

Nursing Homes, COVID-19, and the Consequences of Regulatory Failure

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This essay explores the COVID-19 crisis in America's nursing homes and its lessons for the future of long-term care. It challenges narratives portraying nursing homes as the unfortunate victims of COVID-19 by showing how the crisis is the foreseeable result of regulatory gaps and failures that have long enabled nursing homes to engage in systemic neglect. It then shows how regulatory approaches employed in other parts of the U.S. healthcare system could be used to create a more humane and resilient long-term care system. It concludes by considering the implications of such reforms for enhancing equity and reducing structural ageism.

INTRODUCTION

America's nursing homes have been at the epicenter of the COVID-19 pandemic. The first confirmed case in the U.S. was a thirty-five-year-old man returning from Wuhan, China to Snohomish County, Washington.¹ Within weeks, 129 cases were recorded at a nursing facility in neighboring King County, Washington.² By March 2021, the virus had claimed the lives

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of over 130,000 nursing home residents in the U.S.,³ and nursing home residents accounted for 25% of COVID-19 related deaths,⁴ even though they made up less than half of 1% of the U.S. population.⁵

The nursing home industry has described this crisis as inevitable and largely outside its control—depicting rampant infections and unprecedented mortality rates as the sad result of inherent health risks associated with older adults living with comorbidities and inadequate government support for nursing homes.⁶ This narrative was placed front and center as the industry successfully lobbied for tens of billions of dollars in additional federal funding amid the pandemic⁷ as well as sweeping protections from legal liability.⁸ The Coronavirus Commission for Safety and Quality in Nursing

³ CTRS. FOR MEDICAID & MEDICARE SERVS., COVID-19 NURSING HOME DATA (2021), <https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg/> [https://perma.cc/MGF2-3FA6] (last visited Mar. 23, 2021) (reporting 130,296 resident deaths as of March 7, 2021).

⁴ This figure was calculated by comparing the number of nursing home deaths in the U.S. as of March 7, 2021, see *infra* note 5, with the total number of COVID-19 deaths in the U.S. as of March 7, 2021. See *id.*; see also *Tracking Total COVID Deaths Per State on March 7, 2021*, DETROIT NEWS (Mar. 7, 2021), <https://www.clickondetroit.com/news/national/2021/03/07/tracking-total-covid-deaths-per-state-on-march-7-2021/#/> [https://perma.cc/K2FY-SRR3] (reporting that the U.S. had experienced 524,935 confirmed COVID-19 deaths as of March 7, 2021, and showing the breakdown by state).

⁵ Compare *Total Number of Residents in Certified Nursing Facilities*, KAISER FAM. FOUND., <https://www.kff.org/other/state-indicator/number-of-nursing-facility-residents/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> [https://perma.cc/QGL5-Y2JQ] (last visited Mar. 31, 2021) (reporting 1,246,079 residents in certified nursing facilities as of 2019) with *Population Estimates as of July 2019*, U.S. CENSUS BUREAU, <https://www.census.gov/quickfacts/fact/table/US/PST045219> [https://perma.cc/X34L-DKBK] (reporting 328,239,523 persons living in the U.S.).

⁶ See Jennifer Abbasi, “*Abandoned*” Nursing Homes Continue to Face Critical Supply and Staff Shortages as COVID-19 Toll Has Mounted, 324 JAMA 123, 123–24 (July 14, 2020) (describing how the industry has attributed the COVID-19 crisis in facilities to the government’s failure to provide adequate resources, including personal protective equipment (PPE)); Response from AHCA/NCAL to Human Rights Watch 14 (Dec. 11, 2020), https://www.hrw.org/sites/default/files/media_2021/03/Annex_1.pdf (containing correspondence in which the leading industry organization attributes high COVID-19 death rates in facilities to residents’ advanced age and underlying health conditions).

⁷ More than \$21 billion in additional federal funding has been earmarked for nursing homes in response to the pandemic. See Andrew Soergel, *Nursing Homes Are Getting Billions in COVID Aid — Where is it Going?*, AARP (Nov. 24, 2020), <https://www.aarp.org/caregiving/health/info-2020/nursing-home-covid-federal-aid-transparency.html> [https://perma.cc/7NN6-CMZB].

⁸ See Nina A. Kohn & Jessica L. Roberts, Opinion, *Nursing Homes Need Increased Staffing, Not Legal Immunity*, THE HILL (May 23, 2020, 11:00 AM), <https://thehill.com/opinion/healthcare/499286-nursing-homes-need-increased-staffing-not-legal-immunity> [https://perma.cc/MX34-GF8Q] (last visited Mar. 11, 2021) (detailing the immunity protections granted to nursing homes amid COVID-19 and the rhetoric used by the industry to lobby for them).

Homes assembled by the Trump Administration,⁹ and some scholars working at the intersection of law and medicine,¹⁰ have amplified this message by suggesting that COVID-19 mortality rates are to be expected without more generous funding and that nursing homes should not be blamed for the current crisis.

Yet the nursing-home-as-victim narrative belies the deliberate policy choices and regulatory failures that have shaped long-term care in the U.S. and enabled nursing homes to make choices that have long endangered the health and welfare of their residents. This Essay shows that the skyrocketing death rates in nursing homes are not merely the result of glitches in the public health response to COVID-19, but rather a predictable consequence of the failure to enforce federal regulations, gaps in regulatory requirements for facilities, and policies that steered vulnerable, older adults into these institutions in the first place. It then outlines a series of concrete regulatory reforms that could substantially reduce the unnecessary risk of harm associated with nursing home care. It concludes by considering the broader impact of such reforms for increasing equity and ameliorating structural ageism.

I. ORIGINS OF THE NURSING HOME CRISIS

Nursing home residents are highly susceptible to infectious diseases, including COVID-19. The congregate nature of nursing home care creates numerous vectors for infection because it impedes social distancing and generates a constant flow of staff interacting with residents. Moreover, nursing home residents are medically frail. Thus, nursing home residents who

⁹ See THE MITRE CORPORATION, CORONAVIRUS COMMISSION ON SAFETY AND QUALITY IN NURSING HOMES: COMMISSION FINAL REPORT 18 (Sept. 2020), <https://edit.cms.gov/files/document/covid-final-nh-commission-report.pdf> [https://perma.cc/8HVM-E575] (attributing the COVID-19 crisis in nursing homes in large part to inadequate government funding and support).

¹⁰ See, e.g., R. Tamara Konetzka, *Improving the Fate of Nursing Homes During the COVID-19 Pandemic: The Need for Policy*, 111 AM. J. PUB. HEALTH (2021) (criticizing policymakers for being overly critical of nursing homes, claiming that “research does not support that bad quality is the reason for COVID-19 cases and deaths” in nursing homes, and calling policymakers to them to “set[] aside issues of blame” and punitive measures like fines in favor of providing more assistance and resources to nursing home providers); Rachel M. Werner, Allison K. Hoffman & Norma B. Coe, *Long-Term Care Policy After Covid-19 — Solving the Nursing Home Crisis*, 383 NEW ENG. J. MED. 903, 903–05 (2020) (describing nursing homes as “caught in the crosshairs of the coronavirus pandemic” and attributing the crisis largely to the public healthcare system’s failure to provide adequate financial resources). Notably, Konezka supports her claim that research fails to show a link between quality and COVID-19 cases and infection by citing studies that examined the relationship between the Five-Star rating system used by the federal government and COVID-19 infections and fatalities. See Konezka, *supra* at n. 6–7. That system has long been recognized as failing to accurately capture nursing home quality. See Jessica Silver-Greenberg & Robert Gebeloff, *Maggots, Rape and Yet Five Stars: How U.S. Ratings of Nursing Homes Mislead the Public*, N.Y. TIMES (Mar. 13, 2021) (reporting the results of the New York Times investigation showing that the Five-Star system “[d]espite years of warnings, provided a badly distorted picture of the quality of care at the nation’s nursing homes” because, among other reasons, it relies on often incorrect, self-reported data).

contract COVID-19 are more likely to suffer serious illness or death than other people their age.

The devastation that COVID-19 has wrought on nursing home residents, however, cannot be explained merely by the inherent risks of congregate care or by residents' susceptibility to infection. Rather, as this Section shows, it is the combined effect of an inadequate public health response and preexisting regulatory failures that have long enabled nursing homes to operate in a manner that fosters unsafe and inhumane conditions.

A. INADEQUATE PUBLIC HEALTH RESPONSE

A slow and inadequate public health response exacerbated the crisis in America's nursing homes amid the COVID-19 pandemic. To curtail transmission of COVID-19, nursing homes needed adequate personal protective equipment (PPE) and routine COVID-19 testing for staff and residents. Yet, the Centers for Medicaid and Medicare Services (CMS), the federal agency tasked with oversight of nursing homes, waited until September 2020—six months after COVID-19 was first found in U.S. nursing homes—to require COVID-19 testing of nursing home residents and staff.¹¹ Similarly, the Federal Emergency Management Agency (FEMA), the federal agency tasked with providing PPE to facilities, not only provided a profoundly insufficient amount of PPE but also provided many facilities with unusable forms of PPE such as faulty masks and gowns with no armholes.¹²

The U.S. public health response has also failed to include interventions that might have stemmed the flow of COVID-19 into facilities. For example, some Canadian provinces adopted “one-site” rules barring nursing home staff from working in multiple facilities amid the pandemic.¹³ No U.S. state, however, imposed such limits or required facilities to reduce reliance on part-time staff and agency workers, despite evidence that eliminating such staff linkages between facilities could reduce COVID-19 infections in nursing homes by nearly half.¹⁴

¹¹ Joe Eaton, *Who's to Blame for the 100,000 COVID Dead in Long-Term Care?*, AARP (Dec. 3, 2020), <https://www.aarp.org/caregiving/health/info-2020/covid-19-nursing-homes-who-is-to-blame.html> [https://perma.cc/A74F-TNZS].

¹² See *id.*; see also Anna Wilde Matthews, *Nursing Homes Say Some Protective Gear Sent by FEMA is Unusable*, WALL ST. J. (Jun. 11, 2020, 5:30 AM), <https://www.wsj.com/articles/nursing-homes-say-some-protective-gear-sent-by-fema-is-unusable-11591867808>.

¹³ See, e.g., *COVID-19 Action Plan: Long-Term Care Homes*, ONTARIO MINISTRY OF LONG-TERM CARE (Apr. 15, 2020), <https://www.ontario.ca/page/covid-19-action-plan-long-term-care-homes> [https://perma.cc/EV3Q-P5YS].

¹⁴ M. Keith Chen, Judith A. Chevalier & Elisa F. Long, *Nursing Home Staff Networks and COVID-19*, 118 PROC. NAT'L ACAD. SCI. U.S. 1, 5 (2021) (studying linkages using geolocation data from smartphone users who visited nursing homes between mid-March 2020 and the end of May 2020, and finding that 49% of COVID-19 cases among nursing home residents could be attributed to staff linkages between facilities).

B. REGULATORY GAPS

Nursing homes are subject to extensive federal and state regulatory oversight. The primary source of this oversight is the federal Nursing Home Reform Act of 1987 and its implementing regulations. These impose substantial requirements on nursing homes, entitle residents to a high level of physical and psychological care, and grant residents extensive rights.¹⁵ For example, the regulations require every nursing home to ensure that all of its residents receive individualized care in accordance with professional standards of practice and that no resident experiences avoidable harm or avoidable reductions in functional abilities.¹⁶

The COVID-19 pandemic, however, has exposed a major gap in these seemingly comprehensive requirements. Although demanding in other regards, federal regulations do not require facilities to have what research suggests are the most important predictors of quality care: sufficient nursing staff and an adequate ratio of staff providing resident care to residents receiving care.¹⁷

Research has demonstrated that the ratio of staff to residents is a key predictor of the quality of care nursing home residents receive. Prior to the pandemic, for example, there was widespread agreement among experts that at least 4.1 hours of direct care staff per resident, per day is necessary to avoid systemic neglect in nursing homes.¹⁸ Likewise, staffing levels are a key predictor of COVID-19 infection and fatality rates in nursing homes. Studies conducted during the COVID-19 pandemic show that higher staff levels are associated with a better ability to control the spread of COVID-19 within facilities.¹⁹ For example, a study by the New York State Attorney

¹⁵ Technically, these requirements only apply to facilities that accept Medicare or Medicaid, but virtually every U.S. nursing home does. See CTRS. FOR MEDICARE AND MEDICAID SERVS., NURSING HOME DATA COMPENDIUM 2015 EDITION 1, 10 fig.1.2. (2015) [hereinafter Compendium] (reporting that “15,634 [out of 15,640] nursing homes participated in the Medicare and Medicaid Programs” in 2014).

¹⁶ See 42 C.F.R. §§ 483.21, 483.24–.25 (setting forth requirements for person centered care planning, quality of life, and quality of care).

¹⁷ To be sure, many states have higher nursing home staffing standards than those required by the federal government. State requirements, however, fall short of the minimum standards many researchers, as well as advocates for residents, believe necessary to avoid systemic neglect. See Charlene Harrington, Mary Ellen Dellefield, Elizabeth Halifax, Mary Louise Fleming & Debra Bakerjian, *Appropriate Nurse Staffing Levels for U.S. Nursing Homes*, 13 HEALTH SERVS. INSIGHTS 1 (2020) (noting that the majority of states have minimum staffing standards, but these typically require far lower levels than are necessary to provide adequate care).

¹⁸ See Charlene Harrington, John F. Schnelle, Margaret McGregor & Sandra F. Simmons, *The Need for Higher Minimum Staffing Standards in U.S. Nursing Homes*, 9 HEALTH SERVS. INSIGHTS 13, 15–16 (2016) (discussing research and support for the 4.1 hours figure).

¹⁹ See, e.g., Rebecca J. Gorges & R. Tamara Konetzka, *Staffing Levels and COVID-19 Cases and Outbreaks in U.S. Nursing Homes*, 68 J. AM. GERIATRICS SOC’Y 2462, 2462 (2020) (finding that homes with higher levels of nurse aide hours or higher total nursing hours were less likely to experience an outbreak and had fewer deaths, based on a study of nursing homes that had reported COVID-19 data as of mid-June 2020).

General released in January 2021 found that nursing homes in New York with a high ratio of staff hours to number of residents had substantially lower fatality rates from COVID-19 than nursing homes with low ratios.²⁰ Nursing staff levels appear to be particularly important, with higher levels of nurse staffing linked to a better ability to control the spread of COVID-19 within facilities with reported infections and to lower COVID-19 fatality rates.²¹

Although higher staffing ratios, and adequate levels of nursing staff in particular, are essential to providing high-quality care, nursing homes have a strong economic incentive to keep staffing levels low, because staff costs are a key driver of overall costs in the industry.²² This incentive is particularly strong in for-profit nursing homes, which comprise approximately 70% of the industry.²³ Indeed, low staffing levels are often a key feature of the business model at for-profit facilities,²⁴ which helps explain why these facilities tend to have, on average, more deficiencies than either non-profit or government-run facilities.²⁵

²⁰ N.Y. STATE OFF. OF THE ATT’Y. GEN. LETITIA JAMES, NURSING HOME RESPONSE TO COVID-19 PANDEMIC 22, 28 (Jan. 30, 2021) [hereinafter NEW YORK A.G. REPORT], <https://ag.ny.gov/sites/default/files/2021-nursinghomesreport.pdf> [<https://perma.cc/5A5N-V6XN>].

²¹ See, e.g., Charlene Harrington, Leslie Ross, Susan Chapman, Elizabeth Halifax, Bruce Spurlock & Debra Bakerjian, *Nurse Staffing & Coronavirus Infections in California Nursing Homes*, 21 POL’Y, POL., & NURSING PRAC. 174, 174 (2020).

²² See CORY RUTLEDGE, STEPHEN TAYLOR, MATTHEW WOCKEN & SETH WILSON, 35TH SNF COST COMPARISON & INDUSTRY TRENDS REPORT 26 (2020), https://www.claconnect.com/-/media/files/2020-snf-cost-comparison-and-industry-trends-report.pdf?utm_campaign=Health%20Care&utm_medium=email&hs_mi=97236488&hsenc=p2ANqtz-8ppVu8ObNJP5uzCKyUe7XcpBwKrWz2lJ9NjaYQG3_anhIDZgMpO6lkQjszNmkCCYU11P2meS3KZQmENy8HfkU7GiAg&utm_content=97236488&utm_source=hs_automation [<https://perma.cc/6FVF-NWQ3>] (stating that personnel costs are the “primary expense” for nursing home operators); Maggie Flynn, *Hager: ‘Astonishing’ Expense Increases, Occupancy Drops in Northeast Hotspots Battered Genesis*, SKILLED NURSING NEWS (Aug. 11, 2020), <https://skillednursingnews.com/2020/08/hager-astonishing-expense-increases-occupancy-drops-in-northeast-put-genesis-future-in-doubt/> [<https://perma.cc/4YKL-SG3T>] (quoting the CEO of Genesis Healthcare, a corporation that owns hundreds of skilled nursing facilities, as stating that occupancy levels and “the ability to effectively control labor costs” are primary drivers of financial performance in the industry); CALIFTON LARSON ALLEN, 30TH EDITION SKILLED NURSING FACILITY COST COMPARISON 4 (2015), <https://www.claconnect.com/-/media/files/white-papers/30theditionskillednursingfacilitycostcomparisonreportcliftonlarsonallen.pdf> (stating that “approximately 75% of a skilled nursing facility’s operating costs relate to the cost of labor” and attributing to wages approximately 57% of per resident per day expenses in skilled nursing facilities, as of 2014).

²³ See *Nursing Home Care*, CTRS. FOR DISEASE CONTROL AND PREVENTION: FASTSTATS, <https://www.cdc.gov/nchs/fastats/nursing-home-care.htm> [<https://perma.cc/VHL2-7FER>] (last visited Mar. 27, 2021) (reporting that 69.3% of nursing homes were for-profit in 2016).

²⁴ See NEW YORK A.G. REPORT, *supra* note 20, at 23 (concluding that financial incentives lead to understaffing in for-profit nursing homes in New York state).

²⁵ Ciaran O’Neill, Charlene Harrington, Martin Kitchener & Debra Saliba, *Quality of Care in Nursing Homes: An Analysis of Relationships Among Profit, Quality, and Ownership*, 41 MED. CARE. 1318, 1318 (2003) (finding that proprietary institutions provided lower quality care than nonproprietary ones, and that facilities making the largest profits had significantly more deficiencies and more serious deficiencies); Kai You, Yue Li, Orna

Lack of minimum staffing requirements and financial incentives to understaff seem to be key factors contributing to a situation where most nursing homes in the U.S. fail to maintain the minimum staff necessary to avoid systemic neglect, even in non-pandemic times.²⁶ Amid the pandemic, the problem has become even more acute, with severe staffing shortages becoming increasingly common.²⁷

C. UNDER-ENFORCEMENT OF EXISTING REGULATIONS

Nursing homes tend to treat the Federal Nursing Home Reform Act and its implementing regulations that require high-quality care not as true mandates but rather as aspirational standards.²⁸ The result is that preventable harm is common in these facilities,²⁹ and many facilities routinely fail to comply with federal requirements designed to ensure resident well-being and safety. Nearly 95% of nursing homes have documented deficiencies

Intrator, David Stevenson, Richard Hirth, David Grabowski & Jane Banaszak-Holl, *Do Nursing Home Chain Size and Proprietary Status Affect Experiences with Care?*, 54 MED. CARE 229, 233 (2016) (finding that ownership by “large-sized and medium-sized” for-profit chains correlated with reduced quality of care as reported by families). *See also* Atul Gupta, Sabrina T. Howell, Constantine Yannelis & Abhinav Gupta, *Does Private Investment in Healthcare Benefit Patients? Evidence from Nursing Homes* 1, 3 (Becker Friedman Inst. For Econ., Working Paper No. 2021-20, 2021), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3785329 (estimating that private equity ownership of nursing homes results in a 10% increase in short-term mortality for Medicare patients, as well as increases in indicators of low-quality care including use of antipsychotic medication, decline in mobility, increase in pain intensity, and suggesting that decreases in nursing staff help account for this decline).

²⁶ See Harrington et al., *supra* note 17 at 1 (citing empirical studies to conclude that “most nursing homes do not provide sufficient staffing to ensure basic quality”); *see also* Maggie Flynn, *Registered Nurse Staffing Falls Short in Most Nursing Homes*, SKILLED NURSING NEWS (Mar. 15, 2018), <https://skillednursingnews.com/2018/03/registered-nurse-staffing-falls-short-nursing-homes/> [<https://perma.cc/HB8H-L9P8>] (discussing the understaffing of nursing homes in 2018, pre-pandemic).

²⁷ See, e.g., NEW YORK A.G. REPORT, *supra* note 20, at 24–27 (providing a litany of staffing problems observed in New York state amid the pandemic).

²⁸ Cf. RICHARD J. MOLLOT, *SAFEGUARDING NH RESIDENTS & PROGRAM INTEGRITY: A NATIONAL REVIEW OF STATE SURVEY AGENCY PERFORMANCE* 3 (2015) (noting that nursing homes that provide the level of care required by federal law are “the exception, rather than the rule” and attributing this to inadequate enforcement).

²⁹ DEP’T OF HEALTH & HUM. SERVS., OFF. OF THE INSPECTOR GEN., OEI-06-11-00370, ADVERSE EVENTS IN SKILLED NURSING FACILITIES: NATIONAL INCIDENCE AMONG MEDICARE BENEFICIARIES 2, 22 (Feb. 2014), <https://oig.hhs.gov/oei/reports/oei-06-11-00370.pdf> [<https://perma.cc/6L76-YU9F>] (finding that, prior to the COVID-19 pandemic, approximately 20% of Medicare beneficiaries in skilled nursing homes suffered “clearly preventable” adverse events resulting from neglect or medical errors during their stays).

each year,³⁰ and the majority of nursing homes have recently documented infection control deficiencies.³¹

These patterns are natural consequences of the systemic under-enforcement of existing regulations designed to protect nursing home residents. This under-enforcement takes two forms. First, state inspectors do not always identify quality of care problems and too often classify those they do identify as less severe than they actually are.³² The result is that state inspectors underreport serious regulatory violations including violations that pose an immediate threat to resident health and safety. Second, states fail to penalize violations and to ensure correction. Despite having the statutory authority to do so,³³ regulators rarely impose penalties that would have substantial fiscal implications for facilities, such as monetary fines, holds on new admissions, and holds on payment.³⁴ For most types of violations, no monetary fines are levied.³⁵ When a nursing home is found to be out of compliance—including when that noncompliance places residents at risk of

³⁰ See Percent of Certified Nursing Facilities with Deficiencies, KAISER FAM. FOUND. <https://www.kff.org/other/state-indicator/nursing-facilities-with-zero-deficiencies/?currentTimeframe=0&sortModel=%7B%22collId%22:%22Location%22,%22sort%22:%22asc%22%7D> [https://perma.cc/LJP5-YEH6] (showing deficiency rates by year and indicating that 94.4% of facilities in the U.S. had deficiencies in 2019); see also Compendium, *supra* note 15, at 69 tbl.2.3.a., 70 tbl.2.3.b., 71 tbl.2.3.c., 72 tbl.2.3.d., 73 tbl.2.3.e. (finding that approximately 90% of nursing homes had health-related deficiencies in the years 2010–14).

³¹ Jordan Rau, *Coronavirus Stress Test: Many 5-Star Nursing Homes Have Infection-Control Lapses*, KAISER HEALTH NETWORK (Mar. 4, 2020), <https://khn.org/news/coronavirus-preparedness-infection-control-lapses-at-top-rated-nursing-homes/> [https://perma.cc/6YW9-2WY5] (finding that 63% of nursing facilities were cited for at least one infection control problem during their past two regular inspection periods).

³² See MOLLOT *supra* note 28, at 4 n.6, 9–12 (discussing the under-identification problem, and then using survey data to show the under-classification problem). Notably, the Long-Term Community Care Coalition has since created a database of deficiencies labeled “no harm” despite descriptions of underlying conditions that suggest that actual harm did occur. See 2020: Elder Justice “No Harm” Deficiencies, LONG TERM CARE COMMUNITY COALITION, <https://nursinghome411.org/2020-no-harm/> [https://perma.cc/JP4H-MKHT] (last visited Mar. 28, 2021).

³³ See 42 U.S.C. § 1396r(h)(1)–(2) (2020) (authorizing termination from the Medicare and Medicaid programs, denial of payment, civil monetary fines, and appointment of a temporary manager as penalties for nursing home deficiencies).

³⁴ This approach to enforcement is consistent with the Centers for Medicare and Medicaid Services’ decision to give regional offices substantial discretion to use monetary fines in lieu of more consequential penalties such as temporary management or denial of payment for new admission that are also statutorily permissible. See Memorandum from the Ctrs. For Medicare & Medicaid Servs. On Revisions of Civil Money Penalty (CMP) Policies and CMP Analytical Tool to State Survey Agency Dirs. (Jul. 7, 2017) [hereinafter Memorandum from CMS], <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-37.pdf> [https://perma.cc/74H3-LXNZ] (encouraging the use of civil money penalties if they achieve swift and sustained compliance better than other statutorily available remedies).

³⁵ This is true even where the deficiency is related to abuse of a resident. See U.S. GOV’T ACCOUNTABILITY OFF., NURSING HOMES: IMPROVED OVERSIGHT NEEDED TO BETTER PROTECT RESIDENTS FROM ABUSE 17–18 (2019) [hereinafter GAO, IMPROVED OVERSIGHT], <https://www.gao.gov/assets/gao-19-433.pdf> [https://perma.cc/T625-KBW6] (finding that penalties were implemented in less than 8% of cases where facilities were cited for abuse deficiencies).

serious harm—the facility is typically simply told to correct the deficiency and inspectors may never follow up to determine whether the correction was implemented.³⁶ Moreover, when fines are levied, the amounts assessed are usually so small that they fail to provide a meaningful deterrence.³⁷

The under-enforcement problem intensified under the Trump Administration. The Administration substantially reduced the amount of fines by imposing fewer per-day fines for non-compliance (replacing them with per-instance fines),³⁸ waived key requirements, restricted access by surveyors and ombudsmen, and deliberately idled some enforcement efforts.³⁹ For example, at the start of the pandemic, the Trump Administration waived disclosure requirements related to staffing that inspectors used to assess compliance with quality-of-care standards and suspended enforcement of most regulatory violations committed by nursing homes.⁴⁰

State responses to COVID-19 have further exacerbated the problem. In response to the COVID-19 pandemic, approximately half of the states promulgated statutes or executive orders granting nursing homes new im-

³⁶ See CTRS. FOR MEDICARE & MEDICAID SERVS., STATE OPERATIONS MANUAL, CHAPTER 7 -SURVEY AND ENFORCEMENT PROCESS OF SKILLED NURSING FACILITIES AND NURSING FACILITIES §7400 (Rev. Nov. 2018) <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107c07pdf.pdf> [https://perma.cc/V5AS-H74Z] (setting forth how enforcement approaches and penalties should be determined); DEP’T OF HEALTH & HUM. SERVS., OFF. OF THE INSPECTOR GEN., A-09-18-02000, CMS GUIDANCE TO STATE SURVEY AGENCIES VERIFYING CORRECTION OF DEFICIENCIES NEEDS TO BE IMPROVED TO HELP ENSURE THE HEALTH & SAFETY OF NURSING HOME RESIDENTS 9, 12 (Feb. 2019) (laying out the limited circumstances under which a nursing home will not be provided an opportunity to correct a deficiency prior to imposition of penalties); GAO, IMPROVED OVERSIGHT, *supra* note 35, at 18 & n.32 (finding that, in cases involving abuse-related deficiencies, CMS typically did not implement proposed enforcement actions because facilities “came into compliance prior to the implementation date of the penalty”).

³⁷ See Jordan Rau, *Nursing Home Fines Drop as Trump Administration Heeds Industry Complaints*, KAISER HEALTH NETWORK (Mar. 15, 2019), <https://www.aarp.org/caregiving/health/info-2020/nursing-home-covid-federal-aid-transparency.html> [https://perma.cc/92CM-XQPG] (discussing the size of penalties and the impact on incentives).

³⁸ See generally Memorandum from CMS, *supra* note 34 (setting forth policy change). Notably, these changes are the subject of a recent lawsuit brought by California Advocates for Nursing Home Reform and the National Consumer Voice for Quality Long-Term Care. See Complaint for Declaratory and Injunctive Relief at 2, Nat’l Consumer Voice for Quality Long-Term Care v. Azar, No. 21-162 (D.D.C. Jan. 1, 2018).

³⁹ See Memorandum from Ctrs. for Medicaid and Medicare Servs. On Suspension of Survey Activities to State Survey Agency Directors (Mar. 4, 2020), <https://www.cms.gov/files/document/qso-20-12-all.pdf> [https://perma.cc/R5UY-2HUT] (limiting surveys, in priority order, to “immediate jeopardy complaints” and “allegations of abuse and neglect,” “[c]omplaints alleging infection control concerns,” “[s]tatutorily required recertification surveys,” “re-visits necessary to resolve current enforcement actions,” “[i]nitial certifications,” “[s]urveys of facilities . . . that have a history of [immediate jeopardy level] infection control deficiencies . . . in the last three years,” and “[s]urveys of facilities . . . that have a history of [below immediate jeopardy level] infection control deficiencies”).

⁴⁰ Nina A. Kohn, Opinion, *Addressing the Crisis in Long-Term Care Facilities*, THE HILL (Apr. 23, 2020, 3:00 PM), <https://thehill.com/opinion/civil-rights/494337-addressing-the-crisis-in-long-term-care-facilities> [https://perma.cc/UP9E-X4QS].

munity from liability for negligence during at least a portion of the pandemic.⁴¹ All of these prevented COVID-19 positive residents and their representatives from holding providers liable for negligence. Others also prevented residents without COVID-19 from holding facilities liable for negligence.⁴² In addition, some of these provisions were so broad that they could provide protection to nursing home staff, nursing homes, and even their corporate owners for harms to residents resulting from intentional torts⁴³ and criminal liability.⁴⁴ Moreover, several states explicitly protected nursing homes from harms that result from understaffing, even if that understaffing was deliberate and done solely to increase facility profit.⁴⁵ The effect was that nursing homes and their operators could be increasingly confident that they would never be held accountable for decisions that harmed their residents.

D. FUNDING FAVORING INSTITUTIONAL CARE

Perhaps the most fundamental policy failure contributing to the nursing home crisis is Medicaid's preferential treatment of institutional care relative to community-based care. Specifically, Medicaid, which is the primary payer for long-term care services in the U.S.,⁴⁶ encourages institutionalization by requiring all states to cover nursing home care for all eligible beneficiaries, while making it optional for states to cover most home-based care.⁴⁷ When states opt to provide home- and community-based services (HCBS) to Medicaid beneficiaries who would otherwise qualify for nursing home care, they typically do so by applying for a "Section 1915(c)" waiver

⁴¹ See Kohn & Roberts, *supra* note 8; see also Samuel Brooks, Robyn Grant, & Michael F. Bonamarte, *States Move to Shield LTC Facilities from Civil Liability*, 41 BIFOCAL (2020).

⁴² Kohn & Roberts, *supra* note 8; Brooks, Grant & Bonamarte, *supra* note 41.

⁴³ See, e.g., Mich. Exec. Order No. 2020-30 (Mar. 2020) (granting immunity for harms not caused by gross negligence, a category that is generally not seen as subsuming intentional torts).

⁴⁴ See, e.g., S. 2333, 219th Leg., Reg. Sess. (N.J. 2020) (granting nursing homes civil and criminal immunity for a broad range of acts and omissions during the public health emergency).

⁴⁵ See, e.g., S. B. S7506, 2019-2020 Leg. Sess. (N.Y. 2020) (stating that civil immunity will not apply "if the harm or damages were caused by an act or omission constituting willful or intentional criminal misconduct, gross negligence, reckless misconduct, or intentional infliction of harm . . . provided, however, that acts, omissions or decisions resulting from a resource or staffing shortage shall not be considered to be willful or intentional criminal misconduct, gross negligence, reckless misconduct, or intentional infliction of harm"). The New York Attorney General has suggested that such broad protection would be "contrary to public policy." See NEW YORK A.G. REPORT, *supra* note 20, at 38–39.

⁴⁶ See NGA T. THACH & JOSHUA M. WIENER, AN OVERVIEW OF LONG-TERM SERVICES AND SUPPORTS AND MEDICAID 14 fig.5 (May 2018), <https://aspe.hhs.gov/basic-report/overview-long-term-services-and-supports-and-medicaid-final-report#figure5> [<https://perma.cc/QPP3-2M4X>] (reporting that Medicaid accounts for 51% of U.S. long-term care spending).

⁴⁷ See *Mandatory and Optional Benefits*, MACPAC, <https://www.macpac.gov/subtopic/mandatory-and-optimal-benefits/> [<https://perma.cc/6BCK-6LGU>] (last visited Mar. 12, 2021) (listing benefits for which states are required to provide Medicaid coverage and those for which they are merely permitted to provide Medicaid coverage).

from the federal government.⁴⁸ Yet the Section 1915(c) program does not require states to cover HCBS on equal terms with nursing home care. Rather, the program permits states to cap the number of beneficiaries covered and the amount of home-based care beneficiaries can receive and allows states to limit the cost of those services.⁴⁹

The result is that even though states are increasingly providing HBCS to some Medicaid beneficiaries, most states have waiting lists for at least one type of Medicaid-funded HCBS care.⁵⁰ Older adults in some states may remain waitlisted for home-based care for years.⁵¹ Even if they are taken off a waitlist, beneficiaries may be denied coverage for the level of care they need because approximately three-quarters of states limit how many hours of home care are covered.⁵² In addition, Medicaid encourages institutionalization by covering the cost of room and board for beneficiaries who reside in nursing homes but not for those who reside in non-institutional settings.⁵³

These policies mean that, as a practical matter, individuals in need of long-term care services may have no choice but to enter nursing homes—even if they could live healthier and more satisfying lives in their communities. This preferential treatment of institutionalized care is often justified

⁴⁸ MARYBETH MUSUMECI, MOLLY O'MALLEY WATTS & PRIYA CHIDAMBARAM, KEY STATE POLICY CHOICES ABOUT MEDICAID HOME AND COMMUNITY-BASED SERVICES, app. tbl.1 (Feb. 2020), <https://www.kff.org/medicaid/issue-brief/key-state-policy-choices-about-medicaid-home-and-community-based-services/> [https://perma.cc/5NQT-6ETG] (listing states that had Section 1915(c) waivers as of 2018, and showing that nearly all did).

⁴⁹ In fact, states that have Section 1915(c) waivers that allow them to provide HCBS to Medicaid beneficiaries who would otherwise qualify for nursing home care demonstrate cost neutrality—that is, the average cost of HCBS care cannot be more than the average cost of institutional care. See 42 U.S.C. § 1396n(c)(2)(D) (conditioning waivers on “the average per capita expenditure estimated by the State in any fiscal year for medical assistance provided with respect to” individuals whose services are provided under the waiver not exceeding “100 percent of the average per capita expenditure that the State reasonably estimates would have been made in that fiscal year for expenditures under the State plan for such individuals if the waiver had not been granted”).

⁵⁰ MUSUMECI ET AL., *supra* note 48, at 1 (reporting that “[o]ver three-quarters of states [have] an HCBS waiver waiting list”).

⁵¹ MEDICAID AND CHIP PAYMENT AND ACCESS COMM'N, STATE MANAGEMENT OF HOME-AND COMMUNITY-BASED SERVICES WAIVER WAITING LISTS (Aug. 2020), <https://www.macpac.gov/wp-content/uploads/2020/08/State-Management-of-Home-and-Community-Based-Services-Waiver-Waiting-Lists.pdf> [https://perma.cc/UP24-FRZW].

⁵² MUSUMECI ET AL., *supra* note 48, at 19.

⁵³ See Nina A. Kohn & Jennifer Goldberg, Opinion, *When It Comes to Healthy Aging: Location, Location, Location*, THE HILL (Oct. 15, 2020, 5:30 PM), <https://thehill.com/opinion/civil-rights/521267-when-it-comes-to-healthy-aging-location-location-location> [https://perma.cc/MTP3-LLX9]; Michael Lepore, Molly Knowles, Kristie A. Porter, Janet O’Keeffe & Joshua Wiener, *Medicaid Beneficiaries’ Access to Residential Care Settings*, 31 J. HOUS. FOR ELDERLY 351, 358 (2017) (explaining that federal statutory law prohibits federal Medicaid funds from being used to pay room and board costs for residential community services, and discussing states’ efforts to “make room and board costs affordable for Medicaid beneficiaries”); U.S. DEP’T OF HEALTH & HUM. SERVS., UNDERSTANDING MEDICAID HOME AND COMMUNITY SERVICES: A PRIMER 92–93 (2010), <https://aspe.hhs.gov/system/files/pdf/76201/primer10.pdf> [https://perma.cc/3AVK-JNER] (“Federal Medicaid dollars are not available to pay for the ‘room and board’ expenses . . . of non-institutionalized persons.”).

on fiscal grounds,⁵⁴ but there is no clear evidence that it saves taxpayers' money. To the contrary, there is substantial evidence that expanding access to home- and community-based long-term care services can decrease the total cost associated with long-term care.⁵⁵ Additionally, the current approach may violate the Americans with Disabilities Act insofar as the Act prohibits states from unreasonably requiring individuals with disabilities to receive services in segregated settings.⁵⁶

II. REGULATORY REFORM OPTIONS

As the preceding Section suggests, improving conditions in America's nursing homes will require reforming the regulatory environment in which they operate to create stronger incentives for homes to deliver high-quality, appropriate, and humane care. This Section therefore outlines major regulatory reforms that would better align nursing homes' incentives with quality care.⁵⁷

A. STRENGTHEN ENFORCEMENT OF EXISTING REQUIREMENTS

Regulators could create stronger incentives for higher-quality care simply by using existing statutory authority to enforce existing regulatory requirements. This would mean improving the quality of the survey process to ensure that deficiencies are accurately identified and categorized. It

⁵⁴ See Diane Berish, Ian Nelson, Shahla Mehdizadeh & Robert Applebaum, *Is There a Woodwork Effect? Addressing a 200-Year Debate on the Impacts of Expanding Community-Based Services*, 31 J. AGING & SOC. POL'Y 85, 86 (2019) (explaining that policymakers considering whether to expand access to HCBS have "routinely" cited concerns that providing coverage for home- and community-based services will raise costs by increasing utilization).

⁵⁵ See, e.g., *id.* at 95–96 (concluding, based on a study examining cost impacts of Ohio's expansion of HCBS, that states could likely substantially increase HCBS services without a significant budgetary impact); Arpita Chattopadhyay, Yang Fan & Sudip Chattopadhyay, *Cost-efficiency in Medicaid Long-term Support Services: The Role of Home and Community Based Services*, 2 SPRINGERPLUS 305 (2013) (concluding that state programs that increased HCBS funding were associated with cost-efficient delivery of long-term care services, although the extent of that efficiency varied substantially by state); U.S. Dep't Hous. & Urban Dev., Off. Pol'y Dev. & Research, *Measuring the Costs and Savings of Aging in Place*, EVIDENCE MATTERS 16 (Fall 2013) (stating that in states where HCBS programs were expanded, the expansion eventually resulted in declining annual nursing home expenditures). But cf. R. Tamara Konetzka, Daniel H. Jung, Rebecca J. Gorges & Prachi Sanghavi, *Outcomes of Medicaid Home- and Community-Based Long-Term Services Relative to Nursing Home Care Among Dual Eligibles*, 55 HEALTH SERVS. RES. 973, 973 (2020) (finding, in a study of over a million older adults dually enrolled in Medicare and Medicaid, that those receiving HCBS were hospitalized at higher rates than those residing in nursing homes, raising concerns that studies concluding that HCBS save money based on comparing costs for nursing home care relative to home-based care may overestimate savings by not accounting for the increased costs resulting from greater hospitalization).

⁵⁶ See *Olmstead v. L.C.*, 527 U.S. 581, 581 (1999) (noting that in the ADA "Congress described the isolation and segregation of individuals with disabilities as a serious and pervasive form of discrimination").

⁵⁷ This Section does not attempt to provide an exhaustive list of reforms; rather, its goal is to outline key categories of reforms that could be implemented to substantially reduce current patterns of neglect.

would also mean imposing monetary fines for a broader range of violations. In addition, regulators could incentivize better performance, and weed the worst facilities out of the marketplace by employing a broad range of remedies such as suspending new admissions and payments to facilities that put residents at risk of serious harm by failing to comply with federal regulations.

Ideally, CMS would take a comprehensive approach to ramping up enforcement by applying a broader range of penalties to all nursing homes found to violate regulations designed to protect residents. An alternative, narrower approach would be to expand the current Special Focus Facility (SFF) Program under which nursing homes with consistently high deficiencies are subject to more frequent inspections and potential decertification. Such enforcement efforts would likely be especially impactful if applied not merely to individual facilities but to their owners and operators. This would enable regulators to hold those entities that make decisions that undermine quality of care responsible for those decisions.

B. LINK PAYMENT TO OUTCOMES

Because Medicaid is the primary payer for long-term care services in the U.S.,⁵⁸ the federal government is in an excellent position to use the power of its wallet to incentivize better care. The federal government could use this power by tying a substantial portion of the reimbursement rate paid to facilities for caring for Medicaid and Medicare beneficiaries to metrics of resident well-being. Currently, Medicaid programs reimburse nursing homes for care primarily on a per-resident, per-day basis.⁵⁹ There are some reimbursement increases for patient complexity and some limited increases for certain factors related to quality, but as a general matter, nursing homes that provide excellent care can expect a similar level of reimbursement to those that fall well below acceptable standards. Consequently, nursing homes—especially those that are predominantly supported by Medicaid funds—have insufficient incentive to provide high quality care. Indeed, unscrupulous providers can—and do—strategically cut costs even when doing so places residents at substantial risk of harm.⁶⁰

While pay-for-performance approaches are increasingly common in other parts of the U.S. healthcare system, a robust pay-for-performance system would represent a major change in how nursing homes are reimbursed.

⁵⁸ See THACH & WIENER, *supra* note 46, at 14 fig.5 (comparing sources of payment for long-term care).

⁵⁹ These methods used to determine the per diem amounts can be quite complex. See Edward Alan Miller, David C. Grabowski & Pedro L. Gozalo, *The Devil's in the Details: Trading Policy Goals for Complexity in Medicaid Nursing Home Reimbursement*, 34 J. HEALTH POL., POL'Y AND L. 93, 93, 124–130 (2009) (describing states' methodologies for calculating per diem rates and discussing the implications of their complexity).

⁶⁰ For a sobering discussion of how some unscrupulous providers have cut costs amid the pandemic, see NEW YORK A.G. REPORT, *supra* note 20, at 21, 23.

Some states have offered small bonuses for certain improvements and there is some evidence that these small bonuses improved quality of care among the lowest-performing operators.⁶¹ However, such bonuses were typically too small to make those improvements economically attractive and the U.S. has never tried a strong pay-for-performance system for skilled nursing care on a national level.⁶² Even amid the pandemic, as massive federal relief flowed to nursing homes, this windfall was almost entirely devoid of conditions,⁶³ and much of it may not have been spent on patient care.⁶⁴ The Trump Administration did offer what it termed a “pay-for-performance” scheme in fall 2020,⁶⁵ but that scheme created no new requirements or meaningful, new incentives. It simply offered bonus payments to facilities that kept new COVID-19 infections below a certain threshold—something the per-resident payment model already incentivized.⁶⁶

C. REQUIRE MINIMUM INVESTMENTS IN DIRECT CARE

Perhaps the most direct way to improve the quality of care in America’s nursing homes would be to require all nursing homes to use minimum levels of inputs that reliably predict quality of care. While such an approach would

⁶¹ Rachel M. Werner, Meghan Skira & R. Tamara Konetzka, *An Evaluation of Performance Thresholds in Nursing Home Pay-for-Performance*, 51 HEALTH SERVS. RES. 2282, 2282 (2016) (finding, as part of a study looking at the impact of pay-for-performance schemes in three states, that bonus payment systems were associated with improved quality metrics for the worst-performing facilities but decreased quality for the highest performing facilities).

⁶² CMS conducted a three-year pay-for-performance pilot project in three states. The project, which launched in 2009, offered small bonus payments based on a multi-factor score. The project failed to demonstrate a meaningful impact on quality. See David C. Grabowski, David G. Stevenson, Daryl J. Caudry, A. James O’Malley, Lisa H. Green, Julia A. Doherty & Richard G. Frank, *The Impact of Nursing Home Pay-for-Performance on Quality and Medicare Spending: Results from the Nursing Home Value-Based Purchasing Demonstration*, 52 HEALTH SERVS. RES. 1387, 1403–04 (2017) (reporting on the effect of the program and suggesting that its failure to result in demonstrably improved performance may have reflected, among other things, the size of bonuses, the complexity of the performance metric, and the delay between performance and payment).

⁶³ Eaton, *supra* note 11 (reporting that as of September 2020, nursing homes had received over \$21 billion in relief funds, “[b]ut only \$2.5 billion was specifically allotted to infection control [and] the rest came with almost no strings”).

⁶⁴ Soergel, *supra* note 7 (noting that “[i]ndustry watchdogs worry that some for-profit homes are funneling aid dollars into [separate property and management companies] rather than spending the money on residents’ care”).

⁶⁵ See Press Release, U.S. Dep’t of Health & Hum. Servs., Trump Administration Announces New Half Billion Incentive Payment Distribution to Nursing Homes (Dec. 7, 2020), <https://www.hhs.gov/about/news/2020/12/07/trump-administration-announces-new-half-billion-incentive-payment-distribution-to-nursing-homes.html> [<https://perma.cc/L7DJ-VJ5Z>] (describing the Trump Administration’s scheme that distributed performance payments to nursing homes that maintained COVID-19 infection rates below a specified criteria).

⁶⁶ See U.S. DEP’T OF HEALTH & HUM. SERVS., NURSING HOME QUALITY INCENTIVE PROGRAM METHODOLOGY 6 (Dec. 7, 2020), <https://www.hhs.gov/sites/default/files/nursing-home-qip-methodology.pdf> [<https://perma.cc/9L46-PJDN>] (setting forth the methodology for awarding performance payments to nursing homes that kept COVID-19 infection down relative to the infection rates in their communities, and that also took into consideration mortality rates of COVID-19 positive residents).

not be a substitute for holding nursing homes accountable for actually meeting performance targets, it could complement outcomes-based enforcement. Measuring and monitoring facility-level inputs is likely to be easier than measuring and monitoring resident outcomes, which typically require more complex and individualized data and assessment.

One input-focused strategy would be to require that nursing homes provide the level of staffing that researchers have found is essential to avoid neglect. Thus, in addition to (or in lieu of) increasing payments for facilities that provide good outcomes, the federal government could condition reimbursements or vary reimbursement based on each facility's staffing level. For example, the federal government could tie payment to nursing homes providing the minimum of 4.1 hours of direct care staff per day that experts agree is critical to avoid systemic neglect.⁶⁷ The federal government could also require minimum nurse staffing levels, which have too been found to be strongly predictive of care quality.⁶⁸

Alternatively, or in addition to staffing minimums, the federal government could incentivize investments in direct care staff by requiring facilities to devote at least a certain percentage of federal funds to resident care.⁶⁹ Just as the Affordable Care Act has adopted a "medical loss ratio" approach that requires insurers to spend a minimum of 80 or 85% of premium dollars on patient care,⁷⁰ the federal government could require nursing homes that accept Medicaid or Medicare to spend a threshold percentage of those funds—or a percentage of their aggregate revenue—on direct resident care (as opposed to spending it on administrative costs or simply pocketing it).

A spending ratio approach could reduce the risk that unscrupulous providers will profit by unreasonably compromising resident care, while also providing facility owners and operators with flexibility in determining staffing levels and arrangements. To encourage desired behavior, however, the ratio would need to be properly calibrated so that the required threshold

⁶⁷ This could be combined with a requirement of a particular mix of staff, which would be a more tailored but more complicated approach. See Harrington et al., *supra* note 17, at 8–9 (describing appropriate staffing mix).

⁶⁸ See *id.* at 12; see also *id.* at 5 (finding higher COVID-19 infection rates in nursing homes with registered nurse staffing levels below the .75 hours per resident day rate recommended by CMS in 2001).

⁶⁹ See Joseph G. Ouslander & David C. Grabowski, *COVID-19 in Nursing Homes: Calming the Perfect Storm*, 68 J. AM. GERIATRICS SOC'Y 2153, 2160 (Oct. 2020) (suggesting a medical loss approach should be part of long-term care financing reform because some nursing homes do not spend adequate sums on direct patient care); see also CHARLENE HARRINGTON, LESLIE ROSS, DANA MUKAMEL & PAULINE ROSENAU, IMPROVING THE FINANCIAL ACCOUNTABILITY OF NURSING HOMES 10 (Jun. 2013), <https://www.kff.org/wp-content/uploads/2013/06/8455-improving-the-financial-accountability-of-nursing-facilities.pdf> [https://perma.cc/U2Z4-GP3N] (recommending the use of a medical loss ratio approach for nursing facilities and suggesting that such an approach might cap administrative costs and profits at 20% of revenue).

⁷⁰ See 45 C.F.R. § 158.251(a)(4) (2020).

investments are sufficient to meet resident care needs.⁷¹ In addition, the approach would need to be paired with financial transparency requirements to prevent facilities from disguising profits as expenses (for instance, by paying inflated rent or fees to related entities).⁷²

Notably, while federal approaches would have the broadest impact, both of these input-focused approaches could also be adopted at the state level. In the wake of the pandemic, New Jersey adopted legislation requiring facilities to maintain minimum staffing levels⁷³ and to spend ninety percent or more of aggregate revenue on direct resident care.⁷⁴ Similarly, the Budget Bill adopted by New York's legislature in April 2021 requires 70% of aggregate annual revenue be spent on direct resident care and a minimum subset of that spending on "resident-facing staffing".⁷⁵

D. ELIMINATE MEDICAID'S PREFERENCE FOR INSTITUTIONAL CARE

Perhaps the best way of avoiding harms associated with institutional living is to avoid institutionalization in the first place. However, as discussed in the preceding section, current U.S. long-term care policy steers older adults with substantial care needs into institutions. This preference unnecessarily exposes many of those needing long-term care to the inherent risks associated with nursing home care (for example, that congregate care settings impede common strategies for reducing transmission of infectious

⁷¹ Further research may be helpful to calibrate thresholds. Proposed legislation in New York would have left room for adjustment of rates based on such research. *See S. B. 4336A*, 2021-2022 Leg. Sess. (N.Y. 2021). However, the provisions ultimately adopted as part of the New York Budget Bill, which were more favorable to the industry, did not. *See S. B. 2507C*, part GG, 2021-2022 Leg. Sess. (N.Y. 2021) (providing no option for regulators to increase the threshold above seventy percent).

⁷² Unfortunately, such practices are common. *See* Charlene Harrington, Anne Montgomery, Terris King, David C. Grabowski & Michael Wasserman, *These Administrative Actions Would Improve Nursing Home Ownership and Financial Transparency in the Post COVID-19 Period*, HEALTH AFFS. (Feb. 11, 2021), <https://www.healthaffairs.org/do/10.1377/hblog20210208.597573/full/> [<https://perma.cc/JA2K-6KSW>] (reporting that nearly three-quarters of nursing homes engaged in financial transactions with related entities according to 2015 data); Atul et al., *supra* note 25, at 35 (explaining how payments to related entities in the form of management fees, leasing costs, and interest payments increase after nursing homes are purchased by private equity firms, thus generating profit for the ultimate owners even as facilities show only slight or no profits); *For-Profit Nursing Homes' Pleas For Government Money Brings Scrutiny*, NAT'L PUB. RADIO (Oct. 22, 2020, 5:06 AM), <https://www.npr.org/2020/10/22/918432908/for-profit-nursing-homes-pleas-for-government-money-brings-scrutiny> [<https://perma.cc/7G4M-HNWK>].

⁷³ *See S. B. 2712*, 2020-2021 Leg., Reg. Sess. (N.J. 2020).

⁷⁴ *See Assemb. B. 4482*, 2020-2021 Leg., Reg. Sess. (N.J. 2020).

⁷⁵ This legislation, which was awaiting Governor Cuomo's signature at the time of publication, would require 70% of a facility's revenue to be expended on "direct resident care" and at least 40% of its revenue to be spent on "resident-facing staffing" (including contracted staffing services). *See S. B. 2507C*, part GG, *supra* note 71. For purposes of this calculation, the cost of certain "resident-facing staff costs contracted out by a facility" must be reduced by 15%. *Id.* The legislation, however, would give the Commissioner the ability to waive these requirements on a "case-by-case basis." *Id.*

disease). Institutionalization also unnecessarily reduces subjective well-being, because most Americans strongly wish to avoid nursing home placement.⁷⁶

The federal government could mitigate this problem by barring states from favoring institutional placements over community-based placements. More specifically, the federal government could condition states' participation in Medicaid on a requirement that states cover long-term care in integrated settings when doing so would (1) meet beneficiaries' needs, and (2) not be more expensive, per beneficiary, than providing nursing home care.⁷⁷

Ending Medicaid's preferential treatment of institutional care could both enhance beneficiaries' physical and psychological well-being and increase equity. The pro-institutional bias has a disproportionate impact on already marginalized communities and communities of color. For example, funding room and board only in nursing home settings means that those with less stable housing—who disproportionately are people of color—are especially likely to face institutionalization.⁷⁸

Ending this preference would also help dismantle a key instrument of "structural ageism."⁷⁹ Medicaid's preference for institutionalization not only isolates older adults but also normalizes this isolation and the resultant suffering. In contrast to the currently accepted norm of institutionalizing older adults, the U.S. has, over the past several decades, witnessed a concerted push to develop and support alternatives to institutionalization for children and younger adults with disabilities. Orphanages have been shuttered in favor of foster care. Mental hospitals have been closed in favor of community-based treatment. Large institutions for the developmentally and

⁷⁶ See AARP RESEARCH, 2018 HOME AND COMMUNITY PREFERENCES SURVEY: NATIONAL SURVEY OF ADULTS AGE 18-PLUS 4 (Aug. 2018), https://www.aarp.org/content/dam/aarp/research/surveys_statistics/liv-com/2018/home-community-preferences-survey.doi.10.26419-2Fres.00231.001.pdf [https://perma.cc/AY74-2G7D] (reporting that nearly 80% of adults age fifty and over wish to "remain in their communities and homes as they age").

⁷⁷ In March 2021, U.S. Senators Brown, Hassan, and Casey, as well as U.S. Congresswoman Dingell, circulated draft legislation that would require states to cover home- and community-based services as part of Medicaid's long-term care benefit. See HCBS Access Act of 2021, H.R. 117th Cong. (Draft Mar. 15, 2021), https://debbiedingell.house.gov/uploadedfiles/hcbs_access_act.pdf [https://perma.cc/G47P-8GBH]; Memorandum from The Offs. of Sens. Hassan, Brown, and Casey and Rep. Dingell to All Stakeholders (Mar. 16, 2021), https://debbiedingell.house.gov/uploadedfiles/home_and_community-based_services_access_act_-memo_ad.pdf [https://perma.cc/ZD4T-WDTQ].

⁷⁸ Notably, gaps by race in housing stability appear to be growing amid COVID-19. See Yun Chun, Stephen Roll, Selina Miller, Hedwig Lee, Savannah Larimore & Michal Grinstein-Weiss, *Racial and Ethnic Disparities in Housing Instability During the COVID-19 Pandemic* 1 (Soc. Pol'y Inst., Working Paper No. 10.7936/v0xn-yr31, 2020).

⁷⁹ See Austin S. Kilaru & Rebekah E. Gee, *Structural Ageism and the Health of Older Adults*, JAMA HEALTH F. (Oct. 16, 2020), <https://jamanetwork.com/channels/health-forum/fullarticle/2772140> [https://perma.cc/2EEH-S6EH] (describing the pro-institutional bias of long term-care as an example of "structural ageism").

intellectually disabled have been sidelined in favor of small group homes. During this same period, however, institutionalization of older adults with chronic care needs has remained the norm, and nursing home populations have remained relatively steady. Thus, although Americans have increasingly found institutionalization of younger people to be undesirable and unacceptable—and have demanded inclusion for these populations—the segregation of older adults in institutions has been tolerated. Requiring states to make community-based care available to older adults on equal terms with institutional care would be a powerful symbol that it is likewise unacceptable to segregate older adults.

Ultimately, making community-based care a truly viable option for diverse populations will require doing more than simply ending Medicaid's formal institutional bias. It will also require supporting age-friendly communities—and investing in the transportation, affordable housing, and other infrastructure needed to make it possible for those of all ages with chronic care needs to live safe, healthy lives in the community.

CONCLUSION

COVID-19 has exposed how long-standing regulatory gaps and enforcement failures endanger the safety and well-being of nursing home residents. Specifically, as this Essay has shown, the federal government has enabled the current COVID-19 crisis in America's nursing homes by failing to require minimum staffing levels, failing to use existing statutory authority to hold facilities accountable, and promulgating Medicaid coverage requirements that drive the chronically ill into institutions. Policymakers can and should capitalize on this moment to build a more humane system of long-term care. Doing so will require supporting community-based long-term care as well as refining regulatory requirements for nursing homes and enhancing enforcement efforts. The good news is that implementing such reforms has the potential not only to protect nursing home residents but also to further social equity and reduce structural ageism.