85. 42 C.F.R. § 483.70(k) (2023). An ownership or control interest is defined by cross-reference as an ownership interest totaling 5% or more in a disclosing entity, an indirect ownership interest equal to 5% or more in a disclosing entity, or a combination of direct and indirect ownership interests equal to 5% or more in a disclosing entity. *Id.* §§ 420.201, 455.101.

assessment and assurance committee that includes at least a minimum number of staff members, and includes an “administrator, owner, a board member or other individual in a leadership role.”⁸⁶ Neither of these requirements involves any examination into the qualifications of owners or operators, or the past performance of facilities they own or operate. Moreover, although the governing body and management may control other facilities, performance at these other facilities is not considered.⁸⁷

In short, although federal law requires the Secretary not to certify a home unless it is administered in a way that enables it to provide residents with high-quality care, the Secretary routinely, as a matter of regulatory policy, certifies nursing homes without taking key steps that could ensure quality administration.

B. Using Certification to Drive Quality

HHS has an unrealized opportunity to use its existing certification authority to improve nursing home quality of care by considering the performance record of facilities’ owners and operators. As noted above, the plain language of the NHRA stipulates that the Secretary should not certify a facility if it is administered in a way that undermines its ability to provide residents with the high-quality care necessary for each to reach their highest practicable well-being.⁸⁸ Moreover, the statute authorizes the Secretary to consider the facility’s governing body and management in determining whether the facility is administered in that way.⁸⁹

Accordingly, the Secretary has existing statutory authority to deny certification to facilities that are governed or managed by entities that have shown they are unlikely to administer them in a way that will provide residents with the required quality of care.⁹⁰

86. *Id.* § 483.75(g).

87. *Id.* § 483.70 (laying out the factors considered, and not including performance of such other facilities).

88. 42 U.S.C. §§ 1395i-3(d)(1)(A), 1396r(d)(1)(A); *see also* 42 C.F.R. § 483.24 (2023) (using the same language in the context of care and services that residents must receive); *id.* § 483.35 (2023) (using the same language in the context of nursing services); *id.* § 483.40 (2023) (using the same language in the context of behavioral health services); *id.* § 483.70 (2023) (using the same language in the context of administration).

89. 42 U.S.C. §§ 1395i-3(f)(5)(A), 1396r(f)(5)(A).

90. *See id.* § 1395i-3(f)(5).

The Secretary could, consistent with this authority, refuse to certify facilities owned or operated by entities with a track record of operating facilities that fail to use their resources in the efficient manner necessary for high-quality resident care. For example, the Secretary could deny certification (either outright or by creating a rebuttable presumption of denial) to facilities owned or operated by entities with a history of mismanagement as indicated by, for example, a pattern of serious survey deficiencies.

While the current regulations do not compel the Secretary to take into consideration the past conduct of a facility's owners or operators when deciding whether to certify the facility, they certainly do not prohibit the Secretary from doing so. The underlying statute makes it clear that the Secretary has an affirmative responsibility to ensure that the requirements governing skilled nursing facilities are "adequate to protect the health, safety, welfare, and rights of residents and to promote the effective and efficient use of public moneys."⁹¹ Denying certification to facilities owned or operated by entities with a history of endangering residents is therefore consistent with the Secretary's statutory mandate to refrain from certifying facilities that are not administered in a way that enables them to provide residents with high-quality care.

Implementing this approach would require providing agency staff with criteria for how to determine which owners or operators are known to operate facilities in a way that prevents them from meeting residents' needs. For example, staff might be directed to consider the number and types of deficiencies for which the other facilities owned or operated by the entity are cited.⁹² To facilitate this, a facility might be required to disclose all other facilities operated by the entity that operates the facility, or owned by an entity that has a substantial ownership interest in the facility. Of course, one major challenge with this type of policy would be enforcement, particularly in light of complex ownership schemes and

91. *Id.* §§ 1395i-3(f)(1), 1396r(f)(1).

92. To do this, staff likely would need to know: (i) which types of deficiencies should be considered (*i.e.*, deficiencies as to which measures and which levels or harm or pervasiveness); (ii) how widespread the pattern of deficiencies must be (*e.g.*, some of the entity's facilities, a sizeable portion, a particular percentage); and (iii) who should be treated as an owner or operator (*e.g.*, when related parties own different facilities or shell companies are set up as owners).

limited information exchange among state agencies. That said, fines for failing to disclose the required information could help serve as a deterrent for misbehavior.

III. FINANCIAL PENALTIES AS A LEVER

Under the NHRA, all nursing homes that accept Medicare or Medicaid—which is virtually all⁹³—are subject to routine surveys as part of the recertification process discussed in the previous Part.⁹⁴ If facilities are found to violate federal requirements regarding quality of care, penalties can be assessed. This Part explores how CMS could use the inspection process to greater effect by employing the full range of penalties already available to it. In doing so, it builds on President Biden’s call for enhanced civil monetary fines for non-compliant facilities⁹⁵ and the National Academies’ recognition that insufficient penalties have exacerbated quality-of-care problems.⁹⁶

A. *Current Penalties for Low-Quality Care*

Nursing homes are subject to regular inspections. First, there are routine, unannounced inspections required under the NHRA.⁹⁷ Specifically, the statute provides that, as part of both the certification and recertification process, nursing homes are subject to a life safety code survey,⁹⁸ which primarily addresses fire safety,⁹⁹ and a

93. LONG TERM CARE CMTY. COAL., A GUIDE TO NURSING HOME OVERSIGHT & ENFORCEMENT: EXPLORING THE STATE’S ROLE IN ASSURING QUALITY CARE 9 (2021).

94. See 42 C.F.R. § 488.308 (2023). Specifically, the state must conduct a standard survey of each skilled nursing facility and nursing facility no later than fifteen months after the last day of the previous standard survey. *Id.* § 488.308(a) (2023). The statewide average interval between standard surveys must be no more than twelve months, *id.* § 488.308(b) (2023), and the state may also “conduct a survey as frequently as necessary to—(1) [d]etermine whether a facility complies with the participation requirements; and (2) [c]onfirm that the facility has corrected deficiencies previously cited,” *id.* § 488.308(c) (2023).

95. *Protecting Seniors*, *supra* note 9.

96. NAT’L ACADS. OF SCIS., ENG’G, & MED., *supra* note 66, at 434.

97. See 42 C.F.R. § 488.307 (2023) (authorizing monetary fines for those who notify a facility, or cause a facility to be notified, of the time and date of a survey).

98. *Id.* § 483.90(a) (2023); see also *id.* Part 488, Subpart F (2023) (enforcement regulations that are also applicable to life safety code surveys).

99. See STATE OPERATIONS MANUAL CHAPTER 7, *supra* note 82, § 7410.1.

standard health survey, which addresses quality-of-care issues.¹⁰⁰ Both surveys must be conducted by an interdisciplinary team of trained¹⁰¹ health care professionals¹⁰² who are free from conflicts of interest.¹⁰³ Second, states require inspections in order to maintain a license, and most states require inspections for initial licensure or renewal of a license.¹⁰⁴ Often, these two inspection requirements are conducted concurrently, as the federal government relies on states to conduct the standard health surveys required by CMS.¹⁰⁵ Thus, during these surveys, the state inspectors evaluate the facility's compliance with both state and federal minimum standards and nursing home requirements.¹⁰⁶ Although the surveys are required to be unannounced, reports have shown that this is not always the case, which undermines their effectiveness as a monitoring device.¹⁰⁷

As part of the standard survey, inspectors (called "surveyors") are tasked with determining whether facilities are in compliance with the quality-of-care requirements established by the NHRA and its implementing regulations.¹⁰⁸ Surveyors typically find multiple violations, or "deficiencies," in the nursing homes they inspect; indeed, the average nursing home in the United States has six to seven deficiencies per inspection.¹⁰⁹

The NHRA authorizes the federal government to impose a range of financial sanctions where deficiencies are found.¹¹⁰ These penalties can include termination from the Medicaid or Medicare

100. 42 C.F.R. § 488.305 (2023).

101. Surveyors must have "successfully completed a training and testing program prescribed by the Secretary." *Id.* § 488.314(c).

102. "Professionals include, but are not limited to, physicians, physician assistants, nurse practitioners, physical, speech, or occupational therapists, registered professional nurses, dietitians, sanitarians, engineers, licensed practical nurses, or social workers." *Id.* §§ 488.314(a)(2)-(3) (2023).

103. STATE OPERATIONS MANUAL CHAPTER 7, *supra* note 82, § 7201.2.

104. *See, e.g.*, 10-144-110 ME. CODE R. § 1A.1, 22.B.1 (LexisNexis 2023).

105. *See* LONG TERM CARE CMTY. COAL., *supra* note 93, at 16.

106. *See id.*

107. Jessica Silver-Greenberg & Robert Gebeloff, *Maggots, Rape and Yet Five Stars: How U.S. Ratings of Nursing Homes Mislead the Public*, N.Y. TIMES (Aug. 4, 2021), <https://www.nytimes.com/2021/03/13/business/nursing-homes-ratings-medicare-covid.html> [<https://perma.cc/55GX-9BBZ>].

108. *See* STATE OPERATIONS MANUAL CHAPTER 7, *supra* note 82, § 7001.

109. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 40.

110. This includes denial of payment, civil money penalties, and appointment of temporary management. *See* 42 U.S.C. §§ 1395i-3(h)(2)(B), 1396r(h)(3)(C).

system, denial of payments for services or new admissions, state monitoring, transfer of residents, facility closure, temporary management, directed plans of corrections,¹¹¹ and civil money penalties.¹¹² State survey agencies are responsible for recommending enforcement remedies to CMS, but the CMS regional office determines the final imposition of remedies.¹¹³

In selecting the sanction for non-compliance, CMS considers the seriousness of the deficiencies,¹¹⁴ as indicated by the actual and potential harm that may result in addition to whether the deficiencies are isolated, part of a pattern, or widespread.¹¹⁵ CMS may also consider other factors, including the relationship between deficiencies and the facility's "prior history of noncompliance in general and specifically with reference to the cited deficiencies."¹¹⁶

Some penalties are mandatory. For example, in instances of immediate jeopardy,¹¹⁷ in addition to any other penalties, temporary management must be imposed or the home must be terminated from participation in the Medicare and Medicaid programs.¹¹⁸

However, in most cases where deficiencies are found, no penalties are assessed by CMS.¹¹⁹ Where penalties are used, the more

111. These are plans written by the agency that detail the violations or deficiencies and the specific steps facilities need to take to remedy the deficiencies. They usually have a required time period for compliance. Unfortunately, reports have questioned the utility of these directed plans of correction. GRIMM, *supra* note 19, at 11-13, 18-19.

112. 42 C.F.R. § 488.406 (2023).

113. CTRS. FOR MEDICARE & MEDICAID SERVS., NURSING HOME ENFORCEMENT—FREQUENTLY ASKED QUESTIONS, <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationEnforcement/Downloads/NH-Enforcement-FAQ.pdf> [<https://perma.cc/NJZ7-QKW5>].

114. 42 C.F.R. § 488.404(a) (2023).

115. *Id.* § 488.404(b).

116. *Id.* § 488.404(c).

117. *Id.* § 488.1 (defining immediate jeopardy as "a situation in which the provider's or supplier's noncompliance with one or more Medicare requirements, conditions of participation, conditions for coverage or certification has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident or patient").

118. *Id.* § 488.410 (stating that "the State must (and CMS) does" impose temporary management under such situations); STATE OPERATIONS MANUAL CHAPTER 7, *supra* note 82, §§ 7301.1, 7500. "[E]ven if the facility successfully removes the immediate jeopardy but is still not in substantial compliance," "[i]mmediate imposition of an alternative remedy should be considered." *Id.*

119. See U.S. GOV'T. ACCOUNTABILITY OFF., NURSING HOMES: IMPROVED OVERSIGHT NEEDED TO BETTER PROTECT RESIDENTS FROM ABUSE 17-18 (2019) [hereinafter NURSING HOMES: IMPROVED OVERSIGHT]; PROPUBLICA, *supra* note 25; see also Debbie Cenziper, Joel Jacobs &

stringent ones are rarely used—even in instances where the performance of the facilities warrants severe sanctions.¹²⁰ This is evidenced by the fact that civil monetary penalties have been by far the most common remedy used in recent years.¹²¹ Specifically, from fiscal year 2016 through fiscal year 2020, civil monetary penalties “accounted for nearly 72[%] of the 28,077 enforcement actions taken.”¹²² Although they have increased since 2016, with a moderate dip that roughly coincided with the beginning of the pandemic,¹²³ fines have typically remained quite small: the mean fine amount in July 2019 was just over \$16,000 and decreased slightly to \$15,000 by April 2021.¹²⁴ This reflects the fact that CMS tends to impose penalties at the lower end of the permissible range.¹²⁵ This trend may be shifting, however, with the Biden Administration recently announcing that CMS would “begin using escalating penalties for violations.”¹²⁶

One factor leading to reduced penalties is that facilities are often given the opportunity to avoid penalties by correcting deficiencies.¹²⁷ When there is no finding of immediate jeopardy, the deficiencies do not reach a specified level of severity, and the facility is not designated as a Special Focus Facility due to past problems, the facility may be given an opportunity to avoid penalties by correcting the underlying problem.¹²⁸

Another factor leading to reduced penalties is that nursing homes frequently successfully contest citations. As a California

Shawn Mulcahy, *As Pandemic Raged and Thousands Died, Government Regulators Cleared Most Nursing Homes of Infection-Control Violations*, WASH. POST (Oct. 29, 2020, 4:52 PM), <https://www.washingtonpost.com/business/2020/10/29/nursing-home-deaths-fines/> [<https://perma.cc/395U-LFCG>].

120. DEP’T OF HEALTH & HUM. SERVS., OFF. OF THE INSPECTOR GEN., *NURSING HOME ENFORCEMENT: APPLICATION OF MANDATORY REMEDIES 7* (2006) (reporting that between 2000 and 2002, CMS did not apply a mandatory remedy in 55% of cases).

121. NAT’L ACADS. OF SCIS., ENG’G, & MED., *supra* note 66, at 416.

122. *Id.*

123. Ryan Brooks, *Identifying Trends in CMS Skilled Nursing Penalties*, NAT’L INVESTMENT CTR. FOR SENIORS HOUSING & CARE (July 1, 2021), <https://blog.nic.org/identifying-trends-in-cms-skilled-nursing-penalties> [<https://perma.cc/FSB2-5G8X>].

124. *Id.*

125. NAT’L ACADS. OF SCIS., ENG’G, & MED., *supra* note 66, at 416.

126. *Biden-Harris Administration Announces New Steps*, *supra* note 10.

127. NAT’L ACADS. OF SCIS., ENG’G, & MED., *supra* note 66, at 409.

128. STATE OPERATIONS MANUAL CHAPTER 7, *supra* note 82, § 7304.1.

investigative reporting group found, “[o]n the rare occasions when inspectors issue severe citations, nursing homes can fight them through an appeals process that operates almost entirely in secret.”¹²⁹ According to CMS, 25% of all citations disputed are changed.¹³⁰ CMS has argued that the lack of transparency protects nursing homes whose citations are overturned or downgraded from unfair condemnation, but “the appeals process can be one-sided, excluding patients and their families,” and technical issues have ensured that some citations do not become public even after the appeals process is exhausted.¹³¹

Yet another reason for reduced penalties is that surveyors have incentives not to cite facilities for problems. A *New York Times* investigation found that surveyors are discouraged from citing facilities for serious violations because doing so “requires extra paperwork and additional visits to check that the home has fixed the problem.”¹³² The investigation found that surveyors are sometimes explicitly discouraged from citing facilities for serious problems. For example, inspectors in Pennsylvania were told to be “kinder and gentler with nursing homes”; inspectors in California were told “to act as safety ‘consultants’ to nursing homes and to not take on an enforcement role”; and some inspectors in Arkansas

129. Robert Gebeloff, Katie Thomas & Jessica Silver-Greenberg, *How Nursing Homes’ Worst Offenses Are Hidden from the Public*, N.Y. TIMES (Dec. 9, 2021), <https://www.nytimes.com/2021/12/09/business/nursing-home-abuse-inspection.html> [<https://perma.cc/YD2J-3X9E>]; see also Jocelyn Wiener, *The Case of the Vanishing Fine: How a Massive Nursing Home Penalty Eluded Consumer Detection*, CAL. MATTERS (Dec. 15, 2021), <https://calmatters.org/health/2021/12/rechnitz-nursing-home-fines/> [<https://perma.cc/APS9-VX5A>] (describing secrecy of California system).

130. CTRS. FOR MEDICARE & MEDICAID SERVS., UPDATES TO THE NURSING HOME CARE COMPARE WEBSITE AND FIVE STAR QUALITY RATING SYSTEM: ADJUSTING MEASURE RATINGS BASED ON ERRONEOUS SCHIZOPHRENIA CODING, AND POSTING CITATIONS UNDER DISPUTE 3 (2023).

131. Gebeloff et al., *supra* note 129. Recently, CMS announced it would publicly post citations under dispute, which were previously not posted, on Care Compare. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 130, at 3. Still, incentives to dispute citations remain, as facilities may not have to pay fines until after the dispute is resolved. Dana B. Mukamel, David L. Weimer, Yue Li, Lauren Bailey, William D. Spector & Charlene Harrington, *Nursing Homes Appeals of Deficiency Citations: The Informal Dispute Resolution Process*, 13 J. AM. MED. DIR. ASS’N 512, 512 (2012). Additionally, facilities may choose to appeal so that the deficiencies are not included in their Five-Star Rating calculation during that time.

132. Gebeloff et al., *supra* note 129.

reported that their supervisors “discouraged them from citing homes for immediate jeopardy or actual harm, even when they spotted dangerous conditions.”¹³³ This pressure may reflect the fact that the nursing home industry is a powerful lobbying force at both the national and state level.¹³⁴

B. Using Penalties to Drive Quality

The frequency of quality-of-care deficiencies in nursing homes in the United States suggests that the penalties for non-compliance are not sufficient to incentivize better care. This could be fixed by using CMS’s existing statutory and regulatory authority to impose a wide range of penalties on nursing homes, and to impose those penalties more frequently. Using this authority, CMS could rescind its current guidance that encourages state inspectors to waive any financial penalties for most violations and to rarely use penalties that would have a substantial fiscal bite—such as holds on payment or new admissions.¹³⁵ This guidance—which is, of course, not required by either the underlying statute or regulations—means that when a nursing home fails to comply with regulations designed to protect residents from abuse and neglect, they are typically merely instructed to correct the problem.¹³⁶

Relatedly, with new guidance, CMS could use its existing statutory authority to give teeth to existing quality-of-care requirements

133. *Id.*

134. *See Lobbying*, OPEN SECRETS, <https://www.opensecrets.org/industries/lobbying.php?cycle=All&ind=H02> [<https://perma.cc/D6DL-BUHP>] (reporting that the leading nursing home industry association spent nearly \$4 million lobbying in 2022, in addition to reporting substantial expenditures by other industry members).

135. This failure is consistent with CMS’s decision to give regional offices substantial discretion to use monetary fines in lieu of more consequential penalties such as temporary management or denial of payment for new admissions that are also statutorily permissible. *See STATE OPERATIONS MANUAL CHAPTER 7*, *supra* note 82, § 7300.

136. *See id.* § 7400; DEP’T OF HEALTH & HUM. SERVS., OFF. OF THE INSPECTOR GEN., A-09-18-02000, CMS GUIDANCE TO STATE SURVEY AGENCIES ON VERIFYING CORRECTION OF DEFICIENCIES NEEDS TO BE IMPROVED TO HELP ENSURE THE HEALTH & SAFETY OF NURSING HOME RESIDENTS 9, 12 (2019) (laying out the limited circumstances under which a nursing home will not be provided an opportunity to correct a deficiency prior to imposition of penalties); NURSING HOMES: IMPROVED OVERSIGHT, *supra* note 119, at 18, 32 (finding that, in cases involving abuse-related deficiencies, CMS typically did not implement proposed enforcement actions because facilities “came into compliance prior to the implementation date of the penalty”).

by employing a broader range of statutorily permissible penalties when facilities are determined to have violated regulations designed to protect residents. This means not only heftier monetary fines but also renewed willingness to employ more consequential penalties like holds on new admissions or suspensions of payment.

Even if CMS is not willing to increase the utilization or magnitude of penalties, states should consider using their own statutory authority to do so. Many states' public health statutes allow them to impose separate penalties for survey violations, including civil monetary fines, suspension or revocation of the facility's license, or placement of the facility into receivership.¹³⁷ Thus, states could use state-level penalties where federal ones are not imposed or are insufficient to create proper incentives for quality care. To be sure, nursing homes have lobbied against monetary penalties, claiming that they are counterproductive because they divert money from resident care and might force some facilities to close.¹³⁸ The reality, however, is that civil monetary penalties are not taken out of the nursing home system, but rather used to support investments in improving care.¹³⁹

Moreover, the cost of monetary penalties need not come at the expense of resident care. Best evidence suggests that underperforming nursing homes perform poorly in part because they divert money needed for resident care to profit. For example, for-profit entities (including private-equity firms) that own nursing homes can use payments to related entities—such as management fees, leasing costs, and interest payments—to generate profit for owners while

137. See, e.g., 10-144-110 ME. CODE R. § 22.G.4 (LexisNexis 2023) (permitting license suspension and revocation); MINN. STAT. § 144A.15(2) (2023) (permitting receivership as a remedy); MO. REV. STAT. § 198.067.3 (2023) (permitting the assessment of civil penalties); TENN. CODE ANN. § 68-11-811 (2023) (same).

138. See, e.g., Alex Zorn, *Why Biden's Calls for \$1M Fines, CMS Survey Funding Boost Could Put Some Nursing Homes in Peril*, SKILLED NURSING NEWS (Mar. 28, 2022), <https://skillednursingnews.com/2022/03/why-bidens-calls-for-1m-fines-cms-survey-funding-boost-could-put-some-nursing-homes-in-peril/> [<https://perma.cc/7GLR-386C>] (suggesting that increasing fines would force some nursing homes to shut down entirely).

139. NAT'L ACADS. OF SCIS., ENG'G, & MED., *supra* note 66, at 416.

the facilities they own show minimal or no profit.¹⁴⁰ Higher penalties can serve to discourage owners from diverting money needed to provide adequate care for residents into profit by making such diversions too costly.

While a full discussion of the financial status of nursing homes is beyond the scope of this Article, it is important to recognize that nursing homes are, in many cases, profit centers for corporate owners. Medicare payments for skilled nursing home care are sufficiently generous that in March 2022, MedPac (an independent advisory group charged with advising the federal government on Medicare reimbursement issues) urged Congress to reduce Medicare payments to nursing homes due to their “improved financial performance.”¹⁴¹ While Medicaid reimbursement rates are substantially less generous, Medicaid-dependent institutions can still be quite profitable if owners are willing to sacrifice quality, which explains why they are attractive targets for private-equity firms.¹⁴² The extent of profit in these institutions is further suggested by evidence shared by New York nursing homes as part of a lawsuit they filed against the state of New York. The nursing homes sued the state, alleging that its requirement that nursing homes spend a minimum percentage on direct care would unfairly limit their profits.¹⁴³ The 239 homes that were party to the suit reported that if their profits were capped at 5% annually and they had to spend 70% of income on residents, they would have lost a combined \$510 million in profit in 2019.¹⁴⁴

140. See Gupta et al., *supra* note 57, at 35 (describing this phenomenon with private equity firms); Jordan Rau, *Care Suffers as More Nursing Homes Feed Money Into Corporate Webs*, KAISER HEALTH NEWS (Dec. 31, 2017), <https://khn.org/news/care-suffers-as-more-nursing-homes-feed-money-into-corporate-webs/> [<https://perma.cc/2J2K-B46G>] (describing the increasing trend in related party transactions, with nearly 75% of all nursing homes engaging in related party transactions).

141. MEDICARE PAYMENT ADVISORY COMM'N, MARCH 2022 REPORT TO CONGRESS: MEDICARE PAYMENT POLICY 235 (2022) (describing payment structures in Medicare as leading to “improved financial performance” for skilled nursing facilities).

142. Yasmin Rafiei, *What Happens When Private Equity Takes Over a Nursing Home*, NEW YORKER (Aug. 25, 2022), <https://www.newyorker.com/news/dispatch/when-private-equity-takes-over-a-nursing-home> [<https://perma.cc/75F8-E9PH>].

143. See *LTCCC Alert: NY Nursing Homes Admit Excess Profit*, LONG-TERM CARE CMTY. COAL. (Jan. 21, 2023), <https://nursinghome411.org/nys-provider-lawsuit/> [<https://perma.cc/R6LZ-LNBT>] (analyzing the data shared as part of the lawsuit).

144. *Id.*

Moreover, the use of penalties other than fines—such as holds on new admissions and decertification—can play an important role in ensuring higher quality of care at nursing homes, especially if contextualized for the specific facts and history of a particular facility. At times, these harsher penalties may lead to nursing home closures. A nursing home closure can, of course, have negative ramifications for the residents in these facilities.¹⁴⁵ Yet, so too can substandard quality of care.¹⁴⁶ Weeding out the worst performing nursing homes can be a critically important way to protect the most vulnerable residents: those without family and friends to advocate for “better” placements and those who are seen as less desirable by facilities due to their diagnosis or funding source.

IV. STATE LICENSURE OF NURSING HOMES AS A LEVER

Another potential lever for improving quality-of-care in nursing homes is *state* licensure. Before a nursing home is opened or when there is a significant change in ownership of an existing facility, the owner must apply for a license from a state licensing agency.

This Part shows how states have a largely unrealized opportunity to use licensure to improve nursing home quality. Specifically, it shows how states have authority to, but often do not, consider the performance of the individual facilities being licensed or the performance of those who own and operate them when deciding whether to grant, renew, suspend, and revoke licenses.

A. Overview of Licensure Processes

In all fifty states and the District of Columbia, privately-operated nursing homes¹⁴⁷ must apply for and obtain a license from a state licensing agency before operating a new facility.¹⁴⁸ New licenses are

145. For further discussion of the cost and benefits of closure, *see infra* Part IV.D.2.

146. *See supra* Part II.

147. In all states, applicants may not operate a nursing facility unless they have received a license. *See, e.g.*, MD. CODE REGS. 10.07.02.03 (2023); MO. REV. STAT. § 198.015 (2023); 175 NEB. ADMIN. CODE § 12-003 (2023).

148. This is typically the state’s Department of Health or Department of Human Services. *See, e.g.*, 016-25-2 ARK. CODE R. § 201 (LexisNexis 2023) (identifying the agencies responsible for licensing nursing facilities); 10a N.C. ADMIN. CODE 13D.2103 (2023); S.D. CODIFIED LAWS

typically required before a change in facility ownership, and sometimes required for a facility to expand and add new beds.¹⁴⁹

The application requirements are typically simple: applicants must pay a fee and disclose certain information.¹⁵⁰ That information differs by state, but it typically includes the name of the proposed owners, as well as the name and location of the facility.¹⁵¹ Some states require additional information like the name of the nursing home administrator, bed capacity, proof of financial viability, and information about the background qualifications or record of the applicant.¹⁵²

Applicants wishing to obtain a license for a newly constructed facility may be required to obtain a certificate of need (CON) prior to applying for a license. Thirty-five states and the District of Columbia require an applicant to obtain a CON before they undertake construction of the nursing facility.¹⁵³ CONs came into use in the late 1980s in order to prevent an oversaturation of the nursing home market and to control nursing home costs by limiting the spread of new nursing homes that were able to open and the expansion of existing ones.¹⁵⁴ CONs are typically defended as ensuring that health facilities are meeting actual need and not duplicating

§ 34-12-7 (2023).

149. In the case of a significant change in ownership, applicants are generally required to file a new application for a license. At the least, they are required to file a change in ownership form with the licensing agency prior to the change. *See, e.g.*, 6 COLO. CODE REGS. § 1011-1:2-2.6.1 (LexisNexis 2023); MINN. STAT. § 144A.06(2)(a) (LexisNexis 2023); UTAH ADMIN. CODE r. 432-2-14(1)(b) (LexisNexis 2023) (requiring a new application for licensure prior to a change in ownership).

150. Amounts may vary based on the size and type of facility. *See, e.g.*, IOWA CODE § 135C.7 (2023); N.H. REV. STAT. ANN. § 151:5 (2023) (varying the licensure fee based on facility size).

151. This is required for facilities certified by CMS and by most states. *See* 42 C.F.R. § 455.104(b)(1) (2023) (requiring disclosure of ownership for all those with a 5% or greater interest in a facility).

152. *See, e.g.*, 6 COLO. CODE REGS. § 1011-1:2.8.2 (LexisNexis 2023).

153. *Certificate of Need State Laws*, NAT'L CONF. OF STATE LEGISLATURES, <https://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx> [<https://perma.cc/7DE2-FBM5>].

154. Bichaka Fayissa, Saleh Alsaif, Fady Mansour, Tesa E. Leonce & Franklin G. Mixon, Jr., *Certificate-Of-Need Regulation and Healthcare Service Quality: Evidence from the Nursing Home Industry*, 8 HEALTHCARE 423, 423-24 (2020); NAT'L ACADS. OF SCIS., ENG'G, & MED., *supra* note 66, at 404-05. Interestingly, certificate-of-need laws were adopted by states in anticipation of needing to comply with the National Health Planning and Resource Development Act of 1974, which would have imposed financial penalties on states that did not have certificate-of-need laws. However, those penalty provisions were never effectuated, and the law was repealed in 1986. NAT'L ACADS. OF SCIS., ENG'G, & MED., *supra* note 66, at 404-05.

services that are already available within the given community.¹⁵⁵ However, CONs can create fewer nursing home beds and reduce competition among nursing home providers, thus reducing the incentive to provide high-quality care to residents.¹⁵⁶

After submitting a licensure application and providing the relevant documents, facilities are generally subject to an inspection to ensure they are compliant with physical environment standards (for example, the number of beds in a single room), as well as relevant fire and safety codes.¹⁵⁷ Following an acceptable inspection, the nursing home will be issued a license.¹⁵⁸ While over half of the states' licensing regulations require that licenses are renewed on a yearly basis,¹⁵⁹ some states allow for the issuance of two-year¹⁶⁰ or

155. *Certificate of Need State Laws*, *supra* note 153.

156. See David C. Grabowski, *Nursing Home Certificate-of-Need Laws Should Be Repealed*, HEALTH AFFS. FOREFRONT (June 9, 2017), <https://www.healthaffairs.org/doi/10.1377/forefront.20170609.060529> [<https://perma.cc/2CKL-G5QR>]; see also Edward C. Norton, *Long-Term Care*, in HANDBOOK OF HEALTH ECON. 955, 957 (Anthony J. Culyer & Joseph P. Newhouse eds., 2000); David C. Grabowski & Joseph J. Angelelli, *The Relationship of Medicaid Payment Rates, Bed Constraint Policies, and Risk-Adjusted Pressure Ulcers*, 39 HEALTH SERVS. RSCH. 793, 794 (2004); NAT'L ACADS. OF SCIS., ENG'G, & MED., *supra* note 66, at 405-07 (reviewing the literature on certificate-of-need laws and finding little evidence to suggest that they accomplish their stated purpose in the nursing home setting). We therefore do not recommend using the certificate-of-need process as a lever for quality control. See Christopher J. Conover & James Bailey, *Certificate of Needs Laws: A Systematic Review and Cost-Effectiveness Analysis*, 20 BMC HEALTH SERVS. RSCH. 748, 748 (2020).

157. See, e.g., 175 NEB. ADMIN. CODE § 12-005.01 (2023) (describing initial inspection procedures).

158. See, e.g., *id.* § 12-005.02A (providing that the department will issue a license following a satisfactory inspection).

159. ALA. CODE § 22-21-24 (2023); 16-25-2 ARK. CODE R. § 203 (LexisNexis 2023); 6 COLO. CODE REGS. § 1011-1:2-2.4.1(E) (LexisNexis 2023); DEL. CODE ANN. tit. 16, § 1104(g) (West 2023); D.C. CODE § 44-502(h) (2023); HAW. CODE R. § 11-94.1-6(h) (LexisNexis 2023); IDAHO CODE § 39-1305 (2023); IND. CODE § 16-28-2-4(1) (2023); IOWA CODE § 135C.8 (2023); KAN. STAT. ANN. § 65-429 (2023); 902 KY. ADMIN. REGS. 20:008(2)(11) (2023); LA. STAT. ANN. § 40:2009.9 (2023); 10-144-110 ME. CODE R. § 2(D)(4) (LexisNexis 2023); MICH. ADMIN. CODE r. 325.45113(3) (2023); MINN. STAT. § 144A.05 (2023); 15-16 MISS. CODE R. § 45.7.5 (LexisNexis 2023); 175 NEB. ADMIN. CODE § 12-004.03 (2023); NEV. REV. STAT. § 449.089(1) (2023); N.H. REV. STAT. ANN. § 151:5 (2023); N.J. ADMIN. CODE § 8:39-2.4(e) (2023); N.M. CODE R. § 7.9.2.9(A) (LexisNexis 2023); 10a N.C. ADMIN. CODE 13D.2103 (2023); N.D. ADMIN. CODE § 33-07-03.2-03(1)(b) (2023); OR. ADMIN. R. § 411-085-0015(1) (2023); 35 PA. STAT. AND CONS. STAT. § 448.809(a)(1)(i) (West 2023); 23 R.I. GEN. LAWS § 23-17-7 (2023); S.C. CODE ANN. § 44-7-280 (2023); TENN. CODE ANN. § 68-11-206(a)(8) (2023); VT. STAT. ANN. tit. 33, § 7105(a) (2023); VA. CODE ANN. § 32.1-131 (2023); WASH. ADMIN. CODE § 388-97-4160(7) (2023); WYO. STAT. ANN. § 35-2-904(b) (2023).

160. ALASKA STAT. § 08.01.100(a) (2023); CAL. HEALTH & SAFETY CODE § 1267(b) (West

three-year licenses.¹⁶¹ Some states vary the length of the license or the type of license issued based on the results of the inspection or the applicant's history.¹⁶²

After being issued a license, nursing facilities are eligible to apply for certification from CMS or accreditation from national accrediting agencies.¹⁶³ Thus, licensure is essential to lawfully operate a nursing home and to receive the Medicare and Medicaid funding that comprises the bulk of the income for most facilities.¹⁶⁴

Once the license is issued, nursing homes are also subject to periodic inspections,¹⁶⁵ and in most states, license renewal applications and fees.¹⁶⁶ Renewal determinations present another opportunity for states to ensure that facilities provide sufficient quality of care. If the facility is not providing the quality of care required by the state, the state may be entitled to suspend or revoke the facility's license.¹⁶⁷ Notably, licensing agencies can suspend or revoke licenses of facilities for poor care even outside the renewal process.¹⁶⁸

B. Current Approach to Considering Performance Indicators

The extent to which licensure reflects and drives nursing home quality is contingent upon on whether licensure depends on the performance of the facility or those who own and operate it. This section therefore examines the role that an applicant's past perfor-

2023); CONN. GEN. STAT. § 19a-493(a) (2023); FLA. STAT. § 408.808(1) (2023); 210 ILL. COMP. STAT. 45/3-103(2) (2023); MD. CODE REGS. 10.07.02.03(A) (2023); MASS. GEN. LAWS ch. 111, § 71 (2023); MO. REV. STAT. § 198.015(3) (2023); S.D. CODIFIED LAWS § 34-12-7 (2023); UTAH CODE ANN. § 26B-2-206(4)(a) (LexisNexis 2023).

161. ARIZ. REV. STAT. ANN. § 36-425.02(B) (2023); MONT. ADMIN. R. § 37.106.310(3)(a) (2023); OKLA. STAT. tit. 63, § 1-822(A) (2023); TEX. HEALTH & SAFETY CODE ANN. § 242.033(d) (West 2023).

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

163. See 42 C.F.R. § 483.70(a) (2023).

164. See *supra* note 75 and accompanying text.

165. See, e.g., WASH. REV. CODE ANN. § 18.151.091(1) (West 2023) (stating that nursing homes shall be inspected periodically).

166. See, e.g., ALA. CODE § 22-21-24 (2023) (describing the initial licensure and renewal application and fees).

167. See, e.g., ALA. CODE § 22-21-25(b) (2023) (permitting license revocation or suspension for conduct detrimental to patient welfare).

168. See, e.g., 6 COLO. CODE REGS. § 1011-1:2-2.11.4 (LexisNexis 2023) (permitting adverse licensure action "at any time" when certain conditions are present).

mance in owning or operating nursing homes or other licensed health care facilities plays in licensure determinations.

1. *Related Facilities' Performance*

While it may seem obvious that states would want to prevent repeat bad actors from owning or operating more nursing homes, many states' licensing regimes do not explicitly require the licensing agency to consider the prior performance of the operators or of other homes owned or operated by the applicant for licensure.¹⁶⁹

Most states' statutes or regulations are drafted broadly enough to *allow* for the consideration of performance of other homes operated or owned by the applicant as part of the licensure determination process.¹⁷⁰ However, states vary in whether consideration of the

169. Some states subject applicants to background checks. We categorize such checks as consideration of the applicant's track record only where they include convictions related to the health, safety, or welfare of individuals or patients in a health care facility. *See, e.g.*, 902 KY. ADMIN. REGS. 20:300(1)(b) (2023) (prohibiting operation of a nursing facility by someone listed on the state's caregiver misconduct registry). States that require background checks differ on whether negative findings automatically disqualify the applicant from holding a license. For one approach, see MONT. CODE ANN. § 37-1-203 (2023) (only permitting criminal convictions to be grounds for licensure denial where the applicant was convicted of a criminal offense related to "the public health, welfare, and safety as it applies to the occupation for which the license is sought").

170. *See* ALA. ADMIN. CODE r. 420-5-10.02(4)(c) (2023); ALASKA STAT. ANN. § 47.05.330(a) (West 2023); ARIZ. REV. STAT. ANN. § 36-422(A)(1)(d) (2023); 20-10-229 ARK. CODE R. § 229(c)(3) (LexisNexis 2023); CAL. HEALTH & SAFETY CODE § 1499 (West 2023); 6 COLO. CODE REGS. § 1011-1:2-2.3.3(J) (LexisNexis 2023); CONN. GEN. STAT. ANN. § 19a-528a(b) (West 2023); DEL. CODE ANN. tit. 16, § 1105(a)(6) (West 2023); D.C. Mun. Regs. tit. 22-B, § 3107.7 (LexisNexis 2023); FLA. STAT. ANN. § 408.815(1), (4) (West 2023); GA. CODE ANN. § 31-2-8(c)(4) (2023); HAW. CODE R. § 11-94.2-7 (LexisNexis 2023); IDAHO ADMIN. CODE r. 16.03.02.050(05) (2023); ILL. ADMIN. CODE tit. 77, § 300.140(a)(1) (2023); IND. CODE ANN. § 16-28-2-3(a)(5) (West 2023); IOWA CODE ANN. § 135C.10(9) (West 2023); KAN. STAT. ANN. § 39-931 (2023); 902 KY. ADMIN. REGS. 20:008(2)(4)(b) (2023); MD. CODE REGS. 10.07.02.04(A)(7)(a)(i) (2023); 105 MASS. CODE REGS. 153.012 (2023); MICH. COMP. LAWS ANN. § 333.21755(b) (West 2023); MINN. STAT. § 144A.04(4) (2023); MO. ANN. STAT. §§ 198.022(1)[5]-[6], (5) (West 2023); 175 NEB. ADMIN. CODE § 12-008.01 (2023); NEV. REV. STAT. § 449.174 (2023); N.H. CODE ADMIN. R. ANN. He-P 803.04(a)(11)-(12) (2023); N.J. ADMIN. CODE § 8:39-2.2(d) (2023); N.J. ADMIN. CODE § 8:33-4.10(d) (2023); N.M. CODE R. § 7.9.2.8(B)(3) (LexisNexis 2023); N.Y. PUB. HEALTH LAW §§ 2801-a(2)-(4) (McKinney 2023); N.D. ADMIN. CODE 33-07-03.2-03(1)(a) (2023); OHIO REV. CODE ANN. § 3721.07(A)-(C) (West 2023); OKLA. STAT. ANN. tit. 63, § 1-822(D) (West 2023); OR. ADMIN. R. 411-085-0010(5)(c) (2023); OR. ADMIN. R. 411-089-0040(2) (2023); 216-40 R.I. CODE R. §§ 10-1.7(F)-(G)1.7.1 (LexisNexis 2023); 23 R.I. GEN. LAWS ANN. § 23-17-5.1(b) (West 2023); S.C. CODE ANN. REGS. 61-17(201)(a)(3) (2023); TENN. CODE ANN. § 68-11-206(a) (2023); 26 TEX. ADMIN. CODE § 554.214(a) (2023); TEX. HEALTH & SAFETY CODE ANN. § 242.032(e) (West 2023);

applicant's past performance is required or permitted, and whether that information is dispositive or simply a factor to be weighed.¹⁷¹ Additionally, some state statutes and regulations are silent on specific grounds for denial.¹⁷²

Of the states that consider applicant history in some way, over half explicitly require an applicant's history to be reviewed or disclosed during the initial application process.¹⁷³ The remainder permit the review of an applicant's history, but do not require it.¹⁷⁴

UTAH ADMIN. CODE r. 432-2-8(3) (LexisNexis 2023); WASH. ADMIN. CODE § 388-97-4200(4) (2023); W. VA. CODE ANN. § 16-5C-6(b) (West 2023); WIS. STAT. ANN. § 50.03(4)(b) (West 2023); WIS. ADMIN. CODE HS §§ 132.14(3)-(4) (2023); WYO. STAT. ANN. § 35-2-903(5)-(6) (2023).

171. For example, in Maryland, the licensing agency "shall require" review of applicants' past performance, MD. CODE REGS. 10.07.02.04(A)(7)(a)(i) (2023), whereas in Oregon the licensing agency "may consider" that performance, OR. ADMIN. R. 411-085-0010(5)(c) (2023). Likewise, in Connecticut the agency *shall* deny a license under certain circumstances, CONN. GEN. STAT. ANN. § 19a-528a(b) (West 2023), but in Delaware the agency *may* deny a license under certain conditions, DEL. CODE ANN. tit. 16, § 1105(a)(6) (West 2023).

172. *See, e.g.*, 23 R.I. GEN. LAWS ANN. § 23-17-8 (West 2023) (granting the authority to deny, revoke, or suspend a license without providing specific grounds for such actions).

173. *See* ALASKA STAT. ANN. § 47.05.330(a) (West 2023); ARIZ. REV. STAT. ANN. § 36-422(A)(1)(d) (2023); ARK. CODE ANN. § 20-10-229(c)(3) (West 2023); CAL. HEALTH & SAFETY CODE § 1265.3 (West 2023); 6 COLO. CODE REGS. § 1011-1:2-2.3(J) (LexisNexis 2023); CONN. GEN. STAT. ANN. § 19a-528a(b) (West 2023); DEL. CODE ANN. tit. 16, §§ 1104(c)-(d) (West 2023); FLA. ADMIN. CODE ANN. r. 59A-4.103(1)(a) (2023); GA. CODE ANN. § 31-7-358(a)(1) (2023); HAW. CODE R. § 11-94.2-7(7) (LexisNexis 2023); ILL. ADMIN. CODE tit. 77, § 300.140(a)(1) (2023); IND. CODE ANN. § 16-28-2-3(a)(5) (West 2023); 902 KY. ADMIN. REGS. 20:008(2)(4) (2023); MD. CODE ANN., HEALTH-GEN. § 19-1401.1(b)(2) (West 2023); 105 MASS. CODE REGS. 153.012 (2023); MINN. STAT. § 144A.03(1)(b)(14) (2023); MO. ANN. STAT. § 198.022(1), (5) (West 2023); 175 NEB. ADMIN. CODE § 12-008.01 (2023); NEV. ADMIN. CODE § 449.011 (2023); NEV. REV. STAT. ANN. § 449.122 (West 2023); N.D. ADMIN. CODE 33-07-03.2-03(1)(a) (2023); N.H. CODE ADMIN. R. ANN. He-P 803.04(a)(11)-(12) (2023); N.J. ADMIN. CODE § 8:43-2.1(h) (2023); N.M. CODE R. § 7.9.2.8 (LexisNexis 2023); N.Y. PUB. HEALTH LAW § 2801-a(3-b)(a) (McKinney 2023); OHIO REV. CODE ANN. § 3721.07(A)-(C) (West 2023); 216-40 R.I. CODE R. § 10-1.7(F)-(G)1.7.1 (LexisNexis 2023); S.C. CODE ANN. § 44-7-320(2) (2023); TEX. HEALTH & SAFETY CODE ANN. § 242.032(d), (e) (West 2023); UTAH ADMIN. CODE r. 432-2-8(5) (LexisNexis 2023); WASH. ADMIN. CODE § 388-97-4200(4) (2023); W. VA. CODE ANN. § 16-5C-6(b) (West 2023); WIS. STAT. ANN. § 50.03(4)(a) (West 2023); 048-19 WYO. CODE R. § 19.5(b) (LexisNexis 2023).

174. *See, e.g.*, MICH. ADMIN. CODE r. 325.45125(2) (2023); OR. ADMIN. R. 411-085-0010(5)(c) (2023); D.C. Mun. Regs. tit. 22-B, § 3102.6 (LexisNexis 2023) (permitting review of certain past performance factors for applicant's home and other homes they have owned or operated). Note that occasionally states list past performance indicators as grounds for denial, but do not directly address whether those factors are required to be disclosed or reviewed by the agency during the application process. *See, e.g.*, 15-16 MISS. CODE R. § 1-45.8.1(2) (LexisNexis 2023). Similarly, states occasionally require disclosure of certain information, but do not explicitly state how that information is used. *See, e.g.*, TENN. CODE ANN. § 68-11-206(a)(2)(A)(iv) (2023) (requiring the disclosure of the compliance history of each facility in and outside of Tennessee for which the applicant has a license, but not indicating how that information will be used).

Some states require that a license be denied in certain instances based on an applicant's past performance.¹⁷⁵ The majority have the discretion to either deny or approve a license based on past performance.¹⁷⁶ Some states have both permissive and mandatory grounds for license denial. For instance, in Oregon, the performance history of another facility may be considered by the licensing agency,¹⁷⁷ and applicants must also not have had a license revoked.¹⁷⁸

Even if a state does not explicitly require consideration of past performance, its statutory framework may allow it. In many states, licensing provisions are drafted broadly enough to give licensure bodies the discretion to deny licensure based on a poor track

Michigan appears to limit the circumstances under which the department may request from the facility documentation of non-compliance from state, local, or federal authorities. MICH. ADMIN. CODE r. 325.45125(2)-(3) (2023) (“During review of an application or a licensure survey or complaint investigation, the department may request from the health facility or agency documentation of noncompliance from local, state, or federal authorities if such documentation exists. The department may only cite this rule if the local, state, or federal authority that has jurisdiction over the specific law, rule, regulation, or standard has found the applicant or licensee to be non-compliant, in writing, and there is a need to protect the health, safety, and welfare of individuals receiving care and services in or from the health facility or agency.”).

175. *See, e.g.*, ALASKA STAT. ANN. § 47.05.325(a) (West 2023); CONN. GEN. STAT. ANN. § 19a-528a(b) (West 2023); 902 KY. ADMIN. REGS. 20:008(2)(4)(b) (2023); S.C. CODE ANN. § 44-7-264(B)(1) (2023); N.H. CODE ADMIN. R. ANN. He-P 803.13(8) (2023); N.J. ADMIN. CODE § 8:43-2.1(h) (2023); N.M. CODE R. § 7.9.2.8(B)(3) (LexisNexis 2023); OHIO REV. CODE ANN. §§ 3721.07(A)-(C) (West 2023); W. VA. CODE ANN. § 16-5c-6(b) (West 2023); WIS. ADMIN. CODE HS § 132.14(3)-(4) (2023).

176. *See* ARIZ. REV. STAT. ANN. § 36-425(k) (2023); 016-25-2 ARK. CODE R. § 200 (LexisNexis 2023); CAL. HEALTH & SAFETY CODE § 1265.1(a) (West 2023); 6 COLO. CODE REGS. § 1011-1:2-2.11 (LexisNexis 2023); DEL. CODE ANN. tit. 16, § 1105(a) (West 2023); GA. CODE ANN. § 31-2-8(c) (2023); ILL. ADMIN. CODE tit. 77, § 300.140(a)(1) (2023); IND. CODE ANN. § 16-28-2-3(a)(5) (West 2023); KAN. STAT. ANN. § 39-931a(b) (2023); MD. CODE REGS. 10.07.02.03(F)(2) (West 2023); MD. CODE ANN., HEALTH-GEN. § 19-1401.2 (West 2023); 105 MASS. CODE REGS. 153.014 (2023); MINN. STAT. § 144A.03(1)(b)(14) (2023); MONT. CODE ANN. § 50-5-207(1)(c) (2023); NEV. ADMIN. CODE § 449.99863 (2023); NEV. ADMIN. CODE § 449.99866 (2023); TEX. HEALTH & SAFETY CODE ANN. § 242.061(a-1) (West 2023); UTAH ADMIN. CODE r. 432-3-7 (LexisNexis 2023); WASH. REV. CODE ANN. § 18.51.054 (West 2023).

177. OR. ADMIN. R. 411-085-0010(5)(c) (2023) (“The Department may consider the applicant’s history of compliance with Department rules and orders, including the history of compliance of each person with a 10 percent or more incident of ownership in the applicant.”).

178. OR. ADMIN. R. 411-085-0013(2)(a) (2023) (“Each applicant must: (a) Be free of incident of ownership history in any facility in Oregon that provides or provided (at the time of ownership) care to children, elderly, ill or disabled persons and was involuntarily terminated from licensure or certification, or voluntarily terminated during any state or federal termination process, during the past five years.”).

record.¹⁷⁹ Likewise, most states have broad authority to request information about past performance.¹⁸⁰

2. Facility's Performance in Renewal Determinations

After a facility has been licensed, renewal can be used to monitor compliance and potentially remove a facility that is providing substandard care. However, around half of the states' statutes and regulations do not explicitly list the facility's own past performance as a consideration when determining whether to renew the facility's license.¹⁸¹ Many of these states do include some language allowing

179. See, e.g., MONT. CODE ANN. § 50-5-207(1)(c) (2023) (“The department may deny, suspend, or revoke a health care facility license if ... [t]he applicant or any person managing it has been convicted of a felony and denial of a license on that basis is consistent with 37-1-203 or the applicant otherwise shows evidence of character traits inimical to the health and safety of patients or residents.”); N.H. REV. STAT. ANN. § 151:7(2)(c) (2023) (allowing denial of a license where there are “[c]onduct or practices detrimental to the health or safety or well-being of patients, residents, or employees of said facilities”). *But see* VT. STAT. ANN. tit. 33, § 7105(a) (2023); 12-4 VT. CODE R. § 200.2.3 (2023); 12 VA. ADMIN. CODE 5-371-30 (2023); VA. CODE ANN. § 32.1-129 (2023). These statutes do not appear to contemplate prior history or the applicant's character at all in the issuance of a new license. Note that Maine, North Carolina, and Vermont do partially consider applicant history in the certificate-of-need requirements prior to licensure for a newly constructed facility. ME. REV. STAT. ANN. tit. 22, § 335(7) (2023); N.C. GEN. STAT. § 131E-183(13) (2023); VT. STAT. ANN. tit. 18, § 9440(b)(1)(H) (2023).

180. For instance, Idaho's statute reads:

An application for a license shall be made to the licensing agency upon forms provided by it and *shall contain such information as the licensing agency reasonably requires, which may include affirmative evidence of ability to comply with such reasonable standards, rules[,] and regulations* as are lawfully prescribed hereunder by the board of health and welfare.

IDAHO CODE § 39-1304 (2023) (emphasis added). Requiring applicants to disclose the prior performance of facilities that they owned, operated, or in which they had an ownership interest could easily be considered “affirmative evidence” of their “ability to comply” with standards, rules, and regulations.

181. See ALA. ADMIN. CODE r. 420-5-10.02(4)(c) (2023); ALASKA STAT. ANN. § 18.20.310(a)(5) (West 2023); CONN. AGENCIES REGS. § 19-13-D8t(b)(2)(B) (2023); D.C. Code Mun. Regs. tit. 22-B, § 3107.7 (LexisNexis 2023); HAW. CODE R. § 11-94.2-10(c) (LexisNexis 2023); IDAHO CODE § 39-1305 (2023); MD. CODE REGS. 10.07.02.04(A)(7)(a)(i) (2023); IND. CODE ANN. § 16-28-2-4 (West 2023); KY. REV. STAT. ANN. § 216B.105(2) (West 2023); LA. ADMIN. CODE tit. 48, pt. 1, § 9717(E) (2023); 10-144-110 ME. CODE R. § 3 (LexisNexis 2023); MICH. ADMIN. CODE r. 325.45113 (2023); MO. ANN. STAT. § 198.015 (West 2023); NEV. ADMIN. CODE § 449.0118 (2023); 10A N.C. ADMIN. CODE 13D.2106 (2023); N.J. ADMIN. CODE § 8:43E-5.3(f) (2023); N.Y. PUB. HEALTH LAW §§ 2801-a(3-b)(a)-(b) (McKinney 2023); OHIO ADMIN. CODE 3701.17.03(L) (2023); 216-40 R.I. CODE R. § 10-1.7 (LexisNexis 2023); S.D. CODIFIED LAWS § 34-12-19 (2023); TENN. COMP. R. & REGS. 0720-18-.02(5) (2023); UTAH ADMIN. CODE r. 432-2-13 (LexisNexis 2023); VT. STAT. ANN. tit. 33, § 7111(d) (2023); VA. CODE ANN. § 32.1-131 (2023); W. VA. CODE ANN. § 64-

the state to refuse to renew a license if the facility is generally not in compliance with health and safety or other regulations; however, they do not specify a time period for these violations.¹⁸² Some states appear not to consider past performance at all. The statutes governing license renewal in Ohio and Wyoming, for instance, do not list any license renewal requirements other than payment of a license renewal fee.¹⁸³

Of the states that explicitly consider a facility's past performance in license renewal determinations based on the applicable statutory and regulatory language,¹⁸⁴ fourteen require that the information is considered,¹⁸⁵ and two permit the consideration thereof.¹⁸⁶

13-3.4.4 (West 2023).

182. *See, e.g.*, N.D. ADMIN. CODE 33-07-03.2-03(2) (2023) (“The department shall issue a renewal license when a facility is in substantial compliance with the provisions of these licensing requirements, as determined by periodic unannounced onsite surveys conducted by the department and other information submitted by the facility upon the request of the department.”).

183. *See, e.g.*, OHIO REV. CODE ANN. § 3721.07 (West 2023) (“When the director issues a license, the license shall remain in effect until revoked by the director or voided at the request of the applicant; provided, there shall be an annual renewal fee payable during the month of January of each calendar year. Any licensed home that does not pay its renewal fee in January shall pay, beginning the first day of February, a late fee If either the renewal fee or the late fee is not paid by the fifteenth day of February, the director may ... revoke the home's license.”); WYO. STAT. ANN. § 35-2-904(c) (2023) (“Licenses are renewed annually upon payment of the license fee unless suspended or revoked.”).

184. ARIZ. REV. STAT. ANN. § 36-425(k) (2023); ARK. CODE ANN. § 20-10-229(a)-(c) (West 2023); CAL. HEALTH & SAFETY CODE § 1267(b) (West 2023); 6 COLO. CODE REGS. § 1011-1:2-2.11(A)(8) (LexisNexis 2023); DEL. CODE ANN. tit. 16, § 1105(a) (West 2023); FLA. STAT. ANN. § 408.815(1) (West 2023); GA. COMP. R. & REGS. 111-8-25-.05(2)(a) (2023); IDAHO ADMIN. CODE r. 16.03.02.050(05) (2023); 210 ILL. COMP. STAT. ANN. 45/3-110(a) (West 2023); IOWA CODE ANN. § 135C.10 (West 2023); KAN. STAT. ANN. § 39-931a(b) (2023); 902 KY. ADMIN. REGS. 20:008(2)(4) (2023); MD. CODE REGS. 10.07.02.06(B)(1)(c) (2023); 105 MASS. CODE REGS. 153.014 (2023); MINN. STAT. § 144A.11(2) (2023); 15-16 MISS. CODE R. § 45.8.1.2 (LexisNexis 2023); MONT. ADMIN. R. 37.106.310(3) (2023); N.D. ADMIN. CODE 33-07-03.2-03.1(3) (2023); N.H. CODE ADMIN. R. ANN. He-P 803.13(b) (2023); N.M. CODE R. § 7.9.2.18(E) (LexisNexis 2023); OKLA. STAT. ANN. tit. 63, § 1-826(3) (West 2023); OR. ADMIN. R. 411-089-0040(2)(b) (2023); 35 PA. STAT. AND CONS. STAT. § 448.811(3) (West 2023); S.C. CODE ANN. REGS. 61-17-402(e) (2023); 26 TEX. ADMIN. CODE § 554.214(a) (2023); WASH. REV. CODE ANN. § 18.51.054(5) (West 2023); WIS. STAT. ANN. § 50.03(4) (West 2023); 048-26 WYO. CODE R. § 19-5(b) (LexisNexis 2023). Note that these renewal determinations include both the decision to refuse to renew a license and the decision to limit the license in some way or shorten the duration of the licensure length.

185. *See* ARIZ. ADMIN. CODE § 9-10-111 (2023); ARK. CODE ANN. § 20-10-229(c) (West 2023); 6 COLO. CODE REGS. § 1011-1:2-2.5.1 (LexisNexis 2023); DEL. CODE ANN. tit. 16, § 1105(a) (West 2023); 210 ILL. COMP. STAT. ANN. 45/3-110(a) (West 2023); 902 KY. ADMIN. REGS. 20:008(2) (2023); MD. CODE REGS. 10.07.02.06(B)(1) (2023); MINN. STAT. § 144A.03(1)(b) (2023);

Only a few states require licensing agencies to deny renewal of a license based on performance-related factors.¹⁸⁷

Even if a state does not deny renewal for poor performance, such performance may still have consequences for licensure renewal. Some states condition the length for which a license is renewed on the facility's history of compliance¹⁸⁸ or only issue probationary or limited licenses to facilities with a history of non-compliance.¹⁸⁹

Where performance is considered, the main mechanism for identifying these repeat deficiencies and facility compliance is through the survey or inspection process discussed in Part III. Inspections are one of the main ways that states can ensure compliance with minimum standards that do not rely on self-reporting, and they are relied upon by both state agencies and CMS to determine compliance. Over half of states explicitly require an inspection of the facility before the initial licensure.¹⁹⁰ Other states

MONT. ADMIN. R. § 37.106.310(3) (2023); OKLA. STAT. ANN. tit. 63, § 1-1914.1(C) (West 2023); 28 PA. CODE § 201.13b(a)(2) (2023); S.C. CODE ANN. REGS. 61-17-402(e) (2023); TEX. HEALTH & SAFETY CODE ANN. § 242.032(e) (West 2023); 048-26 WYO. CODE R. § 19-5(b) (LexisNexis 2023).

186. See OR. ADMIN. R. 411-089-0040(2) (2023); WASH. ADMIN. CODE § 388-97-4220(2) (2023).

187. See 902 KY. ADMIN. REGS. 20:008(2)(4) (2023); MINN. STAT. ANN. § 144A.031(a) (West 2023); N.H. CODE ADMIN. R. ANN. He-P 803.13(b) (2023) (requiring denial of a renewal license).

188. See, e.g., ARIZ. REV. STAT. ANN. § 36-425.02(B) (2023); CAL. HEALTH & SAFETY CODE § 1265.3(a) (West 2023); MONT. ADMIN. R. 37.106.310(3) (2023); N.M. CODE R. § 7.9.2.18 (LexisNexis 2023).

189. See, e.g., IND. CODE ANN. § 16-28-3-3 (West 2023) (authorizing probationary licenses valid for three months, after which facilities must demonstrate full compliance with minimum standards).

190. See ALA. CODE § 22-21-29(b) (2023); ARIZ. REV. STAT. ANN. § 36-425(A) (2023); CONN. GEN. STAT. ANN. § 19a-493(a) (West 2023); D.C. CODE § 44-505(a) (2023); ILL. ADMIN. CODE tit. 77, § 300.140(a) (2023); IOWA CODE § 135C.9(1)(b) (2023); KAN. STAT. ANN. § 39-928 (2023); LA. STAT. ANN. § 40:2009.5 (2023); 10-144-110 ME. CODE R. § 2.E.8 (LexisNexis 2023); 105 MASS. CODE REGS. 153.010(A)(1) (2023); MICH. ADMIN. CODE r. 325.45111(1) (2023); 15-16 MISS. CODE R. § 45.3.1 (LexisNexis 2023); MONT. ADMIN. R. § 37.106.310(2) (2023); 175 NEB. ADMIN. CODE § 12-005.01 (2023); NEV. ADMIN. CODE § 449.0112 (2023); N.H. CODE ADMIN. R. ANN. He-P 803.09(b)(1) (2023); N.J. ADMIN. CODE § 8:43E-5.3(a) (2023); N.M. STAT. ANN. § 24-1-5(C) (2023); N.D. ADMIN. CODE § 33-07-03.2-03(1)(a)(2) (2023); OHIO ADMIN. CODE 3721.07(B)(2)(a) (2023); OR. ADMIN. R. § 411-085-0010(4)(p) (2023); 23 R.I. GEN. LAWS § 23-17-12(c) (2023); S.C. CODE ANN. REGS. 61-17-302(A) (2023); S.D. CODIFIED LAWS § 34-12-7 (2023); TENN. COMP. R. & REGS. 1200-08-06-.02(2)(e) (2023); TEX. HEALTH & SAFETY CODE ANN. § 242.033(a) (West 2023); VT. STAT. ANN. tit. 33, § 7108(a) (2023); VA. CODE ANN. § 32.1-126(A) (2023); W. VA. CODE ANN. § 16-5C-9(1) (West 2023).

require inspections, or authorize inspections, but do not explicitly require them prior to initial licensure.¹⁹¹ Currently, ten states and the District of Columbia require inspections upon renewal of licensure.¹⁹²

While not all states explicitly require the review of a facility's track record for renewal, most appear to have the authority to do so.¹⁹³ Additionally, rather than not renew a license, agencies could—consistent with existing authority in some states¹⁹⁴—also consider issuing probationary licenses or premising a license renewal on satisfactory future inspections.

3. Facility's Performance in Suspension and Revocation Determinations

One safeguard against particularly bad care in nursing homes is states' ability to revoke or suspend a license where unsafe conditions exist—outside of the routine renewal process. In most states, the standards for revocation and suspension are identical.¹⁹⁵ However, as a general matter, revocation is a final determination after protracted consideration, whereas suspension is seen as an emergency measure when there is a more immediate threat to the life, health, and safety of residents.¹⁹⁶

191. *See, e.g.*, ALASKA ADMIN. CODE tit. 7, § 10.9600 (2023); DEL. CODE ANN. tit. 16, § 1107(a) (West 2023); HAW. CODE R. § 11-94.2-6(d) (LexisNexis 2023); MO. ANN. STAT. § 198.525(1) (West 2023); N.Y. PUB. HEALTH LAW § 2803(1)(b) (McKinney 2023); 35 PA. STAT. AND CONS. STAT. § 448.806d (West 2023); WASH. ADMIN. CODE § 388-97-4360(1) (2023); WYO. STAT. ANN. § 35-2-907(a) (2023).

192. *See* CONN. GEN. STAT. ANN. § 19a-493(b) (West 2023); D.C. Mun. Regs. tit. 22-B, § 3104.1 (2023); FLA. STAT. ANN. § 408.811 (West 2023); ILL. ADMIN. CODE tit. 77, § 300.140(a)-(c) (2023); 10-144-110 ME. CODE R. § 2.E.8 (LexisNexis 2023); 105 MASS. CODE REGS. 153.010(A)(1) (2023); MONT. ADMIN. R. § 37.106.310(2) (2023); N.H. CODE ADMIN. R. ANN. He-P 803.06 (2023); OKLA. STAT. ANN. tit. 63, § 1-822(A) (West 2023); 216-40 R.I. CODE R. § 10-1.7(A) (LexisNexis 2023); TEX. HEALTH & SAFETY CODE ANN. § 242.033(d)(1) (West 2023).

193. *See, e.g.*, D.C. MUN. REGS. tit. 22-B, § 3107.7 (2023).

194. *See, e.g.*, 10A N.C. ADMIN. CODE 13D.2106 (2023); 10-144-110 ME. CODE R. § 3(D) (LexisNexis 2023); KAN. STAT. ANN. § 39-929 (2023).

195. Over thirty jurisdictions have statutes or regulations that provide the same grounds for suspension and revocation, making it unclear when a facility would be subject to a license suspension versus a license revocation.

196. Various statutes allow for suspensions in emergency situations or where there are immediate threats to health and safety. *See, e.g.*, FLA. STAT. ANN. § 408.814 (West 2023); MD. CODE REGS. 10.07.02.57, .76-.77 (2023); OR. ADMIN. R. 411-089-0040(7) (2023).

Few states require suspension based on the presence of certain indicators of past performance,¹⁹⁷ and the same is true for revocation.¹⁹⁸ In addition, fewer than half of states have statutes or regulations that explicitly lay out how past performance affects license suspension¹⁹⁹ or revocation.²⁰⁰ And these states vary on whether review of past compliance is limited to a certain timeframe.²⁰¹

197. See, e.g., MINN. STAT. § 144A.031 (2023) (requiring suspension based on certain past performance indicators).

198. See, for example, Texas' statute that requires revocation if the department finds that, among other conditions, "the license holder has committed three [particular] violations ... within a 24-month period, that constitute an immediate threat to health and safety related to the abuse or neglect of a resident" and may suspend or revoke a license if the department finds that the license holder has "violated this chapter or a rule, standard, or order adopted or license issued under this chapter in either a repeated or substantial manner." TEX. HEALTH & SAFETY CODE ANN. § 242.061 (West 2023); see also WASH. ADMIN. CODE § 388-97-4220 (2023) (providing conditions under which the licensing agency may revoke or suspend a license and others under which the licensing agency shall revoke or suspend a license).

199. The following states explicitly consider a facility's past performance in license suspension determinations. See CAL. HEALTH & SAFETY CODE § 1424 (West 2023); 6 COLO. CODE REGS. § 1011-1:2-2.12.8 (LexisNexis 2023); 210 ILL. COMP. STAT. ANN. 45/3-119(a)(6) (West 2023); IOWA CODE § 135C.10 (2023); KAN. STAT. ANN. § 39-931a(b)(1) (2023); 15-16 MISS. CODE R. § 1-45.8.1(2) (LexisNexis 2023); MINN. STAT. § 144A.11(2) (2023); NEB. REV. STAT. § 71-450(1)(c) (2023); NEV. ADMIN. CODE § 449.99866 (2023); N.M. CODE R. § 7.9.2.18(E) (LexisNexis 2023); OKLA. STAT. ANN. tit. 63, § 1-826(3) (West 2023); 35 PA. STAT. AND CONS. STAT. § 448.811(3) (West 2023); S.C. CODE ANN. § 44-7-320(A)(2) (2023); TENN. CODE ANN. § 68-11-207(c)(4) (2023); TEX. HEALTH & SAFETY CODE ANN. § 242.061(a-1)-(a-2) (West 2023); WASH. ADMIN. CODE § 388-97-4220(1)(b), (2) (2023); W. VA. CODE R. § 64-13-15.2 (2023); WIS. STAT. ANN. § 50.03(5) (2023).

200. See ARK. CODE ANN. § 20-10-206 (West 2023); CAL. HEALTH & SAFETY CODE § 1424(c) (West 2023); 6 COLO. CODE REGS. § 1011-1:2-2.12.8 (LexisNexis 2023); FLA. STAT. ANN. § 408.815(1)(d) (West 2023); 210 ILL. COMP. STAT. ANN. 45/3-119(a)(6) (West 2023); IND. CODE ANN. § 16-28-5-4 (West 2023); IOWA CODE § 135C.10 (2023); KAN. STAT. ANN. § 39-931a(b)(1) (2023); MD. CODE ANN., HEALTH-GEN. § 19-1401.1-2 (West 2023); 105 MASS. CODE REGS. 153.014(E) (2023); 15-16 MISS. CODE R. § 1-45.8.1(2) (LexisNexis 2023); MINN. STAT. § 144A.11(2) (2023); MONT. CODE ANN. § 50-5-207 (2023); NEB. REV. STAT. § 71-450(1)(c) (2023); NEV. ADMIN. CODE § 449.99866 (2023); N.M. CODE R. § 7.9.2.18(E) (LexisNexis 2023); N.H. CODE ADMIN. R. ANN. He-P 803.13(b)(7) (2023); N.J. ADMIN. CODE § 8:43E-3.9(a)(2) (2023); N.Y. PUB. HEALTH LAW § 2806-b (McKinney 2023); 10AN.C. ADMIN. CODE 13D.2106(e) (2023); OHIO REV. CODE ANN. § 3721.03(B)(5) (West 2023); OKLA. STAT. ANN. tit. 63, § 1-826(3) (West 2023); OR. ADMIN. R. § 411-089-0040(2)(b) (2023); 35 PA. STAT. AND CONS. STAT. § 448.811(3) (West 2023); S.C. CODE ANN. § 44-7-320(A)(2) (2023); TENN. CODE ANN. § 68-11-207(c)(4) (2023); TEX. HEALTH & SAFETY CODE ANN. § 242.061(a-1)-(a-2) (West 2023); UTAH ADMIN. CODE r. R432-3-6, R432-3-7 (LexisNexis 2023); WASH. ADMIN. CODE § 388-97-4220(1)(b), (2) (2023); W. VA. CODE R. § 64-13-15.2 (2023) (explicitly considering facility's past performance in revocation determinations).

201. See, e.g., TENN. CODE ANN. § 68-11-207(f) (2023).

However, most states' statutes and regulations are drafted broadly enough to allow a facility's license to be revoked or suspended based on poor performance.²⁰² For instance, in South Dakota, a license may be revoked for conduct or practices detrimental to the health or safety of residents and employees of any such institutions.²⁰³ This language does not explicitly address a facility's compliance history, but it is broad enough to encompass it. Likewise, some states provide that a license shall or may be revoked if the facility has substantially failed to comply with applicable regulations, although they typically fail to define "substantial failure to comply."²⁰⁴

C. Frequency of Licensure Actions

States rarely deny, suspend, or revoke a nursing home's license. To determine the frequency of such actions, we contacted licensing agencies in all fifty states and the District of Columbia to ask if their state had denied or revoked any nursing home licenses in the past ten years.²⁰⁵ Representatives from twenty-four states responded with the information requested. Eighteen indicated that their state had no license denials in the past ten years.²⁰⁶ Two more

202. See ALASKA STAT. § 18.20.310 (2023); ALA. ADMIN. CODE r. 420-5-10.02(4)(d) (2023); ARIZ. REV. STAT. ANN. § 36-427 (2023); CONN. GEN. STAT. ANN. § 19a-494(a) (West 2023); DEL. CODE ANN. tit. 16, § 1113(4) (West 2023); D.C. Mun. Regs. tit. 22-B, § 3107.7 (2023); GA. CODE ANN. § 31-2-8(b)-(c) (2023); HAW. CODE R. § 11-94.2-69(a) (LexisNexis 2023); IDAHO ADMIN. CODE r. 16.03.02.050(.04)-(.05) (2023); IND. CODE ANN. § 16-28-2-4 (West 2023); KY. REV. STAT. ANN. § 216B.105(2) (West 2023); LA. ADMIN. CODE tit. 48, pt. 1, § 9717(e) (2023); 10-144-110 ME. CODE R. § 3(e) (LexisNexis 2023); N.C. GEN. STAT. § 131E-103(a) (2023); MD. CODE REGS. 10.07.02.57.76.77 (2023); Mich. Comp. Laws Ann. § 333.20165 (West 2023); MONT. CODE ANN. § 50-5-207(1) (2023); MO. ANN. STAT. § 198.036(1) (West 2023); NEV. REV. STAT. ANN. § 449.160 (West 2023); N.D. CENT. CODE ANN. § 23-16-06 (West 2023); 216-40 R.I. CODE R. § 10-1.11(A) (LexisNexis 2023); S.D. CODIFIED LAWS § 34-12-19 (2023); UTAH CODE ANN. § 26B-2-208(1) (West 2023); VT. STAT. ANN. tit. 33, § 7111(d) (2023); 12 VA. ADMIN. CODE § 5-371-90(B)-(C) (2023); W. Va. Code Ann. § 16-5C-12 (West 2023); WIS. STAT. ANN. § 50.03(5) (West 2023); WYO. STAT. ANN. § 35-2-905(a) (2023).

203. S.D. CODIFIED LAWS § 34-12-19 (2023).

204. See, e.g., KY. REV. STAT. ANN. § 216B.105(2) (West 2023); WIS. STAT. ANN. § 50.03(5) (West 2023).

205. Requests were made by e-mail or phone by one of the authors, who identified herself as a research assistant with Yale Law School's Solomon Center for Health Law & Policy. Agencies were asked whether the state had denied or revoked any nursing home licenses in the past ten years.

206. E-mail from Alaska Department of Health, Division of Health Care Services to author

reported that they had no denials in the past three²⁰⁷ and six years,²⁰⁸ which is the length of time for which they retain records.²⁰⁹ In addition, representatives from fourteen states reported that they had not revoked any licenses in the past ten years,²¹⁰ and an

(Apr. 22, 2022, 9:16 AM); E-mail from California Department of Public Health to author (Oct. 31, 2022, 1:37 PM); E-mail from Colorado Department of Public Health and Environment to author (Sept. 21, 2022, 9:01 AM); E-mail from Delaware Department of Health and Social Services, Office of the Secretary to author (Nov. 16, 2022, 10:41 AM); E-mail from Idaho Department of Health and Welfare, Bureau of Facility Standards to author (Sept. 19, 2022, 6:50 PM); E-mail from Hawaii Department of Health to author (Nov. 3, 2022, 12:19 PM); E-mail from North Dakota Department of Health & Human Services to author (Sept. 22, 2022, 10:13 AM); E-mail from Rhode Island Department of Health, Center for Health Facilities Regulation (Apr. 25, 2022, 11:00 AM); E-mail from Nebraska Department of Health and Human Services, Division of Public and Behavioral Health, Bureau of Health Care Quality and Compliance to author (May 5, 2022, 3:37 PM); E-mail from Maryland Department of Health Services, Bureau of Long Term Care Licensing to author (Apr. 27, 2022, 5:45 PM); E-mail from Maine Department of Health and Human Services, Division of Licensing and Certification to author (Nov. 8, 2022, 3:27 PM); E-mail from New Hampshire Department of Health & Human Services, Office of Legal and Regulatory Services to author (Apr. 29, 2022, 2:10 PM); E-mail from New York State Department of Health, Records Access Office to author (July 25, 2023, 4:27 PM); E-mail from Vermont Department of Health, Division of Licensing and Protection to author (Apr. 25, 2022, 10:47 AM); E-mail from Utah Department of Health & Human Services, Bureau of Licensing and Certification to author (Apr. 25, 2022, 11:48 AM); E-mail from Wisconsin Department of Health Services, Division of Quality Assurance Records to author (Apr. 28, 2022, 10:42 AM); E-mail from Virginia Department of Health, Office of Licensure and Certification to author (May 1, 2022, 12:39 PM); E-mail from West Virginia Department of Health & Human Resources, Office of Health Facility Licensure & Certification to author (Sept. 20, 2022, 2:54 PM). Only Texas reported having denied a license in the past ten years. E-mail from Texas Department of Health & Human Services, Long Term Care Records Management Unit to author (May 5, 2022, 5:47 PM). All of these e-mails are on file with the authors.

207. E-mail from Arizona Department of Health Services, Bureau of Long Term Care Licensing to author (Apr. 27, 2022, 5:45 PM) (on file with authors).

208. E-mail from Nevada Department of Health and Human Services, Division of Public and Behavioral Health, Bureau of Health Care Quality and Compliance to author (Sept. 21, 2022, 3:22 PM) (on file with authors).

209. Some responders indicated that official records were not kept and therefore information provided was based on the responder's personal knowledge.

210. E-mail from Alaska Department of Health, Division of Health Care Services to author (Apr. 22, 2022, 9:16 AM); E-mail from Delaware Department Health and Social Services, Office of the Secretary to author (Nov. 16, 2022, 10:41 AM); E-mail from Idaho Department of Health and Welfare, Bureau of Facility Standards to author (Sept. 19, 2022, 6:50 PM); E-mail from Hawaii Department of Health to author (Nov. 3, 2022, 12:19 PM); E-mail from North Dakota Department of Health & Human Services to author (Sept. 22, 2022, 10:13 AM); E-mail from Rhode Island Department of Health, Center for Health Facilities Regulation to author (Apr. 25, 2022, 11:00 AM); E-mail from Maryland Department of Health Services, Bureau of Long Term Care Licensing to author (Apr. 27, 2022, 5:45 PM); E-mail from Maine Department of Health and Human Services, Division of Licensing and Certification to author

additional two reported not having revoked a license in the past three²¹¹ or six years.²¹²

Moreover, even those representatives that reported that their state had denied or revoked a license to a nursing home provider in the past ten years indicated that such denials and revocations were exceptionally rare. A representative of Colorado's licensing agency indicated that it had revoked just one license in the past ten years.²¹³ A representative of Indiana's licensing agency represented that license revocation proceedings were initiated five times in the same time frame; however, some of those facilities closed voluntarily.²¹⁴ The Indiana representative also reported only eleven instances where probationary actions were taken and only one instance in which a license was denied.²¹⁵ Nebraska's representative also reported just one licensure revocation in the past ten years and

(Nov. 8, 2022, 3:27 PM); E-mail from New Hampshire Department of Health & Human Services, Office of Legal and Regulatory Services to author (Apr. 29, 2022, 2:10 PM); E-mail from New York State Department of Health, Records Access Office to author (July 25, 2023, 4:27 PM); E-mail from Vermont Department of Health, Division of Licensing and Protection to author (Apr. 25, 2022, 10:47 AM); E-mail from Utah Department of Health & Human Services, Bureau of Licensing and Certification to author (Apr. 25, 2022, 11:48 AM); E-mail from Wisconsin Department of Health Services, Division of Quality Assurance Records to author (Apr. 28, 2022, 10:42 AM); E-mail from Virginia Department of Health, Office of Licensure and Certification to author (May 1, 2022, 12:39 PM); E-mail from West Virginia Department of Health & Human Resources, Office of Health Facility Licensure & Certification to author (Sept. 20, 2022, 2:54 PM). Only Vermont, Texas, Nebraska, Colorado, and California reported having revoked a license during the requested time period. E-mail from Colorado Department of Public Health and Environment to author (Sept. 21, 2022, 9:01 AM); E-mail from California Department of Public Health to author (Oct. 31, 2022, 1:37 PM); E-mail from Nebraska Department of Health and Human Services, Division of Public and Behavioral Health, Bureau of Health Care Quality and Compliance to author (May 5, 2022, 3:37 PM); E-mail from Texas Department of Health & Human Services, Long Term Care Records Management Unit to author (May 5, 2022, 5:47 PM); E-mail from Vermont Department of Health, Division of Licensing and Protection to author (Apr. 25, 2022, 10:47 AM). All of these e-mails are on file with the authors.

211. E-mail from Arizona Department of Health Services, Bureau of Long Term Care Licensing to author (Apr. 27, 2022, 5:45 PM) (on file with authors).

212. E-mail from Nevada Department of Health and Human Services, Division of Public and Behavioral Health, Bureau of Health Care Quality and Compliance to author (Sept. 21, 2022, 3:22 PM) (on file with authors).

213. E-mail from Colorado Department of Public Health and Environment to author (Sept. 21, 2022, 9:01 AM) (on file with authors).

214. E-mail from Indiana Department of Health, Office of Legal Affairs to author (May 12, 2022, 9:22 AM) (on file with authors).

215. *Id.*

zero denials during that time.²¹⁶ Texas' representative reported that the state had denied one license in 2016 and revoked one license in 2019.²¹⁷

Our findings are consistent with an earlier study from 2010, which found that involuntary terminations from the Medicare and Medicaid programs were extraordinarily rare.²¹⁸ The study found that voluntary terminations were more common, but still quite rare, with the result that many states reported no involuntary or voluntary terminations in a given year.²¹⁹

There are several possible explanations for the lack of licensure revocations or suspensions. At first glance, one might see this as a sign of success, indicating that facilities are complying with regulations and are not providing substandard care. However, given the substantial quality-of-care problems discussed in Part II, this is likely not the case. Utah offers a demonstrative example. A representative from the Utah Department of Health and Human Services reported that the state had not revoked the licenses of any facilities in the past ten years because the federal regulatory process ensures compliance.²²⁰ But according to a ProPublica analysis of CMS data, eighty-four of the ninety-eight homes in Utah have infection-related deficiencies, thirteen have serious deficiencies, six have had payments suspended, and together they have been required to pay \$2.41 million dollars in penalties.²²¹ Additionally,

216. E-mail from Nebraska Department of Health and Human Services, Division of Public and Behavioral Health, Bureau of Health Care Quality and Compliance to author (May 5, 2022, 3:37 PM) (on file with authors).

217. E-mail from Texas Department of Health & Human Services, Long Term Care Records Management Unit to author (May 5, 2022, 5:47 PM) (on file with authors).

218. Yue Li, Charlene Harrington, William D. Spector & Dana A. Mukamel, *State Regulatory Enforcement and Nursing Home Termination from the Medicare and Medicaid Programs*, 45 HEALTH SERVS. RSCH. 1796, 1809 (2010); see also NAT'L ACADS. OF SCIS., ENG'G, & MED., *supra* note 66, at 416 (depicting the paucity of voluntary and involuntary terminations from the Medicaid and Medicare programs).

219. Li et. al. *supra* note 218.

220. E-mail from Utah Department of Health & Human Services, Bureau of Licensing and Certification to author (Apr. 25, 2022, 11:48 AM) (on file with authors) ("Through the federal regulatory processes, nursing facilities in Utah have come into compliance and have not reached the point of having a license revoked or denied by the state.").

221. *Nursing Home Inspect: Utah*, PROPUBLICA (Nov. 27, 2022), <https://projects.propublica.org/nursing-homes/state/UT> [<https://perma.cc/Z87M-FFVW>] (last updated Feb. 2023).

Utah has one Special Focus Facility and five additional facilities that meet the Special Focus Facility requirements.²²²

Given this, a more plausible explanation is that states are reluctant to revoke or suspend a license. Some states indicated in their responses that they rely on CMS to suspend, revoke, or otherwise take disciplinary action against nursing homes.²²³ State representatives we contacted often described their own disciplinary authority as a backstop to the existing federal regulations. In some states, revocations may also be difficult to initiate. Maine requires a court order to initiate revocation proceedings,²²⁴ and there may be a presumption against suspending or revoking a license.²²⁵

Another factor may be that the worst facilities voluntarily choose to surrender their licenses rather than subject themselves to a

222. *Id.*

223. For example, Connecticut's representative explained:

It is very rare that a nursing home's license will actually be revoked. In the normal course of our work as a regulatory body, when the situation demands (*i.e.*, when our agency finds multiple serious violations of the General Statutes or Public Health Code by a licensed entity), licensees almost always voluntarily surrender their license. Our agency works in conjunction with and as a representative of [CMS,] ... the federal agency that administers the Medicare/Medicaid Program and is responsible for the federal certification of nursing homes, hospitals, end-stage renal disease facilities, and other provider types. We can recommend to CMS that a nursing home's provider agreement be terminated. Such a recommendation would follow the conclusion of a survey where egregious deficiencies in the care and services rendered by the nursing home are identified. Again, this is a remedy that is very rarely executed.

E-mail from Connecticut Department of Public Health, Facility Licensing & Investigations Section to author (Apr. 26, 2022, 10:54 AM) (on file with authors). Similarly, Idaho's representative reported:

While states provide licensure to nursing homes, it is a small part of determination on whether they can operate.... The bulk of these regulations are federal which CMS oversees. In Idaho, we have very few state[-]based rules as it defers to the more stringent regulations at the federal level. State employees are contracted to carry forth this survey work. It is rare for a nursing home to be closed down for non-compliance. When they are, the final decision is made by CMS (federal level). I do not know of any cases in Idaho where a facility was unable to obtain their initial license.

E-mail from Idaho Department of Health and Welfare, Bureau of Facility Standards to author (Sept. 19, 2022, 6:50 PM) (on file with authors).

224. 10-144-110 ME. CODE R. § 3 (LexisNexis 2023).

225. *See, e.g.*, MICH. COMP. LAWS ANN. § 333.21799(b)(5) (West 2023) (stating "the department shall make its decisions concerning the nursing home's future operation based on a presumption in favor of keeping the nursing home open.").

state enforcement action.²²⁶ Given the paucity of voluntary surrenders and the extent of quality-of-care problems, this explanation is likely at best incomplete.

Another factor may be that many states do not condition licensure renewal on satisfactory inspection results, but rather allow facilities to bypass such processes through deemed compliance.²²⁷ “Deemed compliance” provisions vary based on the state, but generally exempt nursing homes from certain inspections or other compliance measures if they are accredited by a recognized body. The largest of these bodies is the Joint Commission, a non-profit organization based in the United States that “accredits and certifies more than 22,000 health care organizations and programs in the United States.”²²⁸ The process includes an “on-site survey”²²⁹ using

226. “In the normal course of our work as a regulatory body, when the situation demands (*i.e.*, when our agency finds multiple serious violations of the General Statutes or Public Health Code by a licensed entity), licensees almost always voluntarily surrender their license.” E-mail from Connecticut Department of Public Health, Facility Licensing & Investigations Section to author (Apr. 26, 2022, 10:54 AM) (on file with authors).

227. COLO. REV. STAT. § 25-3-102.1 (2023); W. VA. CODE § 16-5C-9a (2023); HAW. REV. STAT. § 321-571(c) (2023); N.M. STAT. ANN. § 24-1-5(F) (2023); D.C. Mun. Regs. tit. 22-B, § 3104.2 (2023); 175 NEB. ADMIN. CODE § 12-004.09A (2023); MONT. ADMIN. R. 37.106.310 (2023); 35 PA. STAT. AND CONS. STAT. § 448.810(c) (West 2023); TENN. CODE ANN. § 68-11-210(c)(5) (2023); UTAH ADMIN. CODE r. 432-3-3 (LexisNexis 2023); TEX. HEALTH & SAFETY CODE ANN. § 242.047 (West 2023); WYO. STAT. ANN. § 35-2-907 (2023). These states allow for nursing homes to be “deemed compliant” if they have received recognition by an “accredited agency.” States vary in which accrediting bodies they recognize for this purpose. For example, in Pennsylvania, reports by the federal government or national accreditation organizations may be used in lieu of the state agency’s investigation to determine facility compliance. 35 PA. STAT. AND CONS. STAT. § 448.810(c) (West 2023). West Virginia also exempts nursing homes from license inspections if a nursing home receives accreditation “by an accrediting body approved by the secretary and submits a complete copy of the accreditation report.” W. VA. CODE § 16-5C-9a (2023). However, “the secretary may not grant more than one exemption in any two-year period,” and if “a complaint is substantiated, the secretary has the authority to immediately remove the exemption.” *Id.* New Mexico requires a facility’s license to be renewed if it is accredited by a national accrediting organization approved by CMS. N.M. STAT. ANN. § 24-1-5(F) (2023) (“A health facility that has been inspected and licensed by the department, that has received certification for participation in federal reimbursement programs and that has been fully accredited by a national accrediting organization approved by [CMS] or the department shall be granted a license renewal based on that accreditation.”).

228. *Joint Commission FAQs*, JOINT COMM’N, <https://www.jointcommission.org/about-us/facts-about-the-joint-commission/joint-commission-faqs/> [https://perma.cc/J4LW-KMPZ].

229. *Great Achievements Come One Step at a Time*, JOINT COMM’N, <https://www.jointcommission.org/-/media/tjc/documents/accred-and-cert/ncc/ncc-steps-to-accreditation.pdf> [https://perma.cc/9K6B-GSFD].

standards developed by experts that can be “accurately and readily measured.”²³⁰

Notably, while some accrediting organizations relied upon by states are certified by CMS and can simultaneously certify a facility for CMS and grant accreditation for the purpose of “deemed compliance” at the state level,²³¹ some states treat accreditation by bodies not certified by CMS as sufficient for deemed compliance.²³² This is cause for concern because there is a lack of evidence that accreditation is associated with quality improvement,²³³ and a 1998 report found that private accreditation procedures tended to miss serious deficiencies and were less transparent than the typical survey process.²³⁴

D. Using Licensure Determinations to Drive Quality

Nursing home licensure regimes could be used to encourage higher quality care by preventing bad actors from operating facilities. In this Section, we suggest two ways licensure schemes could, with

230. *About Our Standards*, JOINT COMM’N, <https://www.jointcommission.org/standards/about-our-standards/> [<https://perma.cc/FZE7-UX8L>] (describing the standards as “developed with input from health care professionals, providers, subject matter experts, consumers, and government agencies (including [CMS])” and noting that “[n]ew standards are added only if they relate to patient safety or quality of care, have a positive impact on health outcomes, meet or surpass law and regulation, and can be accurately and readily measured”).

231. *CMS-Approved Accrediting Organizations*, CMS (July 22, 2022), <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Accrediting-Organization-Contacts-for-Prospective-Clients-.pdf> [<https://perma.cc/4RW2-78KV>].

232. 175 NEB. ADMIN. CODE § 14-004.09A (2023).

233. Christopher James, *NYUCN’s Dr. Laura Wagner: Study Finds Accreditation Improves Safety Culture at Nursing Homes*, N.Y.U. (Apr. 25, 2012), <https://www.nyu.edu/about/news-publications/news/2012/april/nyucns-dr-laura-wagner-study-finds-accreditation-improves-safety-culture-at-nursing-homes.html> [<https://perma.cc/7563-9252>]. *But see* Beth A. Longo, Stacey C. Barrett, Stephen P. Schmaltz & Scott C. Williams, *A Multistate Comparison Study of COVID-19 Cases Among Accredited and Nonaccredited Nursing Homes*, 23 POL’Y, POL., & NURSINGPRAC. 26, 28, 30 (2022) (finding no differences between accredited and non-accredited nursing homes with respect to the number of COVID-19 cases). *See generally* HEALTH CARE FIN. ADMIN., REPORT TO CONGRESS: STUDY OF PRIVATE ACCREDITATION (DEEMING) OF NURSING HOMES, REGULATORY INCENTIVES AND NON-REGULATORY INITIATIVES, AND EFFECTIVENESS OF THE SURVEY AND CERTIFICATION SYSTEM (1998); Laura M. Wagner, Shawna M. McDonald & Nicholas G. Castle, *Impact of Voluntary Accreditation on Deficiency Citations in U.S. Nursing Homes*, 52 GERONTOLOGIST 561, 562, 567 (2012).

234. *See* HEALTH CARE FIN. ADMIN., *supra* note 233, at iii.

few additional resources, fulfill this objective. Specifically, we recommend that states create a rebuttable presumption of denial for applicants who have previously had licenses revoked, suspended, voluntarily surrendered, or put into receivership, as well as for those who have lost Medicare or Medicaid certification or been designated as a Special Focus Facility. Applicants who fall into this category would be presumptively barred and could only overcome that presumption upon an affirmative showing that they are qualified to operate a nursing home responsibly and safely.²³⁵ Second, we recommend that states require consideration of a facility's performance in licensure determinations, including renewal and revocation decisions.²³⁶

1. Consider Related Facilities' Performance

When considering an application for initial licensure or licensure renewal, licensing bodies should consider the performance of other facilities owned or operated by the applicant.²³⁷ This inquiry should not be limited to homes located in the same state as it is common for owners and operators to purchase and operate homes in multiple jurisdictions. Most state licensing schemes require that applicants

235. Georgia's regulation offers an example of how this could be effectuated. Georgia prohibits "a person who was previously involved in the management or control of any facility which has had its license revoked or application denied within the past twelve (12) months to be involved in the management or control of" a licensed facility unless they "acted diligently and in good faith to ensure correction of violations in a facility" and only "became involved in the management or control of the facility after the facility was notified by the department of violations of licensing requirements giving rise to [a revocation or] denial action." GA. COMP. R. & REGS. 111-8-25-.05 (2023).

236. We recognize that there are additional ways state licensure programs could be more impactful. States might, for example, try to impact quality by increasing the frequency with which licenses must be renewed, at least for the poorest performing facilities. Similarly, states might expand the impact of their licensure programs by improving inspection practices. We have focused on these two changes in particular because they are likely to have the most substantial benefits compared to cost and can be achieved largely without new authority.

237. For example, Kansas requires

[A] list of each current or previously licensed facility in Kansas or any other state, territory or country or the District of Columbia in which the applicant has or previously had any percentage of ownership in the operations or the real property of the facility; and affirmative evidence of the applicant's ability to comply with such reasonable standards and rules and regulations as are adopted under the provisions of this act.

KAN. STAT. ANN. § 39-927(a)(2)-(3) (2023).

be of good character and capable of running the facility for which they are applying for licensure. The performance of other homes owned and operated by the applicant is indicative of the ability of an applicant to successfully operate a nursing home. Additionally, consideration of the past performance of other facilities would incentivize owners and operators to provide quality care at all their facilities.

Implementing this recommendation would require state health departments or licensing agencies to determine which standards they would be willing to accept, and which metrics they would use for these evaluations. In considering past performance, states should examine survey reports from all homes owned or operated by the applicant. It would be insufficient to consider only licensure revocation or suspensions as these penalties are used so infrequently that they would not weed out most applicants with highly concerning compliance histories.

Implementing this approach would require an upfront investment in developing new guidance for licensure agencies (and, in some states, new regulations). Most significantly, states would need to determine which types of past behavior would create a presumption of licensure denial and what evidence could be used to overcome that presumption.

To reduce the information-gathering burden on state agencies, states should also require applicants to disclose the names of all facilities that they operate or in which they have a more than de minimis ownership share, as well as to provide compliance surveys from those facilities. This is important because ownership structures of nursing homes are increasingly complex,²³⁸ fueled in part by the growing role of private equity in the market.²³⁹ The result is that understanding who has an ownership interest in a nursing home can be extremely challenging.²⁴⁰ Fortunately, the challenge

238. See Charlene Harrington, Frode F. Jacobsen, Justin Panos, Allyson Pollock, Shailen Sutaria & Marta Szebehely, *Marketization in Long-Term Care: A Cross-Country Comparison of Large For-Profit Nursing Home Chains*, 10 HEALTH SERVS. INSIGHTS 1, 19-20 (2017).

239. See *supra* notes 56-58 and accompanying text.

240. Charlene Harrington, Leslie Ross & Taewoon Kang, *Hidden Owners, Hidden Profits, and Poor Nursing Home Care: A Case Study*, 45 INT'L J. HEALTH SERVS. 779, 780, 793-94 (2015); see also U.S. GOV'T. ACCOUNTABILITY OFF., *NURSING HOMES: CMS SHOULD MAKE OWNERSHIP INFORMATION MORE TRANSPARENT FOR CONSUMERS* (2023) (describing how

may lessen somewhat if CMS adopts newly proposed regulations requiring increased disclosure of ownership interests in nursing homes.²⁴¹ Even if it fails to adopt robust transparency regulations, however, CMS could facilitate states' ability to access relevant ownership information. Currently, CMS releases notices when facilities are added to the Special Focus Facility list or become SFF candidates²⁴² and when providers are terminated.²⁴³ By including ownership information in these notices, which CMS already releases for active facilities,²⁴⁴ CMS could streamline the process by which states review applicants' ownership of other facilities.

A recent Vermont case highlights the value in states considering performance of related homes. In that case, applicants for a nursing home license in Vermont came under scrutiny by the state licensing board because of their involvement with prior low-performing nursing homes in other states²⁴⁵ and refused to provide financial disclosures related to those facilities.²⁴⁶ Due to the scrutiny, the applicants eventually withdrew their license prior to the licensing

ownership information is not sufficiently transparent to consumers); U.S. DEP'T OF HEALTH & HUM. SERVS., OFF. OF HEALTH POL'Y, CHANGES OF OWNERSHIP OF HOSPITAL AND SKILLED NURSING FACILITIES: AN ANALYSIS OF NEWLY-RELEASED CMS DATA 7 (2022) (noting that CMS cannot verify self-reported ownership information); Charles Duhigg, *At Many Homes, More Profit and Less Nursing*, N.Y. TIMES (Sept. 23, 2007), <https://nytimes.com/2007/09/23/business/23nursing.html> [<https://perma.cc/GYM8-725G>] (describing how complex ownership prevents regulators identifying related parties and transactions and hinders penalty collection).

241. See Ctrs. for Medicare & Medicaid Servs., *Proposed Rule: Medicare and Medicaid Programs; Disclosures of Ownership and Additional Disclosable Parties Information for Skilled Nursing Facilities & Nursing Facilities* (Feb. 15, 2023), <https://www.federalregister.gov/documents/2023/02/15/2023-02993/medicare-and-medicaid-programs-disclosures-of-ownership-and-additional-disclosable-parties> [<https://perma.cc/W7JW-3YJY>].

242. See, e.g., *Special Focus Facility (SFF) Program*, CMS (Feb. 2023), <https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcompliance/downloads/sfflist.pdf> [<https://perma.cc/KT5A-VQYS>].

243. CTRS. FOR MEDICARE & MEDICAID SERVS., *Termination Notices*, <https://www.cms.gov/medicare/provider-enrollment-and-certification/surveycertificationgeninfo/termination-notices> [<https://perma.cc/V4YS-GFMH>].

244. CTRS. FOR MEDICARE & MEDICAID SERVS., *Ownership*, <https://data.cms.gov/provider-data/dataset/y2hd-n93e> [<https://perma.cc/BY4E-J4ZA>].

245. Derek Brouwer, *State Scrutinizes Investors' Bid to Take Over Five Vermont Nursing Homes*, SEVEN DAYS (Dec. 8, 2021, 10:00 AM), <https://www.sevendaysvt.com/vermont/state-scrutinizes-investors-bid-to-take-over-five-vermont-nursing-homes/Content?oid=34417242#:~:text=Genesis%20struck%20a%20deal%20to,Securities%20and%20Exchange%20Commission%20disclosure> [<https://perma.cc/6WZC-DNU6>].

246. *Id.*

agency's determination on their application.²⁴⁷ As this example shows, licensing can be an effective tool to prevent bad actors from entering a state or from being able to operate a nursing home when they have been known to provide substandard care. This is especially important in situations where a nursing home license is being taken over by a new applicant because residents are presumably already residing in the nursing home at that time.

By contrast, a lack of licensure oversight helps explain an egregious chain of events that occurred in 2018 when an operator known as Skyline Healthcare collapsed across multiple states. Skyline Healthcare owned or operated over one hundred skilled nursing facilities in eleven states.²⁴⁸ After a series of financial failures and issues including “dangerously low staffing levels,”²⁴⁹ states began placing Skyline facilities into receivership.²⁵⁰ In 2018, nineteen Skyline facilities in South Dakota, twenty-one facilities in Nebraska,²⁵¹ and fifteen facilities in Kansas were put into receivership.²⁵² Skyline also agreed to surrender five licenses in Massachusetts.²⁵³ Skyline's collapse prompted some to question how other states could have approved Skyline's application to operate nursing homes in their state. In the wake of these events, Kansas passed legislation to require disclosure of every other licensed

247. *Id.*

248. Maggie Flynn, *New Investigation Puts Skyline Healthcare Back in the Spotlight*, SKILLED NURSING NEWS (July 19, 2019), <https://skillednursingnews.com/2019/07/new-investigation-puts-skyline-healthcare-back-in-the-spotlight> [<https://perma.cc/RXA7-6G7M>].

249. Alex Spanko, *Final Three Skyline Nursing Homes in Massachusetts Close Doors*, SKILLED NURSING NEWS (May 28, 2019), <https://skillednursingnews.com/2019/05/final-three-skyline-nursing-homes-in-massachusetts-close-doors/> [<https://perma.cc/T9YG-FUC9>].

250. *Id.*

251. Maggie Flynn, *Chain of 21 Nursing Homes Placed in Receivership*, SKILLED NURSING NEWS (Mar. 26, 2018), <https://skillednursingnews.com/2018/03/chain-21-nursing-homes-placed-receivership> [<https://perma.cc/HK8F-ABVS>].

252. Maggie Flynn, *Skyline Healthcare Collapsing in South Dakota, Could Dissolve Soon*, SKILLED NURSING NEWS (May 1, 2018), <https://skillednursingnews.com/2018/05/skyline-healthcare-collapsing-south-dakota-dissolve-soon> [<https://perma.cc/FT3K-6VTJ>]; Alex Spanko, *Kansas Cracks Down on Nursing Home Owners' Finances in Wake of Skyline Collapse*, SKILLED NURSING NEWS (Apr. 23, 2019), <https://skillednursingnews.com/2019/04/kansas-cracks-down-on-nursing-home-owners-finances-in-wake-of-skyline-collapse/> [<https://perma.cc/7J4X-NMY8>].

253. Alex Spanko, *Skyline Surrender Five Buildings in Mass., SNF in Receivership in Nebraska to Close*, SKILLED NURSING NEWS (Apr. 25, 2019), <https://skillednursingnews.com/2019/04/skyline-surrenders-five-buildings-in-mass-snf-in-receivership-in-nebraska-to-close> [<https://perma.cc/9DVQ-HNSU>].

facility the applicant owned and allowed the state to revoke, suspend, or deny a license if anyone with any amount of ownership interest in a nursing home had a license suspended, revoked, or denied or had been subject to disciplinary action.²⁵⁴ Had Kansas had these requirements before Skyline acquired homes in the state, perhaps some of the damage inflicted on nursing home residents could have been avoided.

2. Consider Facilities' Performance in Renewal and Revocation Determinations

Licensure systems could also incentivize high-quality care by considering a facility's own past performance as part of license renewal, suspension, and revocation decisions. Facilities should not have their licenses renewed if they themselves have demonstrated a pattern of substandard care that endangers residents. Such patterns can only be detected by examining a facility's performance over time.

Licensing agencies should not necessarily wait for routine renewals to act. Where a facility is too dangerous, licensing agencies should be willing to revoke its license. This will not only protect the facility's current residents but can also protect residents in other homes. This is because many state regulations prohibit individuals who have had nursing home licenses revoked from being able to own or operate another nursing home.

This Article acknowledges that denying licenses to existing facilities has real costs. Residents may lose valuable relationships with one another and with staff. Especially in rural locales, residents may be unable to find a nearby facility that can accommodate them, and thus become separated from family and community support systems. And, perhaps as a result, when a facility closes, residents may experience "transfer trauma": physical or mental harm from being moved to a new facility.²⁵⁵ Nevertheless, the cost of allowing

254. Spanko, *supra* note 252.

255. See generally Terri D. Keville, *Studies of Transfer Trauma in Nursing Home Patients: How the Legal System Has Failed to See the Whole Picture*, 3 HEALTH MATRIX 421 (1993) (explaining transfer trauma and reviewing the studies regarding its potential impact on residents of nursing homes).

the worst facilities to continue to operate is too great to tolerate. Residents face unnecessary suffering and premature death when left in facilities with substandard care. Moreover, transfer trauma may be minimized by consistent, predictable enforcement efforts and support from nursing home ombudsmen.²⁵⁶

Another concern is that licensure denials may result in closure, harming the local community by reducing the supply of nursing home beds in that area. This may be a particular concern in states that have actively reduced the supply of nursing home beds through CON requirements. However, denying and revoking nursing home licenses, where warranted by low-quality care, especially in areas without CON requirements, could improve the overall performance of the nursing home market. Moreover, closure of some nursing homes would not preclude those who need nursing home care from getting it as there is excess capacity in the industry: in 2022, nursing home occupancy stood at 72%, a decline from 80% in 2020 (though an increase from the low of 67% in 2021).²⁵⁷

Moreover, revocation of a license need not result in closure. Instead, states could opt for implementing receivership. Temporary “receivers” could replace key management in the nursing homes and be used to bring facilities quickly into compliance with applicable minimum standards.²⁵⁸ Many states explicitly have receivership

256. CYNTHIA RUDDER, SUCCESSFUL TRANSITIONS: REDUCING THE NEGATIVE IMPACT OF NURSING HOME CLOSURES 58 (2016), https://theconsumervoice.org/uploads/files/issues/CV_Closure_Report_-_FINAL_FINAL_FULL_APPENDIX.PDF [<https://perma.cc/GBM2-U2TH>] (explaining that transfer trauma may be particularly acute where residents are “blindsided” by the decision to close a facility, and suggesting that earlier and more consistent enforcement action would reduce this risk).

257. *Certified Nursing Facility Occupancy Rate*, KAISER FAM. FOUND., <https://www.kff.org/other/state-indicator/nursing-facility-occupancy-rates/?activeTab=graph¤tTimeframe=0&startTimeframe=7&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> [<https://perma.cc/3VWS-8FT2>]. Across states, the highest occupancy rate in 2022 was 89% in South Dakota and the lowest was 50% in Montana.

258. The Minnesota Department of Health (MDH) offers this description of how receiverships can be implemented:

During the receivership, the managing agent acts at the direction of MDH. MDH becomes the facility licensee and is issued a new license. As soon as the receivership is in effect, the former operator/licensee is no longer licensed. MDH is the agency with the legal responsibility for the receivership, but it works in partnership with [the Minnesota Department of Health (DHS)] as the state Medicaid agency. There are daily meetings, sometimes several times per day as needed to work through the many issues that occur during a receivership.

statutes,²⁵⁹ and CMS has the explicit authority to install a “temporary manager” or receiver.²⁶⁰ Indeed, this is how Nebraska addressed the Skyline crisis discussed earlier in this Part. By establishing a third-party receivership of twenty-one Skyline facilities,²⁶¹ Nebraska enabled residents to remain in those facilities until a new owner could be found or residents could successfully relocate.²⁶²

In short, states have an opportunity to use their existing licensing systems to protect nursing home residents by preventing irresponsible operators from being licensed and by taking enforcement action against those already licensed. The next Part looks at yet another tool that could be used to incentivize high-quality nursing care.

V. FEDERAL MORTGAGE INSURANCE AS A LEVER

The federal government provides important support to nursing homes by guaranteeing certain loans made to them. Specifically, under Section 232 of the National Housing Act, the Secretary of the federal Department of Housing and Urban Development (HUD) provides mortgage insurance to new or rehabilitated nursing

During the receivership, an enhanced Medicaid rate is set by DHS to pay for the extra costs required during the receivership to get the facility back into compliance with laws, pay the employees, reinstate insurances, and all other costs of operating a facility.

Minnesota Department of Health (MDH) Seeks Nursing Home Receivership Managing Agent Candidates, MINN. DEP’T OF HEALTH (Nov. 8, 2022), <https://www.health.state.mn.us/facilities/regulation/nursinghomes/receivership.html> [<https://perma.cc/5D9Y-LKGQ>].

259. *See, e.g.*, ALASKA STAT. § 18.20.370 (2023); IND. CODE ANN. § 16-28-7-1 (West 2023); MASS. GEN. LAWS ANN. ch. 111, § 72T (West 2023); MICH. COMP. LAWS ANN. § 333.21751 (West 2023); MINN. STAT. § 144A.15 (2023); 15-16 MISS. CODE R. § 1-45.45.1 (LexisNexis 2023); OR. ADMIN. R. § 411-089-0075 (2023); 23 R.I. GEN. LAWS § 23-17.11-5 (2023); VT. STAT. ANN. tit. 33, § 7201 (2023).

260. 42 C.F.R. § 488.415 (2023); *see also* U.S. GOV’T. ACCOUNTABILITY OFF., NURSING HOMES: OPPORTUNITIES EXIST TO FACILITATE THE USE OF THE TEMPORARY MANAGEMENT SANCTION (2009) (outlining recommendations for facilitating the use of temporary management as an alternative to facility closure and describing the actions taken by CMS to implement the recommendations, including the development of training materials and guidance for states on temporary management).

261. *See supra* note 243.

262. *See supra* note 243.

homes.²⁶³ This Part describes the Section 232 program, shows how, at present, it perversely rewards facilities that are at higher risk for bad care, and explains how the Secretary's existing authority could be used to encourage nursing homes to engage in practices associated with higher quality care.

A. Overview of Section 232

Section 232 is a federal program that subsidizes nursing homes by providing public mortgage insurance for loans made to them.²⁶⁴ Specifically, the program allows for long-term, fixed-rate financing up to forty years for new and rehabilitated properties and up to thirty-five years for existing properties without rehabilitation that can be financed with mortgage-backed securities of the Government National Mortgage Association.²⁶⁵ To participate, facilities must accommodate at least twenty residents and be duly licensed.²⁶⁶ Facilities must also obtain the approval of HUD for certain post-closing changes, including changes in management and ownership.²⁶⁷

Section 232 insures a large portfolio of loans. In fiscal year 2021, the program issued 426 commitments covering a total of \$4.9 billion in loans, and managed a total portfolio of 3,816 loans with an unpaid principal balance of \$33 billion.²⁶⁸ The program is also steadily growing as applications for Section 232 loans have increased significantly in recent years.

263. See National Housing Act, 12 U.S.C. § 1715(w).

264. "Section 232 was added by Pub. L. No. 86-372 (1959)." Otto J. Hetzel, Bryan Saddler, Sharon Wilson Géno & Amy Glassman, *Housing and Urban Development*, in DEVELOPMENTS IN ADMINISTRATIVE LAW AND REGULATORY PRACTICE 2004-2005, at 384 n.112 (Jeffrey S. Lubbers ed., 2006).

265. *Mortgage Insurance for Nursing Homes, Intermediate Care, Board & Care and Assisted-Living Facilities: Section 232 and Section 232/223(F)*, U.S. DEP'T OF HOUS. & URB. DEV., https://www.hud.gov/program_offices/housing/mfh/progdesc/procsec232_223f#:~:text=Purpose%3A,term%20care%20or%20medical%20attention [<https://perma.cc/7NBY-U99F>].

266. *Id.*

267. Andrea C. Barach, *So You Have a Great HUD Loan—What's Next?*, 29 HEALTH LAW. 18, 18 (2017).

268. FED. HOUS. ADMIN., ANNUAL MANAGEMENT REPORT: FISCAL YEAR 2021, at 31 (2021), <https://www.hud.gov/sites/dfiles/Housing/documents/FHAFY2021ANNUALMGMNTRPT.pdf> [<https://perma.cc/P637-J6N9>] [hereinafter 2021 ANNUAL REPORT].

Table 1. Section 232 Growth (2013-2021)²⁶⁹

Year	Number of Applications Received	Percentage Change from Previous Year
2021	550	28.21%
2020	429	16.58%
2019	368	(5.88)%
2018	391	(3.93)%
2017	407	32.57%
2016	307	3.37%
2015	297	(21.64)%
2014	379	(57.32)%
2013	888	

In addition, thanks in part to low annual claim rates,²⁷⁰ the overall funding for the Section 232 program will likely continue to increase.

While Section 232 covers a range of residential facilities, over half of projects it insures are nursing home projects.²⁷¹ In 2019, the *New York Times* reported that the Section 232 program “guarantee[d] \$20 billion in mortgages to more than 2,300 nursing homes—about 15 percent of the country’s total, up from about 5 percent a quarter-century ago.”²⁷²

Unfortunately, current regulations governing Section 232 coverage for nursing homes create perverse incentives. First, current regulations limit eligibility to facilities with “[n]ot less than five rental dwelling units or personal care units, 20 medical care beds,

269. The table, compiled from the various annual reports available on the website of the United States Department of Housing and Urban Development, details the rate of program growth. For the data source, see *FHA Annual Management Report*, U.S. DEP’T OF HOUS. & URB. DEV., https://www.hud.gov/program_offices/housing/hsgroom/fhaamr [<https://perma.cc/UNQ9-G7P5>].

270. For the three years prior to the 2021 fiscal year, the claim rates have been 0.12%, 0.34%, and 0.62%, based on the respective annual reports.

271. U.S. DEP’T OF HOUS. & URB. DEV., OFF. OF THE INSPECTOR GEN., COVID-19: CHALLENGES FACED BY SECTION 232 NURSING HOMES DURING THE PANDEMIC 2-3 (Mar. 29, 2022), <https://www.oversight.gov/sites/default/files/oig-reports/HUD/2022-KC-0801.pdf>.

272. Matthew Goldstein, *146 Million Default by Nursing Home Chain Leaves U.S. on the Hook*, N.Y. TIMES (May 31, 2019), <https://www.nytimes.com/2019/05/31/business/nursing-homes-mortgage-hud.html> [<https://perma.cc/VY2M-3LVX>].

or 50 manufactured home pads.”²⁷³ Thus, these regulations preclude participation by small facilities, such as the oft-touted homelike “Green Houses,” which typically have fewer than twenty beds.²⁷⁴ Yet there is growing evidence that these smaller facilities are likely to provide superior, more humane care.²⁷⁵

Second, it appears that HUD may be more demanding of non-profit nursing homes than for-profit and public ones, even though non-profit ownership is associated with better quality of care.²⁷⁶ HUD’s applicable handbook suggests, for example, that only non-profit sponsors are required to demonstrate “a serious long-term commitment to supply housing for the intended resident population,” “strong roots in the neighborhood and local community and a good reputation for reliability, service, and commitment to the people for whom the housing is to be built,” “ties to the local community,” and input from “the local business community.”²⁷⁷

Third, as currently structured, the program seemingly rewards those operating chains and creates barriers to single-facility ownership. The applicable HUD handbook specifies that “[o]nly Borrowers, Operators and Management Agents whose principals have at least three years of experience successfully operating multiple projects with the types of beds proposed will generally qualify for ... mortgage insurance,” and “participants with experience successfully operating only one project must have a longer operating history than three years.”²⁷⁸

273. See 24 C.F.R. § 200.73(c) (2023) (The one exception—for a “group practice facilit[y]”—is not relevant to nursing homes).

274. Lauren Cohen, Sheryl Zimmerman, David Reed, Patrick Brown, Barbara J. Bowers, Kimberly Nolet, Sandra Hudak & Susan Horn, *The Green House Model of Nursing Home Care in Design and Implementation*, 51 HEALTH SERV. RES. 352, 362-63 (2016) (reporting that Green Houses typically have ten to twelve beds).

275. See Terry T. Fulmer, Christopher F. Koller & John W. Roe, *Reimagining Nursing Homes in the Wake of COVID-19*, NAT’L ACAD. MED. (Sept. 21, 2020), <https://nam.edu/reimagining-nursing-homes-in-the-wake-of-covid-19/> [<https://perma.cc/T7FZ-VN6S>].

276. See FED. HOUS. ADMIN., HEALTHCARE MORTGAGE INSURANCE PROGRAM—SECTION 232 OF THE NATIONAL HOUSING ACT: A HUD HANDBOOK, § 6.3 (2017) (setting forth requirements for non-profit sponsors) [hereinafter SECTION 232 HANDBOOK].

277. *Id.*

278. *Id.* § 2.5.

B. Evidence of Current Impact

To determine which nursing homes benefit from Section 232, we identified nursing homes that received Section 232 support in fiscal years 2021 and 2020 based on data publicly available on HUD's website.²⁷⁹ Using data obtained from the Five-Star Nursing Home Quality Rating System (Five-Star System) created by CMS,²⁸⁰ we then gathered the following facility data where available: (i) category of owner; (ii) overall rating; (iii) total number of nurse staff minutes per resident per day; and (iv) health citations.²⁸¹

Our review indicated that Section 232 disproportionately benefits for-profit facilities. Of the 452 projects for which at least some data were available on the Five-Star System,²⁸² 94.9% were for-profit. Over half of these (61.1%) were labeled as "for-profit corporation" with a smaller percentage being labeled as "for-profit individual" (7.9%), "for-profit limited liability company" (18.6%), and "for-profit partnership" (12.4%). Only 3.3% were non-profit, and 1.8% were government entities. These data are consistent with prior analysis indicating that Section 232 disproportionately backs for-profit nursing homes.²⁸³ According to 2016 data gathered by the Centers for Disease Control, just above two-thirds of nursing homes

279. See *Office of Residential Care Facilities*, U.S. DEP'T OF HOUS. & URB. DEV., https://www.hud.gov/federal_housing_administration/healthcare_facilities/residential_care [<https://perma.cc/LYW8-UCJU>].

280. See CTRS. FOR MEDICARE & MEDICAID SERVS., *Find & Compare Providers Near You*, <https://www.medicare.gov/care-compare/> [<https://perma.cc/75B8-3QDF>]; see also CTRS. FOR MEDICARE & MEDICAID SERVS., *Five-Star Quality Rating System*, <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/FSQRS> [<https://perma.cc/QD84-V9VG>] (explanation of the system). While ratings in this system provide one indication of quality, we do not mean to suggest that they fully capture quality. Cf. Kohn, *supra* note 7, at 3 n.10 (discussing the limitations of the system); Silver-Greenberg & Gebeloff, *supra* note 107 (reporting the results of a *New York Times* investigation finding that the Five-Star System "[d]espite years of warnings, ... provided a badly distorted picture of the quality of care at the nation's nursing homes" because, among other reasons, it relies on often incorrect, self-reported data).

281. There were 651 projects. Data were unavailable for 199 projects, and a few projects lacked data for the categories we examined. Except for the analysis on the category of owner in the next paragraph, these projects were not factored into the averages discussed below.

282. CTRS. FOR MEDICARE & MEDICAID SERVS., *Find & Compare Providers Near You*, *supra* note 280.

283. See *supra* note 263 and accompanying text.

in the United States have for-profit ownership,²⁸⁴ and yet, as emphasized above, research has long demonstrated that non-profit nursing homes offer more quality care on average than for-profit nursing homes.²⁸⁵

In addition, our review indicates that facilities supported by Section 232 tend to be in the bottom half of nursing homes in terms of quality. For example, facilities receiving Section 232 funds averaged 208 minutes (or three hours and twenty-eight minutes) of direct care staff per resident per day.²⁸⁶ This is slightly worse than the national average of 226 minutes (or three hours and forty-six minutes).²⁸⁷ Similarly, the average number of health citations is 8.7.²⁸⁸ This is slightly worse than the national average of 8.1.²⁸⁹ In addition, the average overall rating of the nursing homes for which data for all categories were available was 3.1.²⁹⁰ Three stars is described by CMS as “average;” by comparison, CMS describes five

284. CTRS. FOR DISEASE CONTROL, *supra* note 49.

285. See generally Ctr. for Medicare Advoc., *Non-Profit vs. For-Profit Nursing Homes: Is There a Difference in Care?* (Mar. 15, 2012), <https://medicareadvocacy.org/non-profit-vs-for-profit-nursing-homes-is-there-a-difference-in-care/> [<https://perma.cc/Z6ND-R8JH>] (“A review and meta-analysis of [eighty-two] studies comparing quality of care in for-profit and not-for-profit nursing facilities reported that nearly all the studies found higher quality, higher staffing, and fewer pressure sores in not-for-profit facilities.”); Joe Eaton, *Who’s to Blame for the 100,000 COVID Dead in Long-Term Care*, AM. ASS’N OF RETIRED PERSONS (Dec. 3, 2020), <https://www.aarp.org/caregiving/health/info-2020/covid-19-nursing-homes-who-is-to-blame.html?intcmp=AE-HP-BB-LL2> [<https://perma.cc/BN9T-CTGX>] (identifying studies which found that for-profit nursing homes had a disproportionate share of COVID-19 deaths); Michael P. Hillmer, Walter P. Wodchis, Sudeep S. Gill, Geoffrey M. Anderson, Paula A. Rochon, *Nursing Home Profit Status and Quality of Care: Is There Any Evidence of an Association?*, 62 MED. CARE RES. & REV. 139 (2005) (finding that for-profit nursing homes appeared to provide lower quality of care in important areas of both process and outcome).

286. See U.S. DEP’T OF HOUS. & URB. DEV., *Office of Residential Care Facilities*, *supra* note 279; CTRS. FOR MEDICARE & MEDICAID SERVS., *Find & Compare Providers Near You*, *supra* note 280.

287. CTRS. FOR MEDICARE & MEDICAID SERVS., *Find & Compare Providers Near You*, *supra* note 280.

288. See U.S. DEP’T OF HOUS. & URB. DEV., *Office of Residential Care Facilities*, *supra* note 279; CTRS. FOR MEDICARE & MEDICAID SERVS., *Find & Compare Providers Near You*, *supra* note 280.

289. CTRS. FOR MEDICARE & MEDICAID SERVS., *Find & Compare Providers Near You*, *supra* note 280.

290. See U.S. DEP’T OF HOUS. & URB. DEV., *Office of Residential Care Facilities*, *supra* note 279; CTRS. FOR MEDICARE & MEDICAID SERVS., *Find & Compare Providers Near You*, *supra* note 280.

as “much above average quality” and one star as “much below quality.”²⁹¹

On average, then, Section 232 over the last two fiscal years has been granting money to nursing homes that are about average in terms of their overall ratings and somewhat below average in terms of their nurse staff minutes per resident per day and their number of health citations.

C. Using Section 232 to Drive Quality

Section 232 could be used to incentivize nursing homes to adopt practices that are consistent with high quality of care. However, as currently structured, Section 232 regulations create perverse incentives and reward the wrong behavior. As detailed in a previous section, it encourages larger facilities rather than the smaller ones associated with better care, treats for-profit facilities more favorably than non-profit facilities even though the latter are also associated with better care, and creates barriers to entry for non-chain owners.²⁹²

The HUD Secretary has statutory authority to avoid each of these problematic incentives. Using the regulatory process, the Secretary could rescind regulations that make very small facilities ineligible for Section 232 guarantees.²⁹³ Of course, changes to the Section 232 Handbook could be made even more easily.

HUD also has statutory authority to adopt more sweeping provisions that could enable it to use Section 232 to encourage better quality care. Under the program’s authorizing statute, the HUD Secretary has extremely broad discretion: the Secretary may insure mortgages “upon such terms and conditions as he may prescribe.”²⁹⁴

291. See CTRS. FOR MEDICARE & MEDICAID SERVS., *Five-Star Quality Rating System*, *supra* note 280.

292. See *supra* notes 265-70 and accompanying text.

293. See Charles P. Sabatino & Charlene Harrington, *Policy Change to Put the Home Back into Nursing Homes*, 42 BIFOCAL 119, 124 (2021) (suggesting the Department of Housing and Urban Development use “mortgage loan programs” to “stimulate the development of small nursing homes”); NAT’L ACADS. OF SCIS., ENG’G, & MED., *supra* note 66, at 340 (noting that Section 232 could be used to encourage the construction of smaller homes or smaller units within larger homes but not discussing the regulatory mechanics underlying such an approach).

294. See 12 U.S.C. § 1715w(c).

Other regulations could be adopted to have a broader reach. For example, HUD could also adopt regulations that would discourage the worst practices in the industry by barring facilities with problematic owners and operators from participation. Currently, owners and operators are eligible for insurance even if they have a track record of providing poor care.²⁹⁵ The only clear limitation is that the facility being funded cannot be designated as a Special Focus Facility.²⁹⁶ As a result, Section 232 can and is used to subsidize low-quality facilities. Indeed, as the prior Section indicated, our research suggests that Section 232 tends to support the bottom half of nursing homes, not the top.²⁹⁷

Such a change would be consistent with priorities in current regulations. Current regulations recognize a policy in favor of restricting participation to “responsible individuals and organizations who will honor their legal, financial[,] and contractual obligations.”²⁹⁸ However, the regulations suggest that this policy is implemented by reviewing operators’ or owners’ prior participation in housing finance programs.²⁹⁹ The regulations do not appear to contemplate the Secretary excluding facilities owned or operated by entities who have a track record of poor performance when it comes to quality of care.³⁰⁰

In addition to using sticks (ineligibility), the Secretary could use carrots (priorities). In other words, the Secretary might prioritize facilities with certain features known to be consistent with high-quality care. For example, even under existing regulations, the Secretary could establish standards that would prioritize smaller facilities and those with private rooms or other physical features

295. See SECTION 232 HANDBOOK, *supra* note 276, § II, ch. 2, at 1.

296. *Id.* § II, ch. 2, at 4 (listing as an ineligible project: “Projects designated by the Centers for Medicare and Medicaid Services (CMS) as Special Focus Facilities or similar future designation”).

297. See *supra* notes 277-82 and accompanying text.

298. See 24 C.F.R. § 200.210(a) (2023) (“It is [the] policy [of the Department of Housing and Urban Development (HUD)] that, in accordance with the intent of the National Housing Act ... and with other applicable federal statutes, participants in HUD’s housing and healthcare programs be responsible individuals and organizations who will honor their legal, financial[,] and contractual obligations. Accordingly, ... HUD will review the prior participation of Controlling Participants ... as a prerequisite to participation in HUD’s multifamily housing and healthcare programs listed in § 200.214.”).

299. *Id.*

300. See *id.*

associated with better care, as long as certain requirements are met.³⁰¹ Similarly, the Secretary could prioritize facilities with higher staffing ratios.

Notably, HUD is already collecting much of the data it would need to exclude bad actors or facilities, and to prioritize better ones. For example, HUD already considers quality indicators as part of its underwriting risk analysis for loan extensions.³⁰² It requires data related to nursing home quality to be submitted as part of the process for determining whether the facility meets requirements related to professional liability insurance³⁰³ and for the purpose of corporate credit review.³⁰⁴ In addition, lenders must consider and report on indicators of facility quality and provide narrative explanations for certain problematic characteristics.³⁰⁵ Nevertheless, this valuable information appears to be used exclusively to assess financial risk to HUD—and not to ensure that borrowers actually provide quality residential care.

Thus, it is within HUD's authority to not only use the Section 232 program to encourage practices associated with superior care, but also to cease using that authority in ways that encourage problematic practices.

301. See 24 C.F.R. § 200.73 (2023) (“[D]esign, construction, substantial rehabilitation and repairs shall be in accordance with standards established by the Commissioner.... The improvements shall constitute a single project. Not less than five rental dwelling units or personal care units, [twenty] medical care beds, or [fifty] manufactured home pads, shall be on one site, except that such limitations do not apply to group practice facilities.”).

302. SECTION 232 HANDBOOK, *supra* note 276, § II, ch. 2, at 27-28 (explaining that, when evaluating underwriting risk for a proposed extension of a loan term, the Office of Residential Care Facilities (ORCF) considers “[a] high Medicare Star Rating” and “[o]ther considerations as deemed appropriate by ORCF”).

303. *Id.* § II, ch. 14, at A-7 to A-8 (requiring, as part of professional liability insurance review that state licensing surveys be provided for all facilities with “serious unresolved deficiencies”).

304. *Id.* § II, ch. 17, at 9.

305. For instance, lenders are to review state surveys “for the last three years for all skilled nursing facilities owned/operated and/or managed by the Operator and/or Management Agent and for all skilled nursing facilities on the subject’s Professional Liability Insurance policy” to determine whether they show “any instances of actual harm and/or immediate jeopardy, or if there are open findings.” See SECTION 232 HANDBOOK, *supra* note 276, § II, ch. 8, at 8. If these are found, the Lender is to “provide a narrative explanation of the risk and how it will be mitigated.” See *id.* The Lender must also determine whether the facility is “on the Special Focus Facility list or ha[s] been notified of being a Special Focus Candidate” or has “paid Civil Money Penalties above \$10,000 and/or had a Ban or Hold on Admissions; or ... ha[s] any pending, current or anticipated rate reductions.” See *id.*

VI. EXPLAINING THE FAILURE TO USE EXISTING AUTHORITY

This Article has shown how four existing statutory schemes could be leveraged to create stronger incentives for nursing homes to provide high-quality care. The common theme across the four opportunities identified is that they are all cases involving statutory authority that is not being employed to drive quality but could be. This differentiates them from the type of recommendations commonly seen in this space, which focus either on recommendations that new authority be granted or that those with authority do a better job at what they are already doing with that authority.³⁰⁶

In doing so, it bridges a disconnect between social scientists' and health care providers' ideas on how to improve nursing home quality and the legal systems needed to operationalize those ideas. Most notably, our recommendations align with a core recommendation made by the National Academies of Sciences, Engineering, and Medicine's March 2022 report on improving nursing home quality.³⁰⁷ In that report, the Academies called for looking at performance across nursing homes that share a common owner or operator, and not simply at the facility level.³⁰⁸ By showing the specific legal mechanisms that can be used to accomplish this approach—and identifying where they already exist in federal and state law—this Article paves the way to implement this best practice.

Given the growing awareness of the country's nursing home crisis, one might reasonably wonder why so little attention has been paid to the regulatory opportunities identified by this Article. One reason is that some of these opportunities—for example, the use of state licensure schemes to create stronger incentives for nursing home's owners and operators and the increased use of state fiscal penalties—involve state-level regulation. Historically, state regulation of nursing homes has been given little attention by either policymakers or scholars. Indeed, the previously mentioned 600-page National Academies Report hardly even considered state

306. See, e.g., GRIMM, *supra* note 19, at 18-20 (calling for CMS to do a better job overseeing state surveys).

307. NAT'L ACADS. OF SCIS., ENG'G, & MED., *supra* note 66, at 431.

308. *Id.*

licensure of facilities as an avenue for policy change, and when it did simply stated:

State licensure imposes minimum standard requirements that a home must meet in order to continue operating. Historically, however, state licensing decisions have excluded few facilities, as regulators consider the loss or denial of a license to operate to be a drastic remedy that should be reserved for only serious breaches of resident safety and quality-of-care standards. States could potentially take a more active role in screening applications to assess the quality of performance at facilities owned by applicants for the license to operate. Consequently, the primary locus of regulatory stringency lies in the federal requirements of participation as a Medicare- or Medicaid-certified nursing home provider.³⁰⁹

As this dismissive language suggests, lack of attention to state-level tools may reflect the breadth of federal regulation, which allows federal solutions to become more salient. It is perhaps also part of a larger problem of legal scholars and policy experts focusing their talents on federal issues, at the expense of state law. And yet state law plays a critical role in the system: no nursing home can operate without being licensed by a state.

Another reason for the lack of attention to the levers we identify may be that using existing law does not tend to generate political energy and attention. Politicians signal their attention to interest groups by proposing new legislation,³¹⁰ not by pointing to laws already in place. Finding creative uses of laws that already are on the book is the domain of “back office” bureaucrats and industry experts. Where such uses are contrary to the interests of the very industry experts who are in the best position to understand them, it is perhaps no wonder that they go largely unmentioned.

Social attitudes, including ageism, may also contribute. At the same time that institutions for younger adults are being shuttered

309. *Id.* at 403-04 (citation omitted).

310. *Cf.* Avlana Eisenberg, *Expressive Enforcement*, 61 UCLA L. REV. 858, 868-69 (2014) (describing the expressive function of the enactment of hate crime legislation and highlighting elected officials' acknowledgement of this role as reflected in the stated desire to “send a message”).

as unacceptable,³¹¹ the United States continues to tolerate the mass institutionalization of older adults, and even to encourage it through Medicaid funding preferences that favor institutionalization over home-based care for older adults.³¹² As discussed in this Article, nursing homes that violate the NHRA often face no real penalties for doing so.³¹³ By contrast, childcare centers that violate state regulations designed to protect children will commonly lose their licenses and face closure.³¹⁴

But perhaps the primary reason why these relatively simple fixes have yet to come forward is the complexity of the underlying regulatory schemes. Nursing home care is a space that is regulated through a vast series of overlapping state and federal systems. The result is that even those who work in the field often do not know the full regulatory matrix, let alone appreciate the interplay between the elements. This may explain why, although the Biden Administration is trumpeting small, home-like, long-term care facilities,³¹⁵ HUD's Section 232 program is still only providing mortgage assistance to larger ones.³¹⁶ And it may explain why the federal government treats state licensure as a proxy for nursing homes meeting basic standards, when state licensure may provide no indication of quality—and may, as in the case of Ohio and Wyoming,³¹⁷ simply reflect the fact that the facility has paid the state a licensure fee.

This complexity works to the advantage of the industry. The types of authority discussed in this Article, and the intricacies, are primarily only understood by those affiliated with the industry they regulate. Health care consumers, by contrast, are unlikely to be able

311. Kohn, *supra* note 7, at 17-18.

312. *Id.* at 16-17.

313. See *supra* notes 103-18 and accompanying text.

314. See Nina A. Kohn, *The Pandemic Exposed a Painful Truth: America Doesn't Care About Old People*, WASH. POST (May 8, 2020, 8:49 AM), https://www.washingtonpost.com/outlook/nursing-home-coronavirus-discrimination-elderly-deaths/2020/05/07/751fc464-8fb7-11ea-9e23-6914ee410a5f_story.html [<https://perma.cc/47HC-DFQV>] (comparing nursing home enforcement to childcare center enforcement).

315. See *FACT SHEET: Biden-Harris Administration Delivers Funds to Support the Health of Older Americans*, WHITE HOUSE (May 3, 2021), <https://www.whitehouse.gov/briefing-room/statements-releases/2021/05/03/fact-sheet-biden-harris-administration-delivers-funds-to-support-the-health-of-older-americans/> [<https://perma.cc/K9SC-DPZG>].

316. See *supra* notes 165-270 and accompanying text.

317. See *supra* note 176 and accompanying text.

to understand the complex web of regulations and the opportunities buried deep within them.

Indeed, the complex and disjointed nature of nursing home oversight described in this Article provides more evidence of the costs of federalism in the health care space. Scholars such as Dayna Matthew and Nicole Huberfeld have long criticized Medicaid's federalism for permitting state politics to dictate whether the poor and vulnerable can obtain essential benefits.³¹⁸ More recently, Jamila Michener has shown how federalism in social welfare policy, and the Medicaid system in particular, fosters inequality and has negative, downstream consequences for the democratic system of governance.³¹⁹ The costs of federalism illuminated in this Article—administrative complexity leading to bureaucratic ineffectiveness and role confusion—are perhaps more mundane. But they result in much the same problem: a failure to meet the basic needs of the medically needy and vulnerable.

CONCLUSION

American nursing homes are in crisis, with residents facing systemic neglect and unnecessary suffering. By digging through the complex matrix of regulatory authority generated in part by the federalism that characterizes this country's approach to public health, we have shown that state and federal governments already have much of what it takes to fix America's nursing homes. At the federal level, regulators can deny certification to facilities whose owners and operators have shown that they cannot be depended upon to provide safe and humane care to residents, and loan guarantee programs can be targeted to encourage the type of smaller facilities associated with better care, instead of discouraging

318. See Dayna Bowen Matthew, *The "New Federalism" Approach to Medicaid: Empirical Evidence that Ceding Inherently Federal Authority to the States Harms Public Health*, 90 KY. L.J. 973, 977-78 (2002) (discussing how Medicaid's federalism selectively undermines certain populations and public health more broadly); Nicole Huberfeld, *Federalizing Medicaid*, 14 U. PA. J. CONST. L. 431, 480-81 (2011) (arguing that federalism with Medicaid has come at the expense of the poor and vulnerable and remarking that "[i]t is disingenuous to call cutting benefits for budgetary savings a form of state experimentation").

319. See generally JAMILA MICHENER, *FRAGMENTED DEMOCRACY: MEDICAID, FEDERALISM, AND UNEQUAL POLITICS* (2018).

them. At the state level, states can use their existing licensure schemes to ensure that states do not grant licenses to facilities or individuals who are unlikely to provide care that meets minimum standards. And at both levels, stronger financial penalties can be imposed on facilities that put residents at risk. Together, these existing statutory and regulatory authorities could be used to create much stronger incentives for nursing homes to provide high-quality care.

As we reflect on this project, we acknowledge and celebrate the fact that our recommendations are not the type that typically make headlines. Uncovering opportunities in the bowels of existing regulatory systems is hardly the type of action championed by politicians or heralded in the media. Yet that is a large part of its appeal: it sidesteps contentious political processes to get the job done. With more than one million nursing home residents at risk for neglect, that is no small matter.