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A response to *Termination of Skilled Nursing Facility Medicaid Provider Agreements: Procedural Due Process Requirements*

To the Editor:

I would like to comment on the Article, *Termination of Skilled Nursing Facility Medicaid Provider Agreements: Procedural Due Process Requirements*, by Nancy Elizabeth Jones, which appeared in the winter 1981 edition of the *Journal*. These comments are based upon my experience in the Massachusetts State Department of Public Health, where I was responsible for nursing home licensing certification, and earlier in the Massachusetts Department of Public Welfare, where I supervised the Medicaid nursing home program.

The Article provides a full discussion of the trend in case law concerning the protection of publicly conferred benefits, and although I generally sympathize with the tenor of the Article concerning the need for hearings prior to government action terminating a benefit that is tantamount to the "New Property" discussed in Charles Reich's Yale Law Review article of the same name, I feel that the author has somewhat slanted her discussion of the precedents to prove her case. I will refer to some of the inconsistencies I found, but first I would like to discuss some problems I had with its conclusion.

While a pretermination hearing is often desirable in decertifying a Medicaid nursing home, I would hesitate to give a requirement for such a hearing the force of law. The author assumes away problems in protecting patients by saying that Medicaid status can always be revoked in an emergency. She does little to define the conditions that constitute an emergency. In fact, this is the most difficult part of program administration. Emergency conditions in a nursing home are rarely clear-cut. There is much literature on the subject of transfer trauma, but very little research on the effect on morbidity, mortality, and the quality of life of leaving patients in a substandard nursing home for an extended period of time. It may be hard to

characterize roaches in the food, incompetent staff, or errors in medication as an emergency. Nevertheless, these things could kill a nursing home patient just as surely as a fire or boiler explosion. For these reasons, a state agency should have the flexibility to act and hold a decertification hearing after the fact, although the agency would often be well-advised to allow the hearing beforehand. The author makes a telling point that the patients have an interest in avoiding unnecessary transfer, but she overlooks the fact that the patients are in a "captive" state and are rarely in a position to recognize deficiencies in the home and the threats to their own well-being that may follow from such deficiencies. I think the article would have been well-served by a much more detailed discussion of the conditions under which a state agency might be justified in terminating a provider agreement without prior hearing.

I believe that the majority of the courts have acted wisely in not compelling a pretermination hearing. The balancing of interests is much different than that in the case of *Goldberg v. Kelly*, where the state has little to lose and the welfare beneficiary can lose everything. The ordinary nursing home termination occurs when the state really is acting in the best interests of most nursing home patients. Where the decertification is over technical matters not directly affecting patient care (such as fraud) a state agency is well-advised to hold a hearing prior to termination.

My feeling that a pretermination hearing is not compelled by the circumstances or precedents is reinforced by the long iterative process of inspection, notification, and review that occurs before a decertification notice is ever sent. The author argues that this shows that time can be allowed for a pretermination hearing. I would assure her that such hearings often take several months to arrange, hold, and conclude, and that the harm that can come to a patient in the meantime is great. I also question whether a hearing officer, as good as he or she may be in evaluating conformance of the evidence to the regulatory requirements, is in any position to weigh the danger to the health of the patient in a particular facility against the facility's interest in remaining in the Medicaid program.

Having said all this, I think there is one argument that the author has overlooked that falls in her favor. There is a very valid distinction between Medicaid provider status and the normal position of a government contractor. In fact, any firm or individual meeting specified regulatory standards may participate in the Medicaid program as a provider. The state has no discretion in selecting a particular competing contractor to provide nursing home services.

The following reflect a few specific thoughts on individual items in the Article.

1. I believe the author belabors the economic harm argument excessively; anyone familiar with nursing homes will recognize that the loss of provider status is usually a disaster.

2. In discussing the rights of a patient to pretransfer hearings, I think the author unnecessarily confuses the right to a hearing prior to transfer to a lower level of care with the situation in which patients are transferred for their own good because the facility is inferior. Since the patient being transferred to a lower level of care is being transferred for the economic convenience of the state, the pretransfer hearing can be justified on grounds very similar to *Goldberg v. Kelly*. I would also note that most states readily assume the responsibility for transferring patients out of the decertified nursing home, and therefore the spectre raised by the author of Medicaid patients left in a decertified facility rarely applies.

3. The author indicates that decertified SNFs may have a difficult time qualifying as ICFs; therefore, this is reason to require a pretermination hearing. In my experience, many of the reasons for decertifying marginal SNFs would not have prevented them from participating in the ICF program. Furthermore, many states, notably Massachusetts, have a pass-through provision that enables a facility to downgrade to a lower level of care without a specific Determination of Need. Thus, the danger that a facility may not be able to operate at a lower level of care seems somewhat exaggerated.

4. The author's attempt to argue that reasonable cost reimbursement shows that the government is unwilling or unauthorized to impose business risks upon the nursing home owner seems far-fetched. Even reasonable cost reimbursement does not permit the state to pay for bad management or low occupancy. The fact that reasonable cost is used as a method for determining reimbursement is not a very compelling argument that the state has chosen to insulate nursing home providers from business risks.

The author does mention in the end the possibility for alternative sanctions to bring nursing homes into compliance, and I fully agree with her. She might want to look at our article in the *New England Journal of Medicine*,[2] which outlines a plan to impose fines on nursing homes for the amount of reimbursement associated with noncomplying services. In Massachusetts, we also took the stance that it was entirely within our prerogative to stop patient referrals to a facility that was in trouble. I believe that this approach can be defended on the grounds that when the state is placing a patient in a nursing home, it is doing the patient a service by placing him or her in a nursing home that is known to be good, rather than placing him or her in a facility that the state itself is questioning, and from which the patient may soon be transferred. I don't believe that this was ever litigated, and if it has been, I think that there should be a more thorough discussion. We also took the approach that we had no obligation to grant a provider agreement to a facility that was purchased by an owner currently undergoing sanction procedures for other nursing homes. While I was in fact sued personally on this by Clair M. Fay, the suit never came to trial, and I believe

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2 236 NEW ENGLAND J. MED. 222 (1976).

that this is also a possible means of applying pressure to substandard facilities, particularly those that are in an expanding chain.

Notwithstanding these comments, I found much to commend in Ms. Jones' Article. I appreciated especially the extent and depth of her research, and the detailed consideration she gave to many of the complex problems in this area.

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The author responds:

Dear Mr. Feeley:

Thank you for your thoughtful presentation of the practical and administrative problems surrounding termination of skilled nursing facility Medicaid provider agreements, from the perspective of Medicaid program administrators.

As indicated in both your letter and my Article, the problem of determining when and how to terminate a nursing home from the Medicaid program is not susceptible to an easy solution. Important and conflicting interests of patients, the terminated provider, and the state and federal governments are affected and must be protected to the extent possible during whatever process a state chooses to follow. My Article resolves the question of the timing of a hearing for a terminated provider in favor of providing a hearing before termination of Medicaid reimbursements, and discusses one legal framework supporting this solution. This solution is not the only rational response to the complex issues that arise in the termination situation. As other commentators, as well as myself, have pointed out, measures short of termination seem to provide a better approach to remedying nursing home deficiencies. It does appear, however, that a pretermination hearing is desirable in many termination situations, though not all, as your letter agrees.

While I agree with the point made that the types of emergency situations during which a posttermination hearing would be necessary should be identified and described, a detailed discussion and development of a method to classify types of deficiencies was beyond the scope of the Article. Some such classification of deficiencies, however, appears to exist already in Massachusetts, for example, where the Rate Setting Commission relies on a compliance scoring system developed by the Department of Public Health that provides a basis for calculating Medicaid reimbursement rates. Under this system, a higher rate of payment is authorized for long-term care facilities with a good record of compliance with regulatory require-