# THE LEGAL STRUCTURE OF COVID-19 NURSING HOME DEATHS

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Although now a priority group for emergency use authorized COVID-19 vaccines,[1] nursing home residents in the U.S. have borne by far the greatest burden of illness and death from the pandemic. Nearly 200,000 nursing home residents have died over the course of the pandemic, approximately forty percent of all U.S. deaths attributable to the virus.[2] It did not have to be this way.[3] To be sure, the state of being elderly and infirm can predispose anyone to a more severe episode of illness or death following infection.[4] However, the large numbers of COVID-19 nursing home deaths are

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1. Pien Huang, *Health Care Workers, Nursing Home Residents to be Prioritized for COVID Vaccine*, NPR (Dec. 1, 2020 1:37 PM), https://www.npr.org/sections/health-shots/2020/12/01/940700204/should-nursing-home-residents-be-prioritized-for-getting-the-covid-19-vaccine.

2. Priya Chidambaram et al., *COVID-19 Has Claimed the Lives of Long-Term Care Residents and Staff*, KAISER FAM. FOUND. (Nov. 25, 2020), https://www.kff.org/policy-watch/covid-19-has-claimed-the-lives-of-100000-long-term-care-residents-and-staff. Federal and state law will vary the terms used for the institutions and services analyzed in this article. "Skilled nursing facility", "long term care", and "nursing home" each carry statutory and regulatory significance under federal and state law. However, the argument of this paper is broadly and accurately applicable to these categories of state and federally-reimbursed care, and their relationship with each another.

3. Erin Blakemore, *Covid-19 Deaths Reveal Ageist Perceptions of Seniors which Affects the Care They Receive*, WASH. POST (June 20, 2020), https://www.washingtonpost.com/health/covid-19-deaths-reveal-ageist-perceptions-of-seniors-which-affects-the-care-they-receive/2020/06/19/dd7f4c88-b0c2-11ea-8758-bfd1d045525a_story.html; Aman Nanda et al., *COVID-19 in Older Adults*, 32 AGING CLINICAL & EXPERIMENTAL RSCH. 1199–1202 (2020).

4. *Older Adults*, CDC, https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/older-adults.html (last updated Dec. 13, 2020).

also attributable to laws that structure residents' space for living and rehabilitation, healthcare access, and level of care.[5] Those laws minimized preparedness for infectious disease threats, forced residents into potentially infectious hospitals too soon, returned them while infectious from hospitals to nursing homes where the disease spread, and insulated the responsible legal actors from accountability for doing so.[6]

At their core, these laws failed because of their path-dependent and largely incoherent structure that prioritizes deference to *state* enforcement of standards required for participation in *federal* programs.[7] Laws shaping nursing homes' care range from local land use and zoning to the federal conditions for receiving funds from Medicare and Medicaid; it is the juxtaposition of state corporate law and Medicaid enforcement over federal requirements and reimbursement that explain why nursing homes failed to prevent and indeed exacerbated the COVID-19 threat. The structure of federal and state payments and care incentives allowed mostly profit-driven nursing homes to game government reimbursement at the expense of nursing home residents.[8] While the business entities that provide care are formed under state law, licensed by state administrative agencies, and regulated by state standards, the actual welfare of nursing home residents is overwhelmingly dictated by federal law and policy.[9]

The burden of disease and death on nursing home residents occurred because of the pernicious fiction that states lead in the

5. Kevin Brown et al., *Association Between Nursing Home Crowding and COVID-19 Infection and Mortality in Ontario, Canada*, 181 JAMA INTERNAL MED., 229, 230 (2021).

6. Suzy Khimm, *Coronavirus Spreads in a New York Nursing Home Forced to Take Recovering Patients*, NBC NEWS (Apr. 25, 2020, 5:00 AM), https://www.nbcnews.com/news/us-news/coronavirus-spreads-new-york-nursing-home-forced-take-recovering-patients-n1191811.

7. Sarah H. Gordon et al., *What Federalism Means for the U.S. Response to Coronavirus Disease 2019*, JAMA (May 8, 2020), https://jamanetwork.com/channels/health-forum/fullarticle/2766033.

8. EINER R. ELHAUGE, *Obamacare and the Theory of the Firm*, *in* THE FUTURE OF HEALTHCARE REFORM IN THE UNITED STATES 202, 210 (Anup Malani & Michael H. Schill eds. 2015).

9. To this extent, the argument presented herein is consistent with what Glenn Cohen has described as the rise of population-level bioethics and its importance for law, especially in the Medicaid context. I. GLENN COHEN, *The Relationship Between Bioethics and U.S. Health Law: Past, Present, and Future*, *in* THE OXFORD HANDBOOK OF U.S. HEALTH LAW (I. Glenn Cohen, Allison K. Hoffman & William M. Sage eds., 2017).

care of elderly residents.[10] COVID-19 clarified the urgent need to reorganize the structure of nursing home residents' living and care conditions. The urgency is compounded by the fact that in nursing homes, even more than outside them, COVID-19 has disproportionately impacted racial and ethnic minorities.[11] Nursing homes where more than forty percent of residents were Black or Latinx reported 3.3 times as many COVID-19 deaths and cases as nursing homes that had more White residents.[12]

The starting point for better regulation of nursing homes is the acknowledgement that responsibility for the care and security of the elderly in the U.S. is foremost a federal obligation.[13] In many ways, many residents in nursing homes fall victim to COVID-19 because of a system premised upon the idea that federal law only occasionally intervenes in the lives of people whose care is ultimately the responsibility of states. The functional and practical reality is that federal law comprehensively surrounds the elderly, occasionally turning on state law, and is ultimately determinant of their situations.[14] Over some aspects of life, this is explicitly so, as through Medicare and Social Security entitlements.[15] For others, it operates in the shadow, as with the decades-long understaffing of nursing

10. Nathaniel Weixel, *Justice Dept. Probe of State Nursing Home COVID-19 Rules Draws Criticism*, THE HILL (Sept. 3, 2020, 6:00 AM), https://thehill.com/policy/healthcare/514896-justice-probe-of-state-nursing-home-covid-19-rules-draws-criticism.

11. Priya Chidambaram et al., *Racial and Ethnic Disparities in COVID-19 Cases and Deaths in Nursing Homes*, KAISER FAM. FOUND. (Oct. 27, 2020), https://www.kff.org/coronavirus-covid-19/issue-brief/racial-and-ethnic-disparities-in-covid-19-cases-and-deaths-in-nursing-homes; Dayna Bowen Matthew, *Structural Inequality: The Real COVID-19 Threat to America's Health and How Strengthening the Affordable Care Act Can Help*," 108 GEO. L.J. 1679, 1680, 1684 (2020) ("In the United States, the earliest data showed that African-Americans contracted and died from COVID-19 at disproportionately high rates. In 'hotspot' areas such as New York City, Milwaukee, Louisiana, and Chicago, black and LatinX populations were decimated because they are over-exposed to several structural risk factors for COVID-19.").

12. Rebecca Gorges & Tamara Konetzka, *Factors Associated With Racial Differences in Deaths Among Nursing Home Residents With COVID-19 Infection in the US*, JAMA (2021).

13. MaryBeth Musumeci & Priya Chidambaram, *Key Questions About Nursing Home Regulation and Oversight in the Wake of COVID-19*, KAISER FAM. FOUND. (Aug. 3, 2020), https://www.kff.org/coronavirus-covid-19/issue-brief/key-questions-about-nursing-home-regulation-and-oversight-in-the-wake-of-covid-19.

14. Richard Neuworth, *The Elderly, Employment Law and Federal Benefits*, 1 MD. B.J. 117, 118 (2019).

15. Theodore W. Ruger, *Of Icebergs and Glaciers: The Submerged Constitution of American Healthcare*, L. & CONTEMP. PROBS., 2012, at 215, 220 ("Medicare was, and is, a massive federal budgetary commitment to health security . . . .").

homes in violation of federal requirements.[16] Acknowledging that people in the U.S. who are over sixty-five are a federal responsibility is key to eliminating the most significant aspects of state law that resulted in over 195,000 nursing home deaths from COVID-19 and counting.[17] This includes more stringent certification requirements, more robust federal enforcement of nursing home regulations, and private rights of action in federal courts, free from mandatory arbitration clauses in admission agreements.[18]

This article is structured as follows: Part I provides an overview of how nursing home residents came to suffer the most significant burden of illness and death from COVID-19. Part II analyzes the relevant federal and state legal structures, including their weaknesses and gaps, that led to this result. Part III explains why the market for nursing home care cannot address weaknesses in the legal architecture. Part IV refutes the now common claim that residents' susceptibility to COVID-19 explains their high mortality. Part V argues that the U.S. elderly population should be understood as a special federal responsibility and provides the framework for an effective federal approach to nursing homes. Part VI provides a brief conclusion.

## I. THE SCALE OF NURSING HOME DEATHS ATTRIBUTABLE TO COVID-19

To date, of the over 500,000 deaths in the U.S. attributable to COVID-19, more than thirty-eight percent have taken place in nursing homes.[19] This staggering number represents over 195,000

16. Jordan Rau, *Most Nursing Homes are not adequately staffed, new federal data says*, PBS (July 13, 2018 11:19 AM), https://www.pbs.org/newshour/health/most-nursing-homes-are-not-adequately-staffed-new-federal-data-says.

17. Chidambaram et al., *supra* note 2.

18. Charlene Harrington et al., *The Need for Higher Minimum Staffing Standards in U.S. Nursing Homes*, 9 HEALTH SERVS. INSIGHTS 13, 13 (2016); Johnathan F. Lauri, *Saying "No" to Pre-Dispute Arbitration Agreements in Nursing Homes*, NAT'L L. REV. (Nov. 11, 2020), https://www.natlawreview.com/article/saying-no-to-pre-dispute-arbitration-agreements-nursing-homes.

19. Greg Girvan & Avik Roy, *Nursing Homes & Assisted Living Facilities Count for 38% of COVID-19 Deaths*, MEDIUM (May 7, 2020), https://freopp.org/the-covid-19-nursing-home-crisis-by-the-numbers-3a47433c3f70; *Coronavirus in the U.S.: Latest Map and Case Count*, N.Y. TIMES (Feb. 3, 2021), https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html; Stephanie Soucheray, *Nursing Homes Site of 40% of US COVID-19 Deaths*, CIDRAP (June 2, 2020), https://www.cidrap.umn.edu/news-perspective/2020/06/nursing-homes-site-40-us-covid-19-deaths.

residents, 530 dying per day since March 2020.[20] Among forty-one states reporting COVID-19 data at the state level, nursing home residents account for fifty percent or more of all COVID-19 deaths in twenty-seven states.[21] In some states, nursing home deaths are between seventy and eighty percent of COVID-19 deaths.[22] During one week in Connecticut, nearly ninety percent of its COVID-related deaths occurred in nursing homes.[23] Moreover, these numbers underestimate the true toll.[24] State health officials count only deaths that occurred on the grounds of a nursing home facility and do not count those who became infected at a nursing home and later died in a hospital or other facility.[25] A report released in late January

20. AARP Nursing Home COVID-19 Dashboard, AARP (last updated Mar. 11, 2020), *https://www.aarp.org/ppi/issues/caregiving/info-2020/nursing-home-covid-dashboard.html*; *More Than 100,000 U.S. Coronavirus Deaths Are Linked to Nursing Homes*, N.Y. TIMES (last updated Dec. 4, 2020), https://www.nytimes.com/interactive/2020/us/coronavirus-nursing-homes.html.

21. Sarah True et al., *Under the Radar: States Vary in Regulating and Reporting COVID-19 in Assisted Living Facilities*, KAISER FAM. FOUND., (June 16, 2020), https://www.kff.org/coronavirus-covid-19/issue-brief/under-the-radar-states-vary-in-regulating-and-reporting-covid-19-in-assisted-living-facilities; Temet M. McMichael et al. *Epidemiology of Covid-19 in a Long-Term Care Facility in King County, Washington*, 382 NEW ENG. J MED (2020), https://www.nejm.org/doi/full/10.1056/NEJMoa2005412 ("The experience described here indicates that outbreaks of Covid-19 in long-term care facilities can have a considerable impact on vulnerable older adults and local health care systems. The findings also suggest that once Covid-19 has been introduced into a long-term care facility, it has the potential to spread rapidly and widely."); *About 40% of U.S. Coronavirus Deaths Are Linked to Nursing Homes*, N.Y. TIMES (Sept. 16, 2020), https://www.nytimes.com/interactive/2020/us/coronavirus-nursing-homes.html.

22. Avik Roy, *The Most Important Coronavirus Statistic: 42% Of U.S. Deaths Are from 0.6% of the Population*, FORBES (May 26, 2020 12:14 AM), https://www.forbes.com/sites/theapothecary/2020/05/26/nursing-homes-assisted-living-facilities-0-6-of-the-u-s-population-43-of-u-s-covid-19-deaths/#59344af674cd; McMichael et al., *supra* note 21.

23. Charles C. Camosy, *What's Behind the Nursing Home Horror*, N.Y. TIMES (May 17, 2020), https://www.nytimes.com/2020/05/17/opinion/nursing-home-coronavirus.html; *see* Olga Morozova, et al., A Model for COVID-19 Transmission in Connecticut, MEDRXIV 19 (June 16, 2020) (unpublished manuscript) (on file with NCBI), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7310630 ("One of the important factors that may explain relatively high estimates of CFR in Connecticut is related to high mortality among residents of nursing homes and assisted living facilities. About 50% of official COVID-19 related deaths in Connecticut occurred in this subpopulation.").

24. Virginia P Tilden et al., *Sampling Challenges in Nursing Home Research*, 14 J. AM. MED. DIRS. ASS'N. 25, 26 (2013).

25. Luis Ferré-Sadurní & Amy Julia Harris, *Does Cuomo Share Blame for 6,200 Virus Deaths in N.Y. Nursing Homes?*, N.Y. TIMES (July 8, 2020), https://www.nytimes.com/2020/07/08/nyregion/nursing-homes-deaths-coronavirus.html; Jon Kamp, *States are Finding More Unreported Covid-19 Deaths*, WALL ST. J. Mar. 14, 2021, https://www.wsj.com/articles/states-are-finding-more-unreported-covid-19-deaths-11615730402?mod=hp_lead_pos4.

2021 from state Attorney General Letitia James found the New York State Department of Health undercounted COVID-19 deaths among residents of nursing homes by approximately fifty percent. Nearly half of all nursing homes in the U.S. suffered at least one infection.[26]

Nursing home mortality is fueled by the long present racial disparities across the healthcare system and was brought into sharp relief by the pandemic.[27] Even pre-pandemic, nursing homes that serve predominantly Black and Latinx residents were characteristically rated lower during survey, licensing, and certification processes and generally have more residents served by fewer staff.[28] Regardless of the location, size, or government rating, nursing homes where racial minorities make up a significant portion of the residents have been two to three times as likely to have COVID-19 cases than those nursing homes where the residents are "overwhelmingly white."[29] Nursing homes with the fewest White residents are the likeliest to have a coronavirus case or death.[30] The racial disparities that characterize COVID-19 deaths are even more severe among nursing home residents.[31]

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26. Joaquin Sapien & Joe Sexton, *"Fire Through Dry Grass': Andrew Cuomo Saw COVID-19's Threat to Nursing Homes. Then He Risked Adding to It.,"* PROPUBLICA (June 16, 2020), https://www.propublica.org/article/fire-through-dry-grass-andrew-cuomo-saw-covid-19-threat-to-nursing-homes-then-he-risked-adding-to-it; Robert Gebeloff et al., *The Striking Racial Divide in How COVID-19 Has Hit Nursing Homes*, N.Y. TIMES (Sept. 16, 2020), https://www.nytimes.com/article/coronavirus-nursing-homes-racial-disparity.html.

27. Robert Gebeloff et al., *The Striking Racial Divide in How COVID-19 Has Hit Nursing Homes*, N.Y. TIMES (Sept. 16, 2020), https://www.nytimes.com/article/coronavirus-nursing-homes-racial-disparity.html.

28. *Id.*; Lauren J. Campbell, et al., *Racial/Ethnic Disparities in Nursing Home Quality of Life Deficiencies, 2001 to 2011*, 2 GERONTOLOGY & GERIATRIC MED. 1, 1 (2016) ("NHs serving high proportions of minority residents tend to provide lower quality of care, often having a higher average number of deficiencies.").

29. Gebeloff et al., *supra* note 27.

30. *Id.*; *Caring for Seniors Amid the COVID-19 Crisis*, U.S. SPECIAL COMM. ON AGING (May 21, 2020), https://www.aging.senate.gov/hearings/watch?hearingid=C22F8A1D-5056-A066-6005-12658BFD9D13; Gebeloff, et al., *supra* note 27.

31. *See* Gebeloff et al., *supra* note 27.

## II. THE LEGISLATIVE AND REGULATORY PATHWAY TOWARD A BROKEN FEDERAL SYSTEM OF CARE

### *A. The Historical Role of the Federal Government*

Although the idea of governmental support for housing, health, and income for the aged, besides veterans, circulated mostly in the states before 1935, those ideas rarely took the form of federal law.[32] When they did, the resulting programs were underfunded and difficult to access.[33] This was the reason that the 1935 Social Security Act, which long predated Medicare and Medicaid, established public assistance for the elderly.[34] That law established old-age assistance ("OAA"), which supported institutions devoted to the care and housing of the elderly, but prohibited funds for public institutions.[35]

This resulted in the rapid expansion of voluntary and proprietary nursing homes.[36] By 1954, there were 9,000 homes classified as skilled nursing or personal care homes with skilled nursing facilities; eighty-six percent were proprietary, ten percent were voluntary, and four percent were public.[37]

In its beginning years, only slightly more than half of the nation's workers were covered by Social Security.[38] Today, Social Security's coverage is "nearly universal, with about 93 percent of all workers participating in the program."[39] Through over a dozen different legislative enactments, Social Security has become a pervasive law affecting the welfare of the elderly in the U.S.[40] Later amendments added benefits for dependents of disabled beneficiaries,

32. *See Historical Background and Development of Social Security*, SOC. SEC. ADMIN., https://www.ssa.gov/history/briefhistory3.html (last visited Feb. 14, 2020).

33. *Id.*; Marietta Stevenson, *Old-Age Assistance*, 3 LAW & CONTEMPORARY PROBLEMS 236, 236 (1936).

34. INST. OF MED. COMM. ON NURSING HOME REGUL., *Improving the Quality of Care in Nursing Homes* (1986), https://www.ncbi.nlm.nih.gov/books/NBK217556; *Aid for the Aged: Title I of the Social Security Act*, VA. COMMONWEALTH UNIV., https://socialwelfare.library.vcu.edu/public-welfare/aid-for-the-aged.

35. VA. COMMONWEALTH UNIV., *supra* note 34; INST. OF MED. COMM. ON NURSING HOME REGUL., *supra* note 34.

36. INST. OF MED. COMM. ON NURSING HOME REGUL., *supra* note 34.

37. *Id.*

38. *Id.*; Larry DeWitt, *The Development of Social Security in America*, 70 SOC. SECURITY BULL. 1, 7 (2010).

39. DeWitt, *supra* note 38.

40. *Id.*

allowed for disability benefits at any age, and added disabled widow benefits.[41]

Amendments to the Social Security Act passed in 1950 required states to establish a system for licensing nursing homes but did not specify the standards or enforcement procedures states should implement.[42] The context in which this failure was most extensively studied—fire risk—showed that forty-four percent of nursing homes were found to not meet standards issued under the Hill-Burton Act, a 1946 law intended to expand the construction of hospitals, nursing homes, and chronic care facilities across the U.S.[43]

Federal funding from Social Security's OAA continued to increase and was further expanded through legislative amendment in 1956, and this was replaced with a more extensive program in 1960 through the Kerr-Mills Act's Medical Assistance for the Aged ("MAA").[44] Kerr-Mills, which foreshadowed the legal structure of Medicaid, "initiated Federal grants to the States to pay for medical services for the medically indigent elderly."[45] Three years later, only thirty states had initiated the program.[46] After several attempts to expand, such as including children in the program, the program combined with other approaches to create what is now known as Medicaid.[47] In total, OAA funding rose from $35.9 million in 1950 to $280.3 million in 1960 to $1.3 billion through the MAA programs in 1965.[48]

As a result of the lack of standards and procedures in the Social Security Act and its amendments, federal guidelines for nursing home licensure programs were created in 1963.[49] The passage

41. *Id.* at 8.

42. INST. OF MED. COMM. ON NURSING HOME REGUL., *supra* note 34, at 238; *see* Abbe R. Gluck & Nicole Huberfeld, *What Is Federalism in Healthcare For?*, 70 STAN. L. REV., 1698, 1709 (2018) ("Ongoing medical access failures led Congress to enact the Social Security Act Amendments of 1950, which provided federal grants-in-aid to states in the form of vendor payments—capped payments for specific services such as hospital, skilled nursing, and physician care.").

43. INST. OF MED. COMM. ON NURSING HOME REGULATION, *supra* note 34, at 240.

44. Edward Berkowitz, *Medicare and Medicaid: The Past as Prologue*, 27 HEALTH CARE FINANCING REV. 11, 18 (2005); Gluck & Huberfeld, *supra* note 42, at 1709 ("In sum, Kerr-Mills offered incremental reform with more federal money and some federal standard setting, staving off grander federal intervention while preserving states' role in healthcare.").

45. Berkowitz, *supra* note 44, at 18.

46. *Id.*

47. *Id.*

48. INST. OF MED. COMM. ON NURSING HOME REGUL., *supra* note 34, at 239.

49. *Id.* at 240.

came after a Senate subcommittee on problems of the aged and aging found that many nursing homes were low quality with poor staff and few services because existing regulations went unenforced.[50] This committee's findings led to a program by the Public Health Service to evaluate state licensing programs in 1957, which then created the Nursing Home Standards Guide.[51]

While the Nursing Home Standards Guide provided the federal government's perspective, states maintained vastly different licensing, regulatory, and enforcement regimes.[52] In 1961, Frank Moss led a U.S. Senate Special Committee on Aging which found, among other facts, that forty-five percent of America's skilled nursing facilities did not have a registered nurse.[53]

The adoption of Medicare and Medicaid ushered in major new sources of funding for nursing homes as well as the potential for significant federal oversight.[54] The U.S. Department of Health, Education and Welfare ("HEW"), the predecessor agency to the Department of Health and Human Services ("HHS"), was given authority to set the standards nursing homes would have to meet to receive federal funding.[55] Originally, the Medicare standards were stringent, and few nursing homes met them.[56] This led to the political decision to devolve Medicaid regulations to states to broaden participation and, ultimately, to weaken care.[57]

In 1970, the U.S. Senate formed another Special Committee to assess nursing home practices and federal programs.[58] Determining that HEW's "substantial compliance" standard was too stringent for certification, Congress relaxed the standard to the extent that nursing homes could be certified as long as there was no immediate hazard to the health and safety of the residents.[59]

In 1974, Congress approved funding for state surveys and certification and also provided a single set of long-term care

50. Bruce C. Vladeck, UNLOVING CARE: THE NURSING HOME TRAGEDY 59 (1980).
51. INST. OF MED. COMM. ON NURSING HOME REGUL. *supra* note 34, at 240.
52. *Id.* at 72–73.
53. *Id.* at 240–41.
54. *Id.* at 241.
55. *Id.*
56. *Id.* at 14.
57. INST. OF MED. COMM. ON NURSING HOME REGUL., *supra* note 34, at 245.
58. *Id.* at 243.
59. *See id.*

standards.[60] HEW established enforcement offices for the long-term care standards within the federal regional offices with regional directors who had the authority to approve nursing home agreements with Medicare and Medicaid in skilled nursing facilities.[61] The regional directors were also approved to monitor the states and their agency certifications for Medicaid-only facilities.[62]

In 1986, Congress commissioned its most significant investigation to date, which was undertaken by the Institute of Medicine (now the National Academy of Medicine).[63] The Institute of Medicine ("IOM") found that residents of nursing homes were being abused, neglected, and given inadequate care.[64] The IOM proposed reforms, most of which became law in 1987 with the passage of the Nursing Home Reform Act: periodic assessments for each resident; a comprehensive care plan for each resident; nursing services; social services; rehabilitation services; pharmaceutical services; dietary services; and, for most nursing homes, a full-time social worker.[65]

While a 1998 report from the Health Care Financing Administration showed that the Nursing Home Reform Act had improved resident outcomes as intended, the same report also found that the enforcement of the standards was not working.[66] These issues were brought to light during Senate Committee on Aging hearings following a GAO analysis of California nursing homes.[67] That analysis found that thirty percent of California nursing homes were cited for "violations that put residents in immediate jeopardy or caused actual harm to the residents."[68] Only two percent of nursing homes were found to have minimal or no deficiencies in their care.[69] The response was the Nursing Home Initiative, yet another effort to

60. *See id.* at 245.

61. *Id.*

62. *Id.*

63. INST. OF MED. COMM. ON NURSING HOME REGULATION, *supra* note 34, at at v–vi.

64. *See id.* at 2–4.

65. *Id.* at 25–32, 81–83.

66. *Id.* Bernadette Wright, *Federal and State Enforcement of the 1987 Nursing Home Reform* Act, AARP PUB. POL'Y INST. (Feb. 2001) (citing HCFA, STUDY OF PRIVATE ACCREDITATION (DEEMING) OF NURSING HOMES, REGULATORY INCENTIVES AND NON-REGULATORY INCENTIVES, AND EFFECTIVENESS OF THE SURVEY AND CERTIFICATION SYSTEM (1998)), https://www.aarp.org/home-garden/livable-communities/info-2001/federal_and_state_enforcement_of_the_1987_nursing_home_reform_act.html.

67. GAO, SPECIAL REPORT TO THE SPECIAL COMMITTEE ON AGING, U.S SENATE (1998), https://www.gao.gov/assets/230/226087.pdf.

68. *Id.* at 10–11.

69. *Id.* at 9–10.

encourage states to better enforce the law.[70] A review undertaken in 2000 showed that it also had minimal effect.[71]

### *B. Nursing Home Regulatory Reforms 1986–2008*

The 1987 Nursing Home Reform Act ("NHRA") implemented much of the IOM report, especially with respect to the role of Medicare and Medicaid programs.[72] For example, each nursing home is required to have a written plan of care for each resident.[73] The written plan must describe the medical, nursing, and psychosocial needs for each resident and must also explain how these needs will be met.[74] To evaluate how effective the written plan is, a resident assessment must be conducted at least once a year.[75] The resident assessment gives an opportunity for the residents themselves to assess how effective the written plan is by commenting on his or her ability to function daily.[76]

Under the law, residents enjoy rights such as the right to choose a personal physician, to be informed about care and treatment, to be free from restraints, to receive privacy, and to have confidentiality with regard to personal records.[77] Nursing homes are not allowed to compel residents to waive their Medicare and Medicaid benefits as a condition of admission.[78] Conditions of discharge and special accommodations for mental health were also provided.[79]

Despite the nominally strong protections provided in the Nursing Home Reform Act, courts generally found that the law did not provide a right for individual residents or their families to sue under the law to enforce its provisions.[80] Nursing home residents

70. Jan Shankroff et al., *Nursing Home Initiative*, 22 HEALTH CARE FINANCING REV. 113–115 (2001).

71. Wright, *supra* note 66.

72. Eric C. Surette, Annotation, *Construction of and Application of Federal Nursing Home Reform Amendments (FNHRA), 42 U.S.C.A. §§ 1395i-3, 1396r*, 55 A.L.R. Fed. 2d 195, 206 (2011).

73. *Id.*

74. *Id.*

75. *Id.* at 206–07.

76. *Id.*

77. *Id.* at 207.

78. Surette, *supra* note 72, at 207.

79. *Id.* at 208.

80. *See, e.g.*, Schwerdtfeger v. Alden Long Grove Rehab. & Health Care Ctr, Inc. (U.S. Dist. Ct., N.D. Ill., No. 13 C 8316, May 12, 2014); Grove Rehab. & Health Care Ctr., Inc., No

had more success styling their rights as those intended to be protected by 42 U.S.C. § 1983, which allows a civil action against state authorities for violations of federal rights under color of state law.[81] However, even § 1983 theories have subsequently been rejected by federal courts, a problem (and recommended solution) explored in Part IV.[82]

Moreover, NHRA continued the policy of leaving compliance largely up to resource constrained state governments.[83] The law required each state to give periodic inspections of facilities without giving the facility prior notice and to maintain a process by which they could investigate complaints lodged against a nursing home.[84] If a violation is found, the state may recommend a civil penalty to the Secretary of Health and Human Services, who may impose financial penalties or appoint interim managers over nursing homes.[85]

NHRA's weaknesses became clear almost immediately. The Government Accountability Office ("GAO") found that over the fifteen years following the law, penalties failed to address violations.[86] Civil monetary penalties imposed had dwindled over time, from an already paltry level of $500 to approximately $350, even though the allowable range reached $3,000.[87] Nearly half of the sixty-three homes the GAO reviewed with a serious record of deficiencies corrected deficiencies temporarily before reverting back to previous practices.[88] Eight homes cycled in and out of compliance at least seven times.[89] Twenty-seven of the sixty-three homes the GAO studied were cited sixty-nine times for deficiencies that called for immediate sanctions, but the Centers for Medicare and Medicaid Services

13 C 8316, 2014 U.S. Dist. LEXIS 6471, at *1, 5* (N.D. Ill. May 12, 2014); Talevski v. Health & Hosp. Corp. of Marion Cty., No. 2:19 CV 13, 2020 U.S. Dist. LEXIS 52547, at *1, 8 (N.D. Ind. Mar. 26, 2020).

81. Grammer v. John J. Kane Reg'l Ctrs.-Glen Hazel, 570 F.3d 522, 522, 532 (3d Cir. 2009), *cert. denied*, 130 S. Ct. 1524 (2010).

82. Surette, *supra* note 72, at 209.

83. *Id.* at 207.

84. *Id.*

85. *Id.*

86. *See generally* KATHRYN ALLEN, U.S. GOV'T ACCOUNTABILITY OFF., GAO-07-241, EFFORTS TO STRENGTHEN FEDERAL ENFORCEMENT HAVE NOT DETERRED SOME HOMES FROM REPEATEDLY HARMING RESIDENTS (2007) (highlighting the failure of NHRA to assess penalties against violators).

87. *Id.* at 5.

88. *Id.*

89. *Id.*

("CMS") a financing and regulation-issuing authority within the U.S. Department of Health and Human Services, only implemented immediate sanctions in fifty-four of those sixty-nine cases.[90]

CMS was reluctant to involuntarily terminate facilities that were repeat offenders. By the end of 2005, only two repeat offender nursing homes were terminated from participation in Medicaid.[91] Nine other nursing homes were terminated but did so voluntarily.[92] Allowing the facilities to terminate voluntarily meant they could choose their own closing dates, thereby extending the period of harm imposed on their residents.[93] For example, two of the facilities that terminated voluntarily were cited for harming residents over twenty times from 2000–2004 until they finally closed.[94]

In response, CMS created a Special Focus Facilities ("SFF") program which identifies facilities with a history of deficiencies subject to closer scrutiny.[95] Under the program, if facilities subjected to closer scrutiny did not significantly improve in eighteen months, the SFF would be involuntarily terminated.[96] However, of the sixty-three homes GAO reviewed, only two were identified for special scrutiny.[97] So, sixty-one of the problematic facilities are still not receiving effective oversight.[98]

As with individual actions to enforce rights under the law, federal courts have allowed obstacles to litigation to serve the purpose of more effective oversight. For example, nursing homes began to adopt mandatory arbitration clauses in admissions contracts limiting the ability to seek redress in courts.[99] The Federal Arbitration Act ("FAA") provides that arbitration clauses in commercial transactions are "valid, irrevocable, and enforceable" except if there is a general ground that would make the contract void.[100] In *Chestnut Hill v. Schrader*, a federal district court determined whether an

90. *Id.*
91. *Id.* at 6.
92. ALLEN, *supra* note 86.
93. *Id.*
94. *Id.*
95. *Id.* at 17.
96. *Id.*
97. *Id.* at 50.
98. ALLEN, *supra* note 86, at 3.
99. Charlie Sabatino, *Educating Individuals and Families is Key in Wake of New Nursing Home Arbitration Agreement*, 40 J. OF AM. BAR. ASS'N: COMMISSION OF L. & AGING 103, 104 (2019).
100. Federal Arbitration Act, Pub. L. 68-401.

arbitration agreement signed by a resident was unconscionable under state law in light of the FAA.[101] The court acknowledged that arbitration in the nursing home context is a "tool for delay."[102] The court nevertheless found that the arbitration clause was not substantively unconscionable because both the resident and the nursing home could invoke the arbitration clause.[103] The order is representative generally of federal courts' approach to the use of mandatory arbitration clauses in nursing home admission contracts, before CMS prohibited the practice in 2016. [104]

### *C. Changes from 2008–2016*

The Affordable Care Act ("ACA"), better known for its establishment of health insurance exchanges and the expansion of Medicaid, included several provisions to increase the quality of nursing homes.[105] Acknowledging some of the gaps identified above, the ACA aimed to improve nursing home accountability, increase enforcement from CMS, and put programs in place to prevent abuse against nursing home residents.[106] The ACA acknowledged that staffing in nursing homes is often indicative of the quality of care, and it also noted that ninety-seven percent of nursing homes did not provide enough hours of nursing care on a day-to-day basis.[107] Yet, rather than increasing the required number of registered nurses, licensed practical nurses, or nursing assistant caregivers required to meet federal standards, it instead imposed a system to collect data on nursing home staffing and issue a rating based on the appropriate staffing level compared to the actual nursing hours in the home.[108] The ACA also mandated disclosure as to ownership interest, extending to any person with five-percent

101. GGNSC Chestnut Hill LLC v. Schrader, No. 16-10525-DPW, 2018 WL 1582555, at *5 (D. Mass. Mar. 3, 2018).

102. *Id.* at *9.

103. *Id.*

104. *See, e.g.*, *id.* at *4.

105. *Long Term Care Provisions in the Affordable Care Act*, NAT'L CONSUMER VOICE FOR QUALITY LONG TERM CARE, https://theconsumervoice.org/issues/other-issues-and-resources/aca-provisions (last visited Feb. 15, 2021).

106. KAISER FAM. FOUND., IMPLEMENTATION OF AFFORDABLE CARE ACT PROVISIONS TO IMPROVE NURSING HOME TRANSPARENCY, CARE QUALITY, AND ABUSE PREVENTION, 1–2 (Jan. 28, 2013), https://www.kff.org/medicaid/report/implementation-of-affordable-care-act-provisions-to-improve-nursing-home-transparency-care-quality-and-abuse-prevention.

107. *Id.* at 6.

108. *Id.* at 6–10.

ownership interest in the real estate, corporation, or limited liability company.[109]

Congress also required nursing homes receiving Medicaid funds to employ an independent licensed physician, either directly or indirectly.[110] By requiring this independent physician, it was hoped that the physician would feel comfortable making recommendations with unbiased regard for the residents' health and would not be susceptible to shaping their recommendations based on the interests of the nursing home.[111] Congress also created incentives for nursing homes to self-report violations, reducing civil monetary penalties by fifty percent if facilities self-reported and promptly corrected their errors.[112] It also required nursing home owners, operators, employees, managers, agents, and contractors to report suspicions they may have about a crime committed against a resident of the facility where they work.[113]

### *D. Changes from 2017–2020*

Under Director Seema Verma, CMS largely worked to deregulate the nursing home industry.[114] In 2019, the Trump administration withdrew regulations that required an infection specialist to be employed at the nursing home, requiring instead that a specialist spend "sufficient time at the facility."[115] The Trump administration also rescinded the prohibition on the use of mandatory arbitration provisions in admission contracts which, as noted above, prevented victims of nursing home abuse and other harm from suing in state and federal courts and instead channeled them to arbitrators, where litigation costs for complainants are greater and the signaling effect of awards is lower.[116]

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109. *Id.* at 5.

110. *Id.* at 11.

111. *Id.* at 4.

112. KAISER FAM. FOUND, *supra* note 106, at 10.

113. *Id.* at 2.

114. Scott Simon, *The White House Says Nursing Home Regulations are too Tough*, NPR (Nov. 30, 2019 8:42 AM), https://www.npr.org/2019/11/30/783819886/the-white-house-says-nursing-home-regulations-are-too-tough.

115. Jessie Drucker & Jessica Silver-Greenberg, *Trump Administration is Relaxing Oversight of Nursing Homes*, N.Y. TIMES (Mar. 14, 2020), https://www.nytimes.com/2020/03/14/business/trump-administration-nursing-homes.html.

116. Urja Mittal, Note, *Litigation Rulemaking*, 127 YALE L.J. 1010, 1030 (2018) ("Congress may not have delegated to CMS the express authority to regulate binding arbitration agreements between nursing homes and their elderly residents, simply because such

Changes to CMS's policies for nursing homes also came about in 2020 as a result of COVID-19.[117] In July 2020, four months after COVID-19 first emerged in U.S. nursing homes, CMS started requiring nursing homes with a five percent or higher rate of COVID-19 among its residents to test all staff at the nursing home weekly.[118] CMS also created a fast-tracked training program simulating specific COVID-19 scenarios and telehealth options.[119] CMS waived or lowered previous licensing requirements for low-level staff, which, on the one hand, increased the number of healthcare workers, but, on the other, put them in a difficult job with little training.[120]

## III. THE LEGAL AND MARKET STRUCTURE OF U.S. NURSING HOMES

In the U.S., there are approximately 15,600 nursing homes, in which 1.3 million people reside.[121] Nearly three million people receive care in a nursing home during any given year.[122] The number of Americans requiring a nursing home will double by 2030.[123]

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agreements were not common when the Social Security Act was written."); Medicare and Medicaid Programs: Revision of Requirements for Long-Term Care Facilities: Arbitration Agreements, 84 Fed. Reg., 34718, 34718 (July 18, 2019) (to be codified at 42 CFR pt. 483); Toby S. Edelman, *Deregulating Nursing Homes*, 39 BIFOCAL, 31, 31 (2018); *see* Melissa Thompson, *U.S. Supreme Court – the FAA Preempts State Court Ruling in Nursing Home Arbitration Case*, HEALTH L. DIAGNOSIS (May 16, 2017), https://www.healthlawdiagnosis.com/2017/05/us-supreme-court-the-faa-preempts-state-court-ruling-in-nursing-home-arbitration-case.

117. *See* Press Release, CMS News, Trump Administration Announces New Resources to Protect Nursing Home Residents Against COVID-19, (July 22, 2020), https://www.cms.gov/newsroom/press-releases/trump-administration-announces-new-resources-protect-nursing-home-residents-against-covid-19.

118. *Id.*

119. *Id.*

120. *See* CTRS. FOR MEDICARE & MEDICAID SERVICES, COVID-19 EMERGENCY DECLARATION BLANKET WAIVERS FOR HEALTH CARE PROVIDERS, 9 (2020) https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf (stating some positions no longer require licenses, or qualification are easier to obtain).

121. *Nursing Home Care*, CDC, https://www.cdc.gov/nchs/fastats/nursing-home-care.htm (last visited Feb. 13, 2021).

122. AARP PUB. POLICY INST., NURSING HOMES FACT SHEET, 1 (2007), https://assets.aarp.org/rgcenter/il/fs10r_homes.pdf.

123. James R. Knickman, & Emily K. Snell, *The 2030 Problem: Caring for Aging Baby Boomers*, 37 HEALTH SERVS. RSCH. 849, 884 (2002) ("The '2030 problem' involves the challenge of assuring that sufficient resources and an effective service system are available in thirty years, when the elderly population is twice what it is today.").

Another 800,000 Americans reside in assisted living facilities that are far less extensively regulated.[124] According to the National Institute on Aging, assisted living is for people who need help with daily care, but not as much help as a nursing home provides. Assisted living facilities range in size from as few as twenty-five residents to 120 or more. Typically, a few "levels of care" are offered, with residents paying more for higher levels of care. Assisted living residents usually live in their own apartments or rooms and share common areas. They have access to many services, including up to three meals a day; assistance with personal care; help with medications, housekeeping, and laundry; 24-hour supervision, security, and on-site staff; and social and recreational activities.[125]

### *A. Federal Law, Implemented and Enforced by States*

Despite the long history of federal direction and oversight detailed above, nursing homes are charitable organizations or incorporated (typically as limited liability companies or for-profit corporations as analyzed below), licensed, and defined under state law.[126] State statutes differ with respect to definitions, terms of state-level requirements, and the extent to which they explicitly include federal definitions for benefits and regulations under the Social Security Act, Medicare, and Medicaid.[127] Under state law, nursing homes generally require a minimum number of residents, for example four or six, the intent to be residential, and the provision of assistance for daily living activities like bathing, dressing, and eating.[128] Federal law defines services available for reimbursement under Medicare and Medicaid, general facility requirements to receive

124. Frank Main, *Feds Should do More to Safeguard Nursing Homes from COVID-19, U of C Expert tells Senate Panel*, CHI. SUN TIMES (May 21, 2020 1:03 PM), https://chicago.suntimes.com/2020/5/21/21266422/tamara-konetzka-nursing-homes-coronavirus-senate-special-subcommittee-agin-university-of-chicago; LESLIE PRAY ET AL., INST. OF MED. PROVIDING HEALTHY AND SAFE FOODS AS WE AGE: WORKSHOP SUMMARY 26 (2010) ("2 percent (1 million) [of older adults live] in assisted care facilities.").

125. NATIONAL INSTITUTE ON AGING, *Residential Facilities, Assisted Living and Nursing Homes*, https://www.nia.nih.gov/health/residential-facilities-assisted-living-and-nursing-homes (last visited Feb. 16, 2021).

126. *Who Regulates Nursing Homes?*, NURSING HOME LAW CTR., LLC, https://www.nursinghomelawcenter.org/who-regulates-nursing-homes.html (last visited Feb 13, 2021).

127. *Id.*; *see, e.g.*, MASS. GEN. LAWS ch. 111 § 71 (2017).

128. *See, e.g.*, MASS. GEN. LAWS ch. 111 § 71 (2017); *Residential Facilities, Assisted Living, and Nursing Homes*, NAT'L. INST. ON AGING, (May 1, 2017) https://www.nia.nih.gov/health/residential-facilities-assisted-living-and-nursing-homes.

those reimbursements, as well as some specific personnel and specializations eligible facilities must provide.[129] Private insurance policies, which represent only a small portion of the market, may define nursing homes differently for purposes of coverage.[130]

i. Ex Ante Regulation: Staffing and Facility Requirements

Although they are state entities, nursing homes generally rely on federal reimbursement; indeed, approximately seventy percent of the nursing home sector is financed through Medicaid reimbursement.[131] To receive reimbursement under federal programs, nursing homes must comply with approximately 175 minimum quality and safety standards established by CMS.[132] Medicare covers disabled and elderly Americans through a trust funded by a payroll tax.[133] Medicaid covers low-income members of the population through state funds that the federal government matches.[134] States enjoy discretion as to where their share of the Medicaid funding comes from in their budgets.[135]

Compliance standards and regulations are ultimately the responsibility of the Secretary of Health and Health and Human

129. Mark Kander, *How Medicare Reimbursement Works in Skilled Nursing Facilities*, ASHA WIRE (June 1, 2014), https://leader.pubs.asha.org/doi/10.1044/leader.BML.19062014.26; NURSING HOME L. CTR., LLC, *supra* note 126.

130. Henry T. Greely, *Predicting Alzheimer's Disease: Potential Ethical, Legal, and Social Consequences*, NEUROETHICS BLOG (June 17, 2014), http://www.theneuroethicsblog.com/2014/06/predicting-alzheimer-disease-potential.html ("The private long-term care market is relatively new and small."); Crutchfield v. Transamerica Occidental Life Ins. Co., 527 Fed.Appx. 339 (6th Cir. 2013) (defining a nursing home as "[a] facility, or that part of one, which: (1) is operating under a license issued by the appropriate licensing agency; (2) is engaged in providing, in addition to room and board accommodations, nursing care and related services on a continuing inpatient basis to 6 or more individuals; (3) provides, on a formal prearranged basis, a Nurse who is on duty or on call at all times; (4) has a planned program of policies and procedures developed with the advice of, and periodically reviewed by, at least one Physician; and (5) maintains a clinical record of each patient").

131. *See* Charlene Harrington, *Residential Nursing Facilities in the United States*, 323 BMJ 507, 509 (2001).

132. Dana Mukamel et al., *The Effect of State Regulatory Stringency on Nursing Home Quality*, 47 HEALTH SERVS. RSCH., 1791, 1793 (2012).

133. Richard Foster & M. Kent Clemens, *Medicare Financial Status, Budget Impact, and Sustainability – Which Concept is Which?*, 30 HEALTHCARE FIN. REV. 77, 84 (2009).

134. LAURA SNYDER & ROBIN RUDOWITZ, KAISER FAM. FOUND., MEDICAID FINANCING: HOW DOES IT WORK AND WHAT ARE THE IMPLICATIONS? 2 (2015), https://www.kff.org/medicaid/issue-brief/medicaid-financing-how-does-it-work-and-what-are-the-implications.

135. *Id.* at 4.

Services, who is responsible for assuring the federal money is only given to those facilities that comply with the federal standards.[136] States may impose standards that exceed the federal minimum floor.[137] Over ninety percent of nursing homes are thus regulated by federal law and, to differing degrees, more protective state law, at least insofar as the black letter of state statutes and regulations read.[138] Federal standards are frequently stated in general terms.[139] For example, there is no federal guidance for penalties for understaffing.[140]

Similarly, federal law may offer guidance as to staffing based on the best evidence of quality care but generally does not influence nursing home behavior with advisory guidelines.[141] Under federal law, for example, Medicare-certified and Medicaid-certified nursing homes must have a registered nurse ("RN") on duty at least eight hours a day, seven days a week, and a licensed nurse, either a RN or Licensed Practical Nurse ("LPN"), on duty twenty-four hours a day.[142] Whereas RNs generally have two to four years of training,[143] there are no minimum staffing levels for certified nurse's aides ("CNAs"), who typically have two weeks' worth of training and provide most of the day-to-day care.[144] A CMS study found that nursing homes *should* provide 4.1 total nursing hours per resident per day

136. Estate of Smith v. Heckler, 747 F.2d 583, 589 (10th Cir. 1984); *see* Elizabeth Sepper, *Taking Conscience Seriously*, 98 VA. L. REV. 1501, 1507–08 (2012) ("Institutions participating in Medicare must also meet acceptable standards of practice, disclose all treatment options, and respect patients' rights to give informed consent or refuse treatment. Moreover, having accepted a person as a patient, providers have an ethical and legal duty to not abandon her, to treat her in accordance with acceptable standards of medical practice, to inform her of treatments and their risks and benefits, and to refer her for services they are not able to provide.").

137. Kieran Walshe, *Regulating U.S. Nursing Homes: Are We Learning from Experience?*, 20 HEALTH AFF. 128, 131 (2001); Charlene Harrington et al., *The Need for Higher Minimum Staffing Standards in U.S. Nursing Homes*, 9 HEALTH SERV. INSIGHTS 13, 14 (2016).

138. Mukamel et al, *supra* note 132, at 1793.

139. *See* Harrington et al., *supra* note 137, at 13–14. Catherine M. Sharkey, *Preemption as a Judicial End-Run Around the Administrative Process?*, 122 YALE L.J. 1, 2 (2013) ("States must submit a comprehensive state Medicaid plan—and any amendments thereto—to the Centers for Medicare and Medicaid Services (CMS), a subagency of HHS, for approval.").

140. Harrington et al., *supra* note 137, at 17.

141. *Id.* at 16–17; *see also* Vincent Rome et al., *Variation in Licensed Nurse Staffing Characteristics by State Requirements in Residential Care*, 12 RSCH. IN GERONTOLOGICAL NURSING 27 (2019).

142. 42 U.S.C.A. § 1396r.

143. Harrington et al., *supra* note 137, at 14.

144. *Id.* at 14; *see* Paula Span, *Where Are the Nurses?*, N.Y. TIMES (Aug. 13, 2014 11:20 AM), https://newoldage.blogs.nytimes.com/2014/08/13/where-are-the-nurses.

("hrpd") to meet federal quality standards: 0.75 RN hrpd, 0.55 LPN hprd, and 2.8 CNA hprd.[145] The median nursing home in 2014 provided 3.97 total nursing hprd with the lowest ten percent providing 3.18 total nursing hprd.[146] The lowest quartile had one CNA to ten residents in the hours when most labor intensive care is required.[147] This was accompanied by a lower total nursing hprd.[148] In other words, the CNAs, who have less training and the highest workload, are also overseen by fewer medical professional managers who ensure the care of the residents.[149]

In addition to insufficient staffing, nursing homes are often careless with taking the necessary precautions to prevent the spread of disease. In early 2020, the *Sacramento Bee* undertook a comprehensive review of state and federal records related to California nursing homes. Between 2018 and 2020, eighteen nursing homes were cited for violating rules related to infectious disease, which put their residents in "immediate jeopardy."[150] More generally, eighty-two percent of nursing homes in California, comprising 976 facilities, had been cited for some infectious disease violation in that period.[151] Although these violations consist of activities that are seemingly mild, such as employees failing to wash their hands or improperly handling food trays, the results can be dire in the midst of an at-risk population during a global pandemic.[152] With a failure to properly implement measures to prevent the spread of disease before a global pandemic, nursing homes have struggled to implement the additional measures needed to lessen the spread of the coronavirus. Demonstrably, Sterling Place in Baton Rouge, Louisiana, where there were more than eighty coronavirus cases and

145. Harrington et al., *supra* note 137, at 17.

146. *Id.* at 15.

147. *Id.*

148. *See id.*

149. Lawrence O. Gostin & Anna Garsia, *Governing for Health As the World Grows Older: Healthy Lifespans in Aging Societies*, 22 ELDER L.J. 111, 118 (2014) ("Rearranging health services requires not only major changes in the organization, financing, and delivery of health services, but also will require health professional training to identify and effectively prevent risks, and treat injuries and disease.").

150. Jason Pohl & Michael Finch II, *Here are the California nursing homes with infection-control violations, and why that matters* SACRAMENTO BEE, https://www.sacbee.com/news/local/health-and-medicine/article241163226.html (updated Mar. 14, 2020).

151. *Id.*

152. *Id.*

fifteen deaths, was cited because staff members failed to wear masks.[153] Heritage Hall in Leesburg, Virginia, where there were over one-hundred coronavirus cases and eighteen deaths, was cited for failing to separate residents in a common area.[154] Broomall Rehabilitation and Nursing Center in Pennsylvania, where there were over two-hundred coronavirus cases and fifty deaths, was cited for failing to use protective gear.[155]

ii. Ex Post: Enforcement by States

Despite the division of ex ante regulation between federal and state governments, states are charged with monitoring compliance with both sets of standards.[156] The performance criteria are federal, but the federal government has delegated to the states the responsibility to inspect nursing homes using their criteria and to certify their eligibility to participate in the Medicaid program.[157] For the Medicare program, state governments inspect the facilities on behalf of the federal government and similarly issue certification recommendations to the federal government.[158]

> States are charged with issuing sanctions, including citations (or deficiencies), financial penalties, and administrative actions (such as management change or facility closures) when nursing homes do not meet the standards. State licensing and certification offices

153. Debbie Cenziper et al., *As Pandemic Raged and Thousands Died, Government Regulators Cleared Most Nursing Homes of Infection-Control Violations*, WASH. POST. (Oct. 29, 2020), https://www.washingtonpost.com/business/2020/10/29/nursing-home-deaths-fines.

154. *Id.*

155. *Id.*

156. *Examining Federal Efforts To Ensure Quality of Care and Resident Safety In Nursing Homes, Before the U.S. Energy and Commerce Committee*, statement of Kate Goodrich, Director of Center for Clinical Standards and Quality and Chief Medical Officer, Centers for Medicare and Medicaid Services, https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Testimony-Goodrich-Examining-Federal-Efforts-to-Ensure-Quality-of-Care-and-Resident-Safety-in-Nursing-Homes-2018-09-0.pdf.

157. Richard Mollot, *Government Must Enforce Standards for Elder Care*, N.Y. TIMES (Sept. 26, 2014), https://www.nytimes.com/roomfordebate/2014/09/25/finding-humane-care-at-the-end-of-life/government-must-enforce-standards-for-elder-care; *Improving the Quality of Care in Nursing Homes*, COMM. ON NURSING HOME REGULATION 1, 104 (National Academy Press, 1986).

158. *Id.*

> inspect nursing homes every 9 to 15 months. This is referred to as the "annual survey."[159]

Both regimes are therefore dependent upon the resources states invest in compliance.[160] Although CMS supports those activities, there is little incentive for states to prioritize them.[161] Consequently, they do not.[162] State agencies have limited resources allocated to them by CMS enforcement and broad discretion over inspection teams and process.[163] In the lead-up to the pandemic, state authorities had not inspected nearly half of all nursing homes.[164] State budgets for inspections and compliance monitoring vary wildly.[165] "CMS is meant to oversee the performance of state agencies but has done little to monitor them and in any case has limited powers to do anything about performance problems."[166] At least twenty percent of U.S. nursing homes operate with severe and dangerous care deficiencies.[167]

If the nursing home that is cited for a deficiency does not correct the issue, CMS can terminate the facility from participation in Medicare and Medicaid.[168] Those terminations are, however, very rare.[169] Medicaid recipients in nursing homes are often viewed as a

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159. Mukamel et al., *supra* note 132.

160. 42 U.S.C. § 1396r.

161. David Grabowski et al., *Medicaid Payment and Risk-Adjusted Nursing Home Quality Measures*, 23 HEALTH AFF. 243, 245 (2004).

162. *See* David Stevenson, *The Future of Nursing Home Regulation: Time for a Conversation?*, HEALTH AFF. BLOG (Aug. 23, 2018), https://www.healthaffairs.org/do/10.1377/hblog20180820.660365/full; Kieran Walshe, *Regulating U.S. Nursing Homes: Are We Learning From Experience?*, 20 HEALTH AFF. 128, 135 (2001). Robert Miller suggests that in general this problem may be recharacterized as a problem in the costs of monitoring. Providing the correct incentive to those who regularly visit nursing homes and are vested in the standard of care may provide a public-private incentive alternative to command-and-control regulation.

163. *See* Walshe, *supra* note 162, at 140.

164. Michael Brady, *Ctrs. for Medicare & Medicaid Servs.: States haven't inspected nearly half of nursing homes,* MOD. HEALTHCARE (June 1, 2020), https://www.modernhealthcare.com/patient-care/cms-states-havent-inspected-nearly-half-nursing-homes.

165. *See id.*

166. Walshe, *supra* note 162, at 136; Philip C. Aka et. al., *Political Factors and Enforcement of the Nursing Home Regulatory Regime*, 24 J.L. & HEALTH 1, 17, 19 (2011).

167. U.S. GEN. ACCT. OFF., GAO-03-561, NURSING HOME QUALITY: PREVALENCE OF SERIOUS PROBLEMS, WHILE DECLINING, REINFORCES IMPORTANCE OF ENHANCED OVERSIGHT (2003).

168. Y. Li et al, *State Regulatory Enforcement and Nursing Home Termination from the Medicare and Medicaid Programs*, 45 HEALTH SERVS. RSCH. 1796–1814 (2010).

169. *Id.*

burden on state finances. In South Dakota, nursing homes lose fifty-eight dollars a day for each Medicaid-supported resident, resulting in sixty-six million dollars in annual losses. [170] Unsurprisingly, health economists have confirmed that the quality of nursing home care is strongly associated with robust standards and larger state enforcement budgets.[171]

### *B. The Market for Nursing Home Care and Its Failures*

In well-functioning markets, multiple and diverse sellers differentiate their products or services according to price, quality, and scale to multiple and diverse buyers with access to low-cost information and time to decide between sellers' offerings.[172] Mutual gains from transactions abound.[173] If such a world existed for nursing homes, federal and state regulation would be less necessary. Underperforming nursing homes would attract few residents; high-performing nursing homes would be limited in size by the need to invest the optimal resources per resident; and families, with access to abundant, inexpensive information on performance, would be able to transfer their loved ones from the former to the latter without cost.[174]

The nursing home market, to the extent that it is one, is characterized by sellers driven by both profit and charitable motives, the former attempting to maximize profit out of fixed government reimbursements; buyers who often make decisions in crisis, with high costs of information to the extent information is even sought; and, once in residence, the costs of transfer are generally

170. Jack Healy, *Nursing Homes are Closing Across Rural America, Scattering Residents*, N.Y. TIMES (Mar. 4, 2019), https://www.nytimes.com/2019/03/04/us/rural-nursing-homes-closure.html.

171. *See, e.g.*, Mo. Dep't. of Health & Senior Serv., *Nursing Home Inspections*, https://health.mo.gov/safety/nursinghomesinspected/index.php (last visited Feb. 14, 2020) (requiring two annual inspections, more than the federally mandated minimum).

172. Deborah Stone, *Shopping for Long-Term Care*, 23 HEALTH AFF. 191, 192 (2004); *see also* Alvin E. Roth, *The Art of Designing Markets*, 85 HARV. BUS. REV. 118–20 (2007), https://hbr.org/2007/10/the-art-of-designing-markets; *see also* Meera Singh, *Product Quality for Competitive Advantage in Marketing*, 2 INT'L J. OF BUS. AND MGMT. INVENTION 5 (2013).

173. *See* Singh, *supra* note 172, at 5.

174. D.B. Mukamel et. al., *When Patients Customize Nursing Home Ratings, Choices and Rankings Differ from the Government's Version*, 35 HEALTH AFF. 714, 716, 718 (2016); R. Tamara Konetzka & Marcelo Coca Perraillon, *Use of Nursing Home Compare Website Appears Limited by Lack of Awareness and Initial Mistrust of the Data*, 35 HEALTH AFF. 706, 706, 712 (2016); John Jacobi, *Competition Law's Role in Health Care Quality*, 11 ANNALS HEALTH L. 45 (2002).

insuperable.[175] Indeed, as detailed in Part IV, there are few if any foreign jurisdictions in which the market for nursing home care is truly private. In the countries that managed to keep nursing home deaths low—Australia, Finland, New Zealand, Singapore, and South Korea—the state is either a significant direct provider of nursing home care or plays a significant role in the regulation of the nursing home market.

#### i. The Division Between For-Profit and Non-Profit Providers

In the United States, nearly seventy percent of the country's approximately 16,000 nursing homes are organized as for-profit entities, and fifty-seven percent are run by chains; they are largely kept as real estate investments.[176] In Texas, for example, the largest provider of nursing home services, Senior Living Properties, is organized as a limited liability company and manages fifty facilities with approximately 4,500 beds.[177] The second largest is Pyramid Healthcare Corp., organized as a for-profit corporation and managing ten facilities with approximately 1,000 beds.[178] The revenue models for nursing homes assume government reimbursement at fixed rates, which creates an incentive to adopt staffing and compliance policies that maximize the portion of reimbursements that go to investors.[179]

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175. *See* Kristin Madison, *Health Care Quality Reporting: A Failed Form of Mandated Disclosure?*, 13 IND. HEALTH L. REV. 310, 329 (2016); *see also* Stone, *supra* note 172, at 192, 195–96; Vikram R. Comondore et al., *Quality of Care in For-Profit and Not-For-Profit Nursing Homes: Systematic Review and Meta-Analysis*, THE BMJ (Aug. 4, 2009), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2721035. *See generally* Douglas A. Berman, *Developments in the Law: Nonprofit Corporations*, 105 HARV. L. REV. 1578, 1620, 1623 (1992) ("Contract failure occurs when 'consumers' cannot readily compare services before 'purchase,' or cannot adequately evaluate performance, as may occur in the case of home nursing care and day care service.").

176. Abigail Abrams, *A License for Neglect*, TIME (May 14, 2020 2:40 PM), https://time.com/5835228/nursing-homes-legal-immunity-coronavirus; Comondore et al., *supra* note 175.

177. U.S. DEP'T OF HEALTH & HUMAN SERVS., NURSING HOME OWNERSHIP TRENDS AND THEIR IMPACT ON QUALITY OF CARE 9 (2009). *See generally* Alex Spanko, *Genesis Continues ACO Push with Senior Living Properties Partnership*, SKILLED NURSING NEWS (Jan. 22, 2020), https://skillednursingnews.com/2020/01/genesis-continues-aco-push-with-senior-living-properties-partnership (stating that Senior Living Properties is entering a new partnership that will affect its 37 facilities in Texas and Oklahoma).

178. U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 177.

179. *See* Comondore et al., *supra* note 175. *See generally* Henry B. Hansmann, *The Role of Nonprofit Enterprise*, 89 YALE L.J. 835, 864 (1980) ("Because the quality of the nursing services

Nursing home care is expensive, and it is largely supported by Medicaid and to a lesser extent Medicare and the private market.[180] A private room in a nursing home has a median cost of $8,517 a month, and the average nursing home stay is 835 days; therefore, paying out of pocket is not affordable for most residents or their families.[181] Medicaid covers sixty-two percent of nursing home residents.[182]

Medicare, which generally covers persons age sixty-five and over who are eligible for Social Security Benefits, does *not* generally cover nursing home care.[183] Nursing home care is only covered by Medicare "if it follows within 30 days (generally) of a hospitalization of 3 days or more and is certified as medically necessary."[184] Medicare only provides up to one-hundred days of coverage per benefit period and only covers nursing care if the patient requires skilled nursing and rehabilitation services.[185]

Nursing home providers are whipsawed between the interests of the federal programs. Investing more in staff, training, and facilities in nursing homes prevents hospitalizations, and therefore costs to Medicare, but the cost of doing so is borne primarily by owners and the state through Medicaid payments.[186] Investing less in nursing home staff, training, and facilities means more money in the pockets of investors and state coffers, especially as some Medicare reimbursements can be earned post-hospitalization, but resident time in hospitals costs nursing homes reimbursement on those

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and medication provided by a nursing home might be difficult to judge, a proprietary nursing home operator can often get away with providing low-quality services while charging exorbitant prices, or providing unneeded services and billing the patient for the cost.").

180. Caroline Pearson et al., *The Forgotten Middle: Many Middle-Income Seniors Will Have Insufficient Resources for Housing and Healthcare*, 38 HEALTH AFF. 851, 852 (2019); Jacobi, *supra* note 174, at 63.

181. David Levine, *How to Pay for Nursing Home Costs*, U.S. NEWS & WORLD REP. (July 10, 2019), https://health.usnews.com/best-nursing-homes/articles/how-to-pay-for-nursing-home-costs.

182. *Medicaid's Role in Nursing Home Care*, KAISER FAM. FOUND. (June 20, 2017), https://www.kff.org/infographic/medicaids-role-in-nursing-home-care.

183. Earl Dirk Hoffman, Jr. et al., *Overview of the Medicare and Medicaid Programs*, 22 HEALTH CARE FINANCE REV. 1, 4–6 (2000).

184. *Id.* at 4.

185. *Id.*

186. David Grabowski, *Medicare and Medicaid: conflicting incentives for long-term care*, 85 MILBANK Q. 4, 579, 587 (2007).

days, unless a state has a "bed-hold" policy in place, explained below.[187]

For-profit nursing homes generally maximize return to their shareholders, necessarily deemphasizing quality of care.[188] This explains some studied differences between outcomes at for-profit versus non-profit nursing homes. According to the IOM, for-profit nursing homes devote fewer resources to patient care.[189] In aggregate, not-for-profit nursing homes devote more resources to patient care, receive fewer citations for violations, fewer complaints and generally achieve higher outcome-oriented measures, all of which illustrate that not-for-profit nursing homes provide better care.[190] The findings of the IOM have been replicated. There are three main categories to evaluate nursing home care.[191] Those categories are structure, process, and outcomes.[192] Structure refers to the resources used to provide care, process refers to actions used to provide care, and outcomes refer to the results the patients' experience.[193] Since the IOM's report, it has been found that not-for-profit nursing homes have higher levels of staffing and fewer deficiencies than for-profit nursing homes.[194] Also, for-profit nursing homes are more likely to decrease spending on patients to increase profits.[195] For-profit facilities were found to have the lowest staffing levels and the highest number of deficiencies.[196]

A 2010 study by the GAO found that facilities labeled by the CMS as a Special Focus Facility are more likely to be both part of a chain and more likely to be for-profit than non-profit.[197] The *New York Times* in a 2007 report found that private nursing homes were forty-one percent more profitable than non-profit nursing

187. *Id.* at 588.

188. Charlene Harrington et al., *Ownership, financing, and management strategies of the ten largest for-profit nursing home chains in the Unites States*, 41 INT'L J. HEALTH SERVS. 725, 727 (2011).

189. *Non-Profit vs. For-Profit Nursing Homes: Is there a Difference in Care?*, CTR. FOR MEDICARE ADVOC. (Mar. 15, 2012), https://medicareadvocacy.org/non-profit-vs-for-profit-nursing-homes-is-there-a-difference-in-care.

190. *Id.*

191. *Id.*

192. *Id.*

193. *Id.*

194. *Id.*

195. *Non-Profit vs. For-Profit Nursing Homes: Is there a Difference in Care?*, *supra* note 189.

196. *Id.*

197. *Id.*

homes.[198] A study by LeadingAge New York found that not-for-profit facilities performed better on most measures than for-profit facilities, had fewer residents using antipsychotic drugs or physical restraints, had lower hospitalization rates, had more discharges to home, had more nursing staff, had fewer deficiencies, and spent more money on nursing and food.[199] In a review and analysis of eighty-two different studies on nursing homes, not-for-profit nursing homes were found to have higher quality staffing, lower prevalence of pressure ulcers, lower prevalence of restraints, and fewer government cited deficiencies.[200] The reviewers of the studies estimated that if all nursing homes in the U.S. were not-for-profit, then 7,000 fewer residents would experience pressure sores—injuries to skin and underlying tissue resulting from lying for long periods of time in the same position.[201] Nursing home residents would receive 500,000 more hours of care per day if practices at not-for-profit nursing homes were adopted across all facilities.[202]

Death rates and rates of residents who experience pressure sores are higher in for-profit nursing homes compared to not-for-profit nursing homes.[203] For-profit nursing homes are also more likely to use restraints and psychoactive drugs compared to not-for-profit nursing homes.[204] These interventions reduce the need for staff. [205]

State regulatory action is viewed as a burden on investments. Observing nursing home regulations is estimated to cost an average of $208 per nursing home bed and approximately $22,000 per nursing home.[206] This includes monitoring compliance, educational programs for the facilities, investigations of reported neglect, and the process and procedure for conducting surveys.[207]

198. *Id.*

199. *Id.*

200. *Id.*

201. CTR. FOR MEDICARE ADVOC., *supra* note 189.

202. *Id.*

203. *Id.*

204. DAVID P. PAUL, III ET. AL., QUALITY OF CARE AND PROFITABILITY IN NOT-FOR-PROFIT VERSUS FOR PROFIT NURSING HOMES 93 (2016), https://mds.marshall.edu/cgi/viewcontent.cgi?referer.

205. Charles D. Phillips et al., *Reducing the Use of Physical Restraints in Nursing Homes: Will it Increase Costs?*, 83 AM. J. PUB. HEALTH, 342, 343 (1993).

206. Walshe, *supra* note 137, at 132.

207. *Id.*

Not-for-profit nursing homes generally provide better staffing and higher quality services compared to for-profit nursing homes, although they represent only one-third of current facilities.[208] Nursing home residents would receive 500,000 more hours of care per day if all nursing homes were not-for-profit.[209] Not-for-profit nursing homes have been found to provide higher quality care in both process-based and outcome-based tests.[210]

Quality of care is strongly associated with the staffing level of the facility. Non-profit nursing homes tend to maintain more staff, who are better trained than for-profit nursing homes.[211] In a study comparing the ten largest for-profit nursing home chains in the United States to comparable not-for-profit nursing homes, for-profit nursing homes were found to have lower levels of registered nurse staffing and less total staffing hours than non-profit facilities.[212] "The top ten FP chains were also significantly below the national average for LPN staffing, and were also cited for over thirty-six percent more quality deficiencies and forty-one percent more severe deficiencies than NFP facilities. These deficiencies included failure to alleviate pressure sores, injuries, inspections, mistreatment of residents, and poor sanitary conditions."[213]

### ii. Consolidation in the Nursing Home Sector with Adverse Effects on Care

The for-profit share of nursing home care is not only growing, but consolidating. In 2015, Genesis Healthcare merged with the Skilled Healthcare group.[214] After the merger, Genesis operated over 500 nursing homes in thirty-four states.[215] ProMedica Health System's merger with HCR ManorCare created a seven-billion

208. Charlene Harrington, *Residential nursing facilities in the United States*, 23 THE BMJ 507, 507 (2001), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1121085.

209. CTR. FOR MEDICARE ADVOC., *supra* note 189.

210. PAUL ET AL., *supra* note 204, at 93.

211. *Id.*

212. *Id.*

213. *Id.*

214. *History*, GENESIS, https://www.genesishcc.com/about-us/company-profile/history (last visited Feb. 16, 2021).

215. *Id.*

dollar conglomerate in thirty states.[216] The five largest nursing home chains are Genesis Healthcare with over 500 nursing homes, ProMedica/HCR Manorcare with 239 nursing homes, Life Care Centers for America with 214 nursing homes, Atlanta's Sava Senior Care with 201 nursing homes, and the Ensign group with 169 nursing homes.[217] The top five largest nursing home chains own five percent of all nursing homes in the U.S.[218]

A study by *The Sacramento Bee* explored the effectiveness of the twenty-five largest nursing home chains in California, which controlled about half of the 120,000 nursing home beds in the state.[219] The top five chains control about twenty percent of the nursing home beds in the state.[220] California nursing homes owned by Genesis healthcare, one of the largest nursing homes in California, had seven times as many complaints of abuse in 2013 than the average.[221] Genesis healthcare was not an outlier—nine out of the ten largest nursing home chains in the state were below the state average in three out of five staffing measures in 2012.[222] *The Sacramento Bee* found that it was virtually impossible for the general public to take the performance of the nursing home into account when choosing a nursing home.[223]

Between 2013 and 2015, there were 280 nursing home mergers totaling $25.75 billion.[224] The mergers have generally resulted

216. John Commins, *Promedica Finalizes $3.3 B HCR Manorcare Acquisition*, HEALTH LEADERS (July 27, 2018), https://www.healthleadersmedia.com/finance/promedica-finalizes-33b-hcr-manorcare-acquisition.

217. Marty Stempniak, *Genesis leads in new analysis of nursing home chains*, MCKNIGHT'S LONG-TERM CARE NEWS (Oct. 26, 2018), https://www.mcknights.com/news/genesis-leads-in-new-analysis-of-nursing-home-operators.

218. *Id.*

219. *Unmasked: How California's Largest Nursing Home Chains Perform*, CANHR, http://www.canhr.org/newsroom/newdev_archive/2014/Unmasked_How_CA_largest_NH_perform.html (last visited Feb. 16, 2021).

220. *Id.*

221. *Id.*

222. *Id.*

223. Marjie Lundstrom & Phillip Reese, *California Falls Short in Disclosing Nursing-Home Ownership*, SACRAMENTO BEE (Nov. 10, 2014, 10:00 AM), http://www.sacbee.com/news/investigations/nursing-homes/article3657510.html.

224. *Mergers and Acquisitions Long-Term Care Leads the Way*, LEADING AGE (Mar. 3, 2015), https://www.leadingage.org/corporatepartners/mergers-and-acquisitions-long-term-care-leads-way.

in reduced investments in resident care.[225] A study conducted by researchers at University of California San Francisco found that the number of deficiencies and serious deficiencies increased in years after mergers in comparison to the years before.[226] A 2007 *New York Times* analysis focused on a single facility that was acquired by a private nursing home chain.[227] One year after acquisition, the number of RNs was cut in half as was spending on nursing supplies and activities for residents, which resulted in poorer resident care overall.[228] Echoing the *New York Times* study, in 2016, David Grabowski and his co-authors published a study in *Health Affairs* that examined nursing home mergers from 1993–2010.[229] They found that nursing homes that merged with major nursing home chains received more health deficiency citations than those nursing homes that had undergone no change in ownership.[230] The theory behind the drop in level of care post-merger is that major private nursing home chains targeted failing independent facilities with various deficiency citations.[231] Moreover, even facilities that were owned by a nursing home chain that later merged with a different nursing home chain had higher deficiencies than other chain-owned nursing homes on average.[232]

Federal regulatory review of nursing home mergers focuses on conventional competition criteria, not resident welfare. A dated but relevant example illustrates. In 1984, the Department of Justice sued Beverly Enterprises—even at that time a large, national nursing home operator with a long record of sanctions from both state and federal authorities—to enjoin its merger with Southern Medical Services, a regional operator focused on Alabama and Georgia markets. The Department of Justice was aware of the problem, but rarely pursued enforcement to combat mergers to completion.[233] The rationale for the litigation was not that the acquisition would

225. Charlene Harrington et al., *Nurse Staffing and Deficiencies in the Largest For-Profit Nursing Home Chains Owned by Private Equity Companies*, 47 HEALTH SERVS. RSCH. 106, 123 (2012).

226. *Id.*

227. *Id.*

228. *Id.*

229. David C. Grabowski et al., *Low-Quality Nursing Homes Were More Likely Than Other Nursing Homes To Be Bought Or Sold By Chains In 1993–2010*, 35 HEALTH AFF. 907, 907 (2016).

230. *Id.* at 907, 909–10.

231. *Id.*

232. *Id.* at 909–10.

233. *Government Sues to Block Nursing Home Merger*, ASSOCIATED PRESS (Jan. 18, 1984).

reduce resident care, but that there would simply be fewer operators of already inferior care.[234] Beverly Enterprises already operated more than 800 nursing homes, and Southern Medical operated a total of forty-nine nursing homes in metropolitan areas of Alabama and Georgia.[235] The Justice Department noted that if the deal concluded, Beverly Enterprises would control twenty-nine percent of the nursing home beds in Macon, thirty-five percent in Augusta, forty-eight percent in Montgomery, and thirty-six percent in Mobile.[236] If any new nursing home wanted to open in one of those cities, it was required by law to get a certificate of need from a regulatory state body before it could open for business.[237] This certificate of need would be difficult to obtain with a Beverly homogeny.[238] There already exist concerns with private nursing homes with respect to the limited transparency available to consumers.[239] This limited transparency combined with a desire for profit is supplemented with a virtual inability for new competition to arise.

#### iii. The Spatial Marginalization of Nursing Homes

Against the backdrop of a market structure under which nursing home managers manipulate federal reimbursement and state enforcement that enjoys few incentives to robustly enforce federal mandates, local law also pushes nursing homes to the figurative, metaphorical, and experienced periphery of the communities they need.[240]

Nursing homes, like other institutions established for vulnerable and marginal populations, suffer from the not-in-my-backyard, or "NIMBY," discrimination typified by "a community's reaction to the influx of a new and unwanted segment of the general

234. *Id.*; U.S. v. Beverly Enterprises, Civ. Act. No. 84-70-1 (M.D. Ga. 1984).

235. *Government Sues to Block Nursing Home Merger, supra* note 233.

236. *Id.*

237. *Id.*

238. *Id.*

239. U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-11-571, PRIVATE INVESTMENT HOMES SOMETIMES DIFFERED FROM OTHERS IN DEFICIENCIES, STAFFING, AND FINANCIAL PERFORMANCE 1 (2011).

240. *See generally* Robert Weech-Maldonado et al., *Nursing Home Quality and Financial Performance: Is There a Business Case for Quality?*, 56 INQUIRY 1, 3 (2019).

population."[241] Often these communities will recognize the needs for the service provided, but they do not want the burden of its presence in their community.[242] "[E]lderly housing facilities still receive treatment similar to that of homeless shelters and halfway houses."[243] Nursing homes are associated with traffic, too much space for parking, decrepit appearances, and people, both residents and staff, stigmatized as lazy, unemployed, and undesirable.[244] Additionally, nursing home residents suffering from dementia, Alzheimer's, and cognitive impairments are perceived to raise issues of safety for surrounding communities.[245]

These prejudices are codified in zoning laws, which may adopt definitions of "nursing home" that differ from state and federal law.[246] Aside from the above negative notions from the communities themselves, nursing home builders often must navigate additional bureaucratic hurdles. Communities sometimes attempt to exclude them altogether.[247] Zoning laws often put nursing homes on the outskirts of the town, taking residents away from essential services.[248]

Nursing homes often fall into special exception or conditioned use zoning categories.[249] These categories require additional standards to be met to determine if the special exception would have an adverse effect on the community.[250] In several cases, the potential adverse effects that resulted in a denial from zoning boards have been as simple as the possible odors from the kitchen

241. Michael Kling, *Zoned Out: Assisted-Living Facilities and Zoning*, 10 ELDER L. J. 187, 196 (2002).

242. *Id.*

243. *Id.* at 197–98.

244. *Id.* at 197.

245. *See id.* at 196, 197–98.

246. Youth Shelter, Inc. v. Zoning Bd. of Appeals of City of Stamford, No. CV 92 0124456 S. 1993 WL 21245, at * 1–3 (Conn. Super. Ct. Jan. 20, 1993) (concluding that youth shelter facility qualified as "nursing home"). Kastendike v. Baltimore Ass'n for Retarded Children, Inc., 297 A.2d 745, 748–49, (Md. 1972) (holding that zoning ordinance that defined convalescent, nursing or rest home as home for the aged, chronically ill, infirm or incurable persons, or places of rest for those persons suffering bodily disorders but not including hospitals, clinics or similar institutions devoted primarily to diagnosis and treatment of disease and injury or mental illness, included operation of home for the care of other adults requiring mental and emotional care).

247. Urban Farms, Inc. v. Borough of Franklin Lakes, 431 A.2d 163, 166, 172 (N.J. Super. Ct. App. Div. 1981).

248. Kling, *supra* note 241, at 200.

249. *Id.* at 201, 203.

250. *Id.* at 201, 202–03.

and dumpster, intrusion of a residential neighborhood, or erosion from construction.[251] These zoning restrictions have been addressed with age-restricted zones.[252] While in theory this would help counteract zoning regulations, it often creates another hoop to jump through for developers.[253] Municipalities may also exclude the elderly population through amendments requiring stipulations on the projects permitted, such as having to be a certain size, address landscaping so as to obscure the facility, and other requirements that favor assisted living.[254]

Under the Fair Housing Act, nursing homes should be protected from exclusionary zoning laws.[255] The Fair Housing Amendments Act of 1988 ("FHAA") extended the protections of the Fair Housing Act to ensure that discrimination in housing practices was not permitted against persons whom are handicapped or disabled.[256] Within the FHAA, "handicapped" is broadly defined "to include persons with physical or mental impairments that substantially impair one or more of the person's major life activities."[257] These life activities include "caring for oneself, walking, seeing, hearing, speaking, breathing, learning, and working."[258]

While the FHAA protects those in nursing homes from discrimination, this does not address zoning scenarios that create elder care deserts or limit building new nursing homes altogether in some places.[259] These care deserts are due to nursing homes not being able to be built in the first place and pushing nursing homes into undesirable locations.[260] Overall, nursing homes are being pushed out of urban areas and closing in rural ones, but they are not welcomed in suburban areas either.[261] This results in nursing

251. *Id.* at 203.

252. Taxpayers Ass'n of Weymouth Township v. Weymouth Township, 364 A.2d 1016, 1021 (N.J. 1976).

253. *See id.* at 1039, 1040.

254. *See id.* at 1022, 1039.

255. A. Kimberly Hoffman & James Landon, *Zoning and the Aging Population: Are Residential Communities Zoning Elder Care Out?*, 44 URB. LAW. 629, 634–36 (2012).

256. 42 U.S.C. § 3602(h).

257. *Id.* § 3602(h)(1).

258. *Id.* § 12102(2)(a).

259. Hoffman & Landon, *supra* note 255, 634–35.

260. *Id.*

261. *See, e.g.*, Kling, *supra* note 241, 197–98, 200.

homes being on the outskirts of communities, away from essential places and distanced from family members.[262]

The changing spatial distribution of nursing homes also overlaps with racial disparities in nursing home care.[263] Nursing homes are increasingly used by the minority elderly population while the white population moves toward home health care and assisted living.[264] In general, around two-percent of nursing homes close annually, and those closures are disproportionately among hospital-based facilities, serving minority areas, in urban areas.[265] Together, zoning laws and the economics of closure are pushing minority elderly communities, who are more likely to use nursing home care, away from hospitals and their support communities.[266] At the same time, nursing homes serving rural areas are also closing at an accelerated rate.[267]

## IV. HOW FEDERAL AND STATE LEGAL STRUCTURES CHANNELED COVID-19 INTO NURSING HOMES

Pathogens almost always enter nursing homes from outside—caregivers, visitors, practitioners—and therefore once presented with the possibility of an easily transmitted, virulent pathogen, facilities should be able to identify resources and personnel needed, lock down, allow only essential entrants, and aggressively test those essential personnel.[268] Indeed, in countries and a few municipalities that prevented infection in their nursing homes, that is precisely what they did.[269]

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262. *Id.* at 200, 203.

263. *See* Stephen Frochen et al., *Residential Care in Los Angeles: evaluating the spatial distribution of facilities and neighborhood access to care among older adults*, 24 LOCAL ENV'T: INT'L J. JUST. AND SUSTAINABILITY 274, 283–84 (2019).

264. *Id.* at 275, 281.

265. Zhanlian Feng et al., *Geographic Concentration and Correlates of Nursing Home Closures: 1999-2008*, 171 ARCHIVES INTERNAL MED. 806, 810 (2011).

266. Zhanlian Feng et al., *Growth of Racial And Ethnic Minorities In US Nursing Homes Driven By Demographics And Possible Disparities In Options*, 30 HEALTH AFF. 1358, 1359 (2011).

267. Jack Healy, *Nursing Homes are Closing Across Rural America, Scattering Residents*, N.Y. TIMES (Mar. 4, 2019), https://www.nytimes.com/2019/03/04/us/rural-nursing-homes-closure.html.

268. Chih-Cheng Lai et al., *COVID-19 in Long-Term Care Facilities: An Upcoming Threat that Cannot be Ignored*, 53 J. MICROBIOLOGY, IMMUNOLOGY & INFECTION 444, 445–46 (2020).

269. *See* Anna Wilde Matthews et al., *Covid-19 Stalked Nursing Homes Throughout the World*, WALL ST. J. (Dec. 31, 2020, 12:36 PM), https://www.wsj.com/articles/covid-19-stalked-nursing-homes-around-the-world-11609436215.

Once COVID-19 enters a nursing home, it spreads rapidly.[270] Residents take meals and commune in common spaces; there is little personal protective equipment ("PPE") available; and many residents have preexisting respiratory conditions that make coughing more frequent.[271] Nursing home residents share the same air, food, water, caregivers, and medical care.[272] Despite COVID-19 sometimes spreading asymptomatically, before widespread availability of testing, and even now, nursing homes are generally able to identify only symptomatic residents.[273] But, testing remains erratic.[274] This allowed a seemingly healthy COVID-19 positive patient to pass the virus to other residents, who then developed severe illness.[275] Even after the pandemic was declared, nursing homes generally failed to observe federal standards in place to prevent the spread of infectious diseases, including regular hand-washing and donning masks.[276]

The United States confirmed its first case of COVID-19 on January 20, 2020; the Centers for Disease Control and Prevention ("CDC") lifted all federal restrictions on COVID-19 testing on March 3, 2020;[277] a U.S. National Emergency was declared on March 13, 2020; and the first CDC recommendations on social gatherings were issued on March 15, 2020.[278]

In the U.S., the first COVID-19 case to develop in a nursing home occurred in the same location as the broader outbreak:

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270. *See* Jessica Glenza, *COVID-19: Nursing Homes Account for 'Staggering' Share of US Deaths, Data Shows*, THE GUARDIAN (May 11, 2020, 6:00 PM), https://www.theguardian.com/us-news/2020/may/11/nursing-homes-us-data-coronavirus.

271. *Id.*

272. Chih-Cheng Lai et al., *supra* note 268, at 445.

273. *See* Glenza, *supra* note 270.

274. *Id.*

275. Anne Kimball et al., *Asymptomatic and Presymptomatic SARS-CoV-2 Infections in Residents of a Long-Term Care Skilled Nursing Facility – King County, Washington, March 2020*, 69 MORBIDITY & MORTALITY WKLY, REP. 377, 378 (2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6913e1.htm.

276. *See, e.g.*, Debbie Cenziper, *Major Nursing Home Chain Violated Federal Standards Meant to Stop Spread of Disease Even After Start of COVID-19, Records Show*, WASH. POST (May 17, 2020, 2:14 PM), https://www.washingtonpost.com/investigations/major-nursing-home-chain-violated-patient-care-infection-control-standards-before—and-after—pandemic-started-records-show/2020/05/16/f407c092-90b1-11ea-a0bc-4e9ad4866d21_story.html.

277. Associated Press, *U.S. Surpasses 100,000 Deaths from COVID-19: Johns Hopkins University*, CBC (May 27, 2020, 6:13 PM), https://www.cbc.ca/news/world/u-s-surpasses-100-000-deaths-from-covid-19-johns-hopkins-university-1.5587490.

278. Derrick Taylor, *How the Coronavirus Pandemic Unfolded: A Timeline*, N.Y. TIMES (May 26, 2020), https://www.nytimes.com/article/coronavirus-timeline.html.

Seattle, Washington.[279] Beginning in mid-February 2020, a nursing home there experienced a cluster of febrile respiratory illnesses among its residents, all of whom tested negative for influenza but showed COVID-19 symptoms.[280] That nursing home housed 130 residents cared for by 170 staff.[281] One patient was transferred to a hospital with worsening conditions on February 24.[282] She died on March 2.[283] That facility experienced 129 cases of COVID-19, including eighty-one of the residents, thirty-four staff members, and fourteen visitors; twenty-three people died.[284] To combat this,

> Local and state authorities implemented comprehensive prevention measures for long-term care facilities that included 1) implementation of symptom screening and restriction policies for visitors and nonessential personnel; 2) active screening of health care personnel, including measurement and documentation of body temperature and ascertainment of respiratory symptoms to identify and exclude symptomatic workers; 3) symptom monitoring of residents; 4) social distancing, including restricting resident movement and group activities; 5) staff training on infection control and PPE use; and 6) establishment of plans to address local PPE shortages, including county and state coordination of supply chains and stockpile releases to meet needs.[285]

On March 13, 2020, CMS issued guidance to nursing homes encouraging limitation of access by visitors, monitoring of symptoms for those coming from outside, and shutting down communal gatherings, but nevertheless allowing transfer of patients between hospitals and nursing homes, even if there were infections in the

279. Temet M. McMichael et al., *COVID-19 in a Long-Term Care Facility — King County, Washington, February 27–March 9, 2020*, 69 MORBIDITY & MORTALITY WKLY, REP. 339, 339 (2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e1.htm.

280. *Id.*

281. *Id.*

282. *Id.*

283. *Id.*

284. *Id.*

285. McMichael et al., *supra* note 279.

former.[286] CMS announced nursing home testing on March 30, 2020 but did not require reporting of cases to all residents and their families until May 8, 2020.[287] CMS issued a call to action for nursing homes and state and local governments to work closely on access to testing and PPE) only PPE on April 2, 2020.[288]

On March 25, 2020, the New York Department of Health issued an order that nursing homes *must* readmit residents sent to hospitals with the coronavirus and accept new patients as long as they were deemed "medically stable."[289] The order prohibited nursing homes from testing residents for COVID-19 prior to admission or readmission.[290] Theoretically, these orders were designed to ensure that states would not overcrowd intensive care units.[291] But well after hospitalizations peaked, governors maintained those mandates.[292] As recently as April 23, 2020, New York's governor Andrew Cuomo declared that nursing homes "don't have a right to object" to accepting elderly patients with active COVID-19 infections.[293]

On May 10, 2020—after the deaths of nearly 3,000 New York residents of nursing homes and assisted living facilities—the order was partially rescinded.[294] California, Michigan, New Jersey, and Pennsylvania similarly instructed nursing homes that they could not

286. CTRS. FOR MEDICARE & MEDICAID SERVS., GUIDANCE FOR INFECTION CONTROL AND PREVENTION OF CORONAVIRUS DISEASE 2019 (COVID-19) IN NURSING HOMES 2–5 (2020), https://www.cms.gov/files/document/3-13-2020-nursing-home-guidance-covid-19.pdf

287. Press Release, CTRS. FOR MEDICARE AND MEDICAID SERVS., *CMS Announces Indep. Comm'n to Address Safety and Quality in Nursing Homes* (Apr. 30, 2020), https://www.cms.gov/newsroom/press-releases/cms-announces-independent-commission-address-safety-and-quality-nursing-homes.

288. *Id.*

289. Luis Ferré-Sadurní & Amy Julia Harris, *Does Cuomo Share Blame for 6,200 Virus Deaths in N.Y. Nursing Homes?*, N.Y. TIMES (July 8, 2020), https://www.nytimes.com/2020/07/08/nyregion/nursing-homes-deaths-coronavirus.html.

290. *Id.*

291. Kim Barker & Amy Julia Harris, *Playing Russian Roulette: Nursing Homes Told to Take the Infected*, N.Y. TIMES, https://www.nytimes.com/2020/04/24/us/nursing-homes-coronavirus.html (last updated May 7, 2020).

292. Avik Roy, *The Most Important Coronavirus Statistic: 42% Of U.S. Deaths Are From 0.6% of the Population*, FORBES (May 26, 2020), https://www.forbes.com/sites/theapothecary/2020/05/26/nursing-homes-assisted-living-facilities-0-6-of-the-u-s-population-43-of-u-s-covid-19-deaths/#59344af674cd; McMichael TM, Currie DW, Clark S, et al., *Epidemiology of Covid-19 in a Long-Term Care Facility in King County, Washington*, 382 NEW ENG. J. MED. 2005, 2005–11 (2020).

293. Roy, *supra* note 292.

294. *Id.*

reject medically stable patients diagnosed with COVID-19.[295] In just one New Jersey nursing home, at least fifty-three residents died after the sick were housed with the healthy and staffers had little more than rudimentary face shields for protection.[296] California, Massachusetts, Michigan, and New Mexico offered payment incentives for nursing homes to accept COVID-19 patients.[297]

### *A. Ex Ante Incentives to Move Nursing Home Residents to Hospitals*

Given the discrepancy between stated reasons that states issued and maintained these orders, the more likely reason is that the payment incentives between state and federal programs shaped the decisions. State Medicaid programs have little incentive to discourage hospitalization of nursing home residents as, once they are hospitalized, the cost of their care is shifted to the entirely federal Medicare program.[298]

Nursing homes, for their part, may benefit from "bed-hold" policies under which the state pays nursing homes a reduced rate to keep the patient's room or a similar room for when they return from the hospitalization.[299] Minnesota has a bed-hold policy of eighteen days, Washington State will reserve a bed for twenty days, and Connecticut for fifteen days.[300] Other states have determined the expense for a bed-hold is too costly. Alabama, Indiana, Iowa,[301]

295. Deborah Schoch, *Nursing Homes Balk at COVID Patient Transfers From Hospitals*, AARP (Apr. 21, 2020), https://www.aarp.org/caregiving/health/info-2020/coronavirus-transfers-to-nursing-homes.html; *Scalise Demands Answers from Governors on Nursing Home Tragedies*, REPUBLICAN WHIP, https://www.republicanwhip.gov/news/scalise-demands-answers-from-governors-on-nursing-home-tragedies (last updated on Dec. 2, 2020).

296. Olga Khazan, *The U.S. Is Repeating its Deadliest Pandemic Mistake*, ATLANTIC (July 6, 2020), https://www.theatlantic.com/health/archive/2020/07/us-repeating-deadliest-pandemic-mistake-nursing-home-deaths/613855.

297. Maggie Severns & Rachel Roubein, *States Prod Nursing Homes to Take More Covid-19 Patients*, POLITICO (June 4, 2020, 7:55 PM), https://www.politico.com/news/2020/06/04/states-nursing-homes-coronavirus-302134.

298. Grabowski, *supra* note 186, at 580, 586–87.

299. *See id.* at 588.

300. *Provider Manual: Nursing Facilities*, MINN. DEP'T OF HUM. SERVS. (Apr. 18, 2018), https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_008996; *see also* WASH. REV. CODE § 18.20.290 (2012); *see also* CONN. GEN. STAT. § 19a-537(c) (2017).

301. *See, e.g.*, THE NAT'L LONG-TERM CARE OMBUDSMAN RSCH. CTR., MEDICAID BED HOLD POLICIES BY STATE 13 (2019) (New York enacted a bed-hold rate cut in 2012, achieving $18M in annual savings).

Maryland, and Oklahoma have no bed-hold days.[302] New York eliminated its bed-hold reimbursement in 2017.[303] But even in these states, families may hold a bed if they privately pay for it.[304] The average bed-hold cost is between $300–$350 per day.[305] In a six-month period, pre-pandemic, fifteen percent of nursing home residents were hospitalized.[306]

Moreover, once a nursing home resident returns from hospitalization, Medicare covers, at generally double to triple the rate of Medicaid, up to one-hundred days of qualifying nursing home services.[307] Up to day twenty, Medicare covers one hundred percent of the stay; afterward, the patient is responsible for a co-pay. Transferring patients from hospitals is thus a win-win from the perspective of both states and investors.[308] The nursing home receives higher reimbursements, and the state does not have to pay for

302. MD. LEGAL AID, BEDHOLD FOR NURSING HOME RESIDENTS: KNOW THE FACTS 1 (2012); *see also* IND. FAM. & SOC. SERVS. ADMIN., INDIANA HEALTH COVERAGE PROGRAMS: PROVIDER REFERENCE MODULE 1, 19 (2021); *see also* OKLA. ADMIN. CODE § 317:30-5-126(2) (2015).

303. *Alert: 2017-18 Budget has Changed the SNF Bed-Hold Rules*, NYSHFA NEWS! (Apr. 13, 2017), http://update.nyshfa.org/en/1611953/1/6226/Alert-2017-18-Budget-%20has-Changed-the-SNF-Bed-Hold-Rules.htm.

304. MLN MATTERS, CHARGES TO HOLD A BED DURING SKILLED NURSING FACILITY ABSENCE 1–2 (2018).

305. Joanna R. Leefer, *Nursing Home Bed-Hold Days in New York are Eliminated*, ELDER CAREGIVING (July 9, 2017), http://joannaleefer.com/nursing-home-bed-hold-days-new-york-reduced.

306. Orna Intrator et. al., *Hospitalization of nursing home residents: the effects of states' Medicaid payment and bed-hold policies*, 42 HEALTH SERVS. RSCH. 1651, 1652 (2007).

307. Abrams, *supra* note 176 ("Patients who are discharged from a hospital and need to recover from COVID-19 in a nursing home will likely have their stay covered by Medicare, which on average reimburses nursing homes more than double what Medicaid does."); *see also* Paula Span, *In the Nursing Home, Empty Beds and Quiet Halls*, N.Y. TIMES (Sept. 28, 2018), https://www.nytimes.com/2018/09/28/health/nursing-homes-occupancy.html ("Generally, Medicare pays for short-term rehabilitative care in nursing homes following a hospital stay; however, Medicaid, administered by the states, covers long-term care."); *see also* Office of Inspector General, *Post-Hospital Skilled Nursing Facility Care Provided to Dually Eligible Beneficiaries*, U.S. DEP'T OF HEALTH & HUM. SERVS., https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000355.asp (last visited Feb. 5, 2021) ("Because Medicare pays substantially more for SNF care than Medicaid for nursing home care, nursing facilities have financial incentives to increase the level of care to 'skilled.'").

308. *See* Grabowski, *supra* note 186, at 584, 585 ("Because dual eligible can obtain similar home health services under both Medicare and Medicaid, cost shifting across the programs is possible. . . State Medicaid programs have taken advantage of these more liberal guidelines by employing a 'Medicare maximization' strategy whenever possible to ensure that Medicare is the primary payer of home health care services . . . . Unless Medicaid's costs are fully shifted to Medicare, those states with less generous Medicaid benefits may reduce their access to services.").

them.[309] The only losers are the residents, both sick and healthy, because the former's care is managed to maximize profit, and the latter are subjected to infection and likely premature death.[310]

At the CMS level, the most significant measure to address the staffing issue in nursing homes was waiver of the seventy-five hour training requirement for CNAs, replacing it with a free eight-hour online course.[311] This has permitted approximately 38,000 people to obtain certificates as temporary nurse's aides.[312] The intended effect would be more marginally trained personnel, supervised by even fewer qualified RNs and LPNs, although it would provide some people with jobs—again, all at the expense of the quality of care for residents.[313]

### *B. Ex Post Protection from Civil and Criminal Liability*

At the same time that infected nursing home residents were being managed in a way that maximized reimbursements and minimized care, states passed liability shields for nursing homes, and they remained a high-priority in the U.S. Senate until the 2020 elections. [314] Civil litigation would, of course, allow family members, regulators, and the public to obtain records and depositions through the discovery process to better understand what happened to deceased nursing home residents.[315] Federal and state directives to

309. *See* Abrams, *supra* note 176 ("During the pandemic, the Trump administration waived a rule that typically limits Medicare to paying for 100 days of skilled nursing care at a time . . . .").

310. *See* Intrator et al., *supra* note 306, at 1652 (Although there is insufficient research on the direct relationship between state Medicaid nursing home policies and hospitalizations, temporary acute conditions are more likely to occur in facilities with inadequate staffing. "In response to less generous Medicaid payments, nursing homes appear to reduce staffing and the use of nurse practitioners and physician assistants.").

311. Abigail Hauslohner & Maria Sacchetti, *Nursing Homes Turn to Quick Fix Training to Meet Pandemic Staffing Needs*, WASH. POST (May 28, 2020, 11:39 AM), https://www.washingtonpost.com/national/nursing-homes-turn-to-quick-fix-training-to-meet-pandemic-staffing-needs/2020/05/28/418c3802-a020-11ea-9590-1858a893bd59_story.html.

312. *Id.*

313. *Id.*

314. Debbie Cenziper, et. al., *As Nursing Home Residents Died, New COVID-19 Protections Shielded Companies From Lawsuits. Families Say that Hides the Truth*, WASH. POST (June 8, 2020), https://www.washingtonpost.com/business/2020/06/08/nursing-home-immunity-laws.

315. *Id.*

restrict visitors also restricted inspectors from investigating nursing home facilities and staff as well. [316]

Instead, governors issued emergency orders granting immunity to nursing homes for "good faith efforts under the notion that these acts are in the public interest."[317] Some states explicitly included nursing homes in the orders while others enveloped them within broadly defined heath care facilities.[318] Arizona's executive order explicitly stated that it shields nursing care institutions and assisted living facilities from civil liability, except for "gross negligence or reckless or willful misconduct."[319] Arizona's executive order was active until December 31, 2020.[320] Connecticut's order protected nursing homes if "they acted in good faith and without malice, gross negligence, or willful misconduct, and the actions would not otherwise constitute a crime, fraud, or a false claim."[321] Michigan adopted a statute covering any person who complied with all the applicable federal, state, and local rules about COVID-19 as immune from liability related to COVID-19.[322] The statute also specified that an isolated "de minimis" violation of one of the federal, state, or local rules would not affect immunity from liability.[323] Alabama issued an executive order declaring that no healthcare provider or other covered entity would be liable for death or injury related to COVID-19 unless the claimant showed by clear and convincing evidence that the death or injury was the result of the covered entity's wanton, reckless, willful, or intentional misconduct.[324] Georgia's statute provided that no healthcare facility would be liable for an action related to COVID-19 unless the claimant showed that the facility engaged in gross negligence, willful and

316. Human Rights Watch, *US: Ensure Oversight, Not Immunity, for Nursing Homes*, HUMAN RIGHTS WATCH (June 15, 2020, 12:00 AM), https://www.hrw.org/news/2020/06/15/us-ensure-oversight-not-immunity-nursing-homes.

317. Tara Sklar, et. al., *States are making it harder to sue nursing homes over COVID-19: Why immunity from lawsuits is a problem*, THE CONVERSATION (June 9, 2020, 8:19 AM), https://theconversation.com/states-are-making-it-harder-to-sue-nursing-homes-over-covid-19-why-immunity-from-lawsuits-is-a-problem-139820.

318. C. Frederick Geilfuss II et al., *COVID-19: States Protect Long-Term Care Facilities from Liability*, NAT'L L. REV. (May 1, 2020), https://www.natlawreview.com/article/covid-19-states-protect-long-term-care-facilities-liability.

319. *Id.*

320. Az. Exec. Order No. 42 (June 25, 2020).

321. Geilfuss et. al., *supra* note 318.

322. H.B. 6030, 100th Leg., Reg. Sess. (Mich. 2020).

323. *Id.*

324. Al. Exec. Order No. 508 (May 8, 2020).

wanton misconduct, reckless infliction of harm, or intentional infliction of harm.[325] Iowa passed a statute shielding health care providers from liability for claims arising out of the provider's actions to combat COVID-19.[326] The statute then enumerates circumstances where liability is shielded.[327] For example, injury or death resulting from treating someone with a confirmed or suspected case of COVID-19 is shielded.[328]

Even acts or omissions that are unrelated to COVID-19 but still support the state's response to COVID-19 are shielded.[329] Examples of acts that support the state's response to COVID-19 include issues with treating patients outside the normal scope of care of that provider, issues related to limited staff, and issues concerning the use or nonuse of PPE.[330] Wyoming passed a statute that grants immunity to health care providers during a public health emergency.[331] This immunity applies to providers who acted in good faith where good faith can be found by following the instructions of the state, city, town, or county.[332] Good faith can even be found if the provider does not strictly adhere to the applicable guidelines by the state, city, town, or county.[333] This immunity is voided if the provider performs an act or omission that is grossly negligent or is willfully and wanton misconduct.[334] The effect of liability shields is to ensure that even culpable actors are not held to account.[335] Over twenty-six states either shielded or are working to shield nursing homes from lawsuits pertaining to their approaches during COVID-19.[336]

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325. GA. CODE ANN. § 51-16-2 (2020).

326. IOWA CODE § 686D.6 (2020).

327. *Id.*

328. *Id.*

329. *Id.*

330. *Id.*

331. S.B. 1002, 65th Leg., Spec. Sess. (Wyo. 2020).

332. *Id.*

333. *Id.*

334. *Id.*

335. *See* Edward Longosz et al., *States Enact COVID-19 Business Liability Protections as Congress Deadlocks*, ECKERT SEAMANS (Dec. 14, 2020), https://www.eckertseamans.com/legal-updates/states-enact-covid-19-business-liability-protections-as-congress-deadlocks.

336. Samuel Brooks, Robyn Grant, & Michael F. Bonamerte, *States Move to Shield LTC Facilities from Civil Liability*, 41 ABA BIFOCAL 277, 277 (2020), https://www.americanbar.org/groups/law_aging/publications/bifocal/vol-41/vol-41—issue-no-6—july-august-2020-/states-move-to-shield-ltc-facilities-from-liability.

CMS reporting requirements, without liability shields, would provide a rich source of information by which families could hold responsible actors accountable.[337] Under the reporting requirements, nursing homes must report on a weekly basis suspected and confirmed infections among residents and staff, total deaths and COVID-19 deaths among residents and staff, PPE and hand hygiene supplies in the facility, ventilator capacity and supplies in the facility, resident beds and census, access to COVID-19 testing, and staffing shortages.[338]

## V. HOW DEATHS COULD HAVE BEEN PREVENTED

The prevailing narrative is that nursing home residents, who are often sick and elderly, are already susceptible to COVID-19 infection and death, and therefore liability shields are necessary for nursing homes to fully participate in the national response.[339] The president of the American Health Care Association stated that "the grim reality is that, for the elderly, COVID-19 is an almost perfect killing machine."[340] Liability shields have been drafted by industry groups and adopted, verbatim, in Connecticut and New York.[341]

> The immunity measure in Connecticut, where state officials have reported 2,500 COVID-19 deaths linked to nursing homes, came after a group of health-care associations banded together to appeal for relief. In a March 31 letter to the governor's office, the group

337. *See Centers for Medicare and Medicaid (CMS) COVID-19 NHSN Reporting Requirements for Nursing Homes*, CTRS. FOR DISEASE CONTROL & PREVENTION (2020), https://www.cdc.gov/nhsn/pdfs/covid19/ltcf/cms-covid19-req-508.pdf.

338. *Id.*

339. *See* Richard A. Oetheimer & Glenn S. Kerner, *COVID-19 Liability Shields for Nursing Homes and Long-Term Care Facilities in the U.S.*, GOODWIN (Aug. 21, 2020), https://www.goodwinlaw.com/publications/2020/08/08_21-covid-19-liability-shields-for-nursing-homes#:~:text=These%20shields%20protect%20nursing%20homes,a%20state's%20COVID%2D19%20response; *see also Nursing Homes & Long-Term Care Facilities*, CTRS. FOR DISEASE CONTROL & PREVENTION (Sept. 11, 2020), https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-in-nursing-homes.html.

340. Robert Holly, *ACHA President Mark Parkinson: 'For the Elderly, COVID-19 Is an Almost Perfect Killing Machine'*, HOME HEALTH CARE NEWS (Mar. 11, 2020), https://homehealthcarenews.com/2020/03/ahca-president-mark-parkinson-for-the-elderly-covid-19-is-an-almost-perfect-killing-machine.

341. Debbie Cenziper et al., *As nursing-home residents died, new covid-19 protections shielded companies from lawsuits. Families say that hides the truth*, WASH. POST (June 8, 2020), https://www.washingtonpost.com/business/2020/06/08/nursing-home-immunity-laws.

> proposed wording for an executive order. Five days later, Lamont issued an order using some language from the letter. Lamont's office did not respond to repeated requests for comment, but his emergency order said that immunity would encourage "maximum participation".[342]

This narrative is not only inconsistent with the actions that led to nursing home deaths, but also rebutted by practices and laws elsewhere that avoided those deaths.[343] Moreover, it ensures that evidence for preventing future pandemic catastrophes will not be comprehensively gathered to craft effective policies.[344]

### *A. Resident Infection Control Programs and Specialists*

The fundamental steps required to prevent infection in nursing homes and control spread if a pathogen is introduced are not different than for the population in general; there are just more factors that must be managed.[345] In the U.S., infection control was a significant weakness in nursing homes before COVID-19.[346] Between 2013 and 2017, the GAO found that eighty-two percent of nursing homes were cited with infection prevention and control deficiencies in one or more years from 2013 through 2017.[347]

On September 16, 2016, CMS issued a rule requiring that each nursing home facility have an infection control preventionist as part of its full-time staff.[348] The rule required that a nursing home's infection control prevention plan included a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases, written standards,

342. *Id.*

343. *See, e.g.*, Khazan, *supra* note 296.

344. Robert L. Klitzman, *Legal Immunity for Physicians During the COVID-19 Pandemic*, 158 CHEST J. 1343, 1343 (2020); *see also* Laura Strickler & Adiel Kaplan, *Nursing home industry pushes for immunity from lawsuits during coronavirus emergency*, NBC NEWS, (Apr. 27, 2020, 6:00 AM), https://www.nbcnews.com/health/health-care/nursing-home-industry-pushes-immunity-lawsuits-during-coronavirus-emergency-n1192001.

345. Khazan, *supra* note 296.

346. *Id.*; *see also* JOHN E. DICKEN, U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-20-576R, INFECTION CONTROL DEFICIENCIES WERE WIDESPREAD AND PERSISTENT IN NURSING HOMES PRIOR TO COVID-19 PANDEMIC 4 (2020).

347. Khazan, *supra* note 296.

348. 42 C.F.R. § 483.80(a).

policies, and a system for recording incidents and corrective actions.[349]

This type of measure had proven successful in securing nursing homes against transmissible respiratory pathogens elsewhere. Infection of nursing home populations and control of infections are preventable, even in dense urban areas.[350] Hong Kong, with a population of 7.5 million, completely avoided nursing home deaths from COVID-19 until it errantly relaxed quarantine requirements for specific professions in early July 2020.[351] After 2003, when 300 people died from SARS, Hong Kong required nursing homes to have a designated, government-trained infection-control officer.[352]

In South Korea, nursing homes were prioritized as high-risk facilities, universal testing was adopted for those facilities, systems for cohort isolation, infection control consultation, and, most importantly, transfer of patients only to COVID-19 designated hospitals allowed it to minimize deaths in nursing homes.[353] In Singapore, forty percent of nursing homes are run directly by the government, thirty-seven percent by non-profit organizations, and the remaining homes by the private sector.[354] Well before cases spiked, the Ministry of Health revisited transfer protocols between nursing homes and hospitals and mandated temperature screening and social distancing between residents and staff.[355] After the first nursing home case was detected, all visits to nursing homes were suspended and residents were separated from one another.[356] Control of unnecessary transfer of patients between nursing homes and hospitals was a critical factor in keeping Singapore's nursing home deaths to only four residents through May 2020.[357] As of December

349. *Id.*

350. June-Ho Kim et al., *How South Korea Responded to the Covid-19 Outbreak in Daegu*, 1 NEW ENG. J. MED. CATALYST 1, 11 (2020).

351. Khazan, *supra* note 296.

352. *Id.*

353. June-Ho Kim et al, *supra* note 350 at 9, 11–15.

354. Li Feng Tan & Santhosh Kumar Seetharaman, *COVID-19 Outbreak in Nursing Homes in Singapore*, J. OF MICROBIOLOGY, IMMUNOLOGY, & INFECTION, (Apr. 28, 2020), https://doi.org/10.1016/j.jmii.2020.04.018.

355. *Id.*

356. *Id.*

357. Kok Xinghui, *Coronavirus: Singapore moves 2,600 nursing-home employees into hotels to protect elderly*, MICROSOFT NEWS (Aug. 5, 2020), https://www.msn.com/en-sg/news/singapore/coronavirus-singapore-moves-2600-nursing-home-employees-into-hotels-to-protect-elderly/ar-BB13NYDd; *see also* Li Feng Tan & Santhosh Seetharaman, *Preventing the Spread of COVID-19 in Nursing Homes: Experience from a Singapore Geriatric Center*, 68 J. OF THE AM.

31, 2020, similar measures adopted in Australia, Finland, New Zealand, Singapore, and South Korea kept nursing home deaths dramatically lower than elsewhere in Europe and certainly the U.S., where those numbers have at times reached fifty percent of COVID-19 deaths.[358]

Certainly, there are differences in scale given the size of both Hong Kong and Singapore, but with respect to prevention and management, there are no reasons why similarly robust prevention and management could not have prevented spread in the U.S.[359] Yet not only has infection control been neglected in U.S. nursing homes, but even proposed and adopted measures have been rescinded.[360] In 2019, CMS weakened the 2016 requirement, mandating only a consultant be sought as to infection control policies.[361]

### *B. Adequate Equipment and Staff*

CMS's Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers requires that nursing homes have an emergency plan in place for infectious disease emergencies.[362] The plans must address how facilities will respond in an emergency—specifying how nursing homes will decide to shelter in place or evacuate and how they will provide residents with food, water, medicine, and power.[363]

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GERIATRICS SOC'Y 942, 942 (2020); *see generally* Lionel Hon Wai Lum & Paul Anantharajah Tambyah, *Outbreak of COVID-19 - an urgent need for good science to silence our fears?*, 61 SING. MED. J. 55, 55 (2020).

358. Anna Wilde Matthews et al., *COVID-19 Stalked Nursing Homes Around the World*, WALL ST. J. (Dec. 31, 2020), https://www.wsj.com/articles/covid-19-stalked-nursing-homes-around-the-world-11609436215.

359. *See* Joe Eaton, *Who's to Blame for the 100,000 COVID Dead in Long-Term Care?*, AARP (Dec. 3, 2020), https://www.aarp.org/caregiving/health/info-2020/covid-19-nursing-homes-who-is-to-blame.html.

360. *See* Requirements for Long-Term Care Facilities: Regulatory Provisions to Promote Efficiency, and Transparency, 84 Fed. Reg. 34,737 (proposed July 18, 2019) (to be codified at 42 C.F.R. pts. 410, 482, 483, 485, 488); *see also* Abrams, *supra* note 176.

361. Requirements for Long-Term Care Facilities: Regulatory Provisions to Promote Efficiency, and Transparency, 84 Fed. Reg. at 34,738; Abrams, *supra* note 176.

362. Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 81 Fed. Reg. 63,860 (Sept. 16, 2016) (to be codified at 42 C.F.R. pts. 403, 416, 418, 441, 460, 482, 483, 484, 485, 486, 491, 494).

363. *Id.* at 63,955; Bryant Furlow et al., *Nursing Homes Fought Federal Emergency Plan Requirements for Years. Now, They're Coronavirus Hot Spots*, PROPUBLICA (May 29, 2020, 5:00 AM), https://www.propublica.org/article/nursing-homes-fought-federal-emergency-plan-requirements-for-years-now-theyre-coronavirus-hot-spots.

There are no federal regulations mandating minimal PPE reserves for nursing homes.[364] Nor is there an emergency plan at the federal level for pandemic preparedness in nursing homes.[365] As with other aspects of nursing homes that accept Medicare and Medicaid patients, enforcement is left to states.[366] In 2019 and 2020, the HHS inspector general found that inspectors in at least five states—California, New York, Florida, Texas, and Missouri—were not policing the new emergency preparedness rule.[367]

The ad hoc effort coordinated through the Federal Emergency Management Agency ("FEMA") has failed to deliver PPE to nursing homes.[368] FEMA announced in May 2020 that it would send a fourteen-day supply of PPE to nearly 15,000 nursing homes across the nation.[369] FEMA shipments of PPE were "deeply delayed, frequently stocked with useless and expired supplies, and delivered in quantities radically insufficient to help protect older Americans from the deadly coronavirus."[370]

The 2009–10 H1N1 influenza pandemic alerted both federal and state regulators that nursing homes may become sites for acute management of residents with severe respiratory infection.[371] They would therefore need infection control prevention and control practices in place, such as hand hygiene, appropriate PPE, and the ability to cohort sick individuals.[372] Aside from infectious disease threats affecting the respiratory system, the U.S. Centers for Disease

364. Furlow et al., *supra* note 363.

365. *See id.*

366. *See id.*

367. *Id.*

368. Jordan Rau, *Nursing Homes Run Short of Covid-19 Protective Gear as Federal Response Falters*, NPR (June 11, 2020, 5:30 PM), https://www.npr.org/sections/health-shots/2020/06/11/875335588/nursing-homes-run-short-of-covid-19-protective-gear-as-federal-response-falters.

369. *Fact Sheet: Coronavirus Pandemic Response: PPE Packages for Nursing Homes*, FED. EMERGENCY MGMT. AGENCY (May 1, 2020), https://www.fema.gov/fact-sheet/respuesta-la-pandemia-covid-19-equipo-de-proteccion-personal-para-asilos-de-cuido.

370. Letter from Katie Smith Sloan, LeadingAge President and CEO, to Vice President Michael R. Pence (June 11, 2020), https://www.leadingage.org/sites/default/files/LeadingAge%20Pence%20Letter%2061120_final.pdf.

371. Lona Mody & Sandro Cinti, *Pandemic Influenza Planning in Nursing Homes: Are We Prepared?*, 55 J. AM. GERIATRICS SOC'Y 1431, 1433 (2007).

372. *Id.*

Control and Prevention had issued guidance on PPE to be used when residents suffered from infectious agents.[373]

As with infection control, successful models of nursing home preparedness show that many nursing home deaths were avoidable.[374] In Hong Kong, all nursing homes were required to maintain at least a month's supply of face masks and other PPE.[375] In San Francisco, the city immediately prioritized PPE access for nursing homes, and the city has experienced some of the lowest death rates in its nursing homes.[376] Florida's Agency for Healthcare Administration adopted rules limiting transfers from hospitals to nursing homes and requiring negative tests before doing so.[377] Although other measures Florida adopted resulted in a rise in nursing home cases, it has generally kept its nursing home death toll below the national average.

## VI. NURSING HOMES AS A RESPONSIBILITY OF THE FEDERAL GOVERNMENT

The problems identified above are at least partially resolvable through explicit acknowledgement that the elderly population in nursing homes is a federal responsibility and that the federal government should lead the certification of nursing homes, protect them from spatial marginalization, and allow residents and families to enforce those measures.[378]

The federal role in supporting and protecting its elderly population is understandably tied to the establishment of the

373. *Interim Guidance: Implementation of Personal Protective Equipment in Nursing Homes to Prevent Spread of Novel or Targeted Multidrugresistant Organisms (MDROs)*, CTR. FOR DISEASE & CONTROL PREVENTION (July 29, 2019), https://www.cdc.gov/hai/containment/PPE-Nursing-Homes.html.

374. Maggie Severns, *Could Massive Numbers of Nursing Home Deaths Have Been Prevented?*, POLITICO (Aug. 10, 2020, 7:55 PM), https://www.politico.com/news/2020/08/10/could-nursing-home-deaths-be-prevented-393131.

375. Khazan, *supra* note 296.

376. Sara Harrison, *Some Nursing Homes Escaped Covid-19—Here's What They Did Right*, WIRED (May 29, 2020, 7:00 AM), https://www.wired.com/story/some-nursing-homes-escaped-covid-19-heres-what-they-did-right.

377. NOTICE: 23440067, FLA. AGENCY FOR HEALTH CARE ADMIN. (July 17, 2020), https://www.flrules.org/Gateway/View_notice.asp?id=23440067.

378. Theodore Ruger, *A New Deal in a World of Old Ones*, 42 ARIZ. ST. L.J. 1297, 1297 (2010) (describing the Patient Protection and Affordable Care Act and how they reshaped the federal government's role in providing access to health insurance for almost all Americans).

Medicare and Medicaid programs in 1965.[379] Decades before then, however, the federal government formed predecessor programs like the Social Security Act, the Nursing Home Standards Guide, the Federal Social Insurance Program, the Hill-Burton Act, and the Kerr-Mills' Medical Assistance for the Aged.[380] Many of those programs survive today.[381] The history and structure of elderly care in the U.S. today is implemented and shaped at the federal level.[382] It is time to acknowledge federal primacy over nursing homes, and amend the state-level bureaucracies that explain much of the dysfunction that led to severe COVID-19 mortality.[383]

### *A. Stronger Federal Requirements for Nursing Homes*

Over the course of the pandemic response from February 2020 forward, CMS has remained effectively toothless against state inaction or nonfeasance.[384] It has recurrently upbraided state agencies for failing to inspect adequately and terminate bad performers from federal reimbursement, but it lacks willingness and in some cases authority to do much more.[385] Indeed, while tens of thousands of elderly persons were dying of COVID-19, CMS Director Seema Verma sparred with governors over which level of government and its constituent agencies bore greater blame.[386]

379. David A. Bohm, *Striving for Quality Care in America's Nursing Homes: Tracing the History of Nursing Homes and Noting the Effect of Recent Federal Government Initiatives to Ensure Quality Care in the Nursing Home Setting*, 4 DEPAUL J. HEALTH CARE L. 317, 330 (2001).

380. Theodore R. Marmor, *Welfare Medicine: How Success Can Be a Failure*, 85 YALE L.J. 1149, 1151 (1976) ("As a scheme for financing the medical care of some poor Americans, Medicaid retained the Kerr Mills tradition of payments to vendors, but expanded the eligible population to include all medically needy beneficiaries of other federal-state public assistance programs.").

381. INST. OF MED. COMM. ON NURSING HOME REGUL., *supra* note 34, at 15.

382. *See generally* Bohm, *supra* note 379, at 324–35 (outlining the history of federal regulation of nursing homes).

383. *See* Alice Hoffmann, *Discrimination Risks of Alzheimer's as Support for Social Insurance for Long-Term Care*, 46 J. L. MED. & ETHICS 499, 499–500 (2018) ("It has become abundantly clear that the only way to create adequate insurance for long-term care is through a universal social insurance program.").

384. *See* Aka et al., *supra* note 166, at 16–20 (discussing the CMS structure, process, and limited authority).

385. *Id.*; *see also* Laura M. Wagner et al., *Relationship Between Nursing Home Safety Culture and Joint Commission Accreditation*, 38 JOINT COMM'N J. ON QUALITY & PATIENT SAFETY 207, 208 (2012).

386. Ricardo Alonso-Zaldivar, *Harrowing Blame Game Over COVID-19 Toll in Nursing Homes*, ABC NEWS (June 15, 2020, 7:58 PM),

Medicare facilities are also certified by states, but the requirements are more extensive and, for facilities accredited by the Joint Commission, they are deemed to have satisfied Medicare and Medicaid requirements.[387] The Joint Commission accredits approximately 4,500 general, children's, long term acute, psychiatric, rehabilitation and surgical specialty hospitals—approximately eighty-two percent of the nation's hospitals (including critical access hospitals).[388] By contrast, only 1,000 nursing homes seek Joint Commission accreditation.[389]

For those nursing homes that seek Joint Commission accreditation,[390] the evidence shows that they achieve far better outcomes in terms of resident safety and the quality of staffing.[391] In a 2006 study in which Castle and Sonon administered the Hospital Survey On Patient Safety Culture ("HSOPSC"), a survey commonly used in Joint Commission accredited hospitals, to nursing home administrators, "11 of the 12 HSOPSC subscale scores from the nursing home sample were considerably lower than the benchmark hospital scores."[392] "In addition, almost all item scores from nursing homes were considerably lower than the benchmark hospital scores."[393] These results indicate that a less well-developed safety culture exists in nursing homes. The Joint Commission also certifies Veterans' Affairs hospitals. Indeed, safety practices required through Joint Commission surveys have been associated with improved patient outcomes in Veterans' Affairs facilities.[394] VA hospitals were able to

https://abcnews.go.com/Health/wireStory/grim-blame-game-covid-deaths-besieged-nursing-homes-71250148.

387. *Certification Options*, JOINT COMM'N, https://www.jointcommission.org/accreditation-and-certification/health-care-settings/home-care/excel/certification-options (last visited Feb. 14, 2021).

388. *Facts about Joint Commission Accreditation and Certification*, JOINT COMM'N, https://www.jointcommission.org/-/media/deprecated-unorganized/imported-assets/tjc/system-folders/topics-library/accreditation_and_certification_10_09.pdf (last visited Feb. 14, 2021).

389. *Id.*

390. For a general history of nursing home regulation, see Thomas G. Morford, *Nursing Home Regulation: History and Expectations*, HEALTH CARE FIN. REV. 1988 ANN. SUPP. 129 (1988).

391. Wagner et al., *supra* note 385, at 207, 212.

392. N.G. Castle & K.E. Sonon, *A Culture of Patient Safety in Nursing Homes*, 15 QUALITY & SAFETY IN HEALTH CARE 405, 405 (2006).

393. *Id.*

394. William B. Weeks & James P. Bagian, *Developing a Culture of Safety in the Veterans Health Administration*, 3 EFFECTIVE CLINICAL PRAC. 270, 274 (2000).

deploy staff and supplies across its national network, deployed telehealth options it had developed for hard-to-reach veterans, and limited transfers between VA facilities and civilian health systems.

As Part I emphasized, the problem of the federal government delegating enforcement authority to states is not new; it dates to the 1950s, if not before. The relationship between more direct forms of certification and monitoring between the federal government and Medicare or between the federal government and Veterans' Affairs facilities provides one path to addressing deficiencies in nursing homes.

In the wake of COVID-19 nursing home deaths, the preferences of owners and providers are consistent with past regulatory failures.[395] Even before the pandemic, providers anticipating additional nursing home reform sought a greater focus on "consultative elements of quality improvement into the [state] survey process."[396]

### *B. Private Rights of Action in State and Federal Courts*

#### i. State Tort Law

Litigation is a key aspect of advancing public health priorities.[397] State law tort causes of action are generally available against nursing home misconduct.[398] One study, analyzing responses from 278 attorneys in thirty-seven states suggests that statutory and common-law causes of action make up, respectively, forty-nine percent and thirty-six percent of nursing home claims nationwide.[399] More than half of the claims involved the death of a nursing home resident, while the others frequently alleged harms such as bed sores, weight loss, and emotional distress.[400] Although only eight percent of claims reached trial, sixty-one percent of those claims prevailed at trial.[401] For claims resolved without a trial, eighty-eight percent

395. Rachel M. Werner et al., *Long-Term Care Policy after Covid-19—Solving the Nursing Home Crisis*, 383 NEW ENG. J. MED. 903, 903 (2020).

396. Stevenson, *supra* note 162.

397. *See generally* Michael D. Frakes, *The Surprising Relevance of Medical Malpractice Law*, 82 U. CHI. L. REV. 317, 378–80, 385 (2015).

398. David G. Stevenson & David M. Studdert, *The Rise of Nursing Home Litigation: Findings From A National Survey of Attorneys*, 22 HEALTH AFF. 219, 219 (2003).

399. *Id.* at 221.

400. *Id.* at 222.

401. *Id.*

were decided with judgments in favor of plaintiffs and an average recovery of $406,000.[402]

Another study examined lawsuits filed in nursing home facilities in the United States from 1997 to 2001 and found that for-profit nursing homes "had a higher overall mean number of suits, were less likely to meet the long-stay staffing ratios, and had poorer quality indicators in comparison to nonprofit homes."[403] Residents in lawsuits were more likely to be Medicaid beneficiaries.[404]

These lawsuits led to many of the reforms proposed between 1986 and the present, although none fundamentally addressed the nexus between federal reimbursement and state enforcement.[405] The COVID-19 liability shields and mandatory arbitration clauses, in other words, will deprive families of recovery while also reducing the amount of litigation-generated data that will facilitate reform.[406] Federal law should, as it has in the past with respect to arbitration,[407] prohibit states from abrogating common law causes of action against nursing homes that may be vindicated in state courts.

#### ii. Federal Claims under the Supremacy Clause and 42 U.S.C. § 1983

In general, cooperative federal-state programs enacted pursuant to Congress's Spending Clause authority offer states a bargain: Congress provides federal funds in exchange for states' agreement to spend them in accordance with congressionally imposed conditions.[408] The Medicaid Act did not, and does not, include a provision authorizing a private right of action to enforce its provisions.[409] Before 2015, however, the Supreme Court presumed an

402. *Id.* at 222–23.

403. Christopher E. Johnson, et.al., *Predicting Lawsuits against Nursing Homes in the United States*, 1997-2001, 39 HEALTH SERVS. RSCH. 1713, 1725 (2004).

404. *Id.*

405. William M. Sage, *Malpractice Reform As A Health Policy Problem*, 12 WIDENER L. REV. 107, 110 (2005) ("Nursing home liability was broadened in the 1980s and early 1990s when people began to worry about the enforceability of residents' rights and started enacting elder abuse laws.").

406. William M. Sage, *The Role of Medicare in Medical Malpractice Reform*, 9 J. HEALTH CARE L. & POL'Y 217, 224 (2006).

407. Toby S. Edelman, *The Nursing Home Reform Law: Issues for Litigation*, 24 CLEARINGHOUSE REV. 545, 549 (1990).

408. *See* South Dakota v. Dole, 483 U.S. 203, 205–08 (1987).

409. Social Security Act § 1902(a), 42 U.S.C. § 1396a(a); 42 U.S.C. § 1320a-2 alludes to a potential private right of action, but it defers to Supreme Court precedent on the issue.

implied authority to allow judicial remedies that effected the statute's purpose.[410] Private plaintiffs asserted, and the Supreme Court concurred with, the theory that the Supremacy Clause created an implied right of action to enjoin enforcement of state laws that violated federal law.[411] The Court also interpreted 42 U.S.C. § 1983, arguably the most important Reconstruction Era civil rights statute, to provide a cause of action to enforce a program requirement if the relevant statutory provision evidenced a congressional intent to create an enforceable right.[412] The Court also looked to the statute allegedly violated by a state official to determine whether a cause of action might be implied by the statute itself, an inquiry that overlapped significantly with that under § 1983.[413]

In *Wilder v. Virginia Hospital Association*, health care providers sued Virginia to challenge the reimbursements it provided pursuant to its Medicaid plan.[414] The providers argued that Virginia's reimbursement rates violated a federal requirement that required a state Medicaid plan to pay for "hospital services, nursing facility services, and services in an intermediate care facility" for the cognitively disabled through the use of rates that "the State finds . . . are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities . . . ."[415] The Court held that this provision created an enforceable right under § 1983 for the providers because "[t]here can be little doubt that health care providers are the intended beneficiaries" of this provision, given that it "establishes a system for reimbursement of providers and is phrased in terms benefiting health care providers."[416] Moreover, this provision, "cast in mandatory rather than precatory terms," was viewed to impose "a binding obligation on States participating in the Medicaid program to adopt reasonable and adequate

410. Douglas v. Independent Living Center of Southern California, 565 U.S. 606, 611 (2012).

411. *Id.* at 610–15.

412. Maine v. Thiboutot, 488 U.S. 1, 4 (1980); *see* Blessing v. Freestone, 520 U.S. 329, 340–41 (1997) (creating the three-prong test for determining whether a particular federal statute creates an enforceable individual right for purposes of § 1983); *see also* Pennhurst State Sch. & Hosp. v. Halderman, 451 U.S. 1, 17, 28 (1981) (discussing whether Congress created obligations giving rise to an implied cause of action).

413. Gonzaga Univ. v. Doe, 536 U.S. 273 (2002).

414. 496 U.S. 498, 510 (1990).

415. *Id.* at 510 (citing 42 U.S.C. § 1396a(a)(13)(A) (1982 ed., Supp. V)).

416. *Id.* at 510.

rates."[417] The *Wilder* Court viewed this obligation to be "judicially enforceable" based on factors defined by statute and regulation, observing that an examination of the reasonableness of rates, while requiring "some knowledge of the hospital industry," was "well within the competence of the Judiciary."[418] The *Wilder* Court also concluded that Congress did not foreclose § 1983 enforcement of the Medicaid Act.[419] The decision was closely divided, five-four.[420]

In 2015, the Supreme Court's decision in *Armstrong vs. Exceptional Child Center, Inc.* broadly construed violations of Medicaid to be enforceable only by the Secretary of Health and Human Services and only through withholding of Medicaid funds.[421] While not explicit, *Armstrong* also appeared to overrule *Wilder v. Virginia Hospital Association.*[422] However, *Armstrong* was not a § 1983 decision, and the portion of the decision most applicable to § 1983 did not gain five votes.[423]

Nevertheless, the resulting confusion has caused circuit splits across a range of Medicaid programs typically turning on idiosyncratic language that may have never been contemplated as vesting an individually enforceable right or not.[424] Regardless of whether a challenge to state orders regarding COVID-19, infection control programs at nursing homes, or adequate PPE might succeed at the trial level, federal law is too uncertain to be relied upon to ensure that residents are adequately protected now or for future pandemics.[425]

Acknowledgment of the primary federal responsibility for nursing homes would facilitate explicit Congressional language vesting nursing home residents and their caretakers with enforceable, equitable rights to require nursing homes to comply with federal requirements. This would circumvent the clearly dysfunctional

417. *Id.* at 512.

418. *Id.* at 519–20.

419. *Id.* at 523.

420. *Wilder*, 496 U.S. at 524.

421. Armstrong v. Exceptional Child Ctr., Inc., 575 U.S. 320, 328 (2015).

422. *Id.* at 330–31.

423. *Id.* at 344 (Sotomayor, J., dissenting).

424. Lauren E. Pair, *Stretching Armstrong: How the Eighth Circuit Incorrectly Applied Supreme Court Precedent in Does v. Gillespie*, 12 ST. LOUIS U. J. HEALTH L. & POL'Y 215, 237 (2018).

425. Samuel R. Bagenstos, *The Future of Disability Law*, 114 YALE L.J. 1, 58 (2004) ("No court has yet granted final relief to plaintiffs with disabilities who challenge inadequate reimbursement rates for community services providers, and some courts have ruled against these plaintiffs, though a number of cases are still pending.").

system under which resource constrained states are charged with enforcing minimal federal requirements shown to have little relationship with residents' welfare in the routine context, to say nothing of pandemic emergencies like COVID-19.

## VII. CONCLUSION

The COVID-19 deaths in nursing homes are only partially a result of the susceptibility of those residents to the disease or of other idiosyncratic factors. Many of those deaths were preventable and resulted from essential and fundamental defects in the regulatory framework now in place for nursing homes. This article has identified those essential weaknesses, many of which date back decades before adoption of the Medicaid framework. Establishing higher standards at the federal level, certifying compliance through more direct mechanisms, and allowing robust enforcement through state and federal courts would prevent another mass casualty event for the elderly in the U.S., like that wrought by COVID-19.