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Political Factors and Enforcement of the Nursing Home Regulatory Regime

Philip C. Aka

Chicago State University & Indiana University School of Law at Indianapolis

Lucinda M. Deason

University of Akron

Augustine Hammond

Augusta State University

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POLITICAL FACTORS AND ENFORCEMENT OF THE NURSING HOME REGULATORY REGIME

DR. PHILIP C. AKA, ESQ.;* DR. LUCINDA M. DEASON;** AND DR. AUGUSTINE HAMMOND,***

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I. INTRODUCTION AND PURPOSE OF STUDY

Nursing homes are special facilities that provide round-the-clock medical care to persons who, due to old age or disability, have difficulties in navigating activities of daily living (“ADL”), such as bathing, dressing, eating, and using the toilet.¹ For

*Professor of Political Science, Chicago State University; Adjunct Professor of Law, Indiana University School of Law at Indianapolis. We acknowledge the helpful suggestions of the *Journal of Law and Health* editorial board, which changed the original format of the manuscript but improved the Article. We, however, hold ourselves solely responsible for any errors of omission or commission.

**Associate Professor of Political Science, University of Akron. Dr. Deason wrote a dissertation for her Ph.D. degree, received from Michigan State University in 2000, on the enforcement of nursing home regulations.

***Assistant Professor of Political Science, Augusta State University.

¹ See FAMILY CAREGIVER ALLIANCE, SURVEY OF NURSING HOME, ASSISTED LIVING, ADULT DAY SERVICES, AND HOME CARE COSTS (2009), available at <http://www.metlife.com/assets/cao/mmi/publications/studies/mmi-market-survey-nursing-home-assisted-living.pdf> [hereinafter SURVEY OF NURSING HOME]; ROBERTA HUNT, INTRODUCTION TO COMMUNITY-BASED NURSING 393-413 (Margaret Zuccarini et al. eds., Wolters Kluwer/Lippincott Williams & Wilkins, 4th ed. 2009). About 68% (little more than two-thirds) of nursing home residents

these and related ADL tasks, nursing home residents receive help that is provided by a phalanx of caregivers, including nurses, physical therapists, occupational therapists, and social workers.² Nursing homes are a common technique for delivering long-term care (*i.e.*, services and supports to meet health and personal care needs over an extended period of time) in the U.S. and other industrialized countries.³ In the U.S., the history of these facilities dates back to the beginning of the twentieth century when, bereft of national government⁴ assistance for the care of elderly or disabled persons, many states relegated these destitute individuals to decrepit almshouses and poor farms.⁵

Nursing home residents are individuals “who are not sick enough to need hospital care but are not able to remain at home.”⁶ These residents include the

have one to five limitations in their activities of daily living. *See Nursing Homes: Past, Present, and Future*, BUSINESS INNOVATION FACTORY, <http://www.businessinnovationfactory.com/nhf/files/Nursing-Homes-in-America.pdf> (last visited May 3, 2010) [hereinafter *Nursing Homes*].

² *See* HUNT, *supra* note 1, at 393-413.

³ *See* Joan F. Van Nostrand et al., *Nursing Home Care in Five Nations*, U.S. DEP’T OF HEALTH AND HUM. SERVS., <http://aspe.hhs.gov/daltcp/reports/nh5nates.htm> (last visited Apr. 24, 2010). However, the popularity of traditional nursing homes as a technique of choice for delivery of long-term care is increasingly tempered by the fact that, since 2001, the nursing home industry has been losing ground to home health and community-based alternatives, including assisted living. *Ontario Health Coalition*, CENTER FOR MEDICARE ADVOC. (Mar. 31, 2009), www.web.net/ohc/TobyEdelmanPresentation%2003.31.09.ppt [hereinafter *Ontario Health Coalition*].

⁴ Because the states are necessarily an integral component of the U.S. federal system, to minimize confusion, as much as possible, we use the term *national government* (rather than “federal government”) to designate or refer to the U.S. central government.

⁵ PBS, *The Evolution of Nursing Home Care in the United States*, THE ONLINE NEWS HOUR, <http://www.pbs.org/newshour/health/nursinghomes/timeline.html> (last visited May 3, 2010) [hereinafter *Evolution of Nursing Home Care*]. A U.S. Dept. of Labor study in 1925 found these homes to be marked by “dilapidation, inadequacy and even indecency.” *A Brief History of Long-Term Care—Brief Article*, BNET,

http://findarticles.com/p/articles/mi_m3830/is_12_48/ai_58572867/ (last visited May 19, 2010) [hereinafter *Brief History of Long-Term Care*]. Some states appeared to encourage the stigma of inadequate care as a motivating factor to keep people from relying on them. In response, some immigrant communities established organizations that helped newcomers and the aged as a way around using public services. *Evolution of Nursing Home Care*.

⁶ *Nursing Home*, BRITANNICA CONCISE ENCYCLOPEDIA, <http://www.answers.com/topic/nursing-home> (last visited May 3, 2010). In response to payment incentives from the national government, during the 1990s, a new field of sub-acute care emerged to provide care for persons released from hospitals who still needed more care than found in intermediate-care nursing facilities. *Evolution of Nursing Home Care*, *supra* note 5. Medical conditions that can cause nursing home confinement include arthritis, cancer, cardiovascular diseases, dementia (including Alzheimer’s disease), depression, diabetes, falls (3 out of 4 nursing home residents fall each year, double the rate for older adults living in the community, due to environmental hazards, such as wet floors, incorrect bed position, poor lighting, and improperly fitted or maintained wheelchairs; one-third of these falls result in injury, and approximately 1,800 nursing home patients die each year from falls), glaucoma, high blood pressure, incontinence, muscular degeneration, obesity, and stroke, among others. *See Nursing*

elderly (usually individuals 65 years and above) and younger adults with physical or mental disabilities.⁷ Nearly two-thirds of nursing home residents are females; the remaining one-third are males.⁸ As the nation's population grays,⁹ more and more Americans are living in nursing homes.¹⁰ According to the Government Accountability Office ("GAO"), in 2009, more than 1.5 million people resided in the nation's estimated 16,000 nursing homes.¹¹ The GAO is an arm of Congress, created under the Budget and Accounting Act of 1921, that has conducted numerous studies on nursing homes. Dubbed "the investigative arm of Congress," and "congressional watchdog," the agency supports Congress in meeting its constitutional obligations as well as helps improve the performance and ensure the accountability of the federal government through various means that include oversight of federal programs.¹² In the language of its infomercial, the agency "keep[s] a close eye on virtually every federal program, activity, and function," and, "[i]ts highly trained evaluators examine everything from missiles to medicine, from aviation safety to food safety, from national security to social security."¹³ Formerly known as the General

Homes, *supra* note 1. In 2009, the average cost of a nursing home stay was \$219 per day for a private room or \$79,935 a year. SURVEY OF NURSING HOME, *supra* note 1, at 5 (table). The costs vary across nursing homes and from region to region, with some regional nursing homes charging lower than this figure and others higher. *Id.* at 14-19 (table).

⁷ See HUNT, *supra* note 1, at 393-418; JANICE RIDER ELLIS AND CECILIA LOVE HARTLEY, NURSING IN TODAY'S WORLD: TRENDS, ISSUES, AND MANAGEMENT 12 (Hilarie Surrena, ed., Wolters Kluwer Health/Lippincott Williams & Wilkins, 9th ed. 2008). It is estimated that about 66% or nearly two-thirds of nursing home residents are persons in the 75-84 and 85-94 age brackets. Of the 66%, over 34% are in the 75-84 age range, while nearly 32% belong in the 85-94 age category. *Nursing Homes*, *supra* note 1.

⁸ See *Nursing Homes*, *supra* note 1 (in terms of gender 66.5% are females and 33.5% are males).

⁹ STEFFEN W. SCHMIDT ET. AL., AMERICAN GOVERNMENT AND POLITICS TODAY 20 (Thomson Wadsworth, 6th ed. 2005-2006) (noting, "Long a nation of growth, the United States has also become a middle-aged nation with a low birthrate and an increasing number of old citizens who want services from the government."). At the time this text was published, the median age of the U.S. population was 35.5, a number projected to increase to 36.2 years by 2050. *Id.*

¹⁰ From a comparative standpoint, this is a phenomenon not unique to the U.S. but rather is as well observable in other industrialized countries, including even Japan which, in the past, had few nursing homes. See Van Nostrand et al., *supra* note 3.

¹¹ U.S. GOV'T ACCOUNTABILITY OFF., GAO 10-70, ADDRESSING THE FACTORS UNDERLYING THE UNDERSTATEMENT OF SERIOUS CARE PROBLEMS REQUIRES SUSTAINED CMS AND STATE COMMITMENT (2009), available at <http://www.gao.gov/new.items/d1070.pdf>.; U.S. GOV'T ACCOUNTABILITY OFF., GAO 89-689, CMS'S SPECIAL FOCUS FACILITY METHODOLOGY SHOULD BETTER TARGET THE MOST POORLY PERFORMING HOMES, WHICH TENDED TO BE CHAIN-AFFILIATED AND FOR-PROFIT (2009), available at <http://www.gao.gov/new.items/d09689.pdf>.

¹² *Welcome to GAO*, U.S. GOV'T ACCOUNTABILITY OFF., <http://www.gao.gov> (last visited Apr. 22, 2010).

¹³ U.S. GAO, *GAO: Working for Good Government Since 1921*, U.S. GOV'T ACCOUNTABILITY OFF., <http://www.gao.gov/about/history/articles/working-for-good-government/01-introduction.html> (last visited Apr. 22, 2010).

Accounting Office, the GAO changed its name (while making sure to retain the same acronym) to its present name in July 2004.¹⁴ The GAO figure above does *not* include other persons who use these facilities. According to the Centers for Medicare and Medicaid Services (“CMMS”), another organization, like the GAO, versed in this topic,¹⁵ in 2006, about 2.8 million patients stayed in a nursing home (the number includes both long-term and short-term residents after hospitalization).¹⁶ This trend is expected to increase, beginning in 2011, when the first set of “baby boomers,”¹⁷ persons born in 1946, turns 65 years and becomes senior citizens. It is projected that, based on current trends, by 2030, an estimated 5 million people will need nursing home care, and that by 2020, nursing homes will need an estimated 66% more nurses.¹⁸ Nursing home care costs account for about 6% of the nation’s overall healthcare spending;¹⁹ in 2006 total government spending for nursing homes reached a high of \$125 billion.²⁰ For staffing alone, Congress increased its reimbursement to the states from \$24.8 billion in 1990 to \$51 billion in 1998.²¹

This study analyzes the influence of political factors, oversight, and nursing home affiliation or ownership status on the enforcement of the nursing home regulatory *regime*,²² signified by the Nursing Home Reform Act (“NHRA”) and its progeny.²³ Specifically speaking, it measures, using the statistical technique of regression analysis, factors that account for variations across states in the number of deficiencies (or violations of quality standards) cited by nursing home inspectors

¹⁴ David M. Walker, *GAO Answers the Question: What’s in a Name?*, U.S. GOV’T ACCOUNTABILITY OFF., <http://www.gao.gov/about/rollcall07192004.pdf> (last visited Sept. 27, 2010).

¹⁵ Although the acronym suggests a monolithic organization, this is not true, judging even by the plural, “Centers” in the name of the organization. The practice in the literature is to spell the acronym of the organization in a manner that elides one of the “M”s. Because we surmise the practice confusing to the reader, we use an abbreviation that includes the two “M”s. More information on this agency can be found in Part III, *infra*, analyzing the nursing home inspection system.

¹⁶ *Nursing Homes*, *supra* note 1.

¹⁷ “Baby boomers” are persons born in the period following World War II from 1946 to 1964. In the U.S., about 75 million persons, making up about 29% of the nation’s population, were born during this period. See Baby Boomer Headquarters, *So What’s a Boomer, Anyway?*, BABY BOOMER HEADQUARTERS, <http://www.bbhq.com/whatsabm.htm> (last visited October 13, 2010). The term “baby boomer” was coined by Landon Jones in his book *Great Expectations: America and the Baby Boom Generation*. LANDON Y. JONES, *GREAT EXPECTATIONS: AMERICA AND THE BABY BOOM GENERATION* (Coward, McCann, and Geoghegan, 1980).

¹⁸ *Nursing Homes*, *supra* note 1. As the term “nursing” in these facilities bears out, nurses form a critical element in the resources necessary for the effective operation of nursing homes.

¹⁹ *Nursing Homes*, *supra* note 1, at 23.

²⁰ *Id.*

²¹ *Ontario Health Coalition*, *supra* note 3.

²² For the definition of this term, see *infra* note 31 and corresponding text.

²³ This law and the various initiatives designed to promote its effective enforcement are discussed in Part II.

across the states. Our database comprised a sample size of 463 cases, drawn from 49 out of 50 U.S. states, excluding Nebraska, which has a unicameral legislature. Our statistical findings generally confirmed the six theses we tested regarding the influence of political factors and other variables on enforcement of nursing home regulations.²⁴ Our coefficient of determination, adjusted r-square, indicated that these various factors, controlling for other possible variables from 1995 to 2004, accounted for 51% of the variance in our dependent variable. This result is adjudged high in social science fields, such as here, with a history of notoriously low prediction.²⁵

There are two interconnected segments to the organization of this article: the conceptual issues necessary for proper examination and reader understanding of this research, and our statistical analysis. The first segment comprises Sections II to IV, while Section V embodies the second. Section II discusses the nursing home regulatory regime and performs a double function as background overview of the field. Section III presents an overview of the nursing home inspection system. It extends the discussion in the previous section and clarifies for the reader, beyond the level achieved in Section II, the national government's participation in an issue-area which, under the allocation of power scheme of the U.S. federal system,²⁶ is a state function. Section IV analyzes the role of administrators in the policymaking process and justifies our focus on "political factors" in an era of American public administration, such as the present, marked by extensive involvement of public administrators in public policy (not the fiction in the past that claims to separate politics and administration). Turning to segment two, our statistical analysis, Section V presents a review of the potentially influential factors in this study and outcomes on each of the three variables, namely: political party affiliation, oversight, and affiliation or ownership status of nursing homes. Discussion on each of the variables, in turn, embraces a survey of previous studies and scholarship, definition and operationalization of key terms, theses and underlying assumptions, and results.

Since the passage of the NHRA in 1987, various organs of the U.S. national government have published numerous volumes that have evaluated various aspects of the regulatory regime introduced by this statute and its progeny, including the

²⁴ Details on these results are provided in Part V of this Article.

²⁵ JAMES M. DANZINGER, UNDERSTANDING THE POLITICAL WORLD: A COMPARATIVE INTRODUCTION TO POLITICAL SCIENCE 18 (Pearson Longman, 9th ed. 2009). As its very title betrays, this work focuses on the political science discipline. Two of various criticisms of the discipline as a "science" that apply here are that (1) it is not a "real" science, and (2) its subject matter defies generalization. See DANZINGER, *supra*, at 18. Regarding the first, the discipline lacks the qualities that characterize natural and applied sciences, such as chemistry, engineering, and physics. Unlike scholars in these other disciplines, researchers in political science "have not agreed on a coherent set of concepts, theories, and rules of interpretation." *Id.* Concerning the second criticism, "the political world is far too complex and unpredictable for systematic generalizations." *Id.* Specifically, "[p]olitics is based on the actions and interactions of many individuals, groups, and even countries [,]" and "occurs in the midst of many changing conditions that can influence those actions." *Id.* These ever-changing conditions render non-probabilistic generalizations difficult, if not impossible, in politics.

²⁶ For definition of the term, *federalism*, see *infra* note 89.

inspection system. These organs include the GAO,²⁷ the U.S. Senate,²⁸ the U.S. House of Representatives,²⁹ and the Department of Health and Human Services ("DHHS").³⁰ This work is a first of its kind, an analysis not government-related, by a set of public administration scholars that systematically studies the influence of political forces on nursing home regulations and inspection and their ultimate effect on the well-being of nursing home patients.

²⁷ Studies conducted by the GAO include U.S. GOV'T ACCOUNTABILITY OFF., GAO/HEHS 00-197, SUSTAINED EFFORTS ARE ESSENTIAL TO REALIZE POTENTIAL OF THE QUALITY INITIATIVES (2000), available at <http://www.gao.gov/new.items/he00197.pdf>; U.S. GOV'T ACCOUNTABILITY OFF., GAO/HEHS 00-6, NURSING HOME CARE: ENHANCED HCFA OVERSIGHT OF STATE PROGRAMS WOULD BETTER ENSURE QUALITY (1999), available at <http://www.awol-texas.org/articles/he00006.pdf>; U.S. GOV'T ACCOUNTABILITY OFF., GAO/HEHS 99-46, NURSING HOMES: ADDITIONAL STEPS NEEDED TO STRENGTHEN ENFORCEMENT OF FEDERAL QUALITY STANDARDS (1999), available at <http://www.gao.gov/archive/1999/he99046.pdf>; U.S. GOV'T ACCOUNTABILITY OFF., GAO/HEHS 99-80, NURSING HOMES: COMPLAINT INVESTIGATION PROCESSES OFTEN INADEQUATE TO PROTECT RESIDENTS (1999), available at <http://www.gao.gov/archive/1999/he99080.pdf>; U.S. GOV'T ACCOUNTABILITY OFF., GAO/HEHS 98-202, CALIFORNIA NURSING HOMES: CARE PROBLEMS PERSIST DESPITE FEDERAL AND STATE OVERSIGHT (1998), available at <http://www.gao.gov/archive/1998/he98202.pdf>.

²⁸ These studies, all of them hearings by the Senate Special Committee on Aging, include *The Nursing Home Initiative: A Two-Year Progress Report: Hearing Before the Spec. Comm. on Aging*, 106th Cong. (2000), available at http://aging.senate.gov/hearing_detail.cfm?id=272287&; *Nursing Home Bankruptcies: What Caused Them?: Hearing Before the Spec. Comm. on Aging*, 106th Cong. (2000), available at http://aging.senate.gov/hearing_detail.cfm?id=272282&; *Nursing Home Residents Short-Changed by Staff Shortages, Part II: Hearing Before the Spec. Comm. on Aging*, 106th Cong. (2000), available at http://aging.senate.gov/hearing_detail.cfm?id=272279&; *HCFA Regional Offices: Inconsistent, Uneven, and Unfair: Hearing Before the Spec. Comm. on Aging*, 106th Cong. (1999), available at http://aging.senate.gov/hearing_detail.cfm?id=272306&; *Forum: Nursing Home Residents Short-Changed by Staff Shortages: Hearing Before the Spec. Comm. on Aging*, 106th Cong. (1999), available at http://aging.senate.gov/hearing_detail.cfm?id=272305&; *Forum: Consumers Assess the Nursing Home Initiative: Hearing Before the Spec. Comm. on Aging*, 106th Cong. (1999), available at http://aging.senate.gov/hearing_detail.cfm?id=272304&; *The Nursing Home Initiative: Results at Year One: Hearing Before the Spec. Comm. on Aging*, 106th Cong. (2000), available at http://aging.senate.gov/hearing_detail.cfm?id=272299&; *Residents at Risk: Weaknesses Persist in Nursing Home Complaint Investigation and Enforcement: Hearing Before the Spec. Comm. on Aging*, 106th Cong. (1999), available at http://aging.senate.gov/hearing_detail.cfm?id=272290&; *Betrayal: The Quality of Care in California's Nursing Homes: Hearing Before the Spec. Comm. on Aging*, 105th Cong. (1998), available at http://aging.senate.gov/hearings_detail.cfm?id=276917&.

²⁹ See *Trends in Nursing Home Ownership and Quality: Hearing Before the Subcomm. on Health of the H. Comm. on Ways and Means*, 110th Cong. (2007), available at http://www.medicareadvocacy.org/InfoByTopic/SkilledNursingFacility/SNF_07_11.15.TestimonyReNursingHomes.pdf.

³⁰ DEP'T OF HEALTH AND HUM. SERVS., APPROPRIATENESS OF MINIMUM NURSE STAFFING RATIOS IN NURSING HOMES (2007), available at <http://www.allhealth.org/briefingmaterials/abt-nursestaffingratios%2812-01%29-999.pdf>.

II. THE NURSING HOME REGULATORY REGIME

A *regime* is a term of art, with roots in international relations theory, that denotes a set of formal institutions (such as rules, norms, procedures) and informal understandings or expectations that govern behavior in a certain issue-area.³¹ Drawing on this definition, the nursing home regulatory regime comprises formal institutions and informal arrangements that, over the past seventy-five years, have contributed individually and collectively to shape the nursing home industry. We approach this conversation in terms of key events in the field. The first such development was the Social Security Act of 1935.³² The law provided matching grants to each state for Old Age Assistance (“OAA”) to retired workers.³³ But to discourage almshouse living, residents of public institutions were not eligible for the payments. To get around this barrier, individuals and organizations established a variety of private old-age homes to qualify for and collect OAA payments.³⁴ Subsequent amendments to the Social Security Act introduced reforms that inured to the benefit of nursing home patients. These included the Hospital Survey and Construction (or Hill-Burton) Act of 1946,³⁵ which lifted the ban on extending benefits to residents of public facilities;³⁶ a set of changes in 1950 imposing requirements for state licensing of nursing homes;³⁷ and amendments in 1954 that extended grants for nursing homes built “in conjunction with a hospital.”³⁸ The last

³¹ See, e.g., INTERNATIONAL REGIMES 1-2 (Stephen D. Krasner, ed., Cornell Univ. Press 1983); ANDREAS HASENCLEVER, ET. AL., THEORIES OF INTERNATIONAL REGIMES (Cambridge Univ. Press 1997); Charles Lipson, *Why are Some International Agreements Informal?*, 45 INT’L ORG. 495-538 (1991).

³² Social Security Act, Pub. L. No. 74-271, 49 Stat. 620 (1935), now *codified* as the Social Security Act 42 U.S.C.S. § 7 (LexisNexis 2010). The legislative history of the act indicated that the law was designed “to provide for the general welfare by establishing a system of Federal old-age benefits, and by enabling the several States to make more adequate provision for aged persons, blind persons,” among other vulnerable groups. *Legislative History: Social Security Act of 1935*, SOC. SECURITY ONLINE (2010), <http://www.socialsecurity.gov/history/35actpre.html>. The act was drafted during President Franklin D. Roosevelt’s first term in office by his Committee on Economic Security, headed by Frances Perkins, then Secretary of Labor, and passed by Congress as part of the New Deal program. By signing the measure into law on Aug. 14, 1935, Roosevelt became the first president to advocate the protection of the elderly. See ANDREW ACHENBAUM, SOCIAL SECURITY VISIONS AND REVISIONS 25-26 (Cambridge Univ. Press 1986).

³³ See 49 Stat. 602.

³⁴ *Evolution of Nursing Home Care*, *supra* note 5.

³⁵ Social Security Act, Pub. L. No. 79-719, 60 Stat. 978 (1946). The law took its name from its two sponsors, Senator Lister Hill of Alabama and Senator Harold Burton of Ohio. In 1975, the act was amended and became Title XVI of the Public Health Service Act. See Harry Perlstadt, *The Development of the Hill-Burton Legislation: Interests, Issues, and Compromises*, 6 J. HEALTH AND SOC. POL’Y 77-96 (1995); VIRGINIA V. HAMILTON, LISTER HILL: STATESMAN FROM THE SOUTH (Univ. of N. Carolina Press 1987).

³⁶ HAMILTON, *supra* note 35.

³⁷ Social Security Act, Pub. L. No. 90-248, 81 Stat. 823 (1968).

³⁸ *Nursing Homes*, *supra* note 1.

laid the ground for the modeling of the physical construction of nursing homes after hospitals,³⁹ and, equally important, transformed nursing homes from being part of the welfare system to being part of the healthcare system. Some other amendments to the Social Security Act passed in 1965⁴⁰ incorporated Medicare and Medicaid.⁴¹ These changes were an integral part of President Lyndon B. Johnson's "Great Society" campaign against poverty,⁴² and came in the wake of nursing home scandals, such as the one in New York in 1960 that uncovered problems in nursing home staffing, code requirements, and financial irregularities.⁴³ In signing the measures into law on July 30, 1965, President Lyndon B. Johnson noted that "[c]ompassion and reason dictate that this logical extension of our proven Social Security system will supply the prudent, feasible, and dignified way to free the aged from the fear of financial hardship in the event of illness."⁴⁴ More reforms came in 1965 with the passage of the Moss Amendments,⁴⁵ which authorized the then Department of Health, Education, and Welfare ("HEW") to standardize regulations for Medicare and Medicaid and to withhold funding from nursing homes that failed to meet those standards.⁴⁶ Key details of the changes included regulations mandating

³⁹ *Brief History of Long-Term Care*, *supra* note 5.

⁴⁰ See Social Security Act, Pub. L. No. 89-97, 79 Stat. 286 (1965).

⁴¹ *Medicare* is a health insurance program for senior citizens, 65 and older. *Medicare*, ENCYCLOPEDIA.COM, <http://www.encyclopedia.com/topic/Medicare.aspx> (last visited Sept. 29, 2010). In 1972, the U.S. government extended the program to cover disabled persons. See Social Security Act, Pub. L. No. 92-603, 86 Stat. 329 (1972). A recent change to the program is the Medicare Modernization Act, signed into law on Dec. 8, 2003, by another president from Texas, George W. Bush. The law adds an outpatient prescription drug benefit to Medicare, among other changes. *Medicare Modernization Update: Overview*, CENTERS FOR MEDICARE AND MEDICAID SERVICES, <https://www.cms.gov/mmaupdate/> (last visited Sept. 23, 2010). *Medicaid* is the nation's main program used to provide healthcare to Americans with low incomes. *Medicaid*, ENCYCLOPEDIA.COM, <http://www.encyclopedia.com/topic/medicaid.spx> (last visited Sept. 29, 2010). In March 2010, the U.S. government, under Barack Obama, adopted yet another overhaul of healthcare with ramifications for nursing home policy. See Jennifer Loven, *It's the Law of the Land: Health Overhaul Signed*, ABC NEWS (2010), <http://abcnews.go.com/print?id=10176172>.

⁴² Built into proposals traceable to John F. Kennedy's "New Frontier," the social reforms that formed the Great Society agenda aimed to combat poverty and racial injustice. Johnson shared his goals for the Great Society in a speech at the University of Michigan in Ann Arbor on May 22, 1964, during which speech he pledged that his administration would study numerous "emerging challenges" facing the country from which "studies, we will begin to set our course toward the Great Society." See *Remarks at the University of Michigan, May 22, 1964*, LBJ LIBRARY & MUSEUM, <http://www.lbjlib.utexas.edu/johnson/archives.hom/speeches.hom/640522.asp> (last visited Sept. 29, 2010). For some of the numerous works published on this program, see JOHN A. ANDREW, LYNDON JOHNSON AND THE GREAT SOCIETY (Ivan R. Dee 1998); THE GREAT SOCIETY AND ITS LEGACY: TWENTY YEARS OF U.S. SOCIAL POLICY (Marshall Kaplan and Peggy L. Cuciti, eds., Duke Univ. Press 1986).

⁴³ *Evolution of Nursing Home Care*, *supra* note 5.

⁴⁴ *Id.*

⁴⁵ See Social Security Act, Pub. L. No. 90-248, 81 Stat. 821 (1967).

⁴⁶ *Id.* See also Karen Stevenson, *Moss Amendments Strengthen Fire and Nursing Standards*, ELDER WEB (APR. 29, 2007), <http://www.elderweb.com/node/9705>.

nursing homes to meet the life safety code of the National Fire Protection Association; the requirement that skilled nursing facilities have at least one full-time registered nurse (RN) on staff; and the requirement, under pain of federal law, for nursing homes to disclose their ownership and financial interests so as to make it easier to identify fraud and abuse.⁴⁷ Recall that percolating changes dating back to the 1950s included a requirement for state licensing of nursing homes.⁴⁸ Part of the landscape of changes during the 1960s, in the aftermath of the Moss amendments, was an amendment by Senator Ted Kennedy mandating state licensing of nursing home administrators.⁴⁹

Like in anything else, progress in regulation was not unilinear but was instead occasionally marked by setbacks. For example, in April of 1969, in response to rising costs sparked by the enthusiastic response to Medicare, HEW released a statement that eliminated much of the coverage for nursing homes that Medicare had initially allowed.⁵⁰ This change in policy left thousands of elderly persons and their families with huge medical bills.⁵¹ Another temporized measure of change took place in 1981, when, in the aftermath of another outbreak of nursing home scandals across the country during the mid-1970s that paralleled and exceeded the ones of the previous decade, Congress passed the Boren Amendment,⁵² mandating states to ensure “reasonable and adequate” provider reimbursement rates.⁵³

The emerging literature, popular and scholastic alike,⁵⁴ tapped into the disconcerting atmosphere of widespread lapses in nursing home care across the nation and lent testimony to public frustration about the slow pace of reform. For example, in 1974, one analyst wrote a book portraying the “tender loving-greed” of the nursing home industry in “exploiting America's old people and defrauding us

⁴⁷ Stevenson, *supra* note 46.

⁴⁸ See 81 Stat. 823.

⁴⁹ Pub. L. No. 92-223, § 1908, 85 Stat. 802, 809-10 (1967). See also S. 3436, 89th Cong. (1967); S. 3384, 89th Cong. (1967); ROBERT STEVENS AND ROSEMARY STEVENS, WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID 153 (2003).

⁵⁰ See *Evolution of Nursing Home Care*, *supra* note 5 (citing U.S. Dep't of Health, Education and Welfare, Social Security Admin., Bureau of Health Insurance, Intermediary Letter No. 371 (Apr. 1969)).

⁵¹ *Evolution of Nursing Home Care*, *supra* note 5. Opposition to these new standards by individuals and nursing homes impelled Congress to enact a “compromise” measure, creating a new standard, denoted “intermediate-care facilities,” which permitted some homes to qualify for federal reimbursement while maintaining the same level of nursing care or resources. *Id.* The reclassification saved money for the government—but at the expense of lower standards of care for nursing home residents. *Id.*

⁵² Named after Senator David Boren of Oklahoma, who sponsored the bill, the amendment was passed as part of the Omnibus Budget Reconciliation Act. See Omnibus Budget Reconciliation Act, Pub. L. No. 97-35, 95 Stat. 172 (1981).

⁵³ *Id.* Congress, under the control of the Republican Party, repealed the Boren Amendment in 1997. *Evolution of Nursing Home Care*, *supra* note 5.

⁵⁴ For example, in 1950, the magazine *Nursing Homes* was founded. About the same period, Mosby published the first text on Geriatric Nursing in the U.S. by Kathleen Newton. See *Brief History of Long-Term Care*, *supra* note 5.

all."⁵⁵ The frustration regarding the slow pace of change was also noticeable in official circles. In May of 1975, for instance, the Commissioner of the Administration on Aging released a statement that depicted residents of nursing homes as "powerless."⁵⁶ The official first observed that the U.S. "[h]as been conducting investigations, passing new laws, and issuing new regulations relative to nursing homes at a rapid rate during the past few years."⁵⁷ However, "[a]ll of this activity will be of little avail unless our communities are organized in such a manner that new laws and regulations are utilized to deal with the individual complaints of older people who are living in nursing homes[.]" given that "[t]he individual in the nursing home is powerless."⁵⁸ The commissioner then poignantly closed with the notation that "[i]f the laws and regulations are not being applied to [nursing home residents], they might just as well not have been passed or issued."⁵⁹

Another key event in the nursing home regulatory regime was the passage of the Nursing Home Reform Act of 1987.⁶⁰ Like with the Boren Amendment,⁶¹ President Ronald Reagan signed this measure into law only as part of a budget reconciliation package. The law marked "the largest overhaul of federal regulations for nursing homes" since the amendments to the Social Security Act in 1965 creating Medicare and Medicaid,⁶² and the most ambitious attempt since these amendments to create a set of national standards for the care and treatment of patients in nursing homes.⁶³ Although this law took place during his administration, President Reagan cannot take credit for this measure, given his general antipathy toward regulation and decided solicitude for businesses. For example, his administration considered eliminating nursing home residents' rights, as a condition for participation by licensed facilities in the Medicare and Medicaid programs. Although the plan itself was never announced, the draft of the proposal leaked out.⁶⁴ Also, Reagan made a proposal in 1982 for infrequent inspection surveys that also made allowance for self-survey.⁶⁵ Given Reagan's antipathy toward regulation, the initiative for regulatory action during his two terms in office fell on Congress, led by the Democratic Party, which seized on that initiative, repeating a pattern regarding

⁵⁵ See generally MARY A. MENDELSON, *TENDER LOVING-GREED: HOW THE INCREDIBLY LUCRATIVE NURSING HOME BUSINESS IS EXPLOITING AMERICA'S OLD PEOPLE AND DEFRAUDING US ALL* (Alfred A. Knopf 1974).

⁵⁶ *Ombudsmen Program History: The Long-Term Care Ombudsman Program 1972-2009—Program Milestones*, ADMINISTRATION ON AGING, <http://www.Itcombudsman.org/about-ombudsmen/program-history> (last visited Apr. 9, 2010).

⁵⁷ *Id.*

⁵⁸ *Id.*

⁵⁹ *Id.*

⁶⁰ See Omnibus Budget Reconciliation Act, Pub. L. No. 100-203, 101 Stat. 1300 (1987).

⁶¹ See 95 Stat. 172.

⁶² *Evolution of Nursing Home Care*, *supra* note 5.

⁶³ *Ontario Health Coalition*, *supra* note 3.

⁶⁴ *Id.*

⁶⁵ *Id.*

integration of human rights values into U.S. foreign policy that took place under a previous Republican administration.⁶⁶ Democratic Party lawmakers in Congress responded to Reagan's proposals with two legislative moratoria preventing deregulation. As the second moratorium was about to expire, Congress entered into agreement with the Health Care Financing Administration ("HCFA"),⁶⁷ to fund a study conducted by the Institute of Medicine ("IOM").⁶⁸ Released in 1986, the study recommended changes to the entire federal oversight system for nursing homes, including requirements of participation for facilities, survey, and enforcement.⁶⁹ The recommendations formed the basis for the preparation and passage of the NHRA in 1987.⁷⁰

Under the NHRA, the Secretary of Health and Human Services was vested with broad powers to devise and enforce standards for the health, safety, welfare, and

⁶⁶ This was under Richard Nixon when Congress, controlled by the Democratic Party, led the initiative, in opposition to Nixon's Vietnam policy, by passing human rights legislation that, among other things, forbade the extension of U.S. aid to foreign leaders that grossly violate the human rights of their own citizens. See, e.g., Margaret E. Galey, *The Universal Declaration of Human Rights: The Role of Congress*, PS: POL. SCI. & POL. 524, 525 (1998); Jimmy Carter, *The American Road to a Human Rights Policy*, in REALIZING HUMAN RIGHTS: MOVING FROM INSPIRATION TO IMPACT 49 (Samantha Power and Graham Allison, eds., 2000); John Shattuck, *Diplomacy with a Cause: Human Rights in U.S. Foreign Policy* in REALIZING HUMAN RIGHTS, *supra*, at 269-72 (Samantha Power and Graham Allison, eds., 2000). Carter, in his essay, recounted, "Before the presidential election in 1976, a Democratic Congress had enacted a law requiring the State Department to evaluate and report on the state of human rights in nations designated to receive military-related aid. We aimed to follow through in implementing this legislation." Carter, *supra*, at 54.

⁶⁷ Established in 1977 as an agency under the DHHS, the HCFA, on July 1, 2001, changed its name to the Centers for Medicare and Medicaid Services ("CMMS"). See *infra* note 100 and corresponding text.

⁶⁸ Founded in 1970, the IOM seeks "to help those in government and the private sector make informed health decisions by providing evidence upon which they can rely." *About the IOM*, INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMICS, <http://www.iom.edu/About-IOM.aspx> (last visited on Aug. 13, 2010). The organization touts itself as "the health arm of the National Academy of Sciences, chartered under President Abraham Lincoln in 1863." *Id.* Some of the studies the IOM "undertakes began as specific mandates from Congress; still others are requested by federal agencies and independent organizations." *Id.*

⁶⁹ INSTITUTE OF MEDICINE, IMPROVING THE QUALITY OF CARE IN NURSING HOMES (1986). The report recognized nurse staffing as a major factor determining quality of care and quality of life (but did not recommend specific staffing ratios; rather, it called for standardized resident assessment data and empirical studies to determine appropriate staff levels). *Id.* It urged facilities to "place their highest priority on the recruitment, retention, and support of adequate numbers of professional nurses" with training in gerontology and geriatrics. *Id.* at 103.

⁷⁰ IOM staff challenged the staff of National Citizens' Coalition for Nursing Home Reform ("NCCNHR") to work for enactment of the recommendations as federal law. The Coalition then formed Campaign for Quality Care ("CQC"), made up of healthcare professionals, and advocates of the nursing home industry, to identify IOM recommendations that should become law. CQC met frequently for a year to discuss IOM's recommendations. *Ontario Health Coalition*, *supra* note 3.

rights of nursing home residents.⁷¹ Each of the three distinct yet interconnected areas of nursing home policy – care quality for residents, inspection of facilities, and enforcement – was enriched in scope beyond anything seen before. Beginning with quality of care and life for nursing home residents, the law mandated facilities applying for Medicare or Medicaid funding to provide services designed to ensure that each resident attained and maintained the "highest practicable physical, mental, and psycho-social well-being."⁷² This guarantee not only protected nursing home residents from mistreatments, such as abuse, neglect, and loss of personal belongings, that can mark life in nursing homes, but also affords them a phalanx of other rights that includes freedom from physical restraints; the right to be treated with dignity; the right to determine for themselves; the right to privacy; the right to accommodation of medical, physical, psychological, and social needs; the right to participate in resident and family groups; the right to participate in the review of one's care plan, and to be fully informed in advance about any changes in care, treatment, or change of status in the facility; and the right to voice grievances without discrimination or reprisal.⁷³

With respect to inspections (designed to ensure that nursing home facilities meet their quality goals), the NHRA requires states to conduct periodic, unannounced, surveys of nursing homes.⁷⁴ These surveys, which must be led by trained and tested surveyors, must include interviews of residents at least once every fifteen months; and they must focus on the overall quality of care, quality of life, and quality of services provided to residents in nursing homes.⁷⁵ Finally, regarding enforcement, the law stipulated the enactment of a range of intermediate sanctions and imposed more significant remedies for uncorrected or repeated deficiencies.⁷⁶ Table 3 in the appendix encapsulates the full range of these enforcement sanctions, consisting of

⁷¹ See generally 101 Stat. 1300 (1987); see also *Ontario Health Coalition*, *supra* note 3.

⁷² 101 Stat. 1300 (1987); 42 C.F.R. § 483 (West 2010). The phrase mimics or calls to mind the provision in Art.12 of the International Covenant on Economic, Social, and Cultural Rights ("ICESCR") which stipulates, "The State Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 at 51 (1966). The U.S. signed the instrument but has yet to ratify (and therefore become a state party to) the instrument. Similarly, the Universal Declaration of Human Rights, in Art. 25, stipulates: "Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age and other lack of livelihood in circumstances beyond his control." G.A. Res. 217A (III), U.N. DOC. A/810, at 71 (1948).

⁷³ See HANDBOOK OF GERONTOLOGY: EVIDENCE-BASED APPROACHES TO THEORY, PRACTICE, AND POLICY (James A. Blackburn & Catherine N. Dulmus eds., John Wiley & Sons 2007). As part of the quality of life element this law introduced, nurse aides must be trained and competent to provide care; before 1987, half of the states did not require any training. *Ontario Health Coalition*, *supra* note 3. The law also promised "sufficient staff" to meet residents' needs, including provision of a registered nurse on the day shift (regardless of the size of the facility), and availability of licensed nurses around the clock. *Id.*

⁷⁴ 101 Stat. 1300.

⁷⁵ *Id.*

⁷⁶ *Id.* See also *Ontario Health Coalition*, *supra* note 3.

civil monetary penalties, temporary management, denial of payments, directed in-service training, directed plan of correction, state monitoring, and termination.⁷⁷ The table also includes a comparison of the scenario before passage of the NHRA (when the only sanctions in existence were denial of payments and termination) with the situation since the passage of the Act, encompassing all seven sanctions.⁷⁸

Tremendous progress in promoting access to better-quality care for residents in nursing homes across the country has been made in the more than two decades since the passage of the NHRA.⁷⁹ As indicated before, of the panoply of seven sanctions for violations summarized in Table 3 of this article that exists today, only two, denial of payments, and termination, were in place before passage of the NHRA in 1987.⁸⁰ The law was strengthened in 1995 when the Clinton administration issued regulations designed to enforce it; the action followed an attempt by the 104th Congress, under Republican Party control, to repeal the act that President Clinton vetoed.⁸¹ Clinton followed this up in 1998 and again, toward the end of his term in September of 2000, with a series of measures aimed at improving *enforcement* of nursing home quality standards.⁸² For all of these advances, much still remains to be done to reach the target of services for residents that meet their "highest practicable physical, mental, and psycho-social well-being" that this law stipulates. For example, in 2008, the American Association of Homes and Services for the Aging ("AAHSA"), trade association of not-for-profit facilities, issued a report, revealingly

⁷⁷ GAO/HEHS 99-46, NURSING HOMES: ADDITIONAL STEPS NEEDED TO STRENGTHEN ENFORCEMENT OF FEDERAL QUALITY STANDARDS, *supra* note 27.

⁷⁸ *Id.*

⁷⁹ See, e.g., Nursing Home Reform Act (OBRA '87): 20 Years of History, <http://www.gao.gov/new.items/he00006.pdf> (last visited Apr. 23, 2010) (detailing events over 20 years from 1987 to 2007 regarding nursing home care).

⁸⁰ See GAO/HEHS 99-46, NURSING HOMES: ADDITIONAL STEPS NEEDED TO STRENGTHEN ENFORCEMENT OF FEDERAL QUALITY STANDARDS, *supra* note 27; see also *supra* note 77 and corresponding text.

⁸¹ Balanced Budget Reconciliation Act, S. 1357, 104th Cong. § 7421 (1995); see also *Brief History of Long-Term Care*, *supra* note 5.

⁸² See William Hovey, *The Worst of Both Worlds: Nursing Homes Regulation in the United States*, 17 POL'Y STUD. REV. 43-59 (2000). The measures included inspecting nursing homes at random times, including weekends and evenings; targeting repeat offenders with serious violations for frequent follow-up surveys; terminating federal funding of states which fail to provide adequate surveys; imposing immediate sanctions against nursing homes found guilty of a repeat offense where a resident is harmed; and permitting states to impose civil monetary penalties for serious or chronic violation of quality standards. Clinton's 2000 initiatives, released in the course of a radio address, focused on improving nursing home staffing (recruitment, retention, and training of nursing personnel) through various means that included imposition of civil money penalties, and providing a \$1 billion grant. *Ontario Health Coalition*, *supra* note 3. See also *The Nursing Home Initiative: The Results at Year One: Hearing Before the S. Special Comm. on Aging*, 106th Cong. (June 30, 1999) (describing the results of a congressional hearing on the 1998 initiatives).

titled “broken and beyond repair,” calling for a “new oversight model.”⁸³ The American Health Care Association (“AHCA”), a trade association of primarily for-profit facilities, concluded similarly, positing that the system of nursing home inspection “does not reliably measure quality. It does not create any positive incentives.”⁸⁴ It assessed inspectors to be “subjective and inconsistent” because “[t]hey interpret federal standards in different ways,”⁸⁵ and it found cases in which nursing home operators billed the national government for services that “were not provided, or were so wholly deficient that they amounted to no care at all.”⁸⁶

Until today, poor enforcement of existing laws remains the bane of the nursing home regulatory regime. This is an occurrence detrimental to patients, the intended beneficiaries of all nursing home regulations, as study after study by U.S. government agencies seems to validate.⁸⁷ Added to this problem is the issue surrounding ownership of nursing homes by large private investment groups. A study of more than 15,000 nursing homes nationwide in 2007 (over 1,000 of this number purchased by large private investment groups) found that many operators of

⁸³ See *Broken and Beyond Repair: Recommendations to Reform the Survey and Certification System*, AM. ASS'N OF HOMES AND SERVS. FOR THE AGING (June 2008), available at <http://www.aahsa.org/WorkArea/showcontent.aspx?id=3306>.

⁸⁴ Quoted in Robert Pear, *Report Finds Violations At Most Nursing Homes*, N.Y. TIMES (Sept. 30, 2008) at A20.

⁸⁵ *Id.*

⁸⁶ *Id.*

⁸⁷ See e.g., *Medicaid Reform: Quality of Care in Nursing Homes at Risk: Hearing Before the S. Special Comm. on Aging*, 104th Cong. (Oct. 26, 1995) (incorporating Senator William Cohen’s observation to the effect that “[r]ecent inspections of nursing homes reveal that deficiencies, ranging from substandard care to conditions posing immediate harm to residents, still exist in many nursing homes nation wide.”); *Federal Implementation of OBRA 1987 Nursing Home Reform Provision: Hearing Before the S. Special Comm. on Aging*, 101st Cong. (1989) (incorporating Senator David Pryor’s assessment that implementation of NHRA is “seriously floundering.”); *Betrayal: The Quality of Care in California’s Nursing Homes*, *supra* note 28 (incorporating the complaint of Senator Herb Kohl about how “[t]oo many people are suffering and dying” even though “[w]e have laws and regulations already in place that should be preventing these problems, but they are *not enforced in any meaningful way*”) (emphasis added); DHHS, *supra* note 30 (reporting violations in over nine of every ten nursing homes across the country; that about 17% of nursing homes had deficiencies that caused “actual harm or immediate jeopardy” to residents; and substantiating 39% of over 37,000 complaints about conditions in nursing homes). See also GAO 10-70, ADDRESSING THE FACTORS UNDERLYING THE UNDERSTATEMENT OF SERIOUS CARE PROBLEMS REQUIRES SUSTAINED CMS AND STATE COMMITMENT, *supra* note 11 (finding that, from 2002 to 2007, “approximately 70 percent of comparative surveys nationwide” identified “at least one missed deficiency”); U.S. GOV’T ACCOUNTABILITY OFF., GAO-08-517, NURSING HOMES: FEDERAL MONITORING SURVEYS DEMONSTRATE CONTINUED UNDERSTATEMENT OF SERIOUS CARE PROBLEMS AND CMS OVERSIGHT WEAKNESS (2008) (finding that “in all but five states, the number of state [inspections] with such missed deficiencies was greater than 40 percent [.]” and that “[t]he most frequently missed deficiencies identified on comparative [inspections] involved poor quality of care”).

nursing homes reaped lucrative profits as observable declines occurred in the care that they rendered to residents.⁸⁸

III. THE NURSING HOME INSPECTION SYSTEM

This section extends the discussion in the previous section on the nursing home regulatory regime. Additionally, among other things, it clarifies what role the national government has in an issue-area, such as nursing home regulation. Under the scheme of the U.S. federal system, nursing home services are a "local" issue vested in the states, rather than a sphere of responsibility entrusted to the national government.⁸⁹ Arguably, the NHRA is a policy designed to promote uniform standards across the nation in a key service area under state authority. Consistent with the federal scheme, since the 1950s, state governments have overseen and continue to oversee the licensing and certification of nursing homes.⁹⁰ Since the institution of Social Security, the national government has been involved in the design and delivery of nursing home services.⁹¹ But the programs, more than any other, that expanded the national government's involvement or participation in the regulation of nursing home services were Medicare and Medicaid.⁹² All or part of a nursing home may participate in either or both of these two programs.⁹³ Nursing

⁸⁸ See Charles Duhigg, *At Many Homes, More Profit and Less Nursing*, N.Y. TIMES (Sept. 23, 2007) at L1.

⁸⁹ Federalism is understood as "a constitutional division of government power between a central or national government and a set of regional units[.]" such as states in the U.S. system. MICHAEL E. MILAKOVICH AND GEORGE GORDON, *PUBLIC ADMINISTRATION IN AMERICA* 109 (10th ed. 2009). Features of a federal system include that both the national and regional governments have some independent as well as some shared powers over their citizens; that neither government owes its legal existence to the other; and that as a matter of law, neither may dictate to the other(s) regarding structural organization, fiscal policies, or definition of essential functions. *Id.* Under a federal system, the national government and its regional components each has sovereignty in the sense that each level can exercise governmental powers directly over citizens. *Id.*

⁹⁰ See 81 Stat. 823. See also 85 Stat. 802.

⁹¹ The formal rules of federalism apart, the national government can interpose itself and make regulations on a subject area otherwise "belonging" to the sub-national governments where it provides money or other benefits necessary for performance of the service area. The operative principle here, as one adage goes, is that the one who pays the piper dictates the tune. See *South Dakota v. Dole*, 483 U.S. 203, 211-12 (1987) (allowing the national government to indirectly deal with drunk driving by withdrawing highway funds from states who fail to adopt a higher drinking age stipulated by the national government). The coercive hand of the national government is further strengthened by the fact that "the federal government raises more tax revenues than do all fifty states and the thousands of local governments combined." THOMAS E. PATTERSON, *THE AMERICAN DEMOCRACY* 74 (9th ed. 2009). This is made possible by its status, compared to the two other levels of government, as the government with the most elastic taxing base. See MILAKOVICH AND GORDON, *supra* note 89, at 120-21.

⁹² See *Ontario Health Coalition*, *supra* note 3.

⁹³ See CHARLENE HARRINGTON ET AL., *NURSING FACILITIES, STAFFING, RESIDENTS, AND FACILITY DEFICIENCIES, 2001 THROUGH 2007* at 17 (Table 6) (Sept. 2008), *accessible at* <http://www.pascenter.org/documents/OSCAR2007.pdf> (indicating that 99.9% of nursing

homes that participate in the programs become subject to federal requirements regarding staffing and quality of care for residents.⁹⁴ Medicare and Medicaid cover more than two-thirds of the nursing home residents in the U.S. at a cost of more than \$75 billion annually.⁹⁵ Consistent with U.S. federalism, the nursing home regulatory regime and inspection system are embedded in a system of federal-state oversight. Under this oversight program, the national government “evaluate[s] the adequacy of each state [inspection] agency’s performance in ensuring quality care in nursing homes.”⁹⁶

Although federalism affords a good explanation of the national government’s participation in the nursing home regulatory regime and inspection system, from the standpoint of service delivery, the more illuminating concept is intergovernmental relations (“IGR”).⁹⁷ IGR “can be cooperative, competitive, conflicting, or a combination of all three.”⁹⁸ More than constitutional federalism, IGR captures the complexities of the regulatory and inspection system, including classification of proprietorship of nursing homes, rooted in cooperation, competition, and conflict, going beyond the pigeonholes of nation-state and interstate relations, that form the central concern of federalism.⁹⁹

The federal agency that, in partnership with state governments, administers the Medicare and Medicaid programs is the Centers for Medicare and Medicaid Services (“CMMS”).¹⁰⁰ In setting up the agency, the national government sought to “establish consistency among the regions in the process used to assess” state inspection

facilities participate in one or both programs; 3.2% participate in Medicare only, 2.2% in Medicaid only, and 94.5% in both) (last visited Oct. 2, 2010).

⁹⁴ See *id.* at 1.

⁹⁵ Pear, *supra* note 84.

⁹⁶ GAO, NURSING HOME CARE: ENHANCED HCFA OVERSIGHT OF STATE PROGRAMS WOULD BETTER ENSURE QUALITY, *supra* note 27, at 3.

⁹⁷ IGR is “[t]he action side of federalism.” MILAKOVICH AND GORDON, *supra* note 89, at 110. It denominates “an important body of activities or interactions occurring between governmental units of all types and levels within the U.S. federal system.” *Id.* Specifically, IGR embraces “all the permutations and combinations of relations among the units of government in our system,” including national-state and interstate-relations (the areas traditionally emphasized in the study of federalism), as well as national-local, state-local, interlocal, and national-state-local relations.” See *id.*; see RICHARD J. STILLMAN II, PUBLIC ADMINISTRATION: CONCEPTS AND CASES 118 (Wadsworth, 9th ed. 2010) (indicating that the study of IGR “involves comprehending the complexities of the federal system based on mutual interdependence, shared functions, and intertwined influence.”).

⁹⁸ MILAKOVICH AND GORDON, *supra* note 89, at 111.

⁹⁹ See, e.g., *id.*

¹⁰⁰ The organization began its journey as a bureaucracy in 1977 as the Health Care Financing Administration (“HCFA”) under the then Department of Health, Education, and Welfare (“HEW”). Following the split up of HEW in 1980 into two departments (those of Education and Health and Human Services), HCFA became an agency under the Department of Health and Human Services. On July 1, 2001, the HCFA changed its name to the CMMS. Dep’t of Health and Hum. Servs., Centers for Medicare and Medicaid, <http://www.cms.gov/History/> (last visited Oct. 2, 2010).

agencies' performance.¹⁰¹ To implement federal requirements on Medicare and Medicaid relating to nursing home residents, the CMMS issues specific regulations that guide inspections of these homes.¹⁰² Overall, there are more than 150 regulatory standards covering many aspects of resident life, including protection from physical or mental abuse, inadequate care practices, and preparation and storage of food, that nursing homes must observe at all times.¹⁰³

Consistent with its authority over Medicare and Medicaid, the CMMS enters into contracts with states, usually through their health department or department of human services, which permit these states to monitor nursing homes seeking eligibility to provide care to beneficiaries of these two programs.¹⁰⁴ These contracts specify the protocol of onsite inspections, which determines whether each state's nursing homes met the minimum quality and performance standards for Medicare and Medicaid. Under the NHRA and its progeny, states (1) conduct inspections of nursing homes within their jurisdiction about once every fifteen months, or more frequently, if the nursing home is performing poorly; and (2) investigate complaints about nursing home care.

State inspections take place in teams; each team consists of trained inspectors, fire safety specialists, and at least one registered nurse. The team evaluates whether and to what extent each nursing home it inspects meets individual resident needs, looking at many aspects of quality, including resident care processes, staff/resident interactions, and facility compliance with standards for safe construction, among others. Using an established protocol, the team interviews a sample of residents and family members about their lives within the nursing home. It also interviews caregivers and administrative staff as well as reviews clinical records.

When an inspection team finds that a home does not meet a specific regulation, it issues a deficiency citation. Depending on the nature of the problem, the CMMS can take action against the nursing home. Under the NHRA and its progeny, the agency can take a variety of actions, including fining the nursing home, denying payment to the home, assigning a temporary manager, or installing a state monitor.¹⁰⁵ The CMMS considers the *extent of harm* caused by the failure to meet requirements when it takes an enforcement action. Table 2 in the appendix contains a listing of the scope of deficiencies along with sanctions attached to those deficiencies.¹⁰⁶ As the table shows, the scopes could be isolated, evince a pattern, or be widespread; and sanctions imposed for violation could be "required" or "optional" (each of which is further classified into groups based on severity of the violation involved).¹⁰⁷ The

¹⁰¹ *HCFA Regional Offices: Inconsistent, Uneven, and Unfair: Hearing Before the Spec. Comm. On Aging*, 106th Cong., *supra* note 28.

¹⁰² Medicare.gov (Official U.S. Government Site for Medicare), *About Nursing Home Inspections*, available at <http://www.medicare.gov/nursing/AboutInspections.asp> [hereinafter *Nursing Home Inspections*] (last visited Apr. 24, 2010).

¹⁰³ *Id.*

¹⁰⁴ *See generally Nursing Home Inspections*, *supra* note 102.

¹⁰⁵ *See supra* notes 77-78 and corresponding texts.

¹⁰⁶ *See* GAO/HEHS 99-46, NURSING HOMES: ADDITIONAL STEPS NEEDED TO STRENGTHEN ENFORCEMENT OF FEDERAL QUALITY STANDARDS, *supra* note 27.

¹⁰⁷ *Id.*

table also includes classification for severity broken down into four categories: (1) actual or potential for death or serious injury, (2) other actual harm, (3) potential for more than minimal harm, or (4) potential for minimal harm.¹⁰⁸ The CMMS may choose to terminate its agreement with a nursing home where a home cited for violation does not correct its deficiency.¹⁰⁹ When this occurs, the affected nursing home loses its certification to provide care to Medicare and Medicaid residents, meaning that these residents must be transferred to another certified facility.¹¹⁰

To facilitate accomplishment of its inspection role under the nursing home regulatory regime, the CMMS is divided into ten regions covering all 50 U.S. states and territories (Guam, Puerto Rico, Samoa, and the Virgin Islands). Each regional office has responsibility for the states under its jurisdiction. Table 4 in the appendix contains details on the regional offices: states in each region, number of nursing homes in each region, number of regional inspectors, and number of required comparative inspections. To coordinate operations under this complex system, there is a Center for Medicaid and State Operations ("CMSO").¹¹¹ In discharging their duties, CMMS regional offices can use one of three inspection techniques: (1) the state agency quality improvement program ("QIP"), (2) observation, and (3) comparative inspections, or a combination of these three methods.¹¹² Although comparative inspections are the most effective technique for monitoring state

¹⁰⁸ *Id.*

¹⁰⁹ *Id.*; see also *Nursing Home Inspections*, *supra* note 102.

¹¹⁰ *Id.*; see also *Nursing Home Inspections*, *supra* note 102.

¹¹¹ GAO/HEHS 00-6, NURSING HOME CARE: ENHANCED HCFA OVERSIGHT OF STATE PROGRAMS WOULD BETTER ENSURE QUALITY, *supra* note 27. To demonstrate the sheer clearinghouse character of the CMSO, the regional offices are not subordinate to the CMSO. Instead, the office and the ten regional offices report directly to a CMSO administrator. Differences between the CMSO and the regional offices that cannot be settled informally are referred to the CMSO administrator for resolution. *Id.*

¹¹² *Id.* Under the *QIP*, state inspection agencies conduct self-assessment at least once a year to determine if they are in compliance with standards. A major limitation of this technique is that the CMMS regional offices do not independently validate the information that the states provide to them; consequently, it is not certain whether or not all serious problems were identified and corrected. For, example, the GAO found that some states were not promptly reviewing complaints filed against nursing homes and that those same states had not mentioned this problem in their QIP reports. *Id.* Furthermore, the regional offices do not have a policy that spells out consequences for noncompliance with the QIP. Under *observational inspection*, regional inspectors observe state inspectors as they conduct portions of their inspections of nursing homes. This is a technique that the CMMS regional offices favor. See *id.* One report by the GAO indicates that in 90% of cases, this is the method CMMS regional offices use. *Id.* Although this technique helps identify state inspectors' training needs, like QIP, it has its own limitations. One obvious one is that the regional inspectors' presence may make the state inspectors more attentive to their tasks, compared to when they were not being observed. Under *comparative inspection*, CMMS regional inspectors inspect some of the nursing homes that the state inspectors evaluated to see if they can replicate the state inspectors' results. This technique requires the CMMS regional office to conduct validation inspections of at least 5% of the Medicare/Medicaid certified nursing homes in their region within 2 months of the state inspection teams' completion of their inspections. *Id.*

inspection agencies,¹¹³ this is the method least used by regional inspectors.¹¹⁴ Instead, as indicated before, these inspectors favor observational inspection.¹¹⁵

A high level of consistency in the processes used to assess state inspection agencies' performance across the ten regional offices is crucial for ensuring that states are being held uniformly accountable to federal standards.¹¹⁶ However, in going about their oversight function, CMMS regional offices employ different methods that work against the goal of a uniform standard envisaged by the regime of state inspections under the NHRA and its progeny. This occurrence leads to variations in oversight across the regions¹¹⁷ that can effectively jeopardize quality care provided to residents in nursing homes across the nation.¹¹⁸ Some, such as the GAO, have argued that the CMMS has few disciplinary remedies or sanctions at its disposal that it could use to prod poor performing state inspection agencies to correct widespread problems with the inspection process.¹¹⁹ Yet, it is also true that the CMMS does not always put to full effect, the supposedly limited power that the agency has at its disposal. For example, as of 2000, CMMS has only reduced state funding once and has never terminated a state inspection agency's contract.¹²⁰

¹¹³ For example, one GAO review of 64 cases showed that the regional inspectors found more serious deficiencies than the ones identified by the state inspectors in two-thirds of the inspections conducted, implying that some state inspectors do not identify serious deficiencies. *Id.*

¹¹⁴ For example, although required by law to inspect 5% of the homes under their jurisdiction, according to one GAO report, most of the regional offices only conducted one or two comparative inspections per year. *See id.*

¹¹⁵ *See supra* note 112.

¹¹⁶ GAO/HEHS 00-6, NURSING HOME CARE: ENHANCED HCFA OVERSIGHT OF STATE PROGRAMS WOULD BETTER ENSURE QUALITY, *supra* note 27; *HCFA Regional Offices: Inconsistent, Uneven, and Unfair: Hearing Before the Spec. Comm. on Aging, 106th Cong., supra* note 28.

¹¹⁷ GAO/HEHS 00-6, NURSING HOME CARE: ENHANCED HCFA OVERSIGHT OF STATE PROGRAMS WOULD BETTER ENSURE QUALITY, *supra* note 27.

¹¹⁸ *Id.*; *HCFA Regional Offices: Inconsistent, Uneven, and Unfair: Hearing Before the Spec. Comm. on Aging, 106th Cong., supra* note 28. One GAO study found that some regions select facilities with no established patterns of deficiencies, while other regions focus on facilities that the state inspectors have already identified as having serious deficiencies to conduct oversight inspections. GAO/HEHS 00-6, NURSING HOME CARE: ENHANCED HCFA OVERSIGHT OF STATE PROGRAMS WOULD BETTER ENSURE QUALITY, *supra* note 27. The problem with the latter technique is that regions which use that technique are less likely to identify situations in which state inspectors under-reported or overlooked serious deficiencies.

¹¹⁹ GAO/HEHS 00-6, NURSING HOME CARE: ENHANCED HCFA OVERSIGHT OF STATE PROGRAMS WOULD BETTER ENSURE QUALITY, *supra* note 27.

¹²⁰ *HCFA Regional Offices: Inconsistent, Uneven, and Unfair: Hearing Before the Spec. Comm. on Aging, 106th Cong., supra* note 28.

Strong enforcement of regulations counts.¹²¹ Identifying breaches that, because they compromise quality of care, warrant a deficiency citation, is critical to the nursing home inspection system. Under prevailing law, inspectors' citation of deficiencies influences the types of sanctions imposed on nursing homes. Of particular relevance to this study are external actors who can influence the nursing home inspectors' decisions to cite a deficiency.¹²² Indications abound that state inspectors are not citing deficiencies when serious quality of care problems exist due to a range of reasons that includes pressure from external actors.¹²³

IV. THE ROLE OF PUBLIC ADMINISTRATORS IN THE POLICYMAKING PROCESS

Public administrators play an important role in the policymaking process. Professors Milakovich and Gordon, in their text on public administration in America, detailed different stages of agency involvement in policymaking that, besides the familiar roles today of rule making, adjudication, law enforcement, and program operation, include seemingly political or non-administrative roles such as lawmaking.¹²⁴ The position that bureaucrats have a major role in policymaking was not always the conventional wisdom. Instead, for a long time before now, the view, signified by the politics-administration dichotomy, was that agency involvement in policy, to the extent that involvement occurred at all, was limited to rote execution of policies designed by politicians. Under the politics-administration dichotomy, "[t]he bureaucracy was to administer, in an impartial and nonpolitical fashion, the programs created by the legislative branch, subject only to judicial interpretation."¹²⁵ Woodrow Wilson epitomized this notion. Taking as his premise the position that running a constitution was becoming harder to manage than framing one, Wilson, in his classic essay on the study of administration in America, stressed the need to develop effective administrative services free from congressional "meddling."¹²⁶ To him, "[a]dministrative questions are not political questions"; instead public administration was a "field of business... removed from the hurry and strife of

¹²¹ See William D. Spector & Hitomi A. Takada, *Characteristics of Nursing Homes that Affect Resident Outcomes*, 3 J. AGING & HEALTH 427 (1991). This and other studies suggest that instances of poor quality of care occur less in nursing homes where tough sanctions are imposed.

¹²² See GAO 10-70, ADDRESSING THE FACTORS UNDERLYING THE UNDERSTATEMENT OF SERIOUS CARE PROBLEMS REQUIRES SUSTAINED CMS AND STATE COMMITMENT, *supra* note 11; see also Lucinda M. Deason, *Regulatory Enforcement: Do External Environmental Factors or Internal Agency Factors Influence State Nursing Home Inspectors' Activities?* (2000) (unpublished Ph.D. dissertation, Michigan State University).

¹²³ See GAO 10-70, ADDRESSING THE FACTORS UNDERLYING THE UNDERSTATEMENT OF SERIOUS CARE PROBLEMS REQUIRES SUSTAINED CMS AND STATE COMMITMENT, *supra* note 11.

¹²⁴ MILAKOVICH AND GORDON, *supra* note 89, at 432-33. Regarding lawmaking, Milakovich and Gordon contended that "[n]othing of substance would be achieved at [this stage] without the advice of bureaucrats, whose expertise is often called upon to draft coherent bills. In addition, policy agendas are forcefully advanced by government agencies. As holders of near-monopolistic control of information, agencies have considerable ability to shape public opinion and drive legislators to action." *Id.* at 432.

¹²⁵ MILAKOVICH AND GORDON, *supra* note 89, at 41.

¹²⁶ STILLMAN, *supra* note 97, at 410.

politics," and "[a]lthough politics sets the tasks for administration, it should not be suffered to manipulate its offices."¹²⁷

Subsequent administrative thinkers shared this view. Leonard D. White, in his (otherwise) seminal public administration text, published in 1926, advocated a politically-neutral public administration focused exclusively on attainment of economy and efficiency in government service.¹²⁸ Similarly, Goodnow held the view that "political control over administrative functions is liable finally to produce inefficient administration in that it makes administrative officers feel that what is demanded of them is not so much work that will improve their own department, as compliance with the behests of the political party."¹²⁹

However, before the politics-administration doctrine took hold in American public administration, an alternative worldview evolved regarding the "proper relationship" between politics and administration.¹³⁰ The first shot in the alternative view came from Woodruff who, positing that "politics and administration take part jointly in every act performed," indicated that, contrary to any dichotomy, the two spheres of government "are two parts of the same mechanism, related in much the same way as two elements in one chemical compound whose combined qualities give the character to the substance."¹³¹ The long list of administrative thinkers who, more recently, have attacked the politics-administration dichotomy includes the distinguished administrative theorist Dwight Waldo. Waldo concluded, following (his characteristically) extensive review of the literature, that "any simple division of government into politics-and-administration is inadequate."¹³²

¹²⁷ *Id.* at 10. Wilson claimed, "Politics is thus the special province of the statesman, administration of the technical official." *Id.* To be sure, "Policy does nothing without the aid of administration; but administration is not therefore politics." *Id.* Having quoted German authority on the subject, Wilson stated, "this discrimination between administration and politics is now happily too obvious to need further discussion." *Id.* He asserted that "it is the object of administrative study to discover, first, what government can properly and successfully do, and, secondly, how it can do these proper things with the utmost possible efficiency." *Id.* at 6. To him politics interfered with this goal of efficiency.

¹²⁸ See LEONARD D. WHITE, *INTRODUCTION TO THE STUDY OF PUBLIC ADMINISTRATION* (1926); MILAKOVICH AND GORDON, *supra* note 89, at 41.

¹²⁹ FRANK J. GOODNOW, *POLITICS AND ADMINISTRATION* 83 (1900).

¹³⁰ STILLMAN, *supra* note 97, at 410.

¹³¹ A NEW MUNICIPAL PROGRAM: OLD AND NEW 37 (D. Appelton & Co., Clinton R. Woodruff ed. 1919).

¹³² DWIGHT WALDO, *THE ADMINISTRATIVE STATE: A STUDY OF THE POLITICAL THEORY OF AMERICAN PUBLIC ADMINISTRATION* 128 (Ronald, 1948). Writing more recently, Waldo assessed the doctrine as "uninformed, untrue." DWIGHT WALDO, *THE ENTERPRISE OF PUBLIC ADMINISTRATION: A SUMMARY VIEW* 69 (Chandler & Sharp Publishers, Inc., 1980). He remarked that the redesignation of the field to "Public Administration and Public Policy," for which he took some credit in achieving, "was a logical and all but inevitable consequence of the breakdown of the politics-administration dichotomy." *Id.* at 63. Other public administration scholars who attacked the politics-administration dichotomy were PAUL H. APPLEBY, *POLICY AND ADMINISTRATION* 170 (Univ. of AL Press, 1949) (arguing that public administration is "not autonomous, exclusive or isolated" but rather is a part of policy making); James H. Svara, *Complementarity of Politics and Administration as a Legitimate Alternative to the Dichotomy Model*, 30 *ADMIN. & SOCIETY* 676, 678 (1999) (noting that

In sum, the alternative view, regarding the "proper relationship" between politics and administration culminated into a "complementarity" model which depicts that relationship as "characterized by interdependency, extensive interaction, distinct but overlapping roles, political supremacy, and administrative subordination coexisting with reciprocity of influence in both policy making and administration."¹³³ Essentially, administrative agencies influence the policy process and are, in turn, influenced by political factors and external actors.¹³⁴ Not only do public administrators play an important role in the policymaking process, their activities ultimately impact the health and well-being of nursing home residents.

V. POTENTIALLY INFLUENTIAL FACTORS

The dependent variable or matter under examination in this study is the average number of quality of care *deficiencies* against a nursing home cited by a state or regional inspector. A "deficiency" is an emblem of violation that a state inspector cites "[w]hen a nursing home fails to meet a specific requirement."¹³⁵ The severities of those violations (judged by their capacity for injury to a resident), together with scopes (whether isolated, formed a pattern or are widespread) and sanctions for those violations, are summarized in Table 2 in the appendix of this article.¹³⁶ Recall our observation that the CMMS maintains a list of over 150 regulatory standards covering numerous aspects of a nursing home resident's life.¹³⁷ One study measured these deficiencies to include dietary services, physician services, rehabilitative services, dental services, pharmacy services, and infection control, among others.¹³⁸ We operationalize *deficiencies* in this study as the average number of violation emblems cited per facility by state (see also description of our variables in Table 5). Our independent variables, or the factors we predict affect the dependent variable, are *political factors*, *oversight*, and *affiliation or ownership status of nursing homes*.

"there is interdependency and reciprocal influence between elected officials and administrators in policy making").

¹³³ Svava, *supra* note 132, at 678.

¹³⁴ In this study, then, we seek to isolate and measure the political factors that influence inspectors enforcing the nursing home regulatory regime and inspection system. To be on the safe side, we limit our measurement of *political factors* narrowly to political party affiliation. In so doing, we do *not* dispute that other factors involved in this study, such as oversight, and affiliation of nursing homes, are embedded within the wider framework of politics, for they are. Back to the days of Harold Lasswell, political scientists have defined *politics* as the struggle over "who gets what, when, and how." HAROLD D. LASSWELL, *POLITICS: WHO GETS WHAT, WHEN, HOW* (1938). It is "the process through which a society settles its conflicts and decides the policies by which it will be governed." PATTERSON, *supra* note 91, at 12.

¹³⁵ OFF. OF INSPECTOR GEN., DEP'T OF HEALTH AND HUMAN SERVS., OEI-20-00600, *NURSING HOME DEFICIENCY TRENDS AND SURVEY AND CERTIFICATION PROCESS CONSISTENCY* (2003), available at <http://oig.hhs.gov/oei/reports/oei-02-00600.pdf>.

¹³⁶ See also *supra* notes 106-108 and corresponding texts.

¹³⁷ See *supra* note 103 and corresponding text.

¹³⁸ Charlene Harrington et al., *Does Investor Ownership of Nursing Homes Compromise the Quality of Care?* 32 INT'L J. HEALTH SCI. 315 (2002) [hereinafter Harrington et al., 2002 Article].

The discussion that follows involves a review of each of the three variables critical to this study.¹³⁹ For each variable, the conversation embraces a survey of previous scholarship relating to the variable, definition and operationalization of key term or terms, theses and underlying assumptions, and results. Before we get into that discussion, a brief general comment on our methodology and results will be provided. To ascertain whether a statistically significant relationship exists between our dependent and independent variables, we ran a regression analysis, using data drawn from all U.S. states, excluding Nebraska, which has a one-chamber legislature.¹⁴⁰ The results of our regression analysis are summarized in Table 1.¹⁴¹ A

¹³⁹ Table 5 in the appendix also summarizes the set of variables we used in this study.

¹⁴⁰ We employed a longitudinal cross-sectional design utilizing annual panel data for the nine-year period from 1995 through 2004. The estimate of our regression model is as follows: $Deficiencies_{i,t} = C + Political\ Factors_{i,t} (Governor_{i,t} + State\ Legislature_{i,t}) + Oversight_{i,t} (CMS' ten\ Regional\ Offices_{i,t}) + Nursing\ Home\ Affiliation_{i,t} (Chain_{i,t} + Hospital_{i,t}) + Time\ Controls_t (1995_t + 1996_t + 1997_t + 1998_t + 1999_t + 2000_t + 2001_t + 2002_t + 2003_t + 2004_t) + e_{i,t}$ where "i" represents the states and "t" the year. In estimating our regression model, we used a fixed group and time effect model fitted with least square dummy variables. But such measures are bedeviled by the assumptions of independently distributed error terms (no autocorrelation) and constant error variance across observations (homoscedasticity). Data used in this study tended to violate these assumptions, thereby creating problems of autocorrelation and heteroscedasticity, that could result in false inferences. To get around these problems, in estimating our regression model, we used Cochrane-Orcutt and Glejser procedures to test, respectively, for autocorrelation and heteroscedasticity. Our tests revealed the presence of autocorrelation and heteroscedasticity, which problem we then corrected by applying a robust estimation procedure on an autoregressive model using a lagged dependent variable (to estimate the time effect). With respect to data collection, the information for our political factor variables (measured narrowly in terms of political party affiliation) was taken from the *World Almanac and Book of Facts* for the years 1995 through 2004. See THE WORLD ALMANAC AND BOOK OF FACTS (Scripps Howard Co., multiple years). We set aside Region 9 (encompassing California) under the CMMS administrative classification of U.S. states and territories in the inspection system, as a reference and comparison category. While problems with oversight of state inspection agencies are not limited to California, our reasoning in secluding Region 9, comprising this vast state, as the comparison category, is that it is a region whose problems have been extensively studied and documented. See, e.g., GAO/HEHS 98-202, CALIFORNIA NURSING HOMES: CARE PROBLEMS PERSIST DESPITE FEDERAL AND STATE OVERSIGHT, *supra* note 27. To increase reliability in our findings, and hold constant, extraneous factors other than the variables we selected for examination that could affect our dependent variable, we included controls for time, using dummy variables, for the period 1995 through 2004. For nursing home affiliation or ownership status, we obtained our data from Online Survey, Certification, and Reporting System ("OSCAR"), a network of statistics, managed by the CMMS, which covers almost every nursing home in the U.S. OSCAR contains ongoing information on all Medicare and Medicaid certified nursing homes in the U.S., including data on deficiency citations inputted by state agencies and nursing homes. OSCAR data group ownership status of nursing homes into three categories: non-profit, government-affiliated, and for-profit ownership. See Will Mitchell et al., The Commercialization of Nursing Home Care: Does For-Profit Cost-Control Mean Lower Quality or Do Corporations Provide the Best of Both Worlds? (Sept. 17, 2004), available at http://www.caseatduke.org/documents/FPvNP_NursingHomes_mitchell.pdf (last visited Jul. 16, 2010). Our focus in this study is on for-profit and non-profit ownerships, which two categories, between them, comprise 94% of all U.S. nursing homes.

recapitulation of the results involving all of the six theses we examined in the study is provided at the end of this section.

Table 1. Estimated Model of Factors that Influence Citation of Deficiencies in Nursing Homes, 1995 through 2004¹⁴²

Quality of Care – Deficiencies			
	Coefficients ¹⁴³	(S.E.)	t-value
<i>Regional/Spatial Controls (Administrative Oversight)</i>			
Region 1	-1.216	(.334)	-3.64 ***
Region 2	-1.144	(.444)	-2.58 ***
Region 3	-.888	(.278)	-3.19 ***
Region 4	-.524	(.239)	-2.20 **
Region 5	-1.055	(.287)	-3.68 ***
Region 6	-.699	(.276)	-2.54 **
Region 7	-.578	(.308)	-1.88 *
Region 8	-.736	(.265)	-2.78 ***
Region 10	-.315	(.268)	-1.18
<i>Executive Oversight</i>			
Democratic Governor	-.055	(.112)	-0.50
<i>Legislative Oversight</i>			
Unified Democratic Legislature	.246	(.150)	1.65 *
Split Legislature	.115	(.148)	0.78

¹⁴¹ The results indicated that our F-Test yielded a statistically significant result (F (23, 439) = 22.30) and that our model accounted for (or "explained") over 51% of the variation in inspectors' citation of deficiencies. Additionally, consistent with our predictions, we found variations in the number of deficiencies, measured in averages, cited by nursing home inspectors over the years and across the states. As shown in Table 5 in the appendix, while, on average, nursing home inspectors cited about 6 deficiencies a year per state (M = 6.08, SD = 2.65), there were instances where the citations were as low as about 2 deficiencies per year in a state and as high as about 16 deficiencies per year. The lag number of average deficiencies cited ranged from an average of 1.5 to 18.4 with a mean score of 5.84 (SD = 2.56). A comparison of the deficiencies' mean in 1995 with the mean of the lag of deficiencies indicates that fewer deficiencies were cited over the period 1996 to 2004. While citing fewer deficiencies after 1995 might be attributed to several factors, including improved oversight of the state inspection process, it might also point to more compliance and improved quality of care. However, this conclusion is doubtful considering that state inspectors have been found to overlook or understate serious problems with quality of care in nursing homes. See GAO 10-70, ADDRESSING THE FACTORS UNDERLYING THE UNDERSTATEMENT OF SERIOUS CARE PROBLEMS REQUIRES SUSTAINED CMS AND STATE COMMITMENT, *supra* note 11.

¹⁴² The state of Nebraska was not included in this model because it has a unicameral legislature

¹⁴³ N = 463

Table 1. Estimated Model of Factors that Influence Citation of Deficiencies in Nursing Homes, 1995 through 2004 (Continued).

Quality of Care – Deficiencies			
	Coefficients	(S.E.)	t-value
<i>Facility Affiliation</i>			
Hospital	-.002	(.006)	-0.38
Chain	-.012	(.006)	-1.89 *
<i>Time Controls</i>			
1996	-.411	(.214)	-1.92 *
1997	.248	(.221)	1.12
1998	.710	(.222)	3.20 ***
1999	.892	(.220)	4.06 ***
2000	.779	(.219)	3.56 ***
2001	.996	(.216)	4.60 ***
2002	.499	(.217)	2.30 **
2003	1.836	(.214)	8.59 ***
2004	2.781	(.211)	13.15 ***
Lag of Deficiencies	.794	(.026)	30.99 ***
Intercept Term	1.468	(.572)	2.57 **
F (df)	F (23, 439) = 22.30 ***		
Adjusted R ²	.5147		

Note: Significance at the 0.01 level, 0.05, and 0.10 level is indicated by ***, **, and *, respectively.

A. Political Factors

1. Survey of Previous Scholarship

“Political factors” is a broad concept, whose definition, as stated earlier, we restrict in this study to the orientations and proclivities of the two major political parties in the U.S.¹⁴⁴ regarding nursing home regulations. Nursing home policy in

¹⁴⁴ See *supra* note 134 and accompanying text. The U.S. has a strong two-party system where, more than is the case in other two-party systems (such as Britain), the Democratic and Republican Parties dominate the political and electoral landscape. See KENNETH JANDA ET AL., *THE CHALLENGE OF DEMOCRACY: GOVERNMENT IN AMERICA* 227, 229 (10th ed. 2009). See also PATTERSON, *supra* note 91, at 199 (stating that, in the U.S. two-party system, the Democratic and Republican Parties today are the only two parties “with a realistic chance of acquiring political control.”). The activities, dispositions, and/or positions of these two major parties do not exhaust the universe of political forces in the U.S., but they monopolize those forces. For although many Americans identify themselves as “independents” (*i.e.*, disinclined from either of these two parties) and numerous parties have evolved over the years that tap

this country is marked by enduring tension between regulation and market-based approaches.¹⁴⁵ The goal still is how to assure high-quality of care and high-quality of life for nursing home residents. While for some individuals and groups, the means to this goal is regulation, for others that route is market-based techniques. Again, our focus is on the orientations of the two political parties. The Democratic Party tends to *favor* regulations, while the Republican Party tends to *disfavor* them. Specifically, the Democratic Party tends to introduce new regulatory measures and support strong enforcement of regulations in place, while the Republican Party tends to oppose new regulations or works to reduce costs associated with enforcing laws on nursing home care. With respect to the Republican Party, Americans for Democratic Action, an advocate for nursing home care, took this position in 2005, commenting on nursing home policy under President George W. Bush, which it surmised to have “gone awry.”¹⁴⁶ The group accused the U.S. Congress, at the time controlled by the Republican Party, of not appropriating sufficient funds to enforce the NHRA, not providing funding for personnel and training necessary for proper inspection of nursing homes, and of not doing much to promote effective sanctions against non-compliant nursing homes, among other charges.¹⁴⁷

Still at the national level, the attitudes of recent Republican Party presidents bear out similar antipathy toward regulation. Although the NHRA was passed during his period in office, Ronald Reagan was noted for an opposition to regulation that was so far-flung in spectrum it included advocacy for deregulation. His administration contemplated eliminating nursing home residents’ rights, as a condition for participation by facilities in Medicare and Medicaid, and also favored weak inspections that would have allowed nursing homes to survey themselves and less frequently too.¹⁴⁸ To crown things off, the NHRA was passed unobtrusively toward the dying end of the Reagan administration, as part of a budget reconciliation process with Congress, controlled by the Democratic Party, a technique in the social security field initiated with the Boren Amendment¹⁴⁹ that George H. W. Bush, who succeeded Reagan as president, also used. George H. W. Bush meant his administration to be a “kinder, gentler” version of the Reagan government, under which he served for eight years as vice president from 1981 to 1989, and his attitude toward regulations was therefore merely Reagan-lite.¹⁵⁰ Although George W. Bush

into this “independent” mood, these third parties, through their platforms or postures, maintain some degree of affiliation to one of the two major parties.

¹⁴⁵ *Ontario Health Coalition*, *supra* note 3.

¹⁴⁶ See AMERICANS FOR DEMOCRATIC ACTION, 14 THE NURSING HOME CRISIS: PUBLIC POLICY GONE AWRY (2005), available at <http://www.adaction.org/pages/issues/all-policy-resolution/social-amp-domestic/140-the-nursing-home-crisis-public-policy-gone-awry.php>

¹⁴⁷ *Id.*

¹⁴⁸ See *supra* notes 64-65 and corresponding texts.

¹⁴⁹ See *supra* notes 52-53 and corresponding texts. Another instance, under Reagan, that besides these two, involved the use of this technique in social security legislation was Omnibus Budget Reconciliation Act, Pub. L. 99-509 (1986). See generally GEOFFRY KOLLMAN AND CARMEN SOLOMON-FEARS, SOCIAL SECURITY: MAJOR DECISIONS IN THE HOUSE AND SENATE 1935-2000 (Novinka Books, 2002).

¹⁵⁰ Instances under the first Bush administration involving the use of budget reconciliation to achieve passage of social security legislation were the Omnibus Budget Reconciliation Act,

is remembered for expanding Medicare, through the addition of an outpatient prescription drug benefit for elderly citizens,¹⁵¹ he shared the same general attitude of preceding Republican Party governments toward regulation. Additionally, Bush's failed attempt to privatize social security,¹⁵² an occurrence that bore out the revulsion against regulation that he shared with the two previous Republican-led governments, is probably the reason that some observers denominate his nursing home regulation orientation as a "market-based approach."¹⁵³

In contrast, William J. Clinton, who was elected under the platform of the Democratic Party, strongly favored regulation of nursing homes.¹⁵⁴ In 1995, with his presidential veto power, he repulsed the attempt by the 104th Congress, under Republican Party control, to repeal the NHRA.¹⁵⁵ Under Clinton, the 105th Congress, led by the Republican Party, in 1997, repealed the Boren Amendment.¹⁵⁶ The same Congress passed the Balanced Budget Reconciliation Act that cut the amount of money Medicare pays nursing homes, an occurrence that triggered the bankruptcy of four or five large nursing home chains.¹⁵⁷ Moreover, in 1998 and 2000, Clinton unveiled numerous proposals designed to improve the enforcement of existing nursing home laws.¹⁵⁸ A similar attitude in favor of regulation is perceivable under the current Obama administration. Given the financial and housing problems that helped usher him into office, crises that Obama himself blamed on lax regulatory oversight,¹⁵⁹ some analysts predict for his government an attitude toward regulation

Pub. L. 101-239 (1989); Omnibus Budget Reconciliation Act, Pub. L. 101-508 (1990); Omnibus Budget Reconciliation Act, Pub. L. 103-66 (1993). See KOLLMAN AND SOLOMON-FEARS, *supra* note 149.

¹⁵¹ See *supra* note 41.

¹⁵² See, e.g. PATTERSON, *supra* note 91, at 245-46.

¹⁵³ *The President's Budget Proposal Would Eliminate Medicare As We Know It*, Center for Medicare Advocacy, Inc., http://www.medicareadvocacy.org/InfoByTopic/Reform/reform_pres_proposal.htm (last visited Sept. 26, 2010).

¹⁵⁴ *New Gao Report Demonstrates Need for Stronger Enforcement of Nursing Home Quality Standards: Health Reform Provisions Could Help*, Center for Medicare Advocacy, Inc. (May 20, 2010), http://www.medicareadvocacy.org/InfoByTopic/SkilledNursingFacility/10_05.20.GAOonSNFEnforcement.htm.

¹⁵⁵ See *Brief History of Long-term Care* *supra* note 5.

¹⁵⁶ Balanced Budget Act of 1997, Pub. L. No. 105-33, § 1851, 111 Stat. 251. See also *supra* notes 52-53 and corresponding texts.

¹⁵⁷ *Evolution of Nursing Home Care*, *supra* note 5. The specific provision here involved is Title IV, § 1851.

¹⁵⁸ For 1998, see *President Clinton Announces Initiative to Improve the Quality of Nursing Home Care*, White House Fact Sheet, Dep't of Health & Hum. Servs. Press Office (July 21, 1998), accessible at <http://archive.hhs.gov/news/press/1998pres/98072/c.html> (last visited Jul. 16, 2010); for 2000, see Older Americans Act Amendments of 2000, Pub. L. No. 106-501, 114 Stat. 2226. See also *supra* note 82 and corresponding text.

¹⁵⁹ See, e.g. THOMAS R. DYE ET AL., OBAMA: YEAR ONE 85-94 (2010).

of nursing homes so strong it will amount to “re-regulation.”¹⁶⁰ True to the prediction of an orientation toward strong regulation, as part of his overhaul of the healthcare system, under Obama, the 111th Congress, in 2010, passed a set of three laws designed to strengthen the nursing home regulatory scheme.¹⁶¹ The laws are (1) the Nursing Home Transparency and Improvement Law, (2) Elder Justice Act, and (3) Patient Safety and Abuse Prevention Act.¹⁶²

Shifting our focus momentarily to the states, the center of gravity of nursing home inspections, political chief executives also use their appointment powers to influence regulatory agencies. For example, one 1991 study found political appointment to be, for modern chief executives, governors included, a key mechanism of political control that ranks over and above changing budgets, legislation, congressional signals, and administrative reorganization.¹⁶³ These executives choose political appointees for reasons that include these appointees' ability to implement their programs.¹⁶⁴ As with the national level, political affiliation also matters here; governors elected under the label of the Democratic Party tend to favor regulation, while those elected under the label of the Republican Party tend to oppose regulation in favor of deregulation or “market-based” techniques.¹⁶⁵

¹⁶⁰ *Why Health Care Reform is Good for Medicare Beneficiaries*, Center for Medicare Advocacy, Inc. (Sept. 10, 2009), http://www.medicareadvocacy.org/InfoByTopic/Reform/Reform_09_09.10.HCreformisGOODforMedicare.htm.

¹⁶¹ *President Obama Signs Elder Justice Act And Nursing Home Transparency and Improvement Act Into Law*, California Advocates for Nursing Home Reform, available at http://www.canhr.org/newsroom/newdev_archive/2010/ObamaSignsElderJusticeAct.html [hereinafter CA Advocates for Nursing Home Reform] (last visited May 22, 2010).

¹⁶² *Id.* The last created a national program of criminal background checks on employees of long-term care providers with access to residents of facilities or people receiving care in their own homes. *Id.* All three laws are embedded in the Patient Protection and Affordable Care Act, Pub. L. 111-148, 124 Stat. 119 (2010).

¹⁶³ See B. Dan Wood and Richard W. Waterman, *The Dynamics of Political-Bureaucratic Adaptation*, 37 AM. J. POL. SCI. 497-528 (1991).

¹⁶⁴ See, e.g., John T. Scholz, Jim Twombly & Barbara Headrick, *Street-Level Political Controls Over Federal Bureaucracy*, 85 AM. POL. SCI. REV. 829 (1991) (focusing on state environmental protection agencies).

¹⁶⁵ The reader might wonder why the Democratic Party seemingly stands with underdogs, such as poor elderly citizens, while the Republican Party appears to take things, like good care and quality life, away from them. The solicitude is a zeal borne out of altruism: after all, true to the devotion embedded in the preamble of the U.S. constitution regarding promotion of the “general welfare,” U.S. political parties seek to “give voters a chance to influence the direction of the government.” PATTERSON, *supra* note 91, at 213 (providing a definition of political parties). But it is also a solicitude rooted in realist calculations. The Democratic Party draws its supporters from economically vulnerable groups in society, including elderly persons, although recently elderly voters have “split their vote about evenly between the [two] parties.” *Id.* at 223. In contrast, the Republican Party “has historically been the party of tax cuts and business incentives” that draws its support mainly from “white middle class Protestants,” persons living in the suburbs, and persons from regions “where traditional values and a desire for lower taxes and less government regulation of economic activity are most pronounced.” *Id.* at 224.

2. Definition and Operationalization of Key Terms.

We stated earlier that, for this study, we measure "*political factors*" narrowly around the orientation of the two major political parties toward nursing home regulations.¹⁶⁶ Additionally, we make clear that, although our review of previous scholarship on this variable refers to political party events at both the national and state levels, our level of analysis in this study,¹⁶⁷ and to which level we limited our data collection, is the *state*. This is because of data constraints, but even more importantly because the inspection system that forms our object of inquiry in this study is largely state-based.

There are two integral elements to the *political party affiliation* ("PPA") variable used in this study: affiliation of the governor ("governor"), and affiliation of the legislature ("legislature"). The *governor* is a categorical measure coded "0" for the Republican Party and "1" for the Democratic Party (see Table 5 in the appendix). We excluded governors identified as independents from the analysis. The *legislature* is a dummy variable operationalized in terms of whether or not both chambers of the legislature were controlled by the Democratic Party or the Republican Party (see Table 5). For this variable, there were altogether three categories: (1) states with a legislature dominated or controlled by the Democratic Party, (2) states with a legislature dominated or controlled by the Republican Party, and (3) states where neither of the two political parties has achieved domination or maintained a majority. This last scenario or possibility occurs within the context of a bicameral legislature where either the Democratic or Republican Party controls one chamber of the legislature, while the other party controls the other. Consistent with the admonition in statistical research regarding dummy variables,¹⁶⁸ one of these three scenarios, namely, legislatures dominated or controlled by the Republican Party, was used as the comparison category. Because Nebraska has a unicameral legislature, the state was excluded from the analysis and our database covered the remaining 49 states of the union.

3. Theses and Underlying Assumptions, and Results.

No. 1. States with governors affiliated with the Democratic Party are *more likely* to experience more citation of deficiencies, compared to states with governors affiliated with the Republican Party.

The assumption underlying this thesis is that, compared to the Republican Party, officials of the Democratic Party, including governors, are more predisposed to strong enforcement of regulations that turn into citations of deficiencies. In the nursing home setting, this strong predisposition includes a greater willingness to provide funding for enforcement of nursing home regulations. In contrast, members of the Republican Party, including governors, have a tendency to block or blunt strong enforcement of nursing home regulations. As one interest group poignantly

¹⁶⁶ See *supra* note 144 and accompanying text. It should be clear that in so doing, we do not suggest that party affiliation exhausts the universe of political factors, for it does not. To the contrary, all the variables we test in this study may, equally, be denominated "political."

¹⁶⁷ For an elaboration of the concept, *levels of analysis*, in political science, see BRUCE RUSSETT ET AL., *WORLD POLITICS: THE MENU FOR CHOICE* 10-16 (6th ed. 2000).

¹⁶⁸ See DAMODAR N. GUJARATI, *ESSENTIALS OF ECONOMETRICS* 257 (1992).

pointed out, referring to Republican members of the U.S. Congress, such "rearguard" actions could include not appropriating sufficient funds to enforce a law, not providing funding for personnel and training necessary for proper inspection of nursing homes, and not doing much to promote effective sanctions against non-compliant nursing homes, among other steps.¹⁶⁹ There is not enough evidence from our study to support this hypothesis. Instead, contrary to our expectation, the result showed that states with governors affiliated with the Democratic Party experienced fewer citations of deficiencies than states with governors affiliated with the Republican Party. However, at $b = -.055$, $p > .10$, the observed difference is *not* statistically significant.

No. 2. States with legislatures dominated or controlled by the Democratic Party are *more likely* to experience a higher number of deficiency citations, compared to states with legislatures dominated or controlled by the Republican Party.

The assumption underlying this thesis is the same as that for thesis No. 1 above. The premise, applicable also to thesis No. 1, is that from a general standpoint, the Republican Party and its officials, including state legislators, tend to favor less regulation of nursing homes or to toss off "rearguard" obstacles in the way of existing regulations, while the Democratic Party tends to initiate those regulations and/or support stronger enforcement of the ones already on the books. Our regression analyses bore out this result and, at the 90% level, the finding was statistically significant.

No. 3. States with legislatures whose control is split (in the sense that each major political party controls one chamber of the legislature) are *more likely* to experience a higher number of deficiency citations, compared to states with legislatures dominated or controlled by the Republican Party.

The assumption underlying this thesis is that full control of the legislature, signified by a legislature dominated or controlled by the Republican Party, in our comparison variable, is necessary for large numbers of deficiency citations, but that the likelihood for high deficiency citations slips away even with the least loss of control evident in a legislature with split control. There is not enough evidence from our study, based on our regression analysis, to support this thesis.

B. Oversight

Oversight in this study is a concept we tie inextricably to nursing home inspection. Much of the analysis in the last subsection relating to political party affiliation applies here. In other words, just as with regulation, oversight of nursing homes is stronger under governments controlled by the Democratic Party, both at the national and state levels, compared to governments controlled by the Republican Party. The reader should also note that, from a broader perspective, enforcement, touched upon repeatedly in this article, encompasses oversight. The term is measured as a set of regional/spatial variables that isolates and holds out CMMS region 9, encompassing the state of California, the focus of numerous GAO studies analyzing the problems with the inspection system, as the comparison category.

¹⁶⁹ See AMERICANS FOR DEMOCRATIC ACTION, *supra* note 146.

No. 4. Deficiency citations in regional offices 1, 2, 3, 4, 5, 6, 7, 8, and 10 will be different from citation of deficiencies in regional office 9.

Evidence from our study confirmed this hypothesis. Our regression results showed that, compared to region 9, all of the other CMMS regions reported fewer citations of deficiencies, and the differences in citation of deficiencies were statistically significant, except for Region 10, comprising Alaska, Idaho, Oregon, and Washington. Regions 1, 2, 3, 5, and 8, were statistically significant at the 99% level; 4 and 6 were statistically significant at the 95% level; and 7 was statistically significant at the 90% level. Several factors, including differences in budgetary allocations, quality and size of inspection staff, inconsistent standards of evaluation from region to region, time spent on oversight inspections, and different methods for conducting oversight inspections, might account for the variations in citation of deficiencies across regions. Oversight influences inspectors' citation of deficiencies. Accordingly, with the spotlight placed on problems of nursing home oversight in California, it is possible that Region 9, encompassing California, may have tightened its oversight inspection process, an occurrence that probably accounted for the region's citing more deficiencies than the other regions.

C. Affiliation or Ownership Status of Nursing Homes

1. Survey of Previous Scholarship

Do for-profit and not-for-profit nursing homes “behave differently?”¹⁷⁰ Two-thirds of the estimated 16,000 nursing homes in the U.S. are owned by for-profit organizations, the rest by non-profit or government-owned entities.¹⁷¹ Following the introduction of Medicare and Medicaid and before the passage of the NHRA in 1987, a growth occurred in the number of for-profit nursing facilities owned by large chains.¹⁷² The trend continued following enactment of the NHRA, such that, between 1991 and 1997, the percentage of nursing homes owned by multi-unit chain organizations increased from 39% to 43%.¹⁷³ Long before the passage of the NHRA in 1987, the relationship between ownership status of nursing homes and quality of care has been an issue of enormous interest and versed discussion in the literature.¹⁷⁴ While some of these studies found “behavioral differences” in quality of care tied to

¹⁷⁰ See William E. Aaronson et al., *Do For-Profit and Not-for-Profit Nursing Homes Behave Differently?* 34 GERONTOLOGIST 775 (1994).

¹⁷¹ The numbers break down into about 67% by for-profit organizations, 27% by non-profit organizations, and 6% by government and other entities. See Pear, *supra* note 84; *Nursing Homes*, *supra* note 1.

¹⁷² See D.W. Light, *Corporate Medicine for Profit*, 255 SCI. AM. 555 (1986).

¹⁷³ See Jane Banaszak-Holl et al., *Comparing Service and Quality among Chain and Independent U.S. Nursing Homes during the 1990s* (2002), http://www.caseatduke.org/documents/nh_servicequality_mitchell.pdf (last visited Oct. 29, 2010).

¹⁷⁴ See Peter W. Shaughnessy et al., *Case Mix and Surrogate Indicators of Quality of Care Over Time in Freestanding and Hospital-Based Nursing Homes in Colorado*, 98 PUB. HEALTH REP. 486 (1983); S. Winn and K.M. McCaffree, *Characteristics of Nursing Homes Perceived to be Effective and Efficient*, 16 GERONTOLOGIST 415 (1976); R. Hopkins Holmberg and Nancy N. Anderson, *Implications of Ownership for Nursing Home Care*, 6 MED. CARE 300 (1968).

affiliation status, others uncovered no such linkage. One of the studies in the first category, by Shaughnessy and colleagues, found that nursing homes affiliated with hospitals afforded better quality of care compared to freestanding nursing homes.¹⁷⁵ Another study, by Greene and Monahan, compared for-profit and other types of nursing homes and found quality in for-profit homes to be lower.¹⁷⁶ Among studies in the latter category were those by Winn and McCaffree,¹⁷⁷ as well as Holmberg and Anderson,¹⁷⁸ both of which found little difference in the quality of care provided by for-profit nursing homes, compared to not-for-profit facilities.

In the aftermath of the NHRA, studies conducted by the Department of Health and Human Services found that nursing homes owned by for-profit organizations received the most citation for deficiencies, compared to those owned by non-profit organizations or the government. For example, in 2007, 94% of for-profit nursing homes were cited for deficiencies, compared to 91% of homes owned by the government, and 88% of nonprofit homes.¹⁷⁹ Similarly, for-profit nursing homes accumulated a higher average number of deficiencies than the other categories of nursing homes. According to the Health and Human Services report, for-profit nursing homes averaged 7.6 deficiencies per home, compared to 5.7 deficiencies for nonprofit homes, and 6.3 deficiencies for homes owned by the government.¹⁸⁰

According to a New York Times study, two things for-profit nursing homes (especially those run by large private investment companies) do that have a negative effect on nursing home care are (1) cutting costs, and (2) using ownership devices, such as complicated corporate structures. These tactics insulate companies from costly lawsuits because they make it difficult for plaintiffs, damaged by low-quality

¹⁷⁵ Shaughnessy et al., *supra* note 174.

¹⁷⁶ V.L. Greene and D. Monahan, *Structural and Operational Factors Affecting Quality of Patient Care in Nursing Homes*, 29 PUB. POL'Y 399 (1981).

¹⁷⁷ Winn and McCaffree, *supra* note 174.

¹⁷⁸ Holmberg and Anderson, *supra* note 174.

¹⁷⁹ Pear, *supra* note 84. The reader should note that, while the figure for government-owned homes seems high at 91%, these homes, as already indicated (*see supra* text accompanying note 171), make up only 6% of the 16,000 nursing facilities in the U.S.

¹⁸⁰ Pear, *supra* note 84. For similar findings, *see also* Margaret J. McGregor et al., *Staffing Levels in Not-For-Profit and For-Profit Long-Term Care Facilities: Does Type of Ownership Matter?* 172 CANADIAN MED. ASS'N J. 645 (2005); Ciaran O'Neill et al., *Quality of Care in Nursing Homes: An Analysis of Relationships Among Profit, Quality and Ownership*, 41 MED. CARE 1318 (2003); Banaszak-Holl et al., *supra* note 173; Charlene Harrington et al., *Does Investor Ownership of Nursing Homes Compromise the Quality of Care?* 91 AM. J. PUB. HEALTH 1452 (2001) [hereinafter Harrington et al., 2001 Article]; Harrington et al., 2002 Article, *supra* note 138. *See also* William D. Spector et al., *The Impact of Ownership Type on Nursing Home Outcomes*, 7 HEALTH ECON. 639 (1998); Aaronson et al., *supra* note 170; Mark A. Davis, *Nursing Home Ownership Revisited: Market, Cost, and Quality Relationships*, 31 MED. CARE 1062 (1993). Not only did Harrington and her colleagues uncover that not-for-profit facilities afforded more quality care than for-profit homes, they also found that these non-profits have higher staffing levels, compared to their for-profit counterparts. *See* Harrington et al. 2001 Article, *supra*.

care, to bring suit.¹⁸¹ Concerning the first, Professor Harrington of the University of California in San Francisco, who has studied nursing homes extensively and some of whose works we used in building our argument in this piece, was quoted as stating that "[t]he first thing [these private] owners do is lay off nurses and other staff that are essential to keeping patients safe."¹⁸² Harrington added instructively that these "chains have made a lot of money by cutting nurses, but it's at the cost of human lives."¹⁸³

A recent incident that has stimulated a flare-up in the debate regarding the possible influence of ownership status on nursing home care is the takeover of large chains by private equity firms.¹⁸⁴ One such takeover that drew tremendous public and governmental attention was the buy-out of Manor Care, the nation's largest nursing home chain, for \$6.3 billion.¹⁸⁵ The firm engaged in this takeover was the Carlyle Group, which was reputed to be politically connected.¹⁸⁶ Advocates for nursing home residents believe that such takeovers have a negative impact on the quality of care.¹⁸⁷ They argue, for example, that such takeovers result in windfalls that do *not* benefit nursing home residents.¹⁸⁸ Advocates of the nursing home industry (including lobbyists for equity firms like the Carlyle Group) rebut that there is no evidence that private equity ownership negatively impacts care.¹⁸⁹ Instead, in the words of one lobbyist for the American Health Care Association ("AHCA"), "[t]he focus should be on staffing and decision making, instead of who owns the building."¹⁹⁰ Congress has held hearings on private equity firms,¹⁹¹ and as of 2008,

¹⁸¹ Duhigg, *supra* note 88; *see also* Joseph E. Casson and Julia McMillen, *Protecting Nursing Home Companies: Limiting Liability through Corporate Restructuring*, 36 J. HEALTH L. 577 (2003).

¹⁸² Duhigg, *supra* note 88.

¹⁸³ *Id.*

¹⁸⁴ *Trends in Nursing Home Ownership and Quality: Hearing of the Subcommittee on Health House Committee on Ways and Means*, *supra* note 29.

¹⁸⁵ *See* Samuel Loewenberg, *Nursing Home Industry Fights Reforms*, POLITICO.COM (May 27, 2008), <http://dyn.politico.com/printstory.cfm?uuid=26AD3B21-3048-5C12-00AC70E7B99A977D>.

¹⁸⁶ *See id.*

¹⁸⁷ *See* Duhigg, *supra* note 88; Loewenberg, *supra* note 185.

¹⁸⁸ Following the buyout of Manor Care by a private equity firm, the CEO of the company was to receive \$118-\$186 million. The Center for Medicare Advocacy, an advocacy group, calculated how many nursing staff (gristmill for nursing care delivery), that the windfall would have paid for: \$118 m would have hired 5,346 certified nursing assistants (CNAs) and 2,198 registered nurses (RNs), while \$186 m would have purchased 8,427 CNAs and 3,464 RNs. *See* Letter from Toby S. Edelman, Center for Medicare Advocacy, California Advocates for Nursing Home Reform, to Editor, Center for Medicare Advocacy, Inc. (July 2007), *accessible at* http://www.medicareadvocacy.org/Commentary_SNFCEOsWindfall.htm.

¹⁸⁹ *See* Loewenberg, *supra* note 185.

¹⁹⁰ *Id.*, quoting David E. Hebert, former Chief of Staff for then-Majority Whip Roy Blunt (Republican from Missouri and now an AHCA lobbyist).

proposed legislation that will deal with the possible effect of private equity ownership on nursing home quality, including the requirement of more transparency in ownership structure of nursing homes, which private equity firms strongly oppose. This bill, sponsored by Senator Herb (Democrat from Wisconsin) and Senator Chuck Grassley (Republican from Iowa), among others, became the Nursing Home Transparency and Improvement Act that President Obama signed into law, as part of his healthcare overhaul, in March of 2010.¹⁹²

2. Definition and Operationalization of Key Terms.

Affiliation or *ownership status of nursing homes* refers to the ownership status or identity of a nursing home; whether, for example, as we indicated in our survey of previous studies, such a facility is owned by a for-profit, non-profit, or government-owned entity. Two ownership categories this study used are non-profit *hospital-affiliated* and for-profit *chain-affiliated* nursing homes. *Hospital affiliation* was operationalized as the percentage of certified hospital-based facilities in a state by year (see Table 5). *Chain affiliation* was operationalized as the percentage of certified facilities that were owned or leased by multi-facility organizations in a state by year (see Table 5).

3. Theses and Underlying Assumptions, and Results.

Thesis No. 5. Citation of deficiencies by inspectors will *decrease* with *increases* in the percentage of hospital-affiliated nursing homes by state and year.

Thesis No. 6. Citation of deficiencies by inspectors will *increase* with *increases* in the percentage of chain-affiliated nursing homes by state and year.

The general assumption underlying these theses is that, compared to hospital-affiliated nursing homes, nursing homes owned by chains are more likely to engage in cost-cutting maneuvers, designed to increase their profits, that work against quality care.¹⁹³ These measures include laying off nurses and other paramedical personnel who are necessary to keep residents safe, and working to insulate themselves from costly lawsuits by utilizing dubious (if not devious) ownership devices. These tactics increase the likelihood of lower-quality care being provided to residents and make it difficult for residents damaged by incompetent care or their relatives to bring legal action.¹⁹⁴

Our finding supported thesis No. 5, although, intriguingly, the result was *not* statistically significant. Regarding thesis No. 6, our regression analysis uncovered a

¹⁹¹ See *House Ways and Means Committee*, *supra* note 29; *Nursing Home Transparency and Improvement*, U.S. Senate Special Committee on Aging (Nov. 15, 2007), available at http://aging.senate.gov/hearing_detail.cfm?id=321325&.

¹⁹² See *supra* notes 161-162 and corresponding texts. Senator Grassley is the only sponsor of this bill who is affiliated with the Republican Party; the other four sponsors, along with Senator Kohl, are members of the Democratic Party. CA Advocates for Nursing Home Reform, *supra* note 161.

¹⁹³ See *supra* notes 181-183 and accompanying texts.

¹⁹⁴ *Id.*

statistically significant relationship ($b = -.012$ and significant at the 90% level), although *not* the positive one we postulated. In other words, controlling for all the other variables, an *increase* in the percentage of for-profit chain nursing homes in states, results in a *decrease* in the citation of deficiencies. This is a most puzzling finding that runs intriguingly contrary to the grain and weight of the literature. We surmise this result to be due to under-reporting of deficiencies or, less plausibly, chance—although we must disclose that a recent study, using measures different from ours, reached a similar finding.¹⁹⁵

Thesis	Statement	Finding
1	Relationship between party affiliation and citation of deficiencies (Democratic governor)	Not supported and observed difference is not statistically significant.
2	Relationship between party affiliation and citation of deficiencies (Democratic-controlled legislatures)	Supported and statistically significant.
3	Relationship between party affiliation and citation of deficiencies (split-control legislatures)	Not supported and observed difference is not statistically significant.
4	Relationship comparing variations in CMMS regional offices 1-8 and 10 with region office 9 (encompassing California)	Supported and observed differences are statistically significant, except for Region 10.
5	Hospital-affiliated nursing homes and citation of deficiencies.	Supported but not statistically significant.
6	Chain nursing homes and citation of deficiencies	Intriguingly not supported but statistically significant.

¹⁹⁵ See Mitchell et al., *supra* note 140, at 9 (stating that “chain membership may lead to an overall reduction in quality of services.”); see also *id.* at 18 (concluding that, controlling “for a wide range of facility, resident, and market characteristics,” “non-profits have higher quality and costs than for-profit facilities.”).

VI. CONCLUSION

This study analyzed the impacts of political factors, oversight, and affiliation or ownership status of nursing homes on the enforcement of the nursing home regulatory regime as it has evolved from the Social Security amendments creating Medicare and Medicaid through the NHRA to the social security legislation enacted as part of the healthcare overhaul of the current Obama administration. Our specific aim was to understand the factors that influence variations in the citation of deficiencies for violation of standards by state inspectors charged with responsibility for implementing the nursing home regulatory scheme.

Prior studies have speculated on the possible influence of political factors on inspectors' citation of deficiencies for violation of standards.¹⁹⁶ This article is the first of its kind, by political scientists, drawing on public administration concepts, to systematically measure and test some of those political factors, with specific reference to their influence on the citation of deficiencies by state inspectors enforcing the nursing home regulatory regime and inspection system. We are avid students of public administration who, in conducting this study, first had to harmonize our emphasis on "political factors" with an American public administration, which, duly awake to the extensive involvement of unelected bureaucrats in policymaking, long ago yanked off as fiction, the doctrine that claimed to separate politics from administration. Immersion of public administrators into politics, in negation of the politics-administration doctrine, should not preclude us from measuring factors that would seem political, so long as we are able to isolate and diligently pinpoint which factors we are measuring. To be on the safe side, we confined our measurement of political factors around the two major political parties in the U.S. system. Even so we do not dispute the fact that all the factors involved in this study, including oversight, and nursing home ownership are arguably embedded in politics.

Generally, our findings matched our conceptual framework and the literature. They also, as well, provided strong evidence that political factors, in the manner we measured those variables in this Article, influence the citation of deficiencies by inspectors monitoring nursing homes. However, there was insufficient evidence to support our hypothesis that states with governors affiliated with the Democratic Party would experience more citation of deficiencies, compared to governors affiliated with the Republican Party, although for the state legislature variable, states with legislatures dominated or controlled by the Democratic Party registered a higher number of deficiency citations, compared to states controlled by the Republican Party and this finding was statistically significant. Oversight similarly influenced inspectors' citation of deficiencies. Except for Region 10, practically all of the regional office variables were statistically significant. Moreover, compared to Region 9 (our comparison category), all of the other regions registered fewer citations of deficiencies. This finding might reflect under-reporting of deficiencies, variation in the oversight methods the regional offices employed, or better quality of care in most of the regions, compared to Region 9. Contrary to the literature and our expectation, for-profit chain facilities intriguingly received fewer citations of

¹⁹⁶ See GAO 10-70, ADDRESSING THE FACTORS UNDERLYING THE UNDERSTATEMENT OF SERIOUS CARE PROBLEMS REQUIRES SUSTAINED CMS AND STATE COMMITMENT, *supra* note 11; Charlene Harrington & H. Carrillo, *The Regulation and Enforcement of Federal Nursing Home Standards, 1991-1997*, 56 MED. CARE RES. & REV. 471 (1999).

deficiencies. A previous study, using concepts and measurements different from our own, also reached the same result. But given GAO studies that rank these chain homes to be the most poorly performing, this finding, more likely than not, also reflects under-reporting among inspectors.

Despite the light that it sheds on the operations of the nursing home regulatory regime, this study, like any other, has its limitations or caveats. Our focus here relates to the oversight system, specifically measurement of the oversight variable of CMMS's ten regional offices. Constraints in data availability prevented us from capturing components of the oversight system likely to impact citation of deficiencies, such as inspectors' qualifications, hours worked, experience, number of comparative inspections and of observational inspections conducted per year, type and quantity of training provided to state inspectors, budget size, and number of remedies and sanctions imposed on state inspection agencies. Thus, while these and other factors, such as differences in staff size, number of hours spent conducting inspections, and budgetary allocations might provide a more accurate understanding of variations across CMMS regional offices, the lack of available data limited this study to the use of dummy variables. To minimize problems, such as under-reporting, plaguing the inspection system and promote better monitoring of state inspection agencies, CMMS regional offices must begin requiring state inspectors to select homes that have no established patterns of deficiencies. To improve the quality of care to nursing home residents across the nation, they must also begin to comply with regulations mandating them to conduct comparison inspections of 5% of the homes in each region.

Future studies on this topic should focus on the factors we used in this Article as well as broader constructs of variations across CMMS regional offices' oversight. They should also examine interaction among variables that can influence inspectors' citation of deficiencies. The need for broader constructs and interaction variables is dictated by the large variation in deficiency citations unexplained by this study. At a record 48%, the figure suggests the operation of some other factors, not included in our own model, that influence inspectors' citation of deficiencies. Still, our study increased understanding on the impact of political and not-so-political factors, such as oversight and nursing home ownership status, on citation of deficiencies for violations of regulations governing nursing homes. Future studies should also examine how to improve consistency across the CMMS's regional offices oversight in order to ameliorate state inspection processes and, ultimately, quality of care in nursing homes that takes into account the influence of state-level political factors. By this study, we have provided some foundation that those future studies could build on, keeping a close eye on the limitations that we have identified. Finally, ours is a macro-level study of the inspection system that could be complemented with micro-level studies of states other than California. These micro-level studies, percolating already in states like Minnesota and New York,¹⁹⁷ should be extended to other U.S. states and territories.

¹⁹⁷ See, e.g., Cynthia Rudder & Charles D. Phillips, *Citations and Sanctions in the Nursing Home Enforcement System in New York State: Their Use and Effects*, 21 GENERATIONS 21 (1997); Iris C. Freeman, *Nursing Home Politics at the State Level and Implications for Quality: The Minnesota Example* 44 GENERATIONS 48 (1997).

Table 2. Scope and Severity of Deficiencies

Severity Category	Scope			Sanction ^a	
	<i>Isolated</i>	Pattern	Widespread	Required	Optional
Actual or potential for death/serious injury ^b	J	K	L	Group 3	Group 1 or 2
Other actual harm	G	H	I	Group 2	Group 1 ^c
Potential for more than minimal harm				Group 1 for categories D and E; group 2 for category F	Group 2 for categories D and E; group 1 for category F
	D	E	F		
Potential for minimal harm (substantial compliance)	A	B	C	None	None

Source: GAO/HEHS 99-46, NURSING HOMES: ADDITIONAL STEPS NEEDED TO STRENGTHEN ENFORCEMENT OF FEDERAL QUALITY STANDARDS, *supra* note 27.

^aGroup 1: sanctions are directed plan of correction, directed in-service training, and/or state monitoring.

Group 2: sanctions are denial of payment for new admissions or all individuals and/or civil monetary penalties of \$50 to \$3,000 per day of noncompliance.

Group 3: sanctions are temporary management, termination, and/or civil monetary penalties of \$3,050 to \$10,000 per day of noncompliance.

^bThis category is referred to in regulations as "immediate jeopardy."

^cSanctions for category 1 also include option for temporary management.

Note: The letters in the "isolated," "pattern," and "widespread" categories show the severity of the deficiencies, where "A" is a problem with the potential for minimal harm and is an isolated incident. The letter "L" indicates that there is a facility problem that is widespread and many residents have actually been harmed or have the potential for being harmed.

Table 3. Enforcement Sanctions

Sanctions	Description	In Place Before NHRA	Added or Expanded Under NHRA
Civil Monetary Penalties	Penalties ranging from \$50 to \$10,000.		X
Temporary Management	The nursing home accepts a substitute manager appointed by the state with the authority to hire, terminate, and reassign staff; obligate funds; and alter facility procedures as appropriate.		X
Denial of Payments	Medicare and/or Medicaid payments can be denied for all covered residents or for newly admitted residents.		X
Directed in-service Training	The nursing home is required to provide training to staff on a specific issue identified as a problem in the inspection.	X	X
			X

Table 3. Enforcement Sanctions (Continued).

Sanctions	Description	In Place Before NHRA	Added or Expanded Under NHRA
Directed Plan of Correction	The facility would be required to take action within specified time frames according to a plan of correction developed by the HCFA, ¹⁹⁸ the state, or the temporary manager.		
State Monitoring	An on-site state monitor can be placed in the nursing home to help ensure that the home achieves and maintains compliance.		X
Termination	The provider is no longer eligible to receive Medicare and Medicaid payments for beneficiaries residing in the facility.		X
		X	X

Source: GAO/HEHS 99-46, NURSING HOMES: ADDITIONAL STEPS NEEDED TO STRENGTHEN ENFORCEMENT OF FEDERAL QUALITY STANDARDS, *supra* note 27.

¹⁹⁸ The acronym stands for the former name of the agency that is today christened the CMMS. *See supra* note 100.

Table 4. Information on CMMS Regional Offices

Regional Offices	States in Each Region	Number of Nursing Homes in the Region	Number of Regional Inspectors	Number of Required Comparative Inspections
Region I, Boston, MA	ME, VT, NH, MA, CT, RI	1,170	12	59
Region II, New York, NY	NY, NJ, Puerto Rico, Virgin Island	1,020	7	51
Region III, Philadelphia, PA	PA, MD, DE, WV, VA	1,526	12	76
Region IV, Atlanta, GA	GA, FL, KY, TN, NC, SC, GA, AL, MS	2,772	18	139
Region V, Chicago, IL	MN, WI, IL, MI, IN, OH	3,784	22	189
Region VI, Dallas, TX	NM, TX, OK, AR, LA	2,398	11	120
Region VII, Kansas City, MO	MO, IA, KS, NE	1,693	12	85
Region VIII, Denver, CO	UT, WY, MT, ND, SD	666	8	33
Region IX, San Francisco, CA	CA, NV, AZ, HI, Guam, Samoa	1,681	11	84
Region X, Seattle, WA	AK, ID, OR, WA	497	9	25

Source: GAO/HEHS 00-6, NURSING HOMES: ADDITIONAL STEPS NEEDED TO STRENGTHEN ENFORCEMENT OF FEDERAL QUALITY STANDARDS, *supra* note 27.

Table 5. Description of Variables Used in This Study

Variable	Definition	Mean (SD)	Range	N
Deficiencies	The average number of deficiencies cited per facility by state	6.08 (2.65)	1.5 - 15.6	490
Hospital Affiliation	Percent of certified hospital-based facilities	15.06 (11.47)	0 - 69.2	490
Chain Affiliation	Percent of facilities that were owned or leased by multi-facility organizations	52.71 (12.99)	8.1 - 79.8	490
Governor	Categorical measure for the party affiliation of the governor of the state ¹⁹⁹		0 - 1	477
Republican	Dummy variable for states with both houses of legislature controlled by the Republican Party		0 - 1	473
Democrat	Dummy variable for states with both houses of legislature controlled by the Democratic Party		0 - 1	473
Split	Dummy variable for states with each house of legislature controlled by one of the two dominant Parties (Republican and Democratic Parties)		0 - 1	473
Region 1			0 - 1	490
Region 2			0 - 1	490
Region 3			0 - 1	490
Region 4			0 - 1	490
Region 5			0 - 1	490
Region 6			0 - 1	490
Region 7			0 - 1	490
Region 8			0 - 1	490
Region 9			0 - 1	490
Region 10			0 - 1	490

¹⁹⁹ The party affiliation of the governor of the state was coded 0 = Republican Party and 1 = Democratic Party. Governors identified as independents were excluded from the analysis.

Table 5. Description of Variables Used in This Study (Continued)

Variable	Definition	Mean (SD)	Range	N
1995			0 – 1	490
1996			0 – 1	490
1997			0 – 1	490
1998			0 – 1	490
1999			0 – 1	490
2000			0 – 1	490
2001			0 – 1	490
2002			0 – 1	490
2003			0 – 1	490
2004			0 – 1	490
Lag of Deficiencies		5.84 (2.56)	1.5 – 18.4	490

