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THE NURSING HOME CRISIS: VIEWS FROM A TRUSTEE IN THE NONPROFIT SECTOR

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With a few notable exceptions,¹ most of the public discussion and debate regarding the present status and future prospects of the nursing home industry in the United States has been conducted in rather politicized, adversarial language.² Opinions expressed and policy prescriptions recommended vary greatly depending on the particular, generally self-interested, perspective of whomever is the speaker at the time.³ Sides have been chosen (or assigned), and real or perceived enemies demonized.⁴ Thus, at the outset of my entry into this battleground, it is important to delineate the specific role through which I shall attempt to contribute some reflections about this vital subject.

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1. See, e.g., *IMPROVING THE QUALITY OF LONG-TERM CARE* (Gooloo S. Wunderlich & Peter Kohler eds., 2000).

2. See Eric M. Carlson, *Siege Mentality: How the Defensive Attitude of the Long-Term Care Industry is Perpetuating Poor Care and an Even Poorer Public Image*, 31 *McGEORGE L. REV.* 749 (2000); *Editorial, Nursing Home Challenge*, *ST. PETERSBERG TIMES*, Nov. 5, 2000, at D.

A [Florida] state task force ought to look beyond simplistic approaches to nursing home reform and shape a serious and comprehensive solution, not a lobbyist driven one. Why are so many Florida nursing homes going bankrupt? And what should the state do about it? Those questions—at the heart of the ongoing work of the state's Task Force on the Availability and Affordability of Long-Term Care—are enormously complex, though you would hardly know it from the testimony the panel has received thus far. Last week in Tallahassee, as elsewhere, most witnesses offered up predictably simplistic and polarized views. . .

3. See Lindsay Peterson, *Battle Rages Over Proposal to Overhaul Elderly Care*, *TAMPA TRIB.*, Dec. 16, 2000, available in 2000 WL 24607142 (quoting the reaction of "a Tampa lawyer who has earned millions suing nursing homes" to a proposal to curtail lawsuits against nursing homes: "[t]his is a sellout to the industry. It's intended to harm residents of nursing homes and I will do everything in my power to stop it." (emphasis added)); Connecticut Legal Services, e-mail message celebrating the collapse of Florida nursing home tort reform proposals, sent to ELDERBAR@MAIL.ABANET.ORG (quoting Coalition to Protect America's Elders, in turn quoting plaintiff's attorney Susan Guberman-Garcia (Dec. 20, 2000) ("Litigation is just another form of class struggle.")).

4. See, e.g., Stephen Nohlgren, *Task Force Becomes Nursing Homes' Ally*, *ST. PETERSBURG TIMES*, Dec. 15, 2000, at 1B (describing the "outrage" of plaintiffs' attorneys at a legislatively established task force in Florida for "caving in to the industry").

My contribution to this Symposium issue of the *Journal* is based chiefly on my extensive personal experience as a member (and in one instance past-Chair) of Boards of Trustees for two nonprofit nursing homes, as a member of quality assurance committees at several other nonprofit nursing homes, and as a member (and in a number of cases past-Chair) of institutional ethics committees at a handful of similar facilities. My remarks must be interpreted, of course, as those of one person with firsthand experience in a few specific capacities within a small number of nonprofit nursing homes in one geographical region (Southwestern Ohio). However, my own limited hands-on exposure to the realities of operating a nonprofit nursing home in the U.S. at the beginning of a new millennium are supplemented by extensive professional interest and involvement over more than the past two decades in matters pertaining to both the governmental and private sector aspects of long term care public policy.⁵

The thrust of this article is that most of the factors that have converged in the last few years to create a contemporary nursing home "crisis"⁶ affect individual nonprofit nursing homes as seriously as they impact the proprietary sector of the industry. I argue that the majority of nonprofit nursing homes that are being challenged today to make difficult choices with potentially far-reaching consequences, and to operate radically differently in many respects than they have traditionally functioned, really are benevolent and mission-driven because of their community ownership and the sense of altruistic commitment and responsibility ordinarily present on the part of their governing bodies. I agree with the editorialist who recently responded to a leading plaintiff attorney's boast of being out to "destroy the industry" because "[t]here are no good nursing homes," "[h]e is wrong. There are bad ones. There are also many good and caring homes, particularly the nonprofit ones."⁷

5. See Marshall B. Kapp, *Quality of Care and Quality of Life in Nursing Facilities: What's Regulation Got to Do With It?*, 31 McGEORGE L. REV. 707, 707-08 (2000) [hereinafter *Quality*]; Marshall B. Kapp, 'A Place Like That': *Advance Directives and Nursing Home Admissions*, 4 PSYCHOL. PUB. POL'Y & L. 805, 805-08 (1998) [hereinafter *Place*]. See also generally Marshall B. Kapp, *Taking a Long Term View of Long-Term Care: Rightsizing Terms of the Discussion*, 1 QUINNIPIAC HEALTH L. J. 123 (1997); Marshall B. Kapp, *Increasing Liability Risks Among Nursing Homes: Therapeutic Consequences, Costs, and Alternatives*, 48 J. AM. GERIATRIC SOC'Y 97 (2000).

6. See generally Jane K. Straker et al., *Ohio Nursing Homes: An Industry In Transition*, Scripps Gerontology Center, Miami University (1997) (regarding the challenges faced by nursing homes at this moment).

7. Dudley Clendinen, *The Crisis in Providing Care for the Elderly Ill*, N.Y. TIMES, Sept. 2, 2000, at 18A.

Although this is an especially demanding time to be operating a nursing home, either proprietary or nonprofit, from a broad social policy viewpoint, several aspects of the current "crisis" are positive. The major conundrum is finding effective ways to enhance and exploit those salutary developments without inadvertently mortally wounding or destroying those parts of the traditional institutional long term care system—in this instance, the valuable contributions of nonprofit nursing homes in humanely serving older and disabled persons in need—that ought to be preserved and even bolstered as a matter of the public's welfare.

I. FACTORS CONTRIBUTING TO THE PRESENT CRISIS

A number of sometimes independent and sometimes interrelated factors have converged within the past few years to create an atmosphere within and surrounding the U.S. nursing home industry that may justifiably be characterized as a current "crisis." Perhaps the most powerful of these factors has been the development of tremendous, unprecedented pressures on nursing homes in most parts of the country to aggressively compete for "customers" to fill their (in many cases, recently constructed) beds and thus to maintain their resident censuses. Even for facilities that previously were able to enjoy the economic luxury of maintaining waiting lists for admission, competition comes now not only from other nursing homes, but also from the rapidly exploding assisted living industry,⁸ continuing care retirement communities, and a slew of home and community-based services functioning as preferred alternatives to institutional placement. Most persons want to avoid or at least substantially delay their own institutionalization if at all possible,⁹ and a combination of private and public sector initiatives are proving increasingly successful in helping even very frail and disabled persons to satisfy that objective.¹⁰ "[A]bout a quarter million elderly persons who, based on age and sex, would have been in nursing homes in 1985 were not in nursing homes in 1995. Nursing home residents. . . also looked different in 1995: Re-

8. See generally *Is Assisted Living the Right Choice?* 66 CONSUMER REPORTS, Jan. 2001, at 26; ASSISTED LIVING: CURRENT ISSUES IN FACILITY MANAGEMENT AND RESIDENT CARE (Kevan H. Namazi & Paul K. Chafetz eds., 2000); JEREMY CITRO & SHARON HERMANSON, ASSISTED LIVING IN THE UNITED STATES, AARP PUBLIC POLICY INSTITUTE (Fact Sheet 62R) (1999); JAMES E. ALLEN, ASSISTED LIVING ADMINISTRATION: THE KNOWLEDGE BASE (1999); BENJAMIN W. PEARCE, SENIOR LIVING COMMUNITIES: OPERATIONS, MANAGEMENT AND MARKETING FOR ASSISTED LIVING, CONGREGATE, AND CONTINUING-CARE RETIREMENT COMMUNITIES (1998).

9. See *Place*, *supra* note 5, at 805-06.

10. See Jim DeBrosse & David Gulliver, *Ohio's 'Super Seniors' Aren't Filling Up Nursing Homes*, DAYTON DAILY NEWS, Aug. 30, 2000, at A1.

sidents were older and more severely impaired. . . [by the time they had to be admitted].”¹¹

The states are being especially prodded to develop and support a range of home and community-based alternatives to institutional placement for the disabled, including older disabled individuals,¹² under the mandate of the Supreme Court’s interpretation of the Americans with Disabilities Act¹³ in the *Olmstead* case,¹⁴ as that decision is being vigorously enforced by the federal Health Care Financing Administration (HCFA).¹⁵ According to one author, “whether there will be an increase in home and community-based services and changes in state long-term care systems is not a question. It is a conclusion.”¹⁶ The allure of potential cost savings from the use of home and community-based alternatives to nursing homes also gives the states an incentive to move in that direction.¹⁷

The pharmaceutical industry is beginning to experience notable success in developing drugs that effectively treat some of the symptoms of dementia in certain patients.¹⁸ These successes are also play-

11. Judith Feder et al., *Long-Term Care in the United States: An Overview*, 19 HEALTH AFF. 40, 46 (2000). See also WILLIAM D. SPECTOR & JOHN A. FLEISHMAN ET AL., THE CHARACTERISTICS OF LONG-TERM CARE USERS, AGENCY FOR HEALTH CARE RESEARCH AND QUALITY Pub. No. 00-0049 (Sept. 2000).

12. See SARA ROSENBAUM, AM. ASS’N OF RETIRED PERSONS, *OLMSTEAD V. L.C.: IMPLICATIONS FOR OLDER PERSONS WITH MENTAL AND PHYSICAL DISABILITIES*, PUBLIC POLICY INSTITUTE REPORT #2000-21 (Nov. 2000).

13. 42 U.S.C. § 12101-12213.

14. *Olmstead v. Zimring*, 119 S.Ct. 2176, 2178 (1999). See Bazelon Center for Mental Health Law, *Under Court Order: What the Community Integration Mandate Means for People with Mental Illness* (visited Feb. 7, 2001) <<http://www.webcom.com/bazelon/lcruling.html>>. Nat’l Ass’n of Protection and Advocacy Sys., *Olmstead Progress Report: Disability Advocates Assess State Implementation After One Year* (visited Feb. 7, 2001) <<http://www.protectionandadvocacy.com/progressreportfinal.htm>>. But see Paul S. Applebaum, *Least Restrictive Alternative Revisited: Olmstead’s Uncertain Mandate for Community-Based Care*, 40 PSYCHIATRIC SERV. 1271, 1272 (1999) (expressing doubts about the actual impact the *Olmstead* decision will have).

15. The Department of Health and Human Services has set up a Working Group for ADA/Olmstead, staffed through the Health Care Financing Administration Center for Medicaid and State Operations. Information is available at <<http://www.hcfa.gov/medicaid/olmstead/olmshome>>.

16. LINDA VELGOUSE, AM. ASS’N OF HOMES AND SERVICES FOR THE AGING, THE *OLMSTEAD DECISION: RESPONSES AND IMPACT*, TECHNICAL ASSISTANCE BRIEF 17 (2000).

17. See generally LISA MARIA B. ALECXIH ET AL., ESTIMATED COST SAVINGS FROM THE USE OF HOME AND COMMUNITY-BASED ALTERNATIVES TO NURSING FACILITY CARE IN THREE STATES (1996).

18. See generally Barbara B. Sherwin, *Mild Cognitive Impairment: Potential Pharmacological Treatment Options*, 48 J. AM. GERIATRIC SOC’Y 431 (2000); Richard Mayeux & Mary Sano, *Treatment of Alzheimer’s Disease*, 341 NEW ENG. J. MED. 1670 (1999); Rebecca M. Evans & Martin Farlow, *Drug Therapies for Alzheimer’s Disease*, 6 HOME HEALTH CARE CONSULTANT 11 (May 1999). See also Marshall B. Kapp, *Physicians’ Legal Duties Regarding the Use of Genetic*

ing a role in delaying or avoiding nursing home admission for some persons who only a few short years ago certainly would have required institutionalization sooner.

Another factor contributing to the sense of crisis is a strong perception that the extensive, omnipresent legislative¹⁹ and regulatory environments that have enveloped nursing home practice for more than thirty years have lately, and in the future will increasingly, become even more aggressive,²⁰ focused on punitive enforcement,²¹ and unpredictable.²² "Satisfying the regulators and caring for sicker, less stable patients should make nursing home management even more challenging."²³ Besides their longstanding discomfort about regulatory sanctions being imposed as part of the required licensure and Medicaid survey and certification processes,²⁴ nursing homes now are confronted by the realistic possibility of criminal prosecutions for providing sub-optimal levels of quality of care. Criminal indictments may be initiated by local prosecutors under authority of state elder abuse and neglect statutes²⁵ and/or by federal prosecutors, in collaboration with the Department of Health and Human Services' Office of Inspec-

Tests to Predict and Diagnose Alzheimer's Disease, 21 J. LEGAL MED. 445, 459-60 (2000) and sources cited therein.

19. See, e.g., Nursing Home Staffing Improvement Act of 2000, H.R. 5646, 106th Cong. (2000); Nursing Staff Accountability and Training Improvement Act of 2000, H.R. 4614, 106th Cong. (2000); The Nursing Home Quality Protection Act, H.R. 4949, 106th Cong. (2000).

20. See Elaine C. Zacharakis, *Increased Federal Enforcement of Nursing Homes Expected*, 11 HEALTH LAWYER 12, n.1- n.3 (1999).

21. See Robert Pear, *U.S. Toughens Enforcement of Nursing Home Standards*, N.Y. TIMES, Dec. 4, 2000, at 21; see also generally U.S. GEN. ACCOUNTING OFFICE, NURSING HOMES: SUCCESS OF QUALITY INITIATIVES REQUIRES SUSTAINED FEDERAL AND STATE COMMITMENT, GAO/T-HEHS-00-209 (2000); U.S. GEN. ACCOUNTING OFFICE, NURSING HOMES: SUSTAINED EFFORTS ARE ESSENTIAL TO REALIZE POTENTIAL OF THE QUALITY INITIATIVES, GAO/HEHS-00-197 (2000). For an advocacy agency's complaint that the 1999 revisions to the Medicaid State Operations Manual (SOM), available at <<http://www.hcfa.gov/pubforms/progman>>, do not go far enough in the punitive direction, see Toby S. Edelman, *The New Enforcement System*, 2000 NURSING HOME L. LETTER 17 (2000).

22. See, e.g., Lawrence J. Drexler, *Letter, Guidance to Surveyors—Long-Term Care Facilities: Angry Comments from One Down in the Trenches*, 48 J. AM. GERIATRIC SOC'Y 103, 104 (2000) (protesting "the government bureaucrats who will be sending mindless government robots out to survey").

23. David R. Graber & David M. Ward, *Nursing Home Organization and Operations*, in HANDBOOK OF HEALTH ADMINISTRATION AND POLICY 339, 351 (Anne O. Kilpatrick & James A. Johnson eds. 1999).

24. See JAMES E. ALLEN, NURSING HOME FEDERAL REQUIREMENTS AND GUIDELINES TO SURVEYORS (4th ed. 1999).

25. See generally Andrew Julien, *Arrests Rattle Care Industry*, HARTFORD COURANT, Oct. 7, 2000, at B1.

tor General,²⁶ based on the theory that a nursing home that bills the Medicare or Medicaid programs for payments when the care provided was inadequate has attempted to defraud the government and hence violated the False Claims Act.²⁷

Until relatively recently, private civil lawsuits brought by or on behalf of individual residents against specific facilities and/or their staff members alleging professional malpractice were rare enough to be not much of a factor contributing to nursing homes' anxieties.²⁸ For a variety of reasons, this part of the picture has changed dramatically lately. As the plaintiffs' personal injury bar has discovered this potentially lucrative arena²⁹ and closely joined forces with nursing home residents' advocates, consumer groups,³⁰ and regulators, the number of civil malpractice as well as private False Claims Act *qui tam*³¹ actions being filed against nursing homes has escalated tremen-

26. The Department of Health and Human Services Office of Inspector General has announced its intention to devote an increasingly substantial amount of attention to assessing the quality of care in nursing homes, a development that adds to the sense of besiegement from without felt by the nursing home industry. See *Fiscal Year 2001 President's Budget Request for the Health Care Financing Administration: Hearing Before the House Subcommittee on Labor-HHS-Education Appropriations* (statement of Nancy-Ann DeParle, Administrator, HCFA).

27. 31 U.S.C. §§ 3729-3732. See John R. Munich & Elizabeth W. Lane, *When Neglect Becomes Fraud: Quality of Care and False Claims*, 43 ST. LOUIS U. L.J. 27, 35 (1999); Angela S. Quin, *Imposing Federal Criminal Liability on Nursing Homes: A Way of Detering Inadequate Health Care and Improving the Quality of Care Delivered?*, 43 ST. LOUIS U. L.J. 653, 668 (1999); David R. Hoffman, *The Role of the Federal Government in Ensuring Quality of Care in Long-Term Care Facilities*, 6 ANNALS HEALTH L. 147, 147-48 (1997); *United States v. GMS Management-Tucker*, No. 96-1271 (E.D. Pa., Feb. 21, 1996) (\$600,000 settlement). For a criticism of the government's use of the False Claims Act to try to enforce quality standards in nursing homes, see Michael M. Mustokoff et al., *The Government's Use of the Civil False Claims Act to Enforce Standards of Quality of Care: Ingenuity or the Heavy Hand of the 800-Pound Gorilla*, 6 ANNALS HEALTH L. 137, 141-42 (1997).

28. See Marshall B. Kapp & Ronald Markert, *Legal Risk Management Programs in Nursing Homes: Who Has Them and Do They Work?*, 35 HOSP. & HEALTH SERVICES ADMIN. 603, 604 (1990); Marshall B. Kapp, *A Survey of State Medicaid Policies on Nursing Home Legal Risk Management Programs*, 10 PERSPECTIVES HEALTHCARE RISK MGT. 8, 8 (1990).

29. See, e.g., NURSING HOME LITIGATION: INVESTIGATION AND CASE PREPARATION 10 (Patricia W. Iyer ed.) (1999); Steven M. Levin & Janice F. Mulligan, *Litigating Nursing Home Wandering Cases*, 2 ELDER'S ADVISOR 9, 10 (Fall 2000); see also generally Cheryl C. Mitchell & Ferd H. Mitchell, *Handling Tort Recoveries for Persons Over and Under Age 65*, 2 ELDER'S ADVISOR 62 (Fall 2000).

30. Regarding the consumer movement in the long term care sphere, see generally GARY R. ILMINEN, *CONSUMER GUIDE TO LONG-TERM CARE* (1999).

31. 31 U.S.C. § 3730. See John M. Parisi, *A Weapon Against Nursing Home Fraud and Abuse: Using the Federal Civil False Claims Act, Plaintiff Attorneys Can Fight Fraud and Ensure that Nursing Home Residents Who Receive Federal Benefits Get the Care They Need*, 35 TRIAL 48, 48 (1999); Constantinos I. Miskis, *Enforcing Quality Standards in Long-Term Care: The False Claims Act and Other Remedies*, 73 FLA. B.J. 108, 109 (1999); see generally Leon Aussprung, *Fraud and Abuse: Federal Civil Health Care Litigation and Settlement*, 19 J. LEGAL MED. 1 (1998).

dously.³² An increasing number of these cases have resulted in substantial monetary judgments against the defendants, often including awards of punitive damages,³³ or settlements.³⁴ In a logical response to these circumstances, liability insurance carriers in high risk geographic areas such as Florida³⁵ have begun to raise premium rates considerably or withdraw from the nursing home marketplace altogether.

At the same time that these other factors are exerting their influence, nursing homes nationally also are being compelled to confront a severe shortage of nurses, certified nursing assistants, and other workers who are prepared and willing to be employed in nursing homes caring for residents.³⁶ Almost universal difficulties in recruiting and retaining qualified nursing home personnel from administrators³⁷ to line staff,³⁸ and thus in maintaining minimal³⁹ let alone

32. "There is a torrent of new activity surrounding nursing home litigation in the United States. Claims against nursing homes and assisted living facilities have increased 9 percent each year over the last five years with charges of improper nutrition, medication errors, emotional abuse, and more." Brochure advertising Mealey's Nursing Home Litigation Conference on Jan. 24-25, 2001 in Naples, FL.

33. *Rhodes v. HEB Nursing Home*, Tex. Dist. Ct., Tarrant County (Oct. 15, 1998) (\$250 million in punitive damages awarded); *Texas Jury Finds Beverly, Inc. Responsible for Neglect, Fraud in \$83 Million Judgment*, NCCNHR QUALITY CARE ADVOCATE 1 (Fall 1997) (\$70 million punitive damage award); Donald C. Dilworth, *Negligent Nursing Home Care Triggers Juror Outrage*, 34 TRIAL 16, 16 (1998).

34. See *Record Year for Plaintiffs' Attorneys in Nursing Home Litigation*, ANDREWS NURSING HOME LITIGATION REPORTER 1 (Dec. 16, 1999); Edward Felsenthal, *Jury Awards Rise for Improper Care of Elderly*, WALL ST. J., Sept. 5, 1995, at B1.

35. Regarding the nursing home malpractice environment in Florida, see generally Diane C. Lade, *Study Finds Most Nursing Home Lawsuits in Florida Have Merit*, FT. LAUDERDALE SUN-SENTINEL, Dec. 6, 2000, at 1B; Mary Ellen Klas, *State Warns 29 Facilities to Get Insurance*, PALM BEACH POST, Dec. 19, 2000, at 8A ("...Florida nursing homes face three times as many lawsuits as homes in the rest of the nation. The average cost of damages and liability insurance per bed is \$6,282, compared with \$809 in other states."); Jennifer L. Williamson, *The Siren Sound of the Elderly: Florida's Nursing Homes and the Dark Side of Chapter 400*, 25 AM. J.L. & MED. 423, 440 (1999).

36. See Julia Malone, *Clinton Pushes Nursing Home Jobs*, DAYTON DAILY NEWS, Sept. 17, 2000, at 1A ("The Health and Human Services Department says more than half of nursing homes are dangerously understaffed."); William E. Even et al., *Long-Term Care Staffing Needs for Older People in Ohio*, SCRIPPS GERONTOLOGY CENTER (1998).

37. See Douglas A. Singh & Robert C. Schwab, *Retention of Administrators in Nursing Homes: What Can Management Do?*, 38 THE GERONTOLOGIST 362, 368 (1998).

38. See generally JANE K. STRAKER & ROBERT C. ATCHLEY, SCRIPPS GERONTOLOGY CENTER, *RECRUITING AND RETAINING FRONTLINE WORKERS IN LONG-TERM CARE: USUAL ORGANIZATIONAL PRACTICES IN OHIO* (1999); see KARL PILLEMER, *SOLVING THE FRONTLINE CRISIS IN LONG-TERM CARE: A PRACTICAL GUIDE TO FINDING AND KEEPING QUALITY NURSING ASSISTANTS* (1996).

39. See HEALTH CARE FINANCING ADMINISTRATION, *REPORT TO CONGRESS - APPROPRIATENESS OF MINIMUM NURSE STAFFING RATIOS IN NURSING HOMES* (Summer 2000); Charlene Harrington et al., *Experts Recommend Minimum Nurse Staffing Standards for Nursing Facilities in*

desirable staffing levels, is a problem with serious financial, quality of care, marketing,⁴⁰ and regulatory compliance ramifications.

All of the foregoing problems are exacerbated by the loud and constant assault on the image of the nursing home industry as a whole, and on the competence and integrity of specific facilities and their staffs, carried out by the national and local print and electronic media,⁴¹ frequently in collaboration with residents' advocates, regulators, and politicians.⁴² A seemingly unending and often sensationalist serving of scandals and horror stories about bad institutional conditions and misdeeds is voraciously consumed by the public, fueling energy for even more desperation by the public to avoid nursing home admission, the promulgation of all-encompassing regulation, and discouragement of potential workers from accepting employment in this part of the health care enterprise.

Finally (although this listing of factors does not purport to be comprehensive), constraints imposed by the Balanced Budget Act (BBA) of 1997⁴³ on Medicare⁴⁴ and Medicaid⁴⁵ payment rates, cou-

the United States, 40 *THE GERONTOLOGIST* 5, 14 (2000); National Citizens' Coalition for Nursing Home Reform, Federal & State Minimum Staffing Requirements for Nursing Homes: December 1999 (visited Mar. 7, 2001) <http://www.nccnhr.org/Updates/Federal_and_State_Minimum_Staffing.htm>. *But see* Charlene Harrington et al., *Nursing Home Staffing and Its Relationship to Deficiencies*, 55 *J. GERONTOLOGY: SOCIAL SCI.* S278, S284 (2000) (concluding that nursing home characteristics and geographic location are stronger predictors of nursing home care deficiencies than staffing hours).

40. 42 U.S.C. § 1395i-3(b) provides:

8) (A) A skilled nursing facility shall post daily for each shift the current number of licensed and unlicensed nursing staff directly responsible for resident care in the facility. The information shall be displayed in a uniform manner (as specified by the Secretary) and in a clearly visible place.

(B) A skilled nursing facility shall, upon request, make available to the public the nursing staff data described in subparagraph (A).

41. *See* Jennifer Steinhauer, *Shock, But No Longer Surprise Over Nursing Home Problems*, *N.Y. TIMES*, Nov. 9, 2000, at D1; Jim DeBrosse & David Gulliver, *Penalties Few For Poor Care*, *DAYTON DAILY NEWS*, Dec. 6, 1999, at A1; Jim DeBrosse & David Gulliver, *Frail Elderly at Mercy of System*, *DAYTON DAILY NEWS*, Dec. 5, 1999, at A1.

42. *See* Robert Pear, *Congressional Investigators Cite Safety Violations at Nursing Homes*, *N.Y. TIMES*, Oct. 31, 2000, at A24; MINORITY STAFF, SPECIAL INVESTIGATIONS DIVISION, COMMITTEE ON GOVERNMENT REFORM, U.S. HOUSE OF REPRESENTATIVES, *NURSING HOMES IN CHICAGO: MANY HOMES FAIL TO MEET FEDERAL STANDARDS FOR ADEQUATE CARE 2-3* (Mar. 27, 2000). *But see* AM. HEALTH CARE ASS'N, *REPORT PAINTS DISTORTED PICTURE OF THE QUALITY OF SKILLED NURSING CARE* (Apr. 5, 2000) (refuting accuracy of a Congressional report on the quality of nursing care).

43. Pub. L. No. 105-33, 1997 HR 2015.

44. Under the BBA, Congress converted skilled nursing facilities (SNFs) to a prospective payment system (PPS) from the historic retrospective cost-based reimbursement system. Under PPS, Medicare payments to SNFs are divorced from specific allowable costs the SNFs incurred to furnish services to Medicare beneficiaries and instead are based exclusively on prospective rates unilaterally established by HCFA. Regarding the practical

pled with stiff public reluctance so far to embrace the concept of private long term care insurance⁴⁶ despite support for this concept from the federal and state governments,⁴⁷ color darkly the financial climate within which the nursing home industry operates. The cause and effect relationship, if any, between government payment rates (versus other possible explanations such as overexpansion by the industry)⁴⁸ and the current financial instability of many nursing homes is a matter of considerable controversy,⁴⁹ but the existence of that instability is not.⁵⁰ Congress attempted to provide some relief, and thereby improve resident access to and the quality of nursing home care, by enacting the Balanced Budget Refinement Act (BBRA) of 1999⁵¹ to increase the payment rate for care of the frailest older skilled nursing

impact of this and other changes made by the BBA, see Janelle Carter, *Cuts Hurt Nursing Facilities*, DAYTON DAILY NEWS, Sept. 6, 2000, at 3A.

45. The Boren Amendment, previously codified at 42 CFR § 447.253(b)(1)(i), had required that states establish Medicaid payment rates for nursing homes that were reasonable and adequate, and met the costs that efficiently and economically operated facilities incurred to furnish services. The BBA repealed the Boren Amendment and authorized states to develop their own substantive standards, using their own methodologies, to set payment rates.

46. On the limited present role of private long term care insurance, see NAT'L ACADEMY OF ELDER LAW ATTORNEYS, WHITE PAPER ON REFORMING THE DELIVERY, ACCESSIBILITY AND FINANCING OF LONG-TERM CARE IN THE UNITED STATES 6, 9, 12-18 (2000); Feder et al., *supra* note 12, at 45.

47. See Joshua M. Wiener et al., *Federal and State Initiatives to Jump Start the Market for Private Long-Term Care Insurance*, 8 ELDER L.J. 57, 63 (2000).

48. See Debra Sparks, *On the Sick List: Nursing Homes, Street Darlings of the '90s, Have Been Laid Low*, BUS. WK., July 5, 1999, at 68.

49. See generally U.S. GEN. ACCOUNTING OFFICE, NURSING HOMES: AGGREGATE MEDICARE PAYMENTS ARE ADEQUATE DESPITE BANKRUPTCIES, GAO/T-HEHS-00-192 (2000); *Hearing on Medicare Balanced Budget Act Refinements: Testimony Before the Subcommittee on Health of the House Committee on Ways and Means* (Oct. 1, 1999) (statement of William J. Scanlon); U.S. GEN. ACCOUNTING OFFICE, MEDICARE: BETTER INFORMATION CAN HELP ENSURE THAT REFINEMENTS TO BBA REFORMS LEAD TO APPROPRIATE PAYMENTS, GAO/T-HEHS-00-14 (1999):

Our ongoing work suggests that factors in addition to the PPS have contributed to fiscal difficulties for some corporations operating SNFs. Nevertheless, certain modifications to the PPS may be appropriate to ensure that payments are targeted to patients who require more costly care. The potential access problems that may result if Medicare underpays for high-cost cases could lead to beneficiaries' staying in acute care hospitals longer, rather than foregoing care altogether. *Id.*, at 2-3.

50. See Jerry Ackerman, *CareMatrix Seeks Bankruptcy Protection*, BOSTON GLOBE, Nov. 10, 2000, at D4; Scott D. Horsburgh, *18-Month Review—Manor Care, Inc.*, BETTER INVESTING, Sept. 2000, at 44 (describing the nursing home industry's financial problems); Julia Malone, *Nation's Nursing Homes Need \$2 Billion in Federal Aid*, DAYTON DAILY NEWS, Sept. 3, 2000, at 8A.

51. Balanced Budget Refinement Act of 1999, Pub. L. No. 106-113, 113 Stat. 1501 (1999).

facility (SNF) residents, but the real impact of this BBRA remains to be seen at this time.⁵²

II. EFFECTS ON THE NONPROFIT SECTOR

The lion's share of the public commentary expressed thus far regarding the challenging circumstances confronting modern American nursing homes has focused on the roughly three-quarters⁵³ of the industry characterized by investor, or proprietary, for-profit ownership. At its most vituperative, this commentary consists essentially of consumer advocates reflexively condemning anything connected to a capitalist marketplace approach to health and human services, accusing nursing home corporations of purposefully sacrificing quality of resident care in order to maximize short term shareholder profits, and the proprietary sector of the industry indeed focusing its energies and complaints mainly on payment rates, malpractice insurance premiums, the costs of regulatory compliance, and other matters pertaining to the industry's own economic bottom line.

A vital factor that has been largely overlooked amidst the barrage of complementary insults and accusations flowing between consumer advocacy groups and the proprietary trade associations is the real and potential impact of the developments enumerated in the previous section on the continued vitality and viability of nonprofit nursing homes. In light of the proliferation of home and community based long term care alternatives⁵⁴ and assisted living facilities⁵⁵ that enable persons to avoid or substantially delay entry into a nursing home, nonprofit nursing homes feel the financial pinch of vigorous competition just as painfully as does the proprietary sector. Older and disabled individuals are no more anxious to be admitted to a nonprofit nursing home than a proprietary one if there is another real choice. Moreover, nonprofit facilities generally do not have available to them the marketing budgets that most proprietary chains expend to pursue their scramble to find and enroll new residents.

The federal, state, and local regulatory environment affects nonprofit and proprietary nursing homes in exactly the same ways.

52. See Susan C. Emmer, *How the Balanced Budget Refinement Act of 1999 Will Affect Geriatric Medicine*, 48 J. AM. GERIATRIC SOC'Y 450, 451 (2000).

53. See Graber & Ward, *supra* note 24, at 341; *Nursing Homes: When a Loved One Needs Care*, CONSUMER REP., Aug. 1995, at 519.

54. In 1998, about eight million Americans received medical and personal care services from more than 20,000 home health care agencies and hospices. See NATALIE G. TUCKER ET AL., LONG-TERM CARE, AARPP PUBLIC POLICY INSTITUTE FACT SHEET 27R, at 1 (May 2000).

55. In 1998, an estimated 600,000 people were living in about 28,000 assisted living facilities. See *id.*

Neither the survey and certification nor licensure processes, local prosecutors, nor the Office of Inspector General give any special favorable consideration or advantage to nonprofit facilities; the same substantive rules and administrative procedures apply with full force regardless of a facility's ownership status. Similarly, neither tort doctrine, plaintiffs' personal injury attorneys, nor professional liability insurance underwriters draw any distinction between nonprofit and proprietary nursing homes (although it is conceivable that juries might take a nursing home's ownership status into account in considering whether, and to what extent, to award punitive damages).

Likewise, minimum staffing ratio requirements do not offer any dispensation for nonprofit status, and recruiting and retaining qualified staff is no easier for nonprofit than proprietary nursing homes. Few, if any, current or potential nursing home employees are swayed in their job choice by a facility's ownership status. Further, nonprofit nursing homes are by no means exempted from negative media attention, and their reputations and morale levels are tarnished by such reports to at least as great a degree as occurs in the case of proprietary facilities. Finally, Medicare and Medicaid payment rates are no more generous for nonprofit nursing homes than for their proprietary counterparts, and there is no evidence that residents of nonprofit nursing homes are especially likely to have purchased private long term care insurance policies.

III. WHY THE IMPACT ON NONPROFIT NURSING HOMES MATTERS

The fact that the nonprofit sector of the nursing home industry joins its proprietary counterpart in experiencing many aspects of the current crisis ought to matter deeply to those who purport to be concerned about the quality of care and quality of life available to older and disabled persons who need long term care services. Assuming that one accepts a continuing need for the availability of *some* institutional long term care options, most nonprofit nursing homes ought to be recognized and supported as valuable participants who represent an essential middle ground between an arguably excessively financially driven proprietary industry, on one hand, and the nihilistic service vacuum that would neglect and imperil the most vulnerable members of society, on the other, if nursing homes ceased to exist altogether.

In my own experience and observation, the governing boards of most nonprofit nursing homes are overwhelmingly guided by the stated benevolent mission of the institution. Members of these facilities' boards of trustees have no motivation to volunteer their time,

energy, and often financial contributions to this form of non-compensated community service other than a sincere commitment to the particular institutional mission. Dedication to the welfare of the specific community that owns and is served by the nonprofit nursing home is an attitude that permeates the institution from the governance level through the lowliest employee on the institution's organization chart. The vast majority of nonprofit nursing homes would be delighted to offer residents more and higher caliber staffing, nicer and newer physical plants, a wider and more continuous range of constructive activities, and all the other things that contribute to an enhanced quality of care and quality of life, if only available resources—both financial and human—permitted them to do so.

This overarching commitment to a benevolent mission causes nonprofit nursing homes to maintain a sense of moral responsibility to their respective communities—religious,⁵⁶ fraternal, or other. At the same time, excessive naivete among nonprofit nursing home governing bodies about the current realities described earlier will inevitably threaten a facility's long range financial capacity to continue carrying out its benevolent mission. While nonprofit facilities may seek out philanthropic donors (a task which, itself, is becoming ever more competitive), they lack the ability to generate capital from investors. The ultimate irony is that the combination of growing competitiveness for residents, an unfriendly regulatory and litigation environment, the severe shortage of qualified labor, hostile media treatment, and a very cost conscious third-party payer climate is, probably too frequently, compelling nonprofit nursing homes to behave in a more businesslike and less benevolent fashion, and thus to become less and less distinguishable from their proprietary counterparts on both a strategic and an everyday activities basis.

IV. IMPLICATIONS FOR PUBLIC POLICY

Certainly, a number of the factors contributing to the current nursing home crisis have brought about positive ramifications. Keeping people out of nursing homes—proprietary or nonprofit—as long as possible is an accomplishment to be broadly applauded and encouraged, as long as the individuals being diverted from long term care institutions are receiving the help they need and are not simply being neglected. Society ought to support expansion of home and

56. See UNITED JEWISH COMMUNITIES, *LONG TERM CARE SERVICES IN THE NEW MARKET-PLACE: IMPLICATIONS FOR THE JEWISH COMMUNITY* (1999); Marshall B. Kapp, *Ethical Challenges for Jewish Long Term Care Providers*, 9 J. RELIGIOUS GERONTOLOGY 21, 22 (1994).

community-based long term care options, particularly those based on the principle of maximizing consumer choice and control over the service package.⁵⁷

Nonprofit agencies and their community owners should be in the forefront of this diversification,⁵⁸ not just because new product lines and profit centers are needed for financial survival, let alone prospering (although financial viability is both a relevant and legitimate consideration), but because home and community-based long term care options respond to what members of the communities that nonprofit agencies exist to serve prefer in their lives. The major trade association representing nonprofit long term care providers has suggested, "providers will also want to examine the new opportunities *Olmstead* affords for expanding their home and community-based services or for starting an HCBS program. This type of community outreach offers prospects for providers on many levels."⁵⁹

There is another positive note to the current situation. Real fraud, abuse, and waste does take place in public payment programs, and it is difficult to criticize aggressive attempts by the government to eliminate its negative effects.

Those salutary developments notwithstanding, the present crisis places the U.S.⁶⁰ at a crossroads in terms of deciding what role, if any, the populace expects nursing homes to play in the larger national long term care marketplace/system in the future. The answer that probably is not viable, and assuredly is not desirable, is a continuation of the current process of slow demise, confusion, and uncertainty being experienced by both the proprietary and nonprofit sectors of the

57. Regarding consumer choice and control in home and community-based long term care services, see MARSHALL B. KAPP, SCRIPPS GERONTOLOGY CENTER, CONSUMER CHOICE IN HOME AND COMMUNITY-BASED LONG TERM CARE: POLICY IMPLICATIONS FOR DECISIONALLY INCAPACITATED CONSUMERS (2000); Robyn Stone, guest ed., *Theme Issue: Consumer Direction in Long-Term Care*, XXIV GENERATIONS 3, 21 (Fall 2000).

58. "In both 1987 and 1996, the for-profit segment of the nursing home market was nearly entirely represented by nursing homes with only nursing home beds, as opposed to other more organizationally complex nursing home types (nursing homes with affiliated non-nursing home beds and hospital-based nursing homes). Nonprofit and government facilities were more likely than for-profit facilities to have affiliated non-nursing beds, such as assisted or independent living beds." See JEFFREY A. RHODES & NANCY A. KRAUSS, AGENCY FOR HEALTH CARE POL'Y AND RESEARCH PUB. NO. 99-0032, NURSING HOME TRENDS, 1987 AND 1996 (1999).

59. VELGOUSE, *supra* note 16, at 17.

60. Delineating long term care policy is actually an international, not just a U.S., challenge. See TOWARDS AN INTERNATIONAL CONSENSUS ON POLICY FOR LONG-TERM CARE OF THE AGING, WORLD HEALTH ORGANIZATION AND MILBANK MEMORIAL FUND (2000) (proposing eight priority issues and guiding principles).

nursing home industry. The more feasible policy alternatives divide into two basic approaches.

Under one approach, we could decide to discontinue allowing nursing homes to participate in Medicare and Medicaid programs or to otherwise receive public (e.g., Department of Veterans Affairs)⁶¹ payments for providing nursing home services. Any nursing homes remaining in business would have to survive on a combination of private pay residents,⁶² private long term care insurance, and charitable donations. In such a scenario, it is likely that most remaining nursing homes would be proprietary and even more focused on bottom line financial returns. Absent involvement of governmental purse strings, the legal justification for regulatory intrusion into nursing home operations would be greatly diminished.⁶³ Prohibiting nursing homes that do not participate in public financing programs from discriminating in resident admissions and retention on the basis of ability to pay, even if legally permissible,⁶⁴ surely would—whether consciously intended to do so or not—put a quick and complete end to the American nursing home industry.

If a vast reduction in the number, if not total elimination, of nursing homes is the desired practical outcome, the nation had better be exceedingly committed to accomplishing the following: infusing substantial financial resources into expansion of home and community-based long term care options and assisted living; administering those non-institutional or quasi-institutional service programs soundly and efficiently; developing, finding, cultivating, and retaining suitable workers for those programs; and accepting the inevitability that some long term care clients will be at substantial risk of undetected neglect or even abuse and exploitation when relying on services provided in

61. 38 U.S.C. § 1720.

62. In 1998, the average annual cost of care in a nursing home was about \$56,000. See TUCKER ET. AL., *supra* note 5E, at 1. In 1998, out-of-pocket spending for nursing home care totaled \$28.5 billion, or one-third of all nursing home expenditures. See *id.* at 2.

63. For example, the federal government currently regulates nursing homes under the constitutional Taxing and Spending Power, U.S. CONST. art. I, § 8, as a consequence of Medicare and Medicaid program involvement.

64. Cf. Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (1997). EMTALA requires hospital emergency departments to evaluate, and if necessary treat at least to the point of stabilization, all presenting patients without regard to their insurance status or ability to pay, but this act applies only to hospitals receiving Medicare payments. Since the U.S. Constitution does not guarantee anyone a right to funds for health care generally, see, e.g., Harris v. McRae, 448 U.S. 297 (1980), *rehearing denied* 448 U.S. 917 (1980), it would be difficult to argue credibly for a right to long term care unless Congress or the states had created one legislatively.

relatively unmonitored or ineffectively monitored⁶⁵ home and community-based or assisted living⁶⁶ environments.

Each of the approximately 1.6 million persons who presently reside in around 17,000 nursing homes⁶⁷ would need to be cared for somewhere, by someone; more than four-fifths of these individuals require help with three or more activities of daily living, such as bathing, dressing, toileting, transferring from a bed or chair, feeding, and mobility.⁶⁸ As one leading geriatrician has put it, "In this day of 'sicker and quicker' transfer of patients from hospitals to nursing homes, it is rare to find a nursing home resident who does not need nursing home care. I have never met a malingerer living in a nursing home."⁶⁹ In the idealistic scenario posited here— a world without nursing homes⁷⁰—nonprofit, mission-driven organizations should be given financial and other kinds of incentives to be even more active competitors in the home and community-based long term care and assisted living marketplaces to help them meet the challenge. Otherwise, we may be fated to see repeated some version of the massive social problems created by deinstitutionalization of the seriously, chronically mentally ill from large public institutions in the 1960s and 70s without an accompanying widespread commitment to support adequate community treatment and housing entities to serve that dependent population.⁷¹

A different vision of the future of long term care in the U.S. would entail a public policy of bolstering nursing homes and making them more economically and programmatically viable entities than

65. See generally Marshall B. Kapp, *Home Health Care Regulation: Is It Good for the Patient?* 1 J. LONG TERM HOME HEALTH CARE 251, 251 (1999).

66. Regarding the regulation of assisted living facilities, see ROBERT L. MOLLIKA, DEP'T OF HEALTH AND HUMAN SERVICES, STATE ASSISTED LIVING POLICY: 1998 (1998); U.S. GEN. ACCOUNTING OFFICE, ASSISTED LIVING: QUALITY-OF-CARE AND CONSUMER PROTECTION ISSUES IN FOUR STATES, GAO-HEHS-99-27 (1999); see also generally Barry Meier, *States See Problems of Quality of Care at Centers for Aged*, N.Y. TIMES, Nov. 26, 2000, at 1; Paul A. Gordon, *When a Handshake Just Won't Do*, PROVIDER, Apr. 1997, at 39; Kitty Buckwalter et al., *Residential Care for Persons With Dementia: Are Codes and Regulations Protective or Counter-Productive?*, 22 J. GERONTOLOGY NURS. 43 (June 1996)

67. See ROSALIE A. KANE ET AL., THE HEART OF LONG-TERM CARE 17 (1998).

68. See N.A. KRAUSS & B.M. ALTMAN, AGENCY FOR HEALTH CARE POLICY AND RESEARCH PUB. NO. 99-0006, CHARACTERISTICS OF NURSING HOME RESIDENTS—1996 (1998).

69. Leslie S. Libow, *Letter, Long-Term Care for the Frail Elderly*, 342 NEW ENG. J. MED. 823, 824 (2000).

70. See Peter Uhlenberg, *Replacing the Nursing Home*, 128 PUB. INTEREST 73, 84 (1997). Cf. Keren Brown Wilson & Connie J. Baldwin, *Are Nursing Homes Dinosaurs?*, XIX GENERATIONS 69, 69 (Winter 1995-96) (arguing that nursing homes "that do not reinvent themselves will not survive").

71. See generally GERALD N. GROB, THE MAD AMONGST US: A HISTORY OF THE CARE OF AMERICA'S MENTALLY ILL 287-300 (1994).

they are today. As sub-issues to be considered under this general vision, the nursing home industry could be larger, smaller, or the same size as it is presently, and could consist of either the current mix of proprietary and nonprofit facilities or a different ownership profile. One option might be a much smaller role for nursing homes in a total long term care system that is more (but not completely) reliant on home and community-based alternatives, in which the institutional role is fulfilled exclusively by nonprofit facilities.

Successfully pursuing a policy of fostering more viable nursing homes for those who need them, regardless of the eventual size and ownership status of those facilities, would necessitate serious reexamination of the status quo in at least two areas. First, there would need to be a thorough and open-minded reassessment of the actual effectiveness and value (including the cost/benefit ratio) of present regulatory and litigative approaches to assuring acceptable levels of quality of care and quality of life in nursing homes. Second, the ways in which we pay nursing homes for caring for residents must be critically re-thought.⁷² This inquiry ought to address not just the technical, tortuous aspects of Medicare and Medicaid payment methodologies, but also fundamental questions regarding the proper mix of public and private responsibility for financing long term care⁷³ (including the role to be played by the private long term care insurance industry)⁷⁴ and the desirable ratio of spending between institutional and non-institutional long term care.⁷⁵

V. CONCLUSION

This is a moment of great opportunities and challenges for influencing the shape of long term care financing and delivery for a new

72. See KATHLEEN H. WILBER ET AL. EDs., *A SECURE OLD AGE: APPROACHES TO LONG-TERM CARE FINANCING* (1997).

73. See, e.g., MARK MERLIS, COMMONWEALTH FUND PUB. # 343, *FINANCING LONG-TERM CARE IN THE TWENTY-FIRST CENTURY: THE PUBLIC AND PRIVATE ROLES* (1999); Janet Weiner, *Financing Long-term Care: A Proposal by the American College of Physicians and the American Geriatrics Society*, 271 J. AM. GERIATRIC SOC'Y 1525, 1526 (1994) ("We believe that there are appropriate roles for both the public and private sector in long-term care financing.")

74. See LES ABROMOVITZ, *LONG-TERM CARE INSURANCE MADE SIMPLE* (1999). *But see* Feder, Komisar, & Niefeld, *supra* note 13, at 51-54 (favoring expansion of social insurance for long term care, rather than private insurance); *see also generally* Cartoll L. Estes & Thomas Bodenheimer, *Paying for Long-Term Care*, 160 WEST. J. MED. 64 (1994) (*accord*).

75. See Feder et al., *supra* note 11, at 49-50; PHOEBE L. BARTON, *UNDERSTANDING THE U.S. HEALTH SERVICES SYSTEM* 319 (1999) ("Although 70 percent of all public and private LTC expenditures are for institutional care, the majority of people who obtain LTC services receive them in their residences or in community settings.")

millennium.⁷⁶ As we continue to contemplate how society may best care for the most vulnerable and dependent in our midst, namely those individuals who are so frail and debilitated that they are candidates for institutional long term care, noble intentions are essential. The religious and secular communities underlying and embodied in nonprofit nursing homes and their governing boards have historically—at their very core—represented and promoted such noble intentions. However, even the most meritorious intentions are severely challenged today by a constellation of factors that combine to threaten the continued vitality and viability of the U.S. nursing home industry as a whole. How we deal with those factors, strategically and pragmatically, will largely determine the shape of tomorrow's long term care system in this nation and the role played within that system by a nonprofit sector that American society can most ill afford to diminish or destroy.

76. See KANE ET AL., *supra* note 67, at 17; Marc A. Cohen, *Emerging Trends in the Finance and Delivery of Long-Term Care: Public and Private Opportunities and Challenges*, 38 THE GERONTOLOGIST 80, 83, 85 (1998); Robert H. Binstock et al. eds., *THE FUTURE OF LONG-TERM CARE: SOCIAL AND POLICY ISSUES* (1996).