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Final Survey, Certification, and Enforcement Rules for Nursing Facilities

Medicare Discharge-Planning Regulations: An Advocacy Tool for Beneficiaries

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I. Introduction

On December 13, 1994, the Secretary of Health and Human Services (HHS) published in final form Medicare discharge-planning requirements. /1/ The regulations have been published as Conditions of Participation that hospitals must meet in order to participate in the Medicare program. They are a useful advocacy and educational tool for obtaining posthospital care services in the least restrictive setting of choice. This column sets out the regulations, with comments, and suggests ways to utilize them.

II. Discharge-Planning Requirements

A. General Requirement

The hospital must have in effect a discharge planning process that applies to all patients. The policies and procedures for discharge planning must be in writing.

The statute as written requires Medicare-participating hospitals to have a discharge-planning process for Medicare patients. The Secretary, based on her view of the authority conferred on her by sections 1861(e)(9) and 1861(ee) of the Social Security Act, has decided to extend this provision to all hospital patients. /2/ This will be useful for most patients and is in keeping with the practices of most hospitals. /3/

B. Identification of Patients in Need of Discharge Planning

The hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning.

Many advocates expressed concerns about how and when patients in need of discharge-planning services would be identified. Some advocates suggested that the Secretary adopt specific criteria such as age, functional ability, psychological factors, etc., for determining who needed a discharge-

planning evaluation. Instead, the Secretary has asserted that hospitals should have flexibility in this regard.

The Secretary does note in her comments to the regulations, however, that discharge planning presupposes a hospital admission. Thus, in her view, the discharge-planning requirements do not apply to a person who is treated in an emergency room without an admission. /4/

The discharge-planning-evaluation process may be initiated by persons other than hospital staff; patients and/or their representatives may request a discharge-planning evaluation. /5/ As discussed below, the actual discharge plan is developed on the basis of the findings of the discharge-planning evaluation. Physician involvement is presupposed. /6/

C. Discharge-Planning Evaluation

1. The Evaluation Requirement

The hospital must provide a discharge planning evaluation to the patients identified in paragraph (a) of [42 C.F.R. Sec. 482.43] and to other patients upon the patient's request, the request of a person acting on the patient's behalf, or the request of a physician.

It should be noted that the discharge-planning evaluation is different from the discharge plan. The evaluation is an assessment that looks at the patient's physical and mental condition, the likely posthospital living situation, and the patient's ability to engage in daily living activities -- eating, dressing, bathing. The plan, including the type of setting into which the patient is to be discharged, focuses on the medical and social support needs of the patient in that setting.

The Secretary has not established a specific format for the evaluation. She does, however, call attention to the work of the Secretary's Advisory Panel on Needs Assessment, /7/ which submitted its report to Congress on June 30, 1992. The report makes no formal recommendation but states that more work needs to be done on needs-assessment instruments, including field testing to assure administrative feasibility and clinical effectiveness. /8/

Controversy may arise over who can actually cause a discharge plan (distinct from a discharge-planning evaluation) to be written. The regulations establish that the physician has the "last say" as to whether the actual discharge plan is to be written, even if the hospital finds a discharge plan unnecessary. From her comment, it would seem that, if a hospital patient or family member requests a discharge plan but the physician does not agree to the request, there is no way to compel the development of a plan. Patients could, however, consider asking the Peer Review Office (PRO) to review the denial of the plan. /9/ The discharge evaluation would form the basis of any such review. This heightens the need to assure that the discharge-planning evaluation is thorough.

2. Who Performs the Evaluation

A registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, the evaluation.

The Secretary has established no specific criteria for nurses, social workers, or other appropriately qualified persons who perform discharge-planning and discharge-planning-evaluation services. The lack of such standards, in some instances, raises quality-of-service concerns.

It is the Secretary's position that, in keeping with her June 17, 1986, regulatory revision of the Conditions of Participation for hospitals, the agency should, where possible, avoid prescriptive administrative requirements and use of specific details. She does note, however, that these matters will be considered when she develops interpretive guidelines. /10/

It should be noted that the several associations of discharge planners and the various accreditation bodies have made great strides in this area. /11/ Good discharge planning and posthospital placement and follow-up, while helpful to low-income clients, are valuable service, teaching, marketing, and community goodwill assets to hospitals.

3. Elements of the Discharge-Plan Evaluation

The discharge planning evaluation must include an evaluation of the likelihood of a patient needing post-hospital services and of the availability of the services.

Issues concerning whether and to what extent a patient will require posthospital services upon discharge will be ongoing. The question will often turn on both a medical- and a social services -- needs inquiry. Patients who disagree with a discharge-planning evaluation will need an avenue for review and redress. The discharge-planning Conditions of Participation do not address this concern. /12/

In the past, PRO review of discharge planning focused not on its substantive content but on whether the discharge plan was included in the medical record. Absent greater clarification, PRO review will not be useful. The Secretary plans to track compliance with this provision through the survey and certification process and will look for documentation of the discharge-planning evaluation and whether the hospital has arranged for initial implementation. /13/

The discharge-planning statutes in New York /14/ and Massachusetts /15/ provide useful models for assuring that beneficiary concerns are addressed when discharge plans are developed and implemented. Under New York law, patients may not be discharged until the services called for in the discharge plan have been arranged or until they have been reasonably determined to be available in the community. /16/ Under Massachusetts law, the discharge plan must specify the services to be provided, the names and addresses of the providers, medications and prescriptions, and the follow-up schedule for the patient. /17/ A review mechanism for disputes about the discharge plan is also provided. /18/

4. Evaluating the Likelihood of Self-Care

The discharge planning evaluation must include an evaluation of the likelihood of a patient's need for self-care or the possibility of the patient being cared for in the environment from which he or she entered the hospital.

It is important to assure that a patient's wishes are given a great deal of weight in the evaluation process even where using a strict medical or clinical model might suggest that the patient's posthospitalization wishes are not feasible. This is a particular concern where home health care might be more difficult to manage and/or arrange because of the level and frequency of services required.

In her comments, the Secretary states that the patient's wishes are an integral aspect of the capacity for self-care. The Secretary identifies the ability of the patient, the availability and willingness of care givers, the availability of resources in the community, and the patient's preferences as important considerations. /19/

The Secretary notes in her comments that patients who come to the hospital from a nursing home should be offered a full range of options. She also notes that patient preferences are not always realistic due to patients' physical or mental condition, the availability of community resources, or any combination of these. /20/ The Secretary plans to include in her interpretive guidelines a statement that patients admitted to a hospital from a skilled nursing facility are to be afforded a broad range of options, not simply a return to the nursing home setting.

5. Timely Discharge Planning Required

The hospital personnel must complete the evaluation on a timely basis so that appropriate arrangements for post-hospital care are made before discharge and to avoid unnecessary delays in discharge.

While acknowledging that the process of discharge planning, including the patient evaluation and the development of the plan, should be continuous, advocates suggested that the Secretary be more specific about when the discharge-planning process should begin. Many feared that, absent specific timeliness requirements, discharge planning would be a "last-minute" exercise and that options for posthospital care would not be explored fully.

In response, the Secretary stated that she wanted to allow for changes in circumstances that might alter posthospital care needs. In her comments, she is supportive of the notion of allowing sufficient opportunity for the involvement of family and friends in the consideration of posthospital needs and options.

The question of timeliness may be explored with hospital discharge-planning staff and with the Secretary as she develops interpretive guidelines. Advocates want to assure that monitoring and other accountability measures are in place.

6. Documentation of Discharge Planning and Patient Discussion

The hospital must include the discharge planning evaluation in the patient's medical record for use in establishing an appropriate discharge plan and must discuss the results of the evaluation with the patient or individual acting on his or her behalf.

Including the discharge-planning evaluation in the medical record also serves as an initial monitoring and enforcement screen for the survey and certification process. It will demonstrate that at least some assessment of the patient's posthospital care needs has been made. Discussion of the discharge-planning evaluation with the patient's family members should also be documented. Although this is not an explicit requirement, it should be reviewed in the survey and certification process. It can be argued that the requirement of written policies and procedures for the entire discharge-planning process includes documentation of conversations with family members about the patient's posthospital needs. /21/ The Secretary plans to reinforce the need for documentation of discharge-planning procedures in interpretive guidelines. /22/

D. The Discharge Plan

1. Development of a Discharge Plan

A registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, a discharge plan if the discharge planning evaluation indicates a need for a discharge plan.

The field of discharge planning is growing and includes several national discharge-planning associations, journals, and magazines. /23/ These organizations' presence, as well as the JCAHO and AOA accreditation process, gives further assurance of quality measures. Advocates, nonetheless, are concerned about hospitals designating staff who may not have specific training in requisite disciplines to perform discharge planning.

While the Secretary rightly states that specifying qualifications can be inappropriately restrictive and does not necessarily assure quality, guidance as to a core set of principles applicable to the discharge-planning process is necessary. To this end, the Secretary is planning to incorporate a set of minimum discharge-planning criteria in interpretive guidelines and is planning to reevaluate those criteria based on future survey experience. /24/

2. Physician Request for Discharge Plan

In the absence of a finding by the hospital that a patient needs a discharge plan, the patient's physician may request a discharge plan. In such a case, the hospital must develop a discharge plan for the patient.

As stated above, this is likely to be a problem area for advocates. As written, the rule requires that the physician command the actual development of the discharge plan. Without the physician's

consent, no plan (distinct from the discharge evaluation) has to be developed. This places the physician and the patient (or patient representative) in potentially adversarial positions and highlights the importance of the needs-assessment process in determining who might be at risk absent discharge-planning services.

3. Hospital to Arrange Services

The hospital must arrange for the initial implementation of the patient's discharge plan.

The initial implementation of the discharge plan may include any necessary reassessment, based on changed circumstances, of the patient's discharge-planning evaluation. Initial implementation questions will likely focus on whether necessary posthospital services are in fact in place and on the responsibility of the hospital to ascertain whether those services are in fact available and being provided. The Secretary's comments on initial implementation focus on arranging services (42 C.F.R. Sec. 482.43(c)(3)) and transferring and referring patients (42 C.F.R. Sec. 482.43(d)). /25/ These functions do not necessarily presuppose assuring that services are actually in place. The Secretary does note however, that she will include in interpretive guidelines language stating that hospitals should keep accurate information on community long-term care services and facilities so that they can advise patients and their representatives of their options. /26/

4. Reassessing the Discharge Plan

The hospital must reassess the patient's discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan.

The Secretary requires reassessment, as needed, on the basis of the continuing care needs of the patient and the appropriateness of the discharge plan. She does not specify when reassessment is to occur. Some advocates suggested that the regulations specify that patients' discharge plans must be reassessed before discharge. This would, in the Secretary's view, require reassessment before discharge in all cases.

5. Predischarge Counseling

As needed, the patient and family members or interested persons must be counseled to prepare them for post-hospital care.

Counseling as envisioned by this provision is on an as-needed basis. As written, the rule requires hospital discharge-planning staff and the physician to determine whether and under what circumstances counseling services are necessary before discharge. Advocates should watch this process carefully to ensure that patients and their representatives receive counseling before discharge.

The Secretary plans to issue more guidance in her interpretive guidelines on the role of family care givers (or friends) in the discharge-planning process. /27/ This guidance should be helpful in addressing how to determine whether family care givers are available to provide services and in defining the scope of training and related resources that hospitals should make available to family care givers.

E. Transfer and Referral

The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care.

In her response to comments on the proposed regulations, the Secretary acknowledges that she does not have explicit authority to require hospitals to follow through and actually discharge or transfer the patient to facilities or outpatient services. She notes, however, that in her view this authority is implicit in the purpose of the legislation, namely, to assure proper posthospital care. /28/ As mentioned above, the Secretary plans to include in interpretive guidelines a requirement that hospitals keep accurate records of posthospital services available in the community for use in counseling patients about their posthospital care options and in evaluating the ongoing discharge-planning-reassessment process. /29/

E. Reassessment

The hospital must reassess its discharge planning process on an on-going basis. The reassessment must include a review of discharge plans to ensure that they are responsive to discharge needs.

In her comments on the final regulation, the Secretary notes that the overall regulation, 42 C.F.R. Sec. 483.43, requires written policies and procedures for the entire discharge-planning process. It is her view that this is sufficient to assure that hospitals will develop written procedures for its reassessment process. /30/ In addition, the Secretary plans to elaborate on the scope and content of written procedures on reassessment in the forthcoming interpretive guidelines. The guidelines will address (1) the effectiveness of the identification criteria; (2) the quality and timeliness for discharge-planning evaluations and discharge plans; (3) the requirement that hospital discharge personnel maintain complete and accurate information on community long-term care services and facilities and use this information to advise patients and their representatives of appropriate options; and (4) the requirement that the hospital have a coordinated discharge-planning process that integrates discharge planning with other functional departments, include the quality assurance and utilization review activities of the institution, and involve the various disciplines responsible for patient care. /31/

III. Discussion

A. Advocacy Strategies

1. Notice of Discharge-Planning Rights

Important questions about how Medicare beneficiaries and others will be informed about the availability of discharge-planning services remain. Currently, notice of discharge-planning services is included in the general Important Message for Medicare that beneficiaries receive on admission. This notice provides Medicare beneficiaries information about a host of rights and procedures applicable to Medicare-covered hospitalization. It provides no detail about the discharge-planning process (the elements of or steps involved in discharge planning), nor does it provide information that would identify the hospital personnel (doctors, social workers, nurses, or discharge planners) available to assist with discharge planning.

It is the Secretary's position that the Medicare statute does not require notice of discharge-planning rights but that discharge planning is a service that must be provided as described above. The Secretary asserts that the Important Message from Medicare "is already full of information and that more detail on discharge planning would be confusing." /32/ It is true that the Important Message from Medicare "is problematic as a source of notice about any specific service or entitlement." It would follow, therefore, that an additional notice vehicle is necessary. At present, there is no provision for an additional notice on discharge planning. This is an important area for advocacy.

At the administrative level, advocacy could focus on working with the Health Care Financing Administration (HCFA) Office of Survey and Certification to develop interpretive guidelines that require specific notice and/or other procedures that assure notice. Interpretive guidelines focus on requiring hospitals as part of their overall responsibilities under 42 C.F.R. Sec. 483.43 to have in place written procedures and policies for implementing the discharge-planning process.

In addition, advocates might consider adding notice requirements to existing state discharge-planning laws and regulations. In this regard, the Secretary notes that hospitals, as a condition of participation, must comply with stricter state and local requirements. /33/

Further advocacy might include litigation based on a denial of due process where beneficiaries have suffered unfortunate posthospital consequences of inadequate discharge planning (e.g., inappropriate nursing home placement, or accident or injury resulting from a discharge to the home setting without appropriate home care support).

2. Discharge Ombudsman/Patient Information

There is an ongoing need for ombudsmen or other patient advocates to work to assure that discharge-planning services and information about the discharge-planning process are provided to patients and their families or representatives. The work of an ombudsman in assuring that patients are informed about discharge planning as a process and as a patient benefit during hospitalization is substantially different from postdischarge review or accountability measures conducted pursuant to

HCFA's survey and certification process. Advocates may find associations of discharge planners and care managers interested in working on creating mechanisms to assure that patients are provided this type of ombudsman resource.

In addition, a number of hospitals have brochures that describe their discharge-planning services. Advocates may wish to work with hospital discharge planners to develop additional informational pieces on discharge planning and to provide community outreach on discharge planning as a posthospital care planning tool, including long-term care planning.

3. Discharge Planning and Needs-Assessment Instruments

As the Secretary notes in her comments on the final regulations, HHS has submitted its report to Congress on the use of needs-assessment instrument(s). /34/ That report essentially calls for further study of needs-assessment instruments and expresses the concern that needs-assessment instruments are appropriately developed to address individual needs and circumstances. Advocates may want to participate in federal and state initiatives that explore the use of needs-assessment instruments.

4. Developing Interpretive Guidelines

As indicated above, the Secretary anticipates using interpretive guidelines as her major vehicle for implementing the discharge-planning Conditions of Participation. Because interpretive guidelines are not subject to the rule-making procedures of the statute, /35/ advocates will not have a formal vehicle for obtaining notice of HCFA action in developing these guidelines. It is therefore necessary for interested advocates to contact HCFA's Office of Survey and Certification and to seek to become part of various work groups that will focus on the interpretive guidelines for discharge planning.

Advocates who have worked on nursing home and home health issues are familiar with this process. While the process is slow and cumbersome, it does allow for beneficiary-agency dialogue and involvement in the development of interpretive guidelines. It has been a source of insight into specific implementation problems and has provided an opening for beneficiary involvement in policy and program development. /36/

5. Review by the Peer Review Office

The regulatory framework as put forth by the Secretary for discharge planning does not address the issue of PRO review. PROs generally review quality and utilization-of-services issues in health care institutions, mainly hospitals. Currently, PROs have looked only to see if a discharge plan or discharge-planning evaluation is included in the patient's medical record. PROs have not looked at the quality and sufficiency of the discharge-planning evaluation or plan.

Advocates might argue that the failure to provide discharge-planning services, including a discharge plan, before actual discharge constitutes a premature discharge and is thus subject to PRO review. This may serve as a useful tool in delaying a hospital discharge where the patient feels that the appropriate posthospital services are not in place. This might also allow a patient an opportunity to take issue with a physician who does not agree that discharge planning is necessary.

6. Litigation and Administrative Review

Litigation and administrative review activity in the nursing home arena provides some insights. Much activity has focused on HCFA's failure to enforce regulations designed to assure provider compliance with federal statutes, regulations, and survey protocols, and their interplay with state enforcement procedures. While this arena has been labor intensive and time consuming, /37/ beneficiaries have enjoyed incremental successes, namely, in the area of providing input in the design of survey and certification protocols. Generally, however, advocates' and beneficiaries' experience with administrative implementation of nursing home reform has been one of delay and frustration. /38/

The Secretary's failure to address a specific mechanism for patients to obtain review of the sufficiency of discharge planning raises basic due process issues. Advocates may wish to pursue the failure to develop a patient-review mechanism in the context of a due process challenge. Such a challenge may force the agency to take seriously the need to expand PRO review to include a substantive review of the quality of discharge-planning evaluations and discharge planning. /39/

B. Education Strategies

Advocates may wish to consider developing a series of community education presentations on discharge planning and planning for posthospital needs. These events could be grouped with a series of health-information activities important to older people, for example, planning for incapacity, health care decision making, or making the choice between home health care and nursing facility care. It is important to include the perspectives of hospital discharge planners, ombudsman advocates, care managers, and lawyers (or paralegal advocates) in the training design. Together, these perspectives should highlight discharge planning as an advocacy tool for promoting beneficiary choice and access to services.

These strategies can be complemented by the development of training and education materials such as brochures and pamphlets that explain the discharge-planning statute and regulations and provide advocacy tips for patients and their families and representatives. Again, hospital discharge-planning departments may have materials that will be useful in this regard.

IV. Conclusion

Discharge planning provides important opportunities for advocates to assist patients in arranging posthospital services in settings of choice. These opportunities involve developing both

administrative and court initiatives to assure HCFA implementation of discharge-planning policy through its interpretive and enforcement mechanisms. They also involve collaboration with ombudsmen, community advocates, and the discharge-planning staff of Medicare-participating hospitals.

Footnotes

/1/ 59 Fed. Reg. 64141 et seq. (Dec. 13, 1994) (codified at 42 C.F.R. Sec. 482.43). The regulations became effective on January 12, 1995. Discharge-planning requirements are included in the Social Security Act Secs. 861(e), (ee), codified at 42 U.S.C. Secs. 395x(e),(ee). They were added to the statute by the Omnibus Budget Reconciliation Act of 1986 (OBRA-86), Pub. L. No. 99-509, Sec. 9305(c), 100 Stat. 1989 (Oct 21, 1986). The proposed regulations are located at 53 Fed. Reg. 22506 et seq. (June 16, 1988).

/2/ The Secretary's statement of her authority, 59 Fed. Reg. 64143 (Dec. 13, 1994), is not apparent from the language of sections 861(e)(9) and 1861(ee). It is her view that section 861(ee) gives her the "authority to include standards and guidelines beyond those explicitly enumerated in the statute." 59 Fed. Reg. 64143 (Dec. 13, 1994). Later the Secretary writes that the reference in section 861(e)(9) to the "health and safety of individuals who are furnished services in the institution" supports her extension of the provision to all patients of a Medicare-participating hospital. 59 Fed. Reg. 64144 (Dec. 13, 1994).

/3/ It is also the Secretary's view that the discharge-planning standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the American Osteopathic Association (AOA) apply to all patients. 59 Fed. Reg. 64143 (Dec. 13, 1994).

/4/ 59 Fed. Reg. 64145 (Dec. 13, 1994).

/5/ 42 C.F.R. Sec. 82.43(b)(1).

/6/ 59 Fed. Reg. 64147 (Dec. 13, 1994) (preamble); 42 C.F.R. Sec. 5482.43(c)(2) (discharge plan must be developed if the discharge evaluation indicates the need for it, or upon the request of the physician).

/7/ The Advisory Panel on Needs Assessment was created by OBRA-86, Pub. L. No. 99-509, 100 Stat. 1874, Sec. 9305(h).

/8/ / /See Health Care Fin. Admin., Report of the Secretary's Advisory Panel (Dec. 1992) (Publication No. 10957).

/9/ There may be state laws that give beneficiaries additional rights, e.g., New York, Massachusetts, and Connecticut. See infra notes 14 -- 15 and accompanying text.

/10/ 59 Fed. Reg. 64246 (Dec. 13, 1994). Note that interpretive guidelines are general statements of policy, or rules of agency organization, procedure, or practice, and are not subject to the notice and

comment provisions of the Administrative Procedure Act (APA), 5 U.S.C. Sec. 553(b)(3)(A). Zaharakis v. Heckler, 744 F.2d 711 (9th Cir. 1984). These guidelines interpret the statutes and laws an agency administers. See American Hosp. Ass'n v. Bowen, 834 F.2d 1037, 1045 -- 46 (D.C. Cir. 1987) (Clearinghouse No. 42,928). Where the Secretary's interpretive guidelines raise statutory or constitutional questions, they can be challenged on APA grounds. Bowen v. Michigan Academy of Family Physicians, 476 U.S. 667 (1986). Interpretive guidelines, while not having the force and effect of law or APA-promulgated regulation, are given weight and consideration by courts in disputes about an agency's interpretation of the statutes it administers. Friedrich v. Secretary of HHS, 894 F.2d 829 (6th Cir. 1990); Linoz v. Heckler, 800 F.2d 829, 871 (9th Cir. 1986) (Clearinghouse No. 33,817). Rules that effect a change in existing law or policy are subject to the notice and comment rule-making requirements of section 553 of the APA even if the agency has labeled these rules as interpretive. Mount Diablo Hosp. Dist. v. Bowen, 860 F.2d 951, 956 (9th Cir. 1988). See also Robert A. Anthony, Interpretive Rules, Policy Statements, Guidances, Manuals, and the Like -- Should Federal Agencies Use Them To Bind the Public?, 41 Duke L.J. 1311 (1992).

/11/ See American Hospital Association, Guidelines for Discharge Planning (1984); see also literature references in Health Care Fin. Admin., Report of the Secretary's Advisory Panel on the Development of Uniform Needs Assessment Instrument(s) (Dec. 1992) (Publication No. 10957); Secretary's reliance on JCAHO and AOA discharge-planning standards, supra note 3. A few journals and magazines -- Continuing Care, Discharge Planning Update, Journal of Nurse Administration, and Health and Social Work, among others -- address discharge planning.

/12/ Note that disagreeing with a discharge plan should not be viewed as refusing discharge-planning services. Documentation of a patient's choice to refuse discharge-planning services should have its own protocol. To this end, the Secretary plans to mention this situation in her interpretive guidelines. 59 Fed. Reg. 64150 (Dec. 13, 1994).

/13/ 59 Fed. Reg. 64148 (Dec. 13, 1994). The beneficiary community has not as a rule found Peer Review Offices (PROs) particularly open to beneficiary concerns. For the most part, PROs have reflected the concerns of physicians; beneficiary representatives have only occasionally been included in the makeup of PRO committees.

/14/ N.Y. Comp. Codes R & Regs. tit. 10, Secs. 405.22(j) et seq.

/15/ Mass. Gen. L. ch. 111 (amending 1D by inserting Sec. 13, ch. 574, of the Acts of 1985).

/16/ N.Y. Comp. Codes R & Regs. tit. 10, Secs. 405.22(j) et seq.

/17/ Mass. Gen. L. ch. 111.

/18/ Id.

/19/ 59 Fed. Reg. 64147 (Dec. 13, 1994).

/20/ Id.

/21/ See 42 C.F.R. Sec. 82.43(e).

/22/ 59 Fed. Reg. 64149 (Dec. 13, 1994).

/23/ See supra note 11.

/24/ Fed. Reg. 64146 (Dec. 13, 1994).

/25/ Id. at 64148.

/26/ Id.

/27/ Id.

/28/ Id.

/29/ Id.

/30/ Id. at 64149.

/31/ Id.

/32/ Id. at 64150.

/33/ Id.

/34/ Id. at 64149.

/35/ See supra note 10.

/36/ In pursing this avenue, advocates must be careful to maintain a posture such that they can file suit or pursue other advocacy strategies as appropriate.

/37/ See, e.g., Smith v. Shalala, No. 750-M-539 (D. Colo. filed 1975). This 20-year-old Colorado lawsuit seeks Health Care Financing Administration development and enforcement of a federal survey protocol through APA procedures for enforcing nursing facility residents' rights. This case is also a good example of the delays involved in reforming systems that are themselves changing on the basis of a variety of related laws and administrative actions external to the litigation itself. See also Toby S. Edelman et al., Nursing Facility Transfer and Discharge: A Manual for Residents' Advocates (Mar. 1994) (available from the D.C. office of the National Senior Citizens Law Center). In 1984, the Tenth Circuit issued a ruling requiring the Secretary to promulgate regulations that would mandate the collection of information on Medicaid nursing home quality. Smith v. Heckler, 747 F.2d 583, 591 (10th Cir. 1984). The Secretary is seeking release from that order.

/38/ See Valdivia v. California Dep't of Health, Civ. No. S-90-1226 EJG/PAN (E.D. Cal. Apr. 13, 1993) (stipulation of settlement requiring the State of California to comply with the Nursing Home

Reform Law). Serious implementation issues remain in Valdivia, including federal oversight and monitoring of state compliance efforts. The Nursing Home Reform Law, Pub. L. No. 100-203, Secs. 4213 (enforcement), 4212 (survey and certification process), 101 Stat. 1330-207 through 1330-220 (Dec. 22, 1987), applies to Medicare, 42 U.S.C. Sec. 395i-3(a) -- (h), and Medicaid 42 U.S.C. Sec. 396r(a) -- (h).

/39/ t should be noted that advocates have not been satisfied with the PRO review process. Anecdotal experience indicates that PROs tend to give less weight to beneficiary/patient concerns while giving more weight to the interests and point of view of hospitals and physicians; that few PROs have beneficiary representatives; and that PROs tend to make it difficult for beneficiaries to obtain access to data in support of their claims.