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I. INTRODUCTION

In 1965 Congress enacted Medicare and Medicaid to meet the health care needs of the nation’s elderly, poor and disabled. Medicare is administered federally through the Social Security Administration, and is financed by federal payroll taxes. Medicaid is a joint federal and state effort. The federal government sets guidelines and requirements that the states must follow in their administration of the program. Although the administration and financing of the Medicare and Medicaid programs differ, their structure is basically the same. Each employs a vendor payment system. The program beneficiary receives service from a health care provider who is certified to participate in Medicare, Medicaid, or both. Certification is attained when the provider shows compliance with all applicable statutory and regulatory provisions. The provider renders the services and is retrospectively or prospectively reimbursed by the government. The programs, then, involve three parties: the individual beneficiary, the provider, and the government.

The enactment of Medicare and Medicaid has had a great impact on the health care industry in the United States. That impact is probably most visible in the nursing home industry where growth since 1965 has been remarkable and dependence on federal and state monies is substantial. Medicare’s long term care coverage is limited. It will cover services in a skilled nursing facility for up to one hundred days per spell of illness, but only for persons hospitalized for at least three days. Medicare financed two percent of all nursing home expenditures in 1979. Medicaid has much broader coverage of long term care services. It requires that all states finance care in skilled nursing facilities, and makes financing of care in intermediate care facilities

4. Id. § 1395i(a).
5. Id. § 1396a.
9. See notes 24-35 and accompanying text infra.
10. See notes 146-47 and accompanying text infra.
12. Gibson, National Health Expenditures, 1979, HEALTH CARE FINANCING REVIEW 1, 7 (Summer, 1980) [hereinafter Gibson, 1979 Expenditures].
Medicaid financed a remarkable forty-nine percent of all nursing home expenditures in 1979. Given the large role of Medicare and Medicaid in the financing of long term care, it is clear that a nursing home's certification under the programs is a very valuable asset.

When the Department of Health and Human Services or state Medicaid agencies move to decertify nursing homes they are sometimes met with facility challenges to the procedures used for decertification. Courts faced with such challenges have consistently applied the entitlement doctrine to determine the proper amount of protection owed the nursing home in the decertification process. That doctrine examines the relationship between the nursing home and the government to determine whether the facility has an interest in the Medicare or Medicaid programs that is protected by the due process clause of the fifth amendment. If such an interest is found, the court then determines the procedures adequate to protect it.

Several unique features of the Medicare and Medicaid programs distinguish them from other government programs to which the entitlement doctrine has been applied. If these features are not recognized by the courts, the entitlement analysis may not adequately meet the realities of a Medicare or Medicaid decertification. This question, along with past judicial treatment of Medicare and Medicaid provider entitlement claims, will be examined in this Comment.

II. Structure of Medicare and Medicaid Provider Participation

A. The Nursing Home Industry

The nursing home has changed markedly in character in the past twenty years. It has become an industry. Once a relatively small-scale enterprise typified by small, independent operations, it is now dominated by investor-owned proprietary chains.

Although essentially unnoticed by investors and acquisition-oriented health care companies, the nursing home field appears to possess most of the desirable characteristics that both groups seek in making investments. In the following analysis, we attempt to show that: (1) the nursing home industry should continue to be one of the fastest growing, if not the fastest growing, major segments of the U.S. health care industry; (2) the shortage of beds, combined with improvements in the reimbursement system, should assure above-average profitability; and (3) growing economies of scale in nursing homes should provide increasing opportunities for efficient, multifacility operators (such as Beverly
nursing homes were non-profit or public institutions.22 This percentage is likely to decrease in the future as the trend in construction and acquisition of proprietary facilities continues to overtake the unchanging number of non-profit and public nursing home beds.23

The increasing percentage of investor-owned proprietary facilities as a proportion of the total number of nursing homes reflects rapid growth within the industry. There are approximately eighteen thousand nursing homes in the United States today,24 serving a total nursing home population of 2.2 million.25 This reveals a 250 percent increase in the number of nursing home residents between 1963 and 1977.26

Many who have examined the nursing home industry, and health care facilities generally, contend that this remarkable growth has been due largely to the availability of Medicare and Medicaid funds.27 In 1977, only 12.4 percent of the nursing home beds in the United States were not certified for either Medicare or Medicaid.28 Sixty percent of nursing home residents nationally, are supported partially or totally by Medicaid, and two percent by Medicare.29 Thus, of the 2.2 million people in nursing homes today, 1.3 million receive Medicare or Medicaid funds.30

Recent figures on government expenditures for nursing home care reveal further the large role of both the federal and state government in the financing of long term care.31 Although only two percent of all nursing home expenditures were covered by Medicare in 1979,32 Medicaid financed forty-nine percent of nursing home care in that year.33 Translated into dollar amounts, state

Ent. and National Medical Ent.) to grow rapidly by means of acquisition in this highly fragmented industry.

22. Wing & Craige, supra note 21, at 1183.
24. This figure includes nursing homes, personal care homes and domiciliaries. U.S. DEPT. OF HEALTH, EDUCATION AND WELFARE, HEALTH: UNITED STATES 97 (1978).
26. Wing & Craige, supra note 21, at 1182. The size of the facilities themselves, though, has not changed markedly over the last twenty years. The large majority of nursing homes today remain relatively small, with less than one hundred beds. Id. at 1183.
Annual net income of non-profit and for-profit hospitals increased from $29 million in 1950 to $547 million in 1971. . . . Medicare and Medicaid apparently contributed significantly to these improvements.
28. Wing & Craige, supra note 21, at 1183.
30. Richmond Times Dispatch, supra note 25.
31. For example, in 1975 total expenditures for nursing home care were $9,000,300,000. Of this amount $257 million was financed by Medicare and $2,562,900,000 was financed by Medicaid. House Comm., supra note 27, at 109. Total expenditures, both private and public, for long term care have been increasing steadily over the years: $1.3 billion in 1965; $12.6 billion in 1977, Wing and Craige, supra note 21, at 1182; $15.8 billion in 1978, Gibson, National Health Expenditures, 1978, HEALTH CARE FINANCING REVIEW, 1, 4 (Summer, 1979) [hereinafter Gibson, 1978 Expenditures]; and $17.8 billion in 1979, Gibson, 1979 Expenditures, supra note 12, at 5.
33. Id.
and federal expenditures for long term care under Medicare and Medicaid amounted to 7.2 billion dollars in 1978, and 9.1 billion dollars in 1979.

This extensive public funding of nursing home care for the needy elderly has caused great concern over conditions in long term care facilities. Medicare and Medicaid reimbursement can constitute the bulk of the payments going to a nursing home. A facility could potentially provide inadequate medical and nursing services with these federal and state dollars. The desire to prevent improper use of government monies, and to insure that adequate care is provided to all publicly-supported nursing home residents has resulted in a constant effort by both state and federal governments to police the qualifications of facilities receiving government dollars.

B. Terms and Conditions of Nursing Home Certification

Nursing homes must be certified by the state Medicaid agency in order to participate in the Medicaid program. The task of determining Medicare certification is generally handled by the states as well.

Each facility must satisfy several major requirements to gain its certification. It must first comply with the Conditions of Participation. These conditions, which cover both Medicare and Medicaid participation, require compliance with all federal, state and local laws and regulations, including those regarding state licensure. They establish standards relating to facility administration, patients' rights, staffing requirements, facility services, physical plant, and utilization review.

In addition, each facility must meet the requirements set out in the statutes defining skilled nursing and intermediate care facilities. Nursing homes have been classified by the Department of Health and Human Services (HHS) according to the level of care they offer. Those that provide twenty-four hour nursing services are termed skilled nursing facilities. Medicare will cover services in a skilled nursing facility for up to one hundred days per spell of illness. Medicaid provides complete coverage for care in skilled nursing facilities.

The alternative form of services are those provided by intermediate care facilities. They provide less intensive nursing care than skilled nursing facili-

38. Id. § 405.1120.
39. Id. § 405.1121.
40. Id.
41. Id. §§ 405.1122-.1124.
42. Id. §§ 405.1125-.1132.
43. Id. §§ 405.1134-.1136.
44. Id. § 405.1137.
46. Id. § 1395d(a)(2).
47. Id. § 1396d(a)(14)-(15).
ties, and therefore presumably serve a more functional and less ill resident population. Medicare does not finance intermediate care at all. Medicaid gives the states the option to cover such care and currently about one third of the states do so.

Once an inspection determines that the nursing home is in compliance with the Conditions of Participation and all other relevant statutory and regulatory provisions, a provider agreement is executed, which generally relates to finances and reimbursement. Under Medicare, that agreement is made with HHS. The nursing home binds itself not to charge recipients for services not covered by Medicare, to refund any monies incorrectly collected from recipients, and to comply with Title VI of the Civil Rights Act prohibiting discrimination on the basis of race, color or national origin. A statement of financial solvency is also prepared at the time the agreement is executed.

The Medicaid provider agreement is executed with the state Medicaid agency, since Medicaid is a state administered program, but guidelines issued by HHS govern the content of the agreement. The provider must agree to keep adequate records showing services which have been provided to recipients. It must agree to disclose any information kept in those records, or other records regarding payments claimed by the provider, to the state Medicaid agency, HHS, or the state Medicaid fraud control unit, and to comply with all financial disclosure requirements of the Medicaid statute. Since the facility receives federal matching funds, it must also comply with Title VI of the Civil Rights Act.

In an effort to control improper financial dealings and fraud throughout the health care industry, Congress has promulgated strict disclosure requirements for the two programs. Any facility receiving Medicare or Medicaid reimbursement must submit certain information to the government either at the time of its annual survey, or upon request by the applicable state or federal agency. That information relates to three areas: ownership of the reporting facility, other facilities or subcontractors of the facility; significant business transactions with subcontractors or wholly-owned suppliers; and Medicare or Medicaid-related convictions of owners, agents or managing employees of

50. Wing & Craige, supra note 21, at 1183.
52. 42 C.F.R. § 431.107(b) (1980).
53. Id. §§ 420.202-.206, 455.103-.106.
54. The facility must identify: those with an ownership interest in the reporting facility; those with an ownership or controlling interest in any subcontractor in which the disclosing entity has a direct or indirect ownership of 5% or more; the name of any other provider in which an identified individual has an ownership or controlling interest; and any of these individuals who are closely related. Id. §§ 420.206, 455.104.
55. The facility must report its ownership of any subcontractor with whom it has had business transactions of $25,000 or more in the past year, and any significant business transactions between it and wholly-owned suppliers or subcontractors within the last five years. Id. §§ 420.205, 455.105.
In addition, Medicare requires a provider to disclose whether it has hired an individual who was employed by the facility's fiscal intermediary during the preceding year.\footnote{57}

The duration of the nursing home provider agreement is limited to one year.\footnote{58} Since the facility must be inspected prior to renewal of the agreement, theoretically, the facility must at least yearly establish that it is in compliance with all applicable state and federal regulations.\footnote{59} Execution of the provider agreement and compliance with the Conditions of Participation and other statutory provisions constitute certification. Attaining this status grants to the nursing home all of the Medicare and Medicaid provider rights, benefits and responsibilities.

C. Decertification

Decertification of a nursing home by HHS terminates its participation in both the Medicare and Medicaid programs.\footnote{60} It is the most severe measure that can be taken against a facility providing inadequate care. Therefore, HHS and state Medicaid agencies by practice will only commence the decertification action after efforts by other means to bring the nursing home into compliance have failed.\footnote{61} It can be invoked only upon a finding of failure to comply with the statutory or regulatory provisions of Title XVIII or XIX, breach of the provider agreement, failure to furnish information, or permit

\footnote{56} Id. §§ 420.204, 455.106.
\footnote{57} Id. § 420.203. The fiscal intermediary is the organization which actually administers the Medicare program by determining the level of allowable reimbursement of covered services. 42 U.S.C. § 1395h (1976).
\footnote{58} 42 C.F.R. § 489.15 (1980).
\footnote{59} Note though, that upon finding that a facility is not in full compliance, the state agency or HHS has the option of requiring the facility to develop and implement a plan of correction, and to issue a conditional agreement so that the nursing home does not lose its certification. The practice of issuing such conditional agreements is not uncommon. Id.
\footnote{60} Provisions of the Medicare and Medicaid statutes indicate that a facility which is out of compliance for purposes of one program will be considered as such for the other. 42 U.S.C. §§ 1395cc(c)(2), 1396l (1976).
\footnote{61} A number of interim measures can and will be taken to attempt to bring a facility into compliance. A conditional provider agreement can be executed upon the facility's filing a plan of correction; the facility can enter into consultation with the state certifying agency to attempt to correct substandard conditions; or the state can enact civil penalty systems which exact monetary fines for specified violations. See Butler, supra note 29.

North Carolina has never decertified a facility. Its reasoning is that first, the certification agency, the Division of Facility Services, recognizes the severity of revoking the facility owner's right to maintain this business; and second, because of the shortage of nursing home beds in North Carolina, decertification may result in more harm to residents within the facility than would allowing the facility to remain operating. Another reason cited was the difficulty of actually proving that a facility should be decertified in the hearing provided by the Medicare and Medicaid statutes.

Instead the State will work with the facility by granting conditional provider agreements while offering consultation services in all aspects of facility operation.

The Department of Facility Services has a policy of not recommending decertification unless it has found many substandard conditions in the facility, the facility has shown bad faith, and the department has offered consultation which has been rejected or disregarded. Interview with Robert Robeson, Division of Facility Services of the State of North Carolina, in Raleigh, North Carolina (February 28, 1980).
examination of financial records, making of fraudulent statements or excessive requests regarding payment, furnishing excessive or inadequate quality health care, or failure to furnish required information on business transactions, ownership or criminal convictions. 62

The decertification process itself is a lengthy and complex one. 63 Although the Medicare and Medicaid programs each have their own appeals process, the Medicare appeals process is most frequently used. 64 If a skilled nursing facility is participating in Medicare and Medicaid, and the basis for the Medicaid action is also one for Medicare, the state must give the facility the option to use the Medicare or Medicaid appeals procedure, and notify the facility that the decision by HHS under Medicare will be binding on its Medicaid participation. 65

The Medicaid regulations establish minimum requirements for decertification procedures. 66 The state Medicaid agency must make an initial determination that there is sufficient cause to decertify a facility. Generally, this information is acquired through the state’s yearly facility inspection, or an inspection in response to resident complaints. Such a finding may also result from a nursing home’s failure to correct substandard conditions over the term of a conditional provider agreement with the Medicaid agency. Notice to the facility of the finding follows, and it then has a right to contest the determination. 67 The state must provide an evidentiary hearing before the actual termination of participation, or within one hundred-twenty days of the date of notice of the determination. 68 If the state opts for a post-termination hearing, it must offer the facility an informal reconsideration to be carried out before the effective date of the cessation of program payments. That reconsideration must at a minimum provide written notice and bases for the determination to decertify, an opportunity for the facility to refute the findings in writing and a written affirmation or reversal of the state’s initial findings. 69

The facility has a statutory right under Medicaid to appeal an initial or reconsidered decertification determination through a full evidentiary hearing. That administrative hearing must be before an impartial decisionmaker, with the facility represented by counsel who can call witnesses, examine adverse witnesses, and present documentary evidence. There must be a written deci-

63. The complexity of the process is due largely to the end which it may bring. Because decertification may result in the termination of a nursing home’s participation in Medicare and Medicaid, it may effectively result in the termination of the facility’s existence.
64. Provisions such as 42 C.F.R. 431.153(d) making a final decision entered under Medicare procedures binding for purposes of Medicaid participation have had the practical effect of making the Medicare decertification process the one most often used. When a skilled nursing facility is certified to participate in both Medicare and Medicaid, and that facility is not in compliance with the programs’ conditions, the Medicare agency has practical jurisdiction over the facility’s decertification. Its decision will be binding for Medicaid participation as well.
66. Id. §§ 431.151-154.
67. Id. §§ 431.153-.154.
68. Id. § 431.153(b).
69. Id. § 431.154.
sion stating the reasons for the affirmation or reversal of the initial determination and the evidence relied upon.70

The Medicare decertification and appeals procedure is carried out by HHS. It begins with notice of its determination that the facility has shown sufficient cause for decertification, its basis, and information on the nursing home’s right to appeal that determination.71 The appeal takes place after the facility’s termination from the program pursuant to the initial determination. The initial determination is generally based upon the results of the annual survey of the facility, or one generated by resident complaints. The provider will always receive a copy of this report. Decertification may also begin with a determination by HHS not to renew a facility’s provider agreement. It may occur at the termination of the preceding year’s agreement, or upon failure of the facility to make those improvements specified in a conditional provider agreement. Upon the determination not to renew a provider agreement, the provider must request reconsideration by independent decisionmakers within HHS before it may obtain a full administrative hearing.

If the nursing home opts for a hearing it must file a written request within sixty days of receipt of its notice of determination or reconsideration.72 The request must state the specific contentions with which the facility disagrees, and its basis for believing those contentions incorrect.73 The hearing will be a full evidentiary hearing before an administrative law judge with the Bureau of Hearing and Appeals of HHS.74

The administrative law judge has the option of calling a prehearing conference to delineate the issues.75 At the full hearing, counsel for both parties are present and given an opportunity to present their case. Upon concluding, the judge issues a decision confirming or reversing the decertification determination.

Either party can request review of the administrative law judge’s decision by HHS’ appellate body, the Appeals Council. The Council must hear a request made by the facility, but can deny the government’s request. It may affirm, remand or reverse the judgment of the administrative law judge.76

70. Id. § 431.153(c).
71. Id. § 405.1503.
72. Id. §§ 405.1530-.1531.
73. Id. § 405.1531.
74. Id. § 405.1533.
75. Id. § 405.1535. Witnesses and documents can be subpoenaed upon motion. Id. § 405.1544. At the hearing, both the facility and the government are represented by counsel, who can call and cross-examine witnesses, file written documents for evidentiary purposes, and present an oral summation. Id. §§ 405.1545, 1547, 1548. Upon conclusion, the ALJ must issue a written decision with findings of fact and conclusions of law. Id. § 405.1557.
76. Id. § 405.1566(a).
This decision is final and binding unless the facility files an action for review in federal district court.\textsuperscript{77}

There is some justification underlying this maze of federal regulations governing nursing home participation. The availability of federal and state funds to finance long term care has triggered alarming growth in the proprietary nursing home industry.\textsuperscript{78} Along with this growth have come instances of exploitation of both reimbursed funds and the nursing home residents themselves.\textsuperscript{79} HHS hoped that it might be able to curtail abuse of the Medicare and Medicaid programs by establishing new and more stringent standards in areas such as facility staffing and services, residents' rights, and financial disclosure by providers. Whether all of this regulation has been effective is a hotly debated question.

Questions can also be raised regarding the fairness of this decisionmaking process with regard to its impact on individual nursing homes. The fifth amendment provides that no person shall be deprived of property without due process of law.\textsuperscript{80} Due process has frequently been interpreted to require that substantial procedural safeguards be provided individuals and private entities adversely effected by government administrative decisionmaking. Individual facilities and the industry as a whole have repeatedly claimed that the administrative procedures incident to Medicare and Medicaid decertification violate their due process rights. An examination of the content of those challenges and the judicial reaction to them follows.

III. TRADITIONAL ANALYSIS OF PROVIDER ENTITLEMENT CLAIMS

A. Entitlement

When first applied in the 1970 Supreme Court decision of \textit{Goldberg v. Kelly},\textsuperscript{81} the entitlement concept was heralded by many as a basis for protecting individuals from arbitrary termination of government benefits and services. In \textit{Goldberg}, the Court found that welfare benefits are statutory entitlements for persons qualified to receive them,\textsuperscript{82} and therefore, that the recipient has a protected interest in those benefits that cannot be terminated without a hearing.

An exact definition of entitlement is difficult. It does not fall within the concept of property as traditionally defined in common law, yet it is more than a gratuity or privilege granted to the individual by the federal or state government.\textsuperscript{83} Those who enjoy the entitlement have satisfied standards and condi-
tions set by the government, and as long as they continue to meet those criteria, they fully deserve their benefits or services.\textsuperscript{54} It might best be termed a "constitutionally protected interest."

The essential attribute of an entitlement is its classification as an interest that comes within the protection of the due process clause of the fifth\textsuperscript{85} and fourteenth amendments.\textsuperscript{86} It is an interest which, at the least, cannot be deprived without minimum procedural safeguards to protect the entitled individual from unjustified withdrawal of that interest.\textsuperscript{87}

The source of an entitlement is rooted in state action.\textsuperscript{88} Major cases that have found an individual entitled to a benefit have relied upon state action such as statutory language,\textsuperscript{89} regulations,\textsuperscript{90} contracts,\textsuperscript{91} or mutually explicit understandings.\textsuperscript{92} No matter what the source, the essential fact is that the scope of the entitlement is defined by the state itself. The decision as to what relationships rise to the level of a protected interest is left principally to the discretion of the legislatures.\textsuperscript{93}

The deference given by the courts to the state's determination of what interests will constitute an entitlement has raised a number of doubts about the continued use of the concept to protect individuals from arbitrary government action.\textsuperscript{94} If recent decisions represent a trend, then state legislatures may be permitted to narrow the protected interest by limiting the procedures incident to its withdrawal. Without procedural safeguards, the entitlement is robbed of its value. These concerns are not groundless. A plurality of the Supreme Court in \textit{Arnett v. Kennedy},\textsuperscript{95} held that a statute creating a procedure for termination of government employment did not violate the Constitution despite its

\begin{itemize}
\item \textsuperscript{84} Reich, \textit{Individual Rights and Social Welfare: The Emerging Legal Issues}, 74 \textit{Yale L.J.} 1245, 1255 (1965).
\item \textsuperscript{85} U.S. Const. amend. V.
\item \textsuperscript{86} U.S. Const. amend. XIV, § 1.
\item \textsuperscript{87} Procedural due process requirements are discussed in text accompanying notes 99-123 infra.
\item \textsuperscript{88} Property interests, of course, are not created by the Constitution. Rather they are created and their dimensions are defined by existing rules or understandings that stem from an independent source such as state law—rules or understandings that secure certain benefits and that support claims of entitlement to those benefits.
\item \textsuperscript{91} Arnett v. Kennedy, 416 U.S. 134 (1974).
\item \textsuperscript{92} Perry v. Sinderman, 408 U.S. 593 (1972). Other sources have noted that in addition to state action, the individual must rely on the benefit obtained and must presently enjoy it. \textit{Id.} at 564. \textit{See Note, Michigan Compulsory No-Fault Insurance Law Violates Due Process}, B.Y.U. L. Rev. 433, 440 (1979).
\item \textsuperscript{93} Comment, \textit{Entitlement, Enjoyment and Due Process of Law}, 1974 \textit{Duquesne L.J.} 89, 103.
\item \textsuperscript{95} 416 U.S. 134 (1974). These justices found that Kennedy did have an entitlement, but said that the very statute which gave him that right expressly provided also for the procedure by which the right was terminated, and expressly omitted the procedural guarantees mandated by the Constitution. \textit{Note, From Goss to Bishop}, supra note 94, at 529.
\end{itemize}
insufficiency by constitutional due process standards, even though the employment under the statute constituted an entitlement for analytic purposes. This finding that an independent due process analysis need not be applied deprived the entitlement doctrine of its major purpose; individual protection from arbitrary withdrawal of government benefits. The remaining Justices in Arnett maintained that an independent due process analysis must be applied once a statute has been found to create an entitlement.

Another manifestation of the deference given to the states by the federal courts appeared in Bishop v. Wood. In that case, the Supreme Court accepted an extremely narrow interpretation given a municipal ordinance by the North Carolina Supreme Court and the North Carolina federal district court to reach a conclusion that there was no entitlement. Its deference to the questionable interpretation of the other courts on the issue of the existence of an entitlement was virtually complete.

It remains to be seen whether the entitlement doctrine will eventually be emptied of any protective value it may have for the individual confronted with threatened termination of a protected interest. The Supreme Court has not abandoned the doctrine altogether; nor has the court been consistent in its application. A majority of the justices in Arnett supported the preservation of an independent due process analysis, and two recent Supreme Court decisions have given some support for the notion that the terms life, liberty and property in the due process clause have meaning outside of the strict confines of provisions of positive law. The procedural safeguards enunciated in Goldberg are an effective weapon in limiting governmental power. As long as there is some life in the Goldberg doctrine, efforts to secure independent due process standards will continue.

B. Mandates of an Independent Due Process Analysis
Upon Finding An Entitlement

The fifth and fourteenth amendments provide that no person shall be deprived of life, liberty or property without due process of law. The goal of due process is the protection of individuals from arbitrary or erroneous withdrawal of their constitutionally protected interests.

97. On its face the ordinance on which petitioner relies may fairly be read as conferring such a guarantee. However, such a reading is not the only possible interpretation; the ordinance may also be construed as granting no right to continued employment but merely conditioning an employee's removal on compliance with certain specified procedures. . . .

The [North Carolina Federal] District Court's reading of the ordinance is tenable; it derives some support from a decision of the North Carolina Supreme Court, . . . and it was accepted by the Court of Appeals for the Fourth Circuit. These reasons are sufficient to foreclose our independent examination of the state law issue.

Id. at 345, 347.
99. U.S. Const. amend. V.
100. Id. amend. XIV, § 1.
The fundamental requirements of procedural due process are adequate notice and an opportunity to be heard "at a meaningful time and in a meaningful manner".101 Because due process must protect innumerable types of interests with varying levels of importance, it is by no means a standard set of procedures consistently applied to all situations meriting procedural protections. It is a flexible doctrine, and calls for such procedural protections as the particular situation demands.102

When reviewing existing procedures, courts are faced with the challenge of first determining whether or not the procedures sufficiently protect the interest involved. If they are found insufficient, the court must tailor a set of procedures that meet the circumstances of the individual case before it.

In Mathews v. Eldridge,103 the Supreme Court articulated the factors that should be considered when identifying the dictates of due process in any given situation. By drawing on the reasoning of its prior decisions, the Court found it necessary to balance three interests:

First, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail.104

The private interest involved is that of the individual threatened with the termination of a protected interest. In general, there is an interest in the uninterrupted receipt of the benefit or services.105 Courts have most often determined the weight to be given this uninterrupted receipt by the effect the deprivation of that interest would have on the individual. One consideration is the degree of potential harm that may be created by a particular decision.106 The individual may be deprived of subsistence,107 his livelihood,108 or may be faced with a threat to health and safety.109 Another factor often considered is the length of the wrongful deprivation.110 The longer the period the individ-

102. Morrissey v. Brewer, 408 U.S. 471, 481 (1972); Cafeteria Workers Local 473 v. McElroy, 367 U.S. 886, 895 (1961) ("the very nature of due process negates any concept of inflexible procedures universally applicable to every imaginable situation").
104. Id. at 335. The Court's decision in Eldridge has set a pattern for subsequent adjudication of procedural due process issues. Once they have found a constitutionally recognized interest, federal courts have almost invariably employed the Eldridge balancing test when judging the adequacy of a challenged procedure. Note, Mathews v. Eldridge, Reviewed: A Fair Test on Balance, 67 Geo. L.J. 1407, 1412 (1979).
106. Id. at 341 (citing Morrissey v. Brewer, 408 U.S. 471 (1972)).
ual is erroneously denied the benefits, services or employment, the greater the harm he suffers. A final consideration is whether the individual can be made whole if it is later discovered that the termination was erroneous.\textsuperscript{111}

An erroneous termination of a protected interest subjects the individual to undeserved and needless harm. Therefore, the second factor which must be weighed in the \textit{Eldridge} balancing test is the risk that existing procedures may produce an erroneous deprivation. The procedures need not comply with standards that assure perfect, error-free determinations,\textsuperscript{112} but they should be shaped by "the risk of error inherent in the truthfinding process as applied to the generality of cases".\textsuperscript{113} Analysis of the degree of risk of an incorrect termination involves two related aspects of the procedures used: their accuracy, and the type of factual determination to be made by the procedure.\textsuperscript{114} For example, if the determination is one based on objective data, such as prior driving records, police reports or medical records, there is a smaller risk of error than if it is based upon subjective findings such as credibility or fault;\textsuperscript{115} or, if the procedures give the individual an opportunity to appear informally before an official involved in the decision to terminate, there is a greater probability that the decision will be an accurate one.\textsuperscript{116}

The final interest considered in the \textit{Eldridge} test is the governmental interest in terminating benefits and services to those ineligible to receive them. This interest is basically twofold. Procedures provided by the government for termination of a protected interest will often be the minimum it considers required. When a court weighs the possibility of imposing more stringent procedural safeguards on the state or federal government, it creates potential problems. Increased hearings will burden the government both administratively and financially.\textsuperscript{117} The court must weigh these administrative and financial costs against the benefits to be derived from fewer erroneous deprivations. A second and extremely important determination the court must make is whether the denial of summary deprivation procedures to the states will impede the government's interest in the performance of its public protection functions.\textsuperscript{118} These functions include the continued smooth operation of public institutions,\textsuperscript{119} and the protection of the public's health and safety.\textsuperscript{120} Im-


\textsuperscript{112} Mackey v. Montrym, 443 U.S. at 13 (quoting Greenholtz v. Nebraska Penal Inmates, 442 U.S. 1, 7 (1979).

\textsuperscript{113} Mackey v. Montrym, 443 U.S. at 14 (quoting Mathews v. Eldridge, 424 U.S. at 344).

\textsuperscript{114} Note, \textit{supra} note 104, at 1419, 1420.

\textsuperscript{115} The distinction between subjective and objective data often goes to the timing of the hearing, whether it will be pre- or post-termination. Note the results in accordance with this distinction in Dixon v. Love, 431 U.S. at 113; Mathews v. Eldridge, 424 U.S. at 343; Goldberg v. Kelly, 397 U.S. at 269. Courts will also consider who is evaluating the data. Barry v. Barchi, 443 U.S. at 65.

\textsuperscript{116} See Barry v. Barchi, 443 U.S. at 65; Mackey v. Montrym, 443 U.S. at 15; Memphis Light, Gas & Water Division v. Craft, 436 U.S. 1 at 18.

\textsuperscript{117} Mathews v. Eldridge, 424 U.S. at 347.

\textsuperscript{118} Note, \textit{supra} note 104, at 1417.

\textsuperscript{119} Barry v. Barchi, 443 U.S. at 65.

\textsuperscript{120} Dixon v. Love, 431 U.S. at 114; Mackey v. Montrym, 443 U.S. at 17.
portant "public" interests are accorded a great deal of weight, and are often found sufficiently important to outweigh the private interest.\textsuperscript{121}

Each of the Eldridge factors are then examined in relation to one another. Those the court considers of greater relative importance will outweigh others. The result is a set of procedures that reflect the court's ordering of priorities, and basically ensure that the entitlement will not be erroneously deprived.

The due process balancing approach leaves a great deal of discretion to the courts in fashioning appropriate procedures to protect constitutional interests. It has been argued by some commentators that this approach provides insufficient guidance to the courts, and so results in a lack of any distinct due process standards in the decisions.\textsuperscript{122} Federal courts have adopted the Eldridge balancing approach in their treatment of nursing home challenges to existing decertification procedures. That approach, contrary to critics' charges, has produced consistent results in these cases.\textsuperscript{123}

C. Provider Entitlement to Continued Participation in The Medicare and Medicaid Programs

The treatment of provider entitlement claims by the federal courts began with the following statement: "It is clear that Mrs. Case has a property interest in her expectation of continued participation in the Medicaid program."\textsuperscript{124} This holding in Case v. Weinberger was the first of several cases brought by nursing home proprietors against the former Department of Health, Education and Welfare challenging the procedures for termination from the Medicare and Medicaid programs. Subsequent decisions have not departed from the holding in Case, nor have they elaborated to any great extent on its justifications.\textsuperscript{125}

The court in Case obliquely indicated the basis for its holding by citing Board of Regents v. Roth,\textsuperscript{126} but it did not discuss the case.\textsuperscript{127} Hathaway v.
Mathews, decided a year after Case, grounded its finding of a provider entitlement on the fact that once enacted, Medicaid had created expectations on the part of both consumers and providers of health care. It concluded that the federal government could not terminate Medicaid payments without providing notice and a hearing to the person who is to be deprived of the statutory entitlement.

In Washington Nursing Center v. Quern a federal district court applied the holdings in Case and Hathaway to a provider's challenge of a termination from a state program providing supplemental Medicaid reimbursement to facilities that were experiencing financial hardship. The court stated:

What the cases cited [Hathaway and Case] do establish . . . is that the institutional plaintiffs through their expectation of continuing to receive Medicaid payments on behalf of their patients, have a property right protected under the Constitution which cannot be deprived without due process of law.

Cases decided since Washington Nursing Center have assumed without question that there is a provider entitlement to continued participation in the Medicare and Medicaid programs. Two of these cases, however, have rested their findings on much narrower grounds than the expectation of continued participation. In the most recent of these cases, Green v. Cashman, the court asserted that whatever rights the provider had arose exclusively from its provider agreement with the state. It found little persuasion in the "expectation" argument, stating that there was nothing in the Medicare or Medicaid statutes that would indicate an intention to provide financial assistance to health care providers for their own benefit. The statute, the court continued, was designed to aid only the patients of such facilities.

A finding of a provider entitlement based purely on the contract rights created by the provider agreement would indicate that there is a distinction between a decertification decision based upon termination of an existing provider agreement, and one based upon a decision not to renew an expired provider agreement. If the entitlement is based solely in the provider agreement, then theoretically it should end when the provider agreement expires, thereby

128. 546 F.2d 227 (7th Cir. 1976).
129. Id. at 230.
130. Id. at 232.
132. Id. at 26.
135. 605 F.2d at 946.
136. Id. The legislative intent argument that the court used here, in the large majority of cases, has not been applied at this stage of the inquiry into provider entitlement, but at the stage of inquiry, when the court is deciding upon the timing of the hearing to challenge the termination of participation. See notes 142-70 and accompanying text infra. Second, this legislative intent argument may not be a correct one. A number of commentators assert that one of the purposes behind structuring the Medicare and Medicaid programs as they are, was to keep the private health care industry intact and operating. See notes 180-97 and accompanying text infra.
making irrelevant any consideration in that situation of what procedures are required upon terminating an existing entitlement.

Although a number of state courts have adopted this distinction, the federal courts have not been willing to accept it. *Town Court Nursing Center, Inc. v. Beat* involved a refusal to renew the provider agreement of a nursing home. When HEW tried to bring out this distinction, the court rejected it, stating that the legal effects of calling the decertification the termination of an ongoing provider agreement or a refusal to renew an expired agreement were irrelevant. *Town Court* had preceded *Green's* recognition of the provider agreement as the sole source of the provider's interest by a year, but in June, 1980, the Supreme Court cited the Third Circuit's decision with approval.

*O'Bannon v. Town Court Nursing Center, Inc.* arose out of the same decertification proceeding as the lower court decision, but addressed the issue of resident, rather than provider, entitlement. The nursing home had not appealed the lower court's decision, but the Supreme Court, in text and footnote, mentioned the Third Circuit's unanimous holding regarding the provider entitlement issue and repeated that court's holding that the procedures for termination were sufficient to protect Town Court's property interests.

While questions regarding the basis for finding an entitlement can still be raised, at the present time it appears that most courts are willing to find that nursing homes subject to decertification are entitled to due process protection. As will be shown below, it has been the sufficiency of procedures rather than

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137. These cases arose out of state Medicaid agencies' decisions not to renew expired provider agreements. Facility owners challenged these decisions, asserting that they were entitled to a hearing in which the state should justify its decision not to renew. The Ohio courts rejected this argument by finding that the Medicaid statute placed a one year limit on provider agreements, that the provider agreement was the source of the facility's entitlement and that therefore the entitlement ended upon expiration of the agreement. The facility's expectation in continued participation alone was not sufficient to constitute an entitlement. *Marshall Nursing Home, Inc. v. Aggrey*, 50 Ohio App. 2d 15, 361 N.E.2d 522 (1976); *Shady Acres Nursing Home, Inc. v. Canary*, 30 Ohio App. 2d 47, 316 N.E.2d 481 (1973).

A more detailed explanation for the rejection of this argument was given by the California Supreme Court in *Paramount Convalescent Center, Inc. v. Department of Health Care Services*, 15 Cal. 3d 489, 542 P.2d 1, 125 Cal. Rptr. 265 (1976). Using a traditional property interest analysis, the court distinguished this situation from that of the welfare recipient in *Goldberg v. Kelly*, 397 U.S. 254 (1970), or the teacher in *Perry v. Sinderman*, 408 U.S. 593 (1972) by stating that in those cases the chief beneficiary of the entitlement was the person who claimed the right to the hearing, whereas here, the facility was not the primary beneficiary of the program. 15 Cal. 3d at 497, 542 P.2d at 5, 125 Cal. Rptr. at 269. The court also distinguished this case from *Perry v. Sinderman* on another basis. Although both situations involved a one year contract, the regulations under the Medi-Cal program made clear to the nursing home that it would have to show its compliance with applicable federal regulations. This was completely unlike the regulations and practices at the college in *Perry* which had established a de facto tenure system which promised continued employment. *Id.* at 498, 542 P.2d at 6, 125 Cal. Rptr. at 270. Like the Ohio courts, the California court concluded that the expectation in the renewal of the provider agreement was not sufficient to constitute an entitlement. *Id.* at 498-99, 542 P.2d at 6, 125 Cal. Rptr. at 270.

138. 586 F.2d 266 (3d Cir. 1978).

139. *Id.* at 268 n.1. The court based its conclusion on a reading of the regulations. Save one exception, the regulations had no difference in the methods of review of initial decisions to terminate and initial decisions not to renew an existing provider agreement.

140. 447 U.S. 773 (1980).

141. *Id.* at 778 n.6.
the existence of the protected interest which has presented the courts with the more challenging issue.

D. Sufficiency of Procedural Due Process Upon Finding a Provider Entitlement

An entitlement analysis for due process purposes involves two questions. As discussed in the preceding section: does the individual have an interest of sufficient import in the government program to merit its protection from arbitrary termination? If so, what procedures are due or necessary to protect that interest from arbitrary termination?

The HHS decertification appeals process has frequently been challenged by providers. They claim that the available procedures are constitutionally insufficient to protect their interest in continued participation in the Medicare and Medicaid programs. Much of the controversy in the past decade has centered around the timing of the full administrative hearing available to providers threatened with decertification. HHS has consistently asserted that a hearing, if requested by the nursing home, should be offered after the termination of program funding to the facility. Providers however, have claimed that the hearing must be available before termination of the actual payments in order to meaningfully and sufficiently protect their entitlement.

Relying heavily on Goldberg and Eldridge, courts confronted with this issue have reached a decision regarding the proper timing of the administrative hearing by balancing the competing interests involved in the decertification proceeding. Those interests are the provider's private interest in continued participation in the Medicare and Medicaid programs, and the government's interest in the termination of unqualified providers from the programs. A third factor considered by the courts is the risk of an erroneous deprivation of the provider's interest under the existing procedures.

The provider's private interest is expressed in financial terms. They claim that the denial of continuing Medicare and Medicaid reimbursement will force them out of business. This financial dependence of the nursing home on its Medicare and Medicaid reimbursement is readily admitted by the facilities, and is borne out by statistics.

142. See notes 60-77 and accompanying text supra.

143. Although the timing issue has been in the forefront for the past decade, one can speculate regarding other challenges to the provider appeals process which may arise in the future. The fairness of the substance of the administrative review will likely be questioned, with challenges to the adequacy of evidence such as the survey report, or to the presence of conflicting testimony regarding facility compliance.

144. Green v. Cashman, 605 F.2d 945 (6th Cir. 1979); Town Court Nursing Center, Inc. v. Beal, 586 F.2d 266 (3d Cir. 1978); Hathaway v. Mathews, 546 F.2d 230 (7th Cir. 1976); Case v. Weinberger, 523 F.2d 602 (2d Cir. 1975); Schwartzberg v. Califano, 453 F. Supp. 1042 (S.D. N.Y. 1978); Washington Nursing Center v. Quern, 442 F. Supp. 23 (S.D. Ill. 1977).

145. This balancing test is basically that articulated by the Supreme Court in Mathews v. Eldridge, 424 U.S. 319 (1976).

146. See, e.g., Case v. Weinberger, 523 F.2d at 607.

147. For example, in Hathaway v. Mathews, 546 F.2d at 230, all of the residents of the facility were Medicaid recipients. In Paramount Convalescent Center, Inc. v. Department of Health Care
The government interests involved in a nursing home decertification action are the protection of the residents, and the administrative and financial burdens resulting from a requirement of a pretermination administrative hearing. When the alleged violations of the facility place the health, safety or lives of the residents in jeopardy, the courts readily hold that the government has a strong interest in protecting the residents' lives. This interest is rooted in the Medicare and Medicaid statutes. The courts note that the residents are the intended beneficiaries of the two programs, as the foremost legislative intent of Congress was the provision of medical care to the aged and the needy.

The second consideration in assessing the government's interest in the post-termination hearing is the financial and administrative burden involved in continued funding of a nursing home pending a final adjudication of the decertification challenge. The proceedings before an administrative law judge, the Appeals Council, the federal district court, and finally, the appellate courts can take months, if not years. Continued reimbursement to a provider HHS believes to be unqualified to care for its elderly residents would entail substantial sums considering the amounts already being spent to fund nursing home care by the federal and state governments.

The final factor considered is the risk of erroneous termination of the provider's participation in the programs under existing procedures. This requires an examination of the accuracy of the decisionmaking process itself, and of opportunities that a provider may have to correct any errors that have been made in that process. If the initial decertification determination is based upon an annual survey, that report contains defined criteria for evaluation. The provider has an opportunity to respond in writing to the findings of the survey team; and may submit additional evidence after notice of deficiency is given. The evidentiary basis of the recommendation of the survey team is fully disclosed to the provider. In some cases, providers are given the opportunity to meet informally with HHS or the state Medicaid agency before the final decertification decision is made. Many providers have also had an opportunity, even before the formal decertification procedure has begun, to submit a plan of correction of existing violations and execute a conditional short term provider agreement.

Within the courts' balancing of the interests at stake, there are some factors that carry greater weight. When the facility has engaged in informal Services, 125 Cal. Rptr. 265, 271 n.6, 542 P.2d 1, 7 n.6 (1975), the facility candidly admitted that it was unable to function with private patients alone. According to amicus curiae, the California Association of Health Facilities, the overwhelming majority of nursing homes were in the same position. See note 31 and text accompanying notes 28-35 supra.

148. See, e.g., Case v. Weinberger, 523 F.2d at 607; Town Court Nursing Center, Inc. v. Beal, 568 F.2d at 278; Schwartzberg v. Califano, 453 F. Supp. at 1046.

149. Case v. Weinberger, 523 F.2d at 607; Town Court Nursing Center, Inc. v. Beal, 586 F.2d at 277. But see text accompanying notes 180-97 infra regarding the legislative intent behind the Medicare and Medicaid programs.

150. Town Court Nursing Center, Inc. v. Beal, 586 F.2d at 278.

151. Id. at 277-78.

pretermination procedures with the Medicare or Medicaid agency, such as meetings and negotiations, the risk that an error may have been made before the implementation of the decertification decision is greatly reduced. The provider will have had an opportunity to examine the survey report and make needed corrections. In some situations, the facility may even have admitted the charged violations. All of these communications lessen the weight the court need give to the risk of an erroneous decertification by post-termination administrative hearings.

The factor weighing most heavily in the government's interest in the prompt termination of payments is the existence of conditions in the nursing home threatening the lives and safety of the residents. Given an emergency situation and an individual provider interest diminished by previous opportunities to dispute agency findings, judges have recognized a need for summary government action.

The provider's interest in continued participation in the Medicare and Medicaid programs has consistently been given less weight than that of the government by courts facing this issue. Commentators on that individual interest have noted that the provider is a corporation claiming financial hardship, not an individual deprived of all sources of income; and that the provider's "need" for patients, and the reimbursement they bring, has nothing to do with the statutory benefits structure. Indeed, the Second Circuit Court of Appeals in *Case v. Weinberger* held that "[t]he facility's need is incidental. That a particular nursing facility cannot survive without Medicaid participation was certainly not Congress' foremost consideration in its creation of the Medicaid program."

*Case* involved a facility that had had numerous informal pretermination meetings with HHS. Its violations were of the Life Safety Code, HHS' fire prevention regulations. In the view of HHS, the nursing home's noncompliance threatened the lives and safety of the residents. Giving strong weight to the emergency situation and the minimal chance of an erroneous decision, the court held that a post-termination full administrative hearing was sufficient to protect the interest of the provider. *Schwartzberg v. Califano*, and *Town Court Nursing Center, Inc. v. Beal*, 586 F.2d 266 (3d Cir. 1978); *Case v. Weinberger*, 523 F.2d 602 (2d Cir. 1975); *Schwartzberg v. Califano*, 453 F. Supp. 1042 (S.D. N.Y. 1978).

158. *Case v. Weinberger*, 523 F.2d at 607.
159. 523 F.2d 602 (2d Cir. 1975).
160. *Id.* at 607. Only the Seventh Circuit Court of Appeals has given great weight to the individual interest deprived by the termination of government payments. That is because the court in *Hathaway v. Mathews*, 546 F.2d at 230-31, believed the individual interest at stake was not only that of the provider, but also that of the residents faced with transfer to a different facility.
Court Nursing Center, Inc. v. Beal\textsuperscript{163} dealt similarly with the fact situations that paralleled Case, holding that under these circumstances a post-termination hearing sufficiently protected the nursing homes' interest in continued participation in the Medicare and Medicaid programs.\textsuperscript{164}

Hathaway v. Mathews\textsuperscript{165} stands alone to date as the only federal case finding that a pretermination administrative hearing was necessary to protect private interests in Medicare and Medicaid participation. The decision was based, however, on a relatively unique fact situation. Unlike Case, Schwartzberg, and Town Court, the provider in Hathaway had no opportunity for informal meetings of negotiations with HHS. It had merely received a letter notifying it of its noncompliance.\textsuperscript{166} Another unusual feature of the case was the position of the state Medicaid agency, which contended that the facility was in compliance with the regulations governing intermediate care facilities.\textsuperscript{167} The lack of agreement between the state and federal government agencies indicated genuine questions as to whether any violations constituting a threat to residents' lives existed.

The court's conclusion relied heavily upon the strong possibility of error and uncertainty in the federal government's initial decertification decision and the lack of any emergency situation. It agreed with the Second Circuit's holding in Case that had there been an emergency situation, a post-termination hearing would have been sufficient.\textsuperscript{168}

This examination of the traditional analysis of provider entitlement claims leaves two conclusions. There is a general consensus among the federal courts that nursing home owners do have an interest in continued participation in the Medicare and Medicaid programs,\textsuperscript{169} and that where the lives or safety of the residents are threatened, that interest is sufficiently protected by a post-termination evidentiary hearing.\textsuperscript{170}

Nevertheless, these conclusions leave several questions unanswered. Is an

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  \item \textsuperscript{162} 453 F. Supp. 1042 (S.D.N.Y. 1978);
  \item \textsuperscript{163} 586 F.2d 266 (3d Cir. 1978).
  \item \textsuperscript{164} In another case growing out of the Town Court decertification proceedings, the Supreme Court also noted the Third Circuit's holding regarding the provider entitlement issue. O'Bannon v. Town Court Nursing Center, 447 U.S. 773, 778 n.6 (1980).
  \item \textsuperscript{165} 546 F.2d 227 (7th Cir. 1976).
  \item \textsuperscript{166} Id. at 232.
  \item \textsuperscript{167} Id. at 230.
  \item \textsuperscript{168} Hathaway was decided in 1976. Given the coming period of fiscal conservatism, one can only speculate as to whether that decision would be repeated if heard again in 1980. Town Court, a 1978 decision recently noted in a related Supreme Court decision, made specific mention of the strong public interest in preserving scarce financial and administrative resources, and the high cost of providing pretermination hearings. Town Court Nursing Center, Inc. v. Beal, 586 F.2d at 278, cited in O'Bannon v. Town Court Nursing Center, Inc., 447 U.S. at 773 n.6.
  \item \textsuperscript{169} See text accompanying notes 124-141 supra.
  \item \textsuperscript{170} See notes 142-166 and accompanying text supra. At first reading, the "life and safety threatening" language would seem to substantially limit those situations in which a post-termination hearing would sufficiently protect provider interests. But, as the cases bear out, it is generally only those facilities with emergency situations which the state or federal government will attempt to decertify. This is due to several factors. Chief among them are the great need for certified nursing home beds, the harsh financial results for the decertified provider, and the difficulty of proof in a decertification action.
\end{itemize}
entitlement analysis appropriate in the nursing home decertification situation? Is the provider really an unintended beneficiary of the Medicare and Medicaid programs? Is the government's interest in protecting the lives and safety of nursing home residents best served by decertification? These, and other issues presented by the court's standard analysis of nursing home decertification questions, will be addressed next.

IV. THE ENTITLEMENT ANALYSIS IN NURSING HOME DECERTIFICATION: DOES IT WORK?

A. The First Step of the Entitlement Analysis: Factors Not Considered By Courts

When faced with a nursing home's challenge to the Medicare/Medicaid decertification process, courts have consistently applied the entitlement analysis to determine the proper amount of protection owed the nursing home. This analysis looks to the provider within the programs. It examines the statutory, regulatory and contractual relationships between government and nursing home. The legal result is generally a determination that the facility has a property interest in its continued participation in the programs that cannot be terminated without a hearing. The practical result is generally the termination of Medicare and Medicaid reimbursement to the facility pending an evidentiary hearing on the subject. The residents within the facility are consequently transferred to another qualified nursing home; yet the transfer may result in increased morbidity and mortality among them. Nursing home residents often form strong psychological bonds with their environment. A sudden move to another facility can traumatize the resident, causing sickness or death.

Furthermore, the number of qualified beds available in the state is often insufficient to house those residents being transferred, and those beds that are available may be hundreds of miles from residents' family and friends. Unlike the situation with hospitals, the demand for nursing home care constantly exceeds the supply of beds. This is for several reasons. States, in enacting their Medicaid programs, may establish eligibility standards that leave it with more eligible persons than its nursing home bed supply can support. The Certificate of Need, enacted to prevent overutilization by limiting nursing home and hospital expansion and construction, maintains a set level of beds to meet what the state determines the need should be. And finally, increased longevity due to improved treatment of many acute diseases, has resulted in a growing population of older individuals with chronic diseases and conditions.

171. See text accompanying notes 124-170 supra.
who cannot be cared for by families at home. Ultimately, the decertification of a nursing home leaves the publicly supported health care system with one less facility to meet the ever-increasing demand for long term care, and, ironically, the attempt to maintain the quality of the existing facilities may result in the death or disability of some member of the class such efforts are intended to protect.

These human factors are as much a part of a nursing home decertification as a provider's alleged breach of its statutory or contractual relationship with the government. A legal analysis that considers only the provider and government directly interested in the nursing home's decertification seems decidedly narrow. Yet, this is precisely the legal effect of the entitlement analysis traditionally used in the case law.

There are also several aspects of Medicare and Medicaid that set them apart from other government programs providing benefits or services to individuals. The Medicare and Medicaid programs directly involve three parties, government, provider and recipient of services, whereas other government programs essentially involve only two, government and recipient. The traditional entitlement analysis is more easily applied in the two party situation, as each of the parties' interests is more clearly defined. However, when the entitlement analysis is applied in the Medicare and Medicaid nursing home decertification context, in which the interests of three parties will be effected, difficulties arise. A doctrine whose analysis has been limited to the consideration of the relationship between only two parties may be wholly inadequate in a context requiring the determination of the interests of three parties in an entitlement program. When a nursing home is being decertified, all parties in fact have a large stake in the result.

Resolution of this question of interests in the federal health care programs should begin with an examination of congressional intent at the time of their enactment. Title XIX of the Social Security Act, the statutory authorization for the Medicaid program, authorizes appropriations to the states for the purpose of enabling them to furnish medical and rehabilitative services to families with dependent children and to aged, blind or disabled individuals whose income and resources are insufficient to meet the costs of necessary medical services. The issue of the residents' interest in a nursing home's decertification was decided by the Supreme Court in O'Bannon v. Town Court Nursing Center, 447 U.S. 773 (1980). The Court considered the issue to be whether a patient has an interest in receiving care in a particular facility that entitles him/her to a hearing before the government can decertify that facility. The Court held that the decertification of a nursing home has an impact on the residents which is only indirect and incidental, and that the due process clause does not protect such indirect interests. Only the government and the provider were parties with a direct interest in the facility's decertification.

175. The issue of the residents' interest in a nursing home's decertification was decided by the Supreme Court in O'Bannon v. Town Court Nursing Center, 447 U.S. 773 (1980). The Court considered the issue to be whether a patient has an interest in receiving care in a particular facility that entitles him/her to a hearing before the government can decertify that facility. The Court held that the decertification of a nursing home has an impact on the residents which is only indirect and incidental, and that the due process clause does not protect such indirect interests. Only the government and the provider were parties with a direct interest in the facility's decertification.


wage earners throughout the country.\textsuperscript{178} A senate report on the legislation that was to become Medicare and Medicaid clearly stated that an overall purpose of the bill was to provide a coordinated approach for health insurance and medical care for beneficiaries under the Social Security Act, and to make medical services for the needy more generally available.\textsuperscript{179} The recipient of medical services under either of these programs was intended to be the principal beneficiary in the program.\textsuperscript{180}

Yet the Medicare and Medicaid programs were also enacted with the intention that the private health care system provide the needed services. The concept of nationalized health insurance with publicly-owned and controlled health care facilities was not politically feasible in 1965. The sentiments of a majority of Congress clearly ran against the idea and supported instead a major role for the private health care industry in a system of governmental reimbursement for the provision of medical services for certain categories of beneficiaries.

There were also several major forces acting upon Congress in its attempt to establish health care reform measures in 1965, not the least of which were representatives of the health care establishment such as Blue Cross of America, the American Medical Association, the American Hospital Association,\textsuperscript{181} and the American Nursing Home Association. The provider representatives' great objection to the Medicare portion of the 1965 legislation was its insurance concept of supplying health care to all persons over sixty-five years old without regard to financial need.\textsuperscript{182} This program, they believed, was too close to a nationalized health insurance concept, which could potentially disrupt the private health care system. The American Hospital Association repeatedly threatened Congress with a boycott by the core providers of services under Medicare—the hospitals, if there was any federal interference in hospital operations.\textsuperscript{183} As a result, Medicare was conceived as a federally funded hospital insurance program, which essentially mimicked the private health insurance industry in terms of organization and administration.\textsuperscript{184} The system diverged from existing private health insurance programs only in that the source of payment would be different. Participation in that portion of Medicare which covered physician's services was optional and required pay-


\textsuperscript{180} This interest was clarified in O'Bannon v. Town Court Nursing Center, 447 U.S. 773 (1980), where the Supreme Court stated that the government cannot withdraw patients' benefits without notice and a hearing.

\textsuperscript{181} S. LAW, BLUE CROSS: WHAT WENT WRONG 32 (1977).

\textsuperscript{182} Hearings on Medical Care for the Aged: Hearings on H.R. 3920 Before the House Comm. on Ways and Means, 88th Cong., 2d Sess. 1863 (1964).

\textsuperscript{183} A witness for the AHA at hearings on Medicare explained: "We believe that a free hospital system should be afforded the right to decide upon the administration of any program through which they elect to provide their services." LAW, supra note 181, at 38.

\textsuperscript{184} R. STEVENS, WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID 50 (1974).
ment of a monthly premium. The doctors and hospitals would be reimbursed according to their reasonable charges, and the patient could be charged more than Medicare would reimburse. The law specifically stated that the federal government would not supervise or control the practice of medicine, or the provision of medical services in health care facilities. Essentially, the broad assumption was that the Medicare program would be quietly absorbed into the private "mainstream" system.

The Medicaid program was more a form of public assistance than health insurance. The provisions of the 1965 legislation that became Medicaid were strengthening an already existing program of medical assistance to the needy aged. They were far less controversial than the Medicare provisions because Medicaid was still based on a financial means test. The program was designed along the lines of existing welfare programs, appropriating funds to the state to distribute according to federal and state guidelines. The plan differed from welfare, however, in incorporating the vendor payment system. The system, rather than allocating money for the purchase of health care directly to program recipients, reimbursed providers for medical services given recipients. The American Nursing Home Association had endorsed the Kerr-Mills legislation, a forerunner to Medicaid, and in 1965 urged a strengthening of that legislation rather than the enactment of Medicare. In 1964, testifying on an earlier version of the Medicare legislation that failed to pass, the Association articulated its position on reimbursement for nursing home care. It contended that only with increased payments could nursing home care improve; and that where reimbursement levels were highest, the availability of nursing home beds was greatest. The legislation that became Medicaid did indeed strengthen and increase payment to proprietary nursing homes. Here again, the desire to give the private health care industry a major role in the government program was revealed.

The 1972 amendments to the Medicare and Medicaid programs re-

187. R. STEVENS, supra note 184, at 50.
190. One of the original reasons for payment to vendors rather than beneficiaries was a fear by state welfare administrative agencies that direct beneficiary payments would result in beneficiaries absconding with the money, and beneficiaries obtaining inadequate care with the money. STEVENS, supra note 184, at 22-23.
192. Id.
193. Id.
194. At least one commentator has stated that the price of giving the private health care system a major role in Medicaid has been the extremely rapid rise in health care costs, both to the government and private individuals. R. STEVENS, supra note 184, at 202.
NURSING HOME DEcertification

relected a shift in congressional thinking from the provision of comprehensive medical services to concern with the rapidly rising costs of the programs. Although not altering the basic structure of the private health care industry's role in Medicare and Medicaid, conditions were placed on its participation. Among them were the required establishment of utilization review plans to discourage prolonged hospital and nursing home stays, and compliance with certificate of need for major capital expenditures.

While a detailed list of all the Medicare and Medicaid provisions reflecting the needs of providers has not been presented, it is certain that those needs have been a part of the explicit and implicit objectives of this legislation as passed, and as amended. Medicare and Medicaid are diverse and complicated programs that serve a number of objectives. Although the statute and legislative history have the express purpose of providing medical services to the aged and needy, there is also an intention to preserve the private health care system and, perhaps, an unstated intention to forestall any system of nationalized health insurance.

More importantly, for some kinds of providers, Congress set up a system that became their lifeblood. The support of the long term care concept as a less expensive alternative to hospital care stimulated construction in the field almost unheard of in the health care industry. The programs provided funds for growth of the nursing home industry without which such growth could not have taken place. The fact that Medicare and Medicaid finance fifty-one percent of nursing home care in the United States attests to the critical role played by those programs in the financial survival of the industry.

Given federal programs with such diverse objectives, situations will inevitably arise when the interests of the elderly recipients and nursing homes will conflict. One such situation is a nursing home decertification. At first glance, one might assert that the interests of the two parties are the same; both want to continue to receive or provide care in the same facility. But that is when the similarity ends. The conflict of interests becomes evident upon examining the motivation behind these positions.

The interest of the program recipient is that of living in a basically safe facility that provides adequate health care, without the threat of an unsafe transfer. The facility, on the other hand, is concerned with retaining its status as a Medicare or Medicaid provider to sustain its steady income that allow for an appropriate amount of return. Any institution will be tempted to cut back on essential services since what is not spent becomes profit; or to incur

196. 42 U.S.C. § 1396b(g) (1976).
197. Id. §§ 1301-10.
201. R. Stevens, supra note 184, at 188.
202. This is possible when Medicaid reimburses the nursing home on a flat fee basis set by the state. F. Moss & V. Halamandaris, Too Old, Too Sick, Too Bad: Nursing Homes in America 141 (1977).
higher amounts of reimbursable costs, rather than concentrating on patient care. Critics have charged that the residents' interest in the provision of adequate health care with limited reimbursed funds, cannot be reconciled with the provider's interest in maximizing its income. The conflict is aggravated when proprietary chain ownership is involved. In chain operations, investors expect yearly growth and return; indeed, the basis for chain operations is greater profits by reason of lower unit costs.

The opportunity for the nursing home to derive substantial economic benefit from participation in the Medicare and Medicaid programs does not come without responsibility. This interweaving of the provider's economic interests with its obligations to its residents is another unique feature of the Medicare and Medicaid programs. The legislative history of Medicare and Medicaid indicates that accompanying the federal government's agreement not to control the provision of medical services, was the provider's responsibility for the care of the recipients of the services. The existence of this obligation for care is implicit in the structure of nursing home participation in the Medicare and Medicaid programs. It commits itself to comply with minimum standards of care and operation set out in the conditions of participation and the state licensing requirements. The federal government, when awarding the private nursing home the benefits of program participation, is also charging it with the responsibilities of program participation.

When faced by a provider challenge to the decertification process, the first step of the court's analysis is framed by the question: does the nursing home have a protected interest in its participation in the Medicare and Medicaid programs? By its very nature this first step in the entitlement analysis restricts the court. The court must look only to the nursing home and the program, and their statutory, regulatory and contractual relationship. Yet, the Medicare and Medicaid programs are unique in their three party system, dual objectives, and special role given the nursing home. They require an analysis that considers these features at the outset. It must look not only to the rights created for the nursing home by the words of the statute or regulations, but also the home's responsibilities created by the statute and regulations, and the interests of the residents.

B. The Second Step of the Entitlement Analysis: Opportunity for Limited Consideration of Medicare and Medicaid's Unique Features

When a court finds that a provider has a protected interest in program participation, it must then determine the procedure adequate to protect that interest. This inquiry is not a simple one. If the judiciary is to continue em-
ploying the traditional entitlement analysis to questions of nursing home interests in the Medicare and Medicaid programs, then in determining adequacy of procedure, it must struggle with all of the questions raised in the first part of this discussion.

The Mathews v. Eldridge balancing test provides some opportunity to consider and recognize the interests of the residents and the responsibilities of the nursing home. When Congress passed the Medicare and Medicaid legislation, the federal and state governments undertook the obligation of overseeing the provision of adequate quality health care to the needy elderly. The safety and welfare of residents in publicly supported nursing homes thus became a part of the government’s interest in a decertification situation. When the alleged violations of the facility place the health, safety or lives of the residents in jeopardy, the courts have been quick to note that the government has a strong interest in protecting residents’ lives, and that summary procedures are justified. Yet all of the residents’ interests are not adequately represented. As well as being concerned with the receipt of sufficient care, the residents are interested in avoiding transfer to another facility. By limiting resident interests considered to those the government can assert as its own, the government precludes recognition of concerns which are uniquely those of the residents.

Armed with the limited consideration that can be given to legislative intent and resident safety in the second step of the analysis, courts have tipped the balance in favor of the government’s interest in ending an emergency situation. They have asserted that the residents are the real beneficiaries of the Medicare and Medicaid programs, that the health and safety of the residents is much more important than the financial survival of the facility, and that the protected interest the provider does have is merely a statutory business relationship. Ironcally, what was important enough to constitute an interest protected by the due process clause in the first step of an analysis, becomes a mere business relationship in the second step of that analysis. This result illustrates the constraints put upon the judiciary by the first step of the traditional entitlement analysis. In a vacuum, without consideration of other relevant factors, the nursing home seems to have an important protected interest in its expectation of continued participation in the Medicare and Medicaid programs. Yet when the courts reach the second step of the analysis, and must decide how that expectation should be protected, its significance lessens con-

208. See notes 142-68 and accompanying text supra.
209. See notes 148-49 and accompanying text supra.
210. Transfer from a facility can be avoided by the appointment of a medical receiver to operate the facility and bring it back into compliance with applicable standards. The facility can then be returned to the control of its original owners, or sold to another. See Butler, Assuring the Quality of Care and Life in Nursing Homes: The Dilemma of Enforcement, 57 N.C.L. Rev. 1317, 1352 (1979).
211. See notes 155-60 supra.
212. Town Court Nursing Center, Inc., v. Beal, 586 F.2d 266, 277 (3d Cir. 1978); Case v. Weinberger, 523 F.2d 602, 607 (2d Cir. 1975).
considerably in light of the limited recognition that the judges can make of the residents' interests and the nursing home's responsibilities.

C. Modification of the Traditional Entitlement Analysis to Meet the Unique Features of the Medicare and Medicaid Programs

The unique three-party structure of the Medicare and Medicaid programs must be recognized in the traditional entitlement analysis if it is to adequately deal with the realities of a nursing home decertification. Three sets of interests are at stake in any nursing home decertification: the facility's, the government's, and the residents'. The physical well-being of the residents is as much a part of that decertification as the financial well-being of the facility. Assuring consideration of the third party, the resident, in an essentially two-party analysis can be achieved through either of two mechanisms.

The first of these mechanisms requires the nursing home to show that it is meeting its statutory obligation to its residents. The nursing home's obligation to provide adequate health care services to needy program recipients is as much a part of the statutory relationship between the provider and the government as its financial expectation of continued participation in the programs.

The legislative history of the 1965 health care reform measures indicates that Congress intended to integrate the private health care system into its provision of publicly-funded health care services. Yet, the express purpose of the Medicare and Medicaid statutes was to provide health care services to certain categories of needy and deserving individuals. The private health-care network was to be the government's conduit for delivery of the actual health care services. Any judicial analysis of the relation between the government and the nursing home must include recognition of this statutory commingling of the benefits of incorporation into the programs' structure and the obligation to provide health care services to program beneficiaries.

The most likely result of this recognition of the nursing home's obligations to its residents is a stronger consideration of the residents' interests at the second stage of the entitlement analysis. Examination of the facility's showing regarding its compliance with its responsibilities to the residents will allow the court to evaluate the health and conditions of the residents. The results of that examination will then figure prominently in the factors to be balanced by the trial judge when determining the procedures appropriate to protect the nursing home's entitlement. If the effect of the provider's alleged noncompliance on the residents does not present an immediate threat to the health and safety of the residents, and the potential harmful effects of resident

213. See text accompanying notes 181-97 supra.
214. See text accompanying notes 177-80 supra.
215. The most extreme result would be a finding that the nursing home's statutory obligation to its residents is the most important aspect of its relationship with the government. The facility's statutory business relationship with the government would be all but obviated, resulting in a finding of no entitlement. This result is not a desirable one. Such a finding would leave the post-termination hearing intact when a hearing at that time would not meet the needs of the residents or the facility.
transfer and limited bed supplies are before the court, a pretermination hearing may well be required. If, on the other hand, there is a real threat to the residents' health and safety, immediate termination of facility reimbursement and a post-termination hearing are in order.

The second mechanism for assuring consideration of the residents' interests in a nursing home's decertification is a broadening of the scope of the government's interest. The required showing of interest should be expanded to encompass not only consideration of the immediacy of the danger to the residents' health and safety caused by the alleged noncompliance, but also the severe consequences of transfer on the residents' physical and psychological well-being. Where the government cannot show that the threat of transfer trauma and bed shortages will not outweigh the immediate dangers presented by the noncompliance there is no emergency situation justifying summary government procedures and therefore, a pretermination hearing is in order.

Although the residents may not have the right to direct involvement in the hearing on the merits of the decertification, consideration of their interests must not be precluded. In O'Bannon v. Town Court Nursing Center, the Supreme Court noted that both HHS and the state medicaid agency would benefit from input by the residents regarding facility compliance, citing regulations which require patient interviews under some circumstances as part of the periodic review of facility compliance. That requirement should be broadened to include patient input where the initial decertification determination is being made. In addition, during the hearing on the merits the government should be bound to show that the dangers presented by transfer to another facility and bed shortages will not outweigh those dangers currently faced by residents because of alleged facility noncompliance.

Any judicial modification of the traditional entitlement analysis to better meet the realities of Medicare and Medicaid nursing home decertifications would be a welcome and needed change. The recognition of the nursing home's obligations to its residents, and the broadening of the scope of the government's interest can be a beneficial part of that modification.

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216. See text accompanying note 175 supra.
217. 447 U.S. at 782 n.15.