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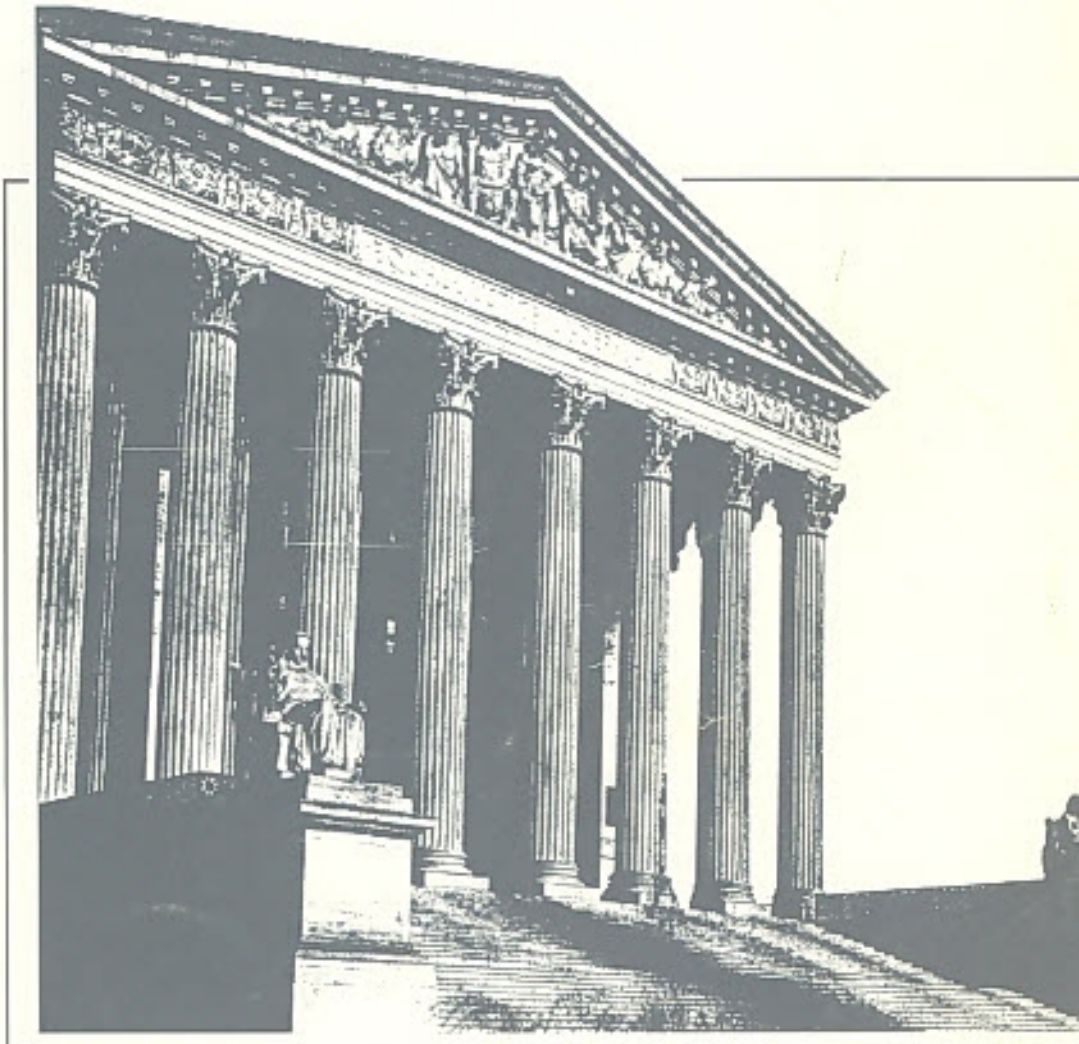

Decisions Concerning Access to Federal Court During the Supreme Court's 1995–96 Term

Assuring Quality: The Debate over Private Accreditation and Public Certification of Health Care Facilities

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I. Introduction

Assuring quality of care in the delivery of health services is vital, and both federal and state governments play an important role in doing so through licensing and certification standards. However, in the United States, public authorities have relied on private, provider-run accrediting organizations, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), to set standards for care and to determine compliance with those standards. Such accreditation has been criticized as a poor indicator of quality care. Nonetheless, the delegation of public regulatory and enforcement authority to provider-run entities is a growing trend -- increasingly evident in legislative actions and in litigation, in which states have argued that private accreditation serves as prima facie proof of constitutionally adequate care.

This article explores both the practical and the legal significance of private accreditation and the related issue of government certification of public facilities. Part II traces the growth of private accreditation and public certification of the health industry. Part III explains how private accrediting organizations such as JCAHO operate. Part IV reviews the process through which public mental retardation facilities are certified to receive Medicaid reimbursement for the care they provide to Medicaid-eligible residents and explains why advocates have rejected assertions that such certification is the equivalent of minimally adequate care. Parts V and VI discuss how private accreditation relates and compares to public regulation and oversight of health care facilities and why private accreditation and public certification alone are not reliable measures of quality of care. Part VII offers possible lessons for advocacy by describing how the issue was litigated during the most recent round of the landmark Wyatt case, which challenges inadequate care in Alabama's public mental illness and mental retardation service systems. Finally, the article examines future trends and policymakers' increased desire to expand the role of private-sector self-monitoring in lieu of direct government oversight.

II. The Growth of Private Accreditation and Public Certification of the Health Industry

Until the early 1900s, government oversight and regulation of health care providers was largely nonexistent. /1/ Private accreditation of hospitals began in 1919 with the hospital standardization program of the American College of Surgeons, an attempt by the medical profession to standardize hospital facilities in response to flagrant institutional inadequacies. /2/

Throughout the early 20th century, hospital quality assurance remained predominantly a private matter. /3/ Then, in 1946, Congress passed the Hill-Burton Act, providing financial assistance to states for construction of hospitals and other health care facilities. /4/ However, to receive funding, states had to promulgate and enforce minimum standards for maintenance and operation of the facilities. /5/

With Hill-Burton spurring state regulation of health care facilities, the hospital industry and the medical profession grew increasingly concerned about retaining control over the definition and regulation of quality in hospitals. /6/ In 1951, the American College of Surgeons joined with other physician associations and the American Hospital Association to form the Joint Commission on Accreditation of Hospitals (JCAH) and to foster private accreditation as a regulatory model. /7/

Initially, JCAH accredited only hospitals. Today, however, the renamed Joint Commission on Accreditation of Healthcare Organizations accredits more than 14,000 health care institutions. These include some 5,200 hospitals and more than 9,000 other organizations, including psychiatric facilities, rehabilitation programs, long-term care facilities, home health agencies, and, most recently, health care networks. /8/ JCAHO is the nation’s largest and most influential private accrediting organization. /9/

III. Inadequacies of Private Accreditation

Private accrediting organizations are closely tied to the industries they oversee and monitor. /10/ For example, 21 of the 28 board members of JCAHO are appointed by the American Medical Association, the American Hospital Association, the American College of Physicians, the American College of Surgeons, and the American Dental Association. The remaining seven, as of 1994, included one nurse and six members of the general public. /11/

Furthermore, JCAHO is supported financially by the organizations it monitors. /12/ Health care organizations purchase not only JCAHO accreditation services but also technical assistance and consulting services to improve survey performance. Although JCAHO asserts that it has procedures to avoid conflicts of interest, its close ties to and financial dependency on the industry it regulates and its dual role as enforcer and adviser raise clear concerns about its independence and objectivity. /13/

The infrequency of surveys is of further concern. Organizations accredited by JCAHO are generally surveyed every three years, although follow-up surveys may be scheduled more frequently. In

contrast, most state licensing authorities require annual inspections to determine compliance with health and safety standards.

The size and composition of the survey teams vary with the type and size of the facility. For hospitals, the team usually includes three health care professionals -- a physician, a nurse, and a hospital administrator. As a rule, surveys last about three days but may be longer, again depending on the size of the facility. /14/

Until recently, JCAHO scheduled all surveys several months in advance, giving facilities ample time to prepare. During Senate hearings in 1985, staff of Joint Commission-accredited hospitals testified about "efforts to 'spruce up' hospitals, including extra cleaning, personalization of wards, new clothing for patients and, especially, improvements in paperwork." /15/ Staff were even instructed to assemble patients "to give the appearance of a scheduled class." /16/ When the survey team left, however, the amenities and improvements disappeared. /17/

A decade after the Senate hearings exposed the impact of advance notification on the outcome of Joint Commission surveys, 95 percent of JCAHO surveys are still scheduled in advance, /18/ and facilities continue to take full advantage of the lead time. In one psychiatric hospital, for example, workers testified that wards were both cleaner and better staffed during JCAHO tours. /19/ Some facilities invite outside consultants and conduct "mock surveys" to assess and correct ahead of any identified deficiencies. /20/ Again, such quick fixes are often temporary. /21/ As a result, JCAHO survey teams generally do not see the facility as it typically operates. /22/

The JCAHO survey protocol has been repeatedly criticized for its reliance on paper and its focus on process or structure rather than on the outcomes of care. /23/ Despite recent changes in the survey process, JCAHO surveyors still largely focus on a facility's written policies and procedures. /24/ Indeed, JCAHO even admits that "surveyors do not judge directly whether the care given to a specific patient is good, bad, right or wrong." /25/ JCAHO also makes no provision for interested third parties to speak confidentially with the survey team. /26/ In fact, it is JCAHO's policy to disclose to the facility the identity of anyone seeking a public information interview with a surveyor /27/ -- a process unlikely to encourage staff, patients, or interested members of the public to come forward with complaints.

After the survey is completed, the surveyors score each of hundreds of applicable standards on a scale from one to five (one being highest). Individual surveyors have much discretion and use their own judgment when evaluating a facility. /28/ Consequently, there is great variation in how standards are scored. /29/ Although JCAHO's publicity materials indicate that hospitals and other health care organizations can and do receive "perfect" performance scores, /30/ perfect scores do not necessarily reflect 100-percent compliance with the standards. This is because, under the guidelines established in the JCAHO scoring manual, a score of one requires a showing of only 91-percent compliance, while a score of two requires a showing of only 76-percent compliance. /31/ Thus, even a facility with significant problems affecting large numbers of patients can attain a high score.

Moreover, due to the complex scoring methodology, low scores on individual standards often have no impact on a facility's aggregate score or its accreditation status. /32/ Even with serious deficits

in care and treatment, hospitals obtain and retain JCAHO accreditation. For example, in 1991, JCAHO awarded Searcy Hospital, a public psychiatric facility in Alabama, accreditation with 50 type 1 recommendations (the most serious deficiencies). /33/ In November 1994, the North Alabama Regional Hospital, a public psychiatric hospital, was accredited with seven type 1 recommendations. /34/ Some of the most serious violations noted by surveyors involved medication management and monitoring. Surveyors found "no documented definition of significant medication errors" and "no mechanism for the formal identification of adverse drug reactions that were physician-driven, such as a change in medication or stopping a drug." They also found numerous life safety code deficiencies and a demonstrated need to revise the life safet y management program for purposes of ongoing identification of such deficiencies and for purposes of prompt corrective action. /35/ More recently, in Washington, D.C., St. Elizabeth's Hospital, a public psychiatric hospital, retained its JCAHO accreditation even though the hospital was without adequate heat and hot water for most of the winter. /36/

Validation surveys conducted by the Health Care Finance Administration (HCFA) of the federal Department of Health and Human Services (HHS) regularly confirm that JCAHO-accredited facilities have significant deficiencies. /37/ In 1992, for example, 34 percent of JCAHO-accredited hospitals failed to meet one or more Medicare conditions of participation. /38/ According to a recent study by the Public Citizen Health Research Group, HCFA's data suggest that as many as 1,800 of approximately 5,300 JCAHO-accredited facilities nationwide "may be placing their patients at risk without timely intervention by JCAHO." /39/

Hospitals maintain JCAHO accreditation even when deficiencies are serious and long-standing. For example, in one of the hospitals visited by Senate staff, the JCAHO standard mandating that progress notes be made regularly had been violated on four previous surveys and was still not being met. Yet, the pattern of repeat violations had no adverse impact on the hospital's accreditation status. /40/ At Bryce Hospital in Tuscaloosa, Alabama, JCAHO documented serious life safety code violations in one unit over a six-year period. Yet at no time was Bryce Hospital's accreditation seriously threatened. /41/

The failure to impose meaningful sanctions against facilities for deficits in quality and care of patients is confirmed by JCAHO's own statistics showing that less than one percent of facilities are denied accreditation. /42/ Indeed, "JCAHO imposes meaningful penalties so infrequently that it fails to adequately deter violations of quality standards designed to safeguard the public's health." /43/

IV. Medicaid Certification of Public Mental Retardation Facilities

While conducted by public (state) rather than private entities, reviews of public facilities for people with mental retardation raise many of the same issues as the JCAHO-accreditation reviews.

Since 1971, Title XIX of the Social Security Act /44/ has permitted public facilities for individuals with mental retardation to receive Medicaid funds as intermediate care facilities for the mentally retarded" (ICF/MRs) so long as they meet criteria established by the federal government. /45/ ICF/MR regulations were first promulgated by the Department of Health, Education and Welfare

(HEW) in 1974 and revised in 1988 by HHS. These regulations, known as ICF/MR "conditions of participation," /46/ address various issues relating to the care received by institutionalized mentally retarded individuals, /47/ including resident rights protections, /48/ facility staffing, /49/ the requirement that institutional residents receive "active treatment" /50/ and health care services, /51/ and standards governing facilities' physical environment. /52/ HCFA is responsible for administering the ICF/MR program. /53/

Title XIX certification allows public mental retardation facilities to obtain federal Medicaid reimbursement of 50 -- 78 percent of the cost of care for the Medicaid-eligible residents of these institutions. /54/ In order for a public facility to participate in the ICF/MR program, it must be evaluated and certified approximately once a year as eligible. /55/ Nearly every state has attempted to obtain ICF/MR certification for its public mental retardation facilities, and many have spent large sums of money to bring their institutions into conformity with ICF/MR standards. /56/

If a facility is found out of compliance with ICF/MR standards, the "ultimate sanction" is termination of its eligibility for Medicaid reimbursement. /57/ In reality, however, loss of ICF/MR certification is extremely rare. /58/

Although Congress created the ICF/MR program with some admirable goals, /59/ advocates have long contended that Title XIX certification is not the equivalent of minimally adequate institutional care, in large part because of inadequacies in the certification process. For example, although mental retardation institutions undergo a certification survey approximately once a year, the survey is not carried out by HCFA surveyors or other federal agents. Rather, a state agency (usually the state health agency or other Medicaid reimbursement agency) is responsible for reviewing institutions and certifying that these facilities meet the ICF/MR conditions of participation. /60/ Advocates have argued that making one state agency responsible for evaluating and possibly stripping a sister agency of millions of dollars in Medicaid reimbursement creates an inherent conflict of interest and a disincentive to strict application of HCFA criteria. /61/

Similar concerns have been raised regarding the limited time and limited number of team members available to conduct ICF/MR surveys. /62/ Advocates have also contended that surveyors sometimes miss critical evidence of inadequate conditions /63/ and that Title XIX standards are not consistently applied from one survey to the next or from one state to the next. /64/ Although HCFA established a program of federal "look-behinds" as a form of oversight over the work of state surveyors, /65/ look-behind surveys in state mental retardation institutions have become increasingly rare in recent years since HCFA has been required to do regular look-behinds of nursing home facilities.

A variety of institutional reform cases has documented inadequate care and conditions -- by either constitutional or ICF/MR standards -- in many Title XIX -- certified state mental retardation facilities. /66/ It appears that, even with serious, long-lasting deficiencies, mental retardation facilities may retain their Title XIX certification. /67/ Moreover, advocates contend, Title XIX surveyors -- like JCAHO surveyors -- rarely get an accurate picture of institutional life. At least one study has shown that institutional residents have far more interaction with staff and far greater access to leisure materials during a Title XIX certification visit than when surveyors are not present. /68/ Even providers have expressed concerns about inconsistent survey results, surveys'

failure to distinguish between low-quality and high-quality service provision, and the apparent subjectivity of survey decisions. /69/ As a result, many professionals in the field contend that Title XIX certification is primarily a tool for public mental retardation facilities to gain federal funding but not an indicator of minimally adequate care. During the 1995 litigation in the long-standing Wyatt case in Alabama, this view was articulated by one of plaintiffs' expert witnesses, who currently serves as special master in the landmark Pennhurst litigation: /70/

[F]irst of all, more than 97 percent of large State-operated facilities for people with mental retardation are Title 19 certified. Many of these facilities that are or have been Title 19 certified have been found to provide inadequate care. Pennhurst was a perfect example. Forest Haven [a now-closed mental retardation facility in the District of Columbia] was [another]. Embreeville[, a Pennsylvania facility,] is a Title 19 facility and the State just said we admit we cannot provide adequate habilitation here and we're closing it down over the next two years. And Hissom State School in Oklahoma was a Title 19 facility that just closed. It was clear that it was inadequate to provide services. /71/

Today, the primary advocacy issue for institutionalized mentally retarded individuals is their asserted right to live in less restrictive settings. Yet concerns about whether anyone with mental retardation should live in an institutional setting /72/ -- and how community placement should occur -- are not reflected either in ICF/MR regulations themselves /73/ or in their enforcement. /74/

V. Deemed Status: The Delegation of Regulatory Authority to Private Accreditation Organizations

In a development that illustrates the weaknesses of both the public certification and private accreditation processes, federal and state governments are increasingly relying on private accreditation of health care facilities by JCAHO and other organizations to determine compliance with requisite standards and eligibility for participation in certain government programs. Since its inception in 1965, for example, the Medicare program has accepted or "deemed" JCAHO accreditation of hospitals, including psychiatric hospitals, /75/ as equivalent to compliance with Medicare certification standards. /76/ Subsequent amendments to the law gave the Secretary of HHS discretion to grant deemed status to a wide variety of accredited institutions, provided that HHS finds that accreditation by a national body offers reasonable assurance that Medicare certification conditions are met. /77/

Most recently, Congress enacted legislation as part of the fiscal year 1996 budget resolution that mandates expanded use of deemed status in the Medicare program. /78/ Specifically, the legislation provides that HHS must accord deemed status to certain accredited providers if the Secretary finds that private accreditation demonstrates compliance with conditions of participation in the Medicare program. The legislation also dramatically reduces the frequency of surveys for home health agencies from once every 15 months to once every 36 months, unless the agency is a poor performer or it experiences a change in ownership. Only skilled nursing facilities (SNFs), renal dialysis facilities, and durable medical equipment suppliers are exempt. /79/ However, their exemption may be short-lived. The legislation also directs HCFA to study and to report to Congress within a year the cost-effectiveness of expanding deemed status to SNFs and to report on other

"innovative regulation and non-regulatory incentives" to improve the quality of services provided to Medicare and Medicaid beneficiaries. /80/

States also have turned to private accreditation as a means of determining whether health care facilities meet requisite standards for licensure. /81/ Approximately 42 states and the District of Columbia rely on JCAHO accreditation in whole or in part for licensing health care institutions. /82/ Moreover, states are moving quickly to expand the use of private accreditation within the regulatory framework. Legislation recently introduced in Iowa, for example, would give nursing homes the option of choosing to be inspected either by the state or by JCAHO, and any nursing facility attaining JCAHO accreditation would automatically be licensed under the state standards. /83/

VI. Government Oversight of the Accreditation Process

In addition to granting "deemed" status to JCAHO-accredited hospitals, the 1965 Medicare statute as initially enacted prohibited the federal government from imposing more stringent requirements on such hospitals. /84/ Furthermore, the statute made no provision for federal auditing of the JCAHO-accreditation process. HEW, at the time responsible for oversight of the Medicare program, did not even have access to JCAHO's accreditation reports. /85/

In 1972, pressure from consumer groups and litigation challenging deemed status as an illegal delegation of legislated power /86/ led to changes in the deemed status arrangement accorded JCAHO-accredited facilities. /87/ First, Congress authorized HEW to impose hospital certification standards that were more stringent than JCAHO standards. Additionally, for the first time, HEW was empowered to validate JCAHO accreditation through random and complaint-based inspections by state agencies and to receive JCAHO survey reports for validation purposes. /88/ Subsequent amendments to the Medicare statute expanded slightly the federal government's authority to obtain survey reports and related information from private accreditation organizations. /89/

Theoretically, HCFA is legally empowered to take action against facilities found out of compliance with Medicare conditions of participation as a result of a validation survey. First, HCFA can withdraw deemed status. /90/ Second, if conditions in the facility put the health and safety of patients in immediate jeopardy, HCFA can move quickly to terminate the facility's participation in the Medicare program. /91/ If conditions are deficient but not serious, the facility must submit a plan of correction and attain compliance within a reasonable period of time, usually 60 days. /92/

"HCFA's enforcement program, however, has in fact neither been more aggressive nor more effective than the Joint Commission." /93/ Although 35 percent of accredited hospitals were given termination notices by HCFA during the validation process in fiscal year 1992, none was in fact terminated from Medicare. /94/

Lack of adequate public oversight of the private accreditation process is compounded by the shroud of secrecy that surrounds JCAHO accreditation decisions. Although both federal and state governments have succeeded in gaining access to JCAHO survey results and underlying data, public access to meaningful JCAHO survey data is virtually nonexistent. At the federal level, laws

and regulations permitting disclosure of accreditation documents to federal agencies prohibit redisclosures to the public except "to the extent that information is related to an enforcement action." /95/ Only home health agencies are exempted from this rule. /96/ At the state level, 17 states that rely on JCAHO accreditation for licensure prohibit redisclosure to the public. /97/

The maintenance of strict confidentiality is based on the notion that private accreditation is a peer review process directed at self-improvement. /98/ Many states recognize a privilege protecting materials generated during a peer review process from disclosure. In Niven v. Siqueira, a medical malpractice case, the Illinois Supreme Court refused to permit discovery of JCAHO accreditation reports on the grounds that they were privileged under an Illinois statute protecting from disclosure all materials used in the course of internal quality control to improve medical care. /99/ Similarly, in Zion v. New York Hospital, another medical malpractice case, the court ruled that JCAHO accreditation reports were "records relating to performance of a medical or quality assurance review function" and therefore were privileged and confidential under New York's statute protecting such materials from disclosure. /100/

Significantly, federal courts are not bound by state statutory privilege where jurisdiction is premised on a federal question. /101/ In deciding whether to incorporate state statutory privilege into federal common law, federal courts apply a balancing test comparing the federal and state interest at issue. /102/ In federal question cases, the special interest in seeking the truth almost always outweighs a state's interest in preserving a statutory privilege. /103/ The federal interest in seeking the truth is especially strong where plaintiffs sue for redress of violations of their civil rights at the hands of state officials. /104/ Plaintiffs have thus succeeded in obtaining access to JCAHO accreditation reports and correspondence in cases involving alleged violations of constitutional rights in state-operated mental health and mental retardation facilities. /105/

Courts may also be persuaded to authorize disclosure of JCAHO accreditation reports on the grounds that JCAHO acts more as a regulator than a peer review entity. In Patients of Philadelphia State Hospital v. Pennsylvania, for example, plaintiffs successfully sued the Pennsylvania Department of Public Welfare (DPW) to inspect a JCAHO accreditation report pertaining to Philadelphia State Hospital. /106/A key finding by the court was that the JCAHO report was relied upon by DPW to confer licensure and therefore was a "public record" subject to disclosure under Pennsylvania law. In Georgia Hospital Association v. Ledbetter, the Supreme Court of Georgia also granted disclosure of JCAHO accreditation reports on the grounds that the reports in question were generated as part of the state's licensing activities. /107/ The Ledbetter court specifically rejected the hospital association's argument that JCAHO reports were peer review materials and therefore privileged. The court's reasoning was short and to the point:

Since the accreditation surveys in questions were presented by the hospitals to the DHR for licensing in lieu of the hospitals' submitting to a DHR inspection, and since DHR inspection reports on hospitals not submitting JCAHO reports are routinely disclosed under the Open Records Act, common sense dictates that the JCAHO reports used for licensing be also released. /108/

Absent litigation, however, JCAHO makes little information available to the public. For $30 per request, members of the public can obtain a "performance report" for a particular facility. Such a report contains a list of aggregate scores, the number of type 1 recommendations made, and a short

summary of the issues to which the recommendations relate. However, these summaries do not reveal any of the surveyor's recommendations or the particular deficiencies identified during the survey. /109/ Performance reports offer consumers virtually no meaningful information about the quality of care provided. Moreover, when a performance report is ordered, JCAHO notifies the facility of the release of the information and the name and address of the person who requested the information. /110/

VII. A Case Study of Arguments About the Legal Effect of Accreditation and Certification: The Wyatt Litigation

The assertion that JCAHO accreditation and Title XIX certification are equivalent to minimally adequate care surfaced recently in the decades-old litigation of the Wyatt case, a class action regarding Alabama's care of individuals with mental illness and mental retardation. /111/ In 1972, the case produced landmark rulings establishing minimal standards for the state's care of people with mental illness and mental retardation, which became known as the "Wyatt standards." /112/ In 1986, the parties signed a consent decree in which the state pledged, among other things, to obtain and maintain JCAHO and Title XIX certification at 11 psychiatric and mental retardation facilities in which class members were confined. /113/

In the spring of 1995, the parties returned to court for a 35-day hearing on whether the defendants had complied with the 1986 consent decree and the Wyatt standards, the substantive due process requirements of the Fourteenth Amendment, /114/ and the Americans with Disabilities Act (ADA). /115/ Since 1991, defendants had contended that they were in compliance with the consent decree and that continued judicial supervision was unnecessary. By contrast, plaintiffs asserted that defendants were not in compliance either with the decree or with the ADA and that additional relief -- imposition of a court monitor or special master -- was warranted.

In this latest round of litigation, defendants asserted that the JCAHO accreditation and Title XIX certification of their facilities were prima facie proof that these facilities provided minimally adequate care. In their briefs and through the trial testimony of expert and lay witnesses, they argued that there were substantial similarities in subject matter between the accreditation and certification standards and the Wyatt standards. Moreover, defendants asserted that the accreditation and certification standards provided more detailed guidance to states and facilities and thus that JCAHO and Title XIX ICF/MR standards were superior to the Wyatt standards. /116/ Finally, as discussed below, they asserted that their position was supported by existing case law.

The Wyatt defendants' assertions regarding the meaning of accreditation and certification were contested by the plaintiffs and by the United States, amicus curiae in the litigation, and have twice been rejected by the district court.

A. The Court's Rulings and the Relevant Case Law

Although the district court has yet to rule on the merits in Wyatt, the court rejected defendants' accreditation/certification argument both in a pretrial summary judgment ruling /117/ and in a

posttrial preliminary injunction regarding unsafe conditions at defendants' psychiatric facility for children. /118/ In its summary judgment opinion, the court held that

> [JCAHO a]ccreditation means that the facility is capable of providing more than custodial care and is eligible for Medicare and third-party reimbursement; it does not mean that patients' constitutional and statutory rights are protected. . . . And as is the case with JCAHO accreditation, [Title XIX] certification does not mean that residents receive adequate care. /119/

Similarly, the court's preliminary injunction opinion stated: "[T]his court heard a great deal of evidence on JCAHO accreditation during the 35-day hearing, and concludes that JCAHO accreditation does not ensure that patients are safe and not abused and neglected." /120/

In reaching this conclusion, the court relied in part on case law holding that, while Title XIX certification or JCAHO accreditation may be relevant in institutional cases, neither certification nor accreditation alone is an acceptable substitute for a finding of minimum standards of care. /121/ In United States v. Illinois, for example, the court characterized HCFA standards as "irrelevant and immaterial" in determining whether a facility provided minimally adequate care according to constitutional standards and refused to allow the state to use certification as an affirmative defense. /122/ Lelsz v. Kavanaugh found that Title XIX standards "tell the Court little about the actual care clients receive." /123/ Robbins v. Budke held that JCAHO accreditation was "by no means an assurance that abuse and neglect of patients does not take place in an institution, or that patients' constitutional and statutory rights are being protected." /124/ United States v. Tennessee noted that facilities with "serious deficiencies" could remain Title XIX certified as long as they pledged to correct problems. /125/ Accordingly, the court found, "certification does not guarantee that constitutional minima exist" and "is not equivalent to a legal presumption of constitutional conditions, although it may provide some evidence on this point." /126/

The Wyatt court was not persuaded by defendants' attempt to rely on two appellate decisions, the Second Circuit's ruling in Woe v. Cuomo /127/ and the Fourth Circuit's ruling in Thomas S. v. Flaherty. /128/ Woe and Thomas S. found that "accreditation and certification created a presumption of minimally adequate care, but . . . the presumption may be rebutted," the Wyatt court held. /129/ In Wyatt, the court found, plaintiffs had put forth sufficient evidence to rebut any presumption of adequate care created by the accreditation and certification of Alabama facilities. /130/

In posttrial briefs, defendants claimed (for the first time in the litigation) that a presumption of adequate care created by accreditation or certification could be rebutted only by evidence uncovered by a survey team itself or by evidence that the accrediting body had allowed its standards to fall below constitutional minima. /131/ As support for this argument, defendants again cited Woe and Thomas S. /132/ The Wyatt court held, however, that "the type of evidence needed to overcome any presumption created by JCAHO accreditation has not been limited." /133/ As both plaintiffs and the United States asserted, the courts in Woe and Thomas S. never limited their consideration of evidence in the manner suggested by defendants. Both courts considered evidence other than evidence of inadequacies in the JCAHO process or of deficiencies uncovered by the surveyors themselves, and both found the presumption created by JCAHO accreditation to be

rebutted based on such evidence. In Woe the Second Circuit relied on the report of an HHS monitoring team. /134/ Woe noted that HHS and JCAHO had "conflicting evaluations" of a JCAHO-accredited facility and found that HHS' findings and the facility's loss of HHS certification "may signal inadequate institutional conditions even when JCAH accreditation is in order." /135/ In Thomas S. neither the Fourth Circuit nor the trial court stated that JCAHO review team findings were the only means by which a presumption of constitutional conditions could be rebutted. To the contrary, both courts treated the findings as supplementary to evidence compiled by the plaintiffs' expert. /136/

B. Plaintiffs' Focus on the Evidence

Plaintiffs opposed defendants' accreditation/certification theory by relying in large part on evidence demonstrating that, even though Alabama's institutions are JCAHO accredited and Title XIX certified, these facilities afford class members woefully inadequate care. For example, plaintiffs pointed out that one of defendants' mental retardation facilities remained Title XIX certified during a period when an undercover operation documented such gross staff abuse of residents that staff members were indicted for such acts as kicking residents and hitting them with their hands, with a bolt-studded board, and with a broom. /137/ A behavioral peer review group with which defendants had contracted found that none of Alabama's mental retardation facilities -- all Title XIX certified -- were providing minimally adequate care in behavioral programming. /138/ Similarly, plaintiffs noted that Alabama's mental illness facilities obtained and retained JCAHO accreditation despite such problems as inadequate staffing in all levels of professional staff and significant problems with medication administration and monitoring. /139/

Plaintiffs' experts strongly disputed the contention that accreditation or certification is a substantial indicator of minimally adequate care. One of plaintiffs' experts, the only testifying expert who had actually been a JCAHO surveyor, testified that surveyors "simply miss areas of deficit." /140/ Another of plaintiffs' experts, a former state director of licensure and certification, stated that Title XIX surveyors might not cite facilities for violations of Title XIX standards if "the State itself doesn't have the understanding, doesn't have the passion, doesn't have the commitment to move the provider community forward." /141/

Moreover, plaintiffs used information from Alabama accreditation and certification reports to rebut any presumption of minimally adequate care at defendants' institutions. Plaintiffs pointed out numerous instances of facilities having retained their certification or accreditation despite being cited for deficiencies time and again. In Alabama's mental retardation facilities, for example, Title XIX ICF/MR surveyors documented violations of Title XIX standards in the areas of habilitation, programming, and supervision. /142/ These institutions were cited for violating Title XIX standards requiring adequate nutrition, basic cleanliness, and safety. /143/ In some cases, surveyors found the self-same problem in both an initial survey and a "revisit" to determine whether facilities had actually made the improvements they promised. /144/

Similarly, JCAHO repeatedly cited Alabama's mental illness facilities for serious violations of critical standards. The state's largest public psychiatric hospital had been repeatedly cited for failure to ensure a therapeutic environment. /145/ Another hospital had received only the lowest

form of JCAHO accreditation because of serious deficiencies throughout, including the failure to meet patient needs through treatment planning and adequate staffing. /146/ Yet another hospital, which also received the lowest form of JCAHO accreditation, was cited by surveyors for violations of standards governing medication management and monitoring. /147/ The children's psychiatric facility that the district court found so unsafe as to warrant preliminary relief /148/ was cited by JCAHO for failing to comply with standards regarding the therapeutic environment, patient privacy, and special treatment procedures. /149/

C. The United States' Arguments

Plaintiffs' assertions regarding the meaning of JCAHO accreditation and Title XIX certification were bolstered significantly by the U.S. Department of Justice, amicus curiae in Wyatt. /150/ In a pleading filed during the 1995 proceedings, the United States asserted unequivocally that "[t]he Department of Justice does not agree that Title XIX regulations represent the equivalent of minimal constitutional standards, nor does it agree that Title XIX certification under these regulations is the equivalent of compliance with minimum constitutional standards." /151/

The United States described Title XIX ICF/MR regulations as "simply reimbursement criteria. . . . [W]hen a facility is found to comply with HCFA regulations, the only meaning that can be attributed to the certification is that the facility is eligible to claim federal reimbursement for services it has provided to eligible clients. . . . Neither the standards themselves nor certification equate with constitutional levels of care and treatment." /152/

In support of its position, the United States asserted that Title XIX regulations are written in a "broad fashion, are dated and fail to specifically address all areas of care implementing the constitutional and statutory rights" of institutionalized individuals with mental retardation. /153/ The United States maintained that, while Title XIX regulations and guidelines fail to address in detail many critical aspects of care for individuals in mental retardation facilities or to incorporate professional standards of care, "courts have set forth detailed standards for care, training and medical services to which residents of mental retardation facilities are entitled." In addition, the United States noted that Title XIX ICF/MR regulations have not been revised since 1988, are "virtually the same" as regulations drafted in 1974, and do not reflect many of the technological and professional advances that, over the past 20 years, have altered professional standards and the level of constitutionally required standards of care. /154/ In contrast to Title XIX standards, the United States asserted, "case law defining constitutional standards, which is based on accepted professional standards, has continually expanded applicable constitutional rights to keep pace with changes in professional standards." /155/

Moreover, as did plaintiffs, the United States analyzed existing case law (much of it developed in litigation brought by the United States) and argued that courts have "consistently held that HCFA certification does not automatically constitute constitutional adequacy of services." /156/ Finally, the United States noted that, regrettably, mental retardation facilities continue to be certified despite continuing deficiencies in care. /157/

VIII. Issues for the Future

Clearly, the limitations of both private and public mechanisms for assuring quality care in the health industry leave the public vulnerable. Of the two, however, private accreditation is the more problematic. First, private, provider-dominated accrediting organizations are not accountable to the public. Second, the public has almost no access to the information they generate. And, third, effective enforcement is virtually nonexistent.

Rather than shore up direct public oversight of the health industry, the trend is clearly toward the less rigorous and more secretive private-accreditation approach. The recent effort led by industry lobbyists to expand deemed status to nursing facilities under the Medicare program is just one manifestation of this growing interest.

Private accreditation is also being promoted as an appropriate model for assuring quality in the burgeoning managed care industry. JCAHO has already published a set of standards for health care networks and has surveyed and accredited some. /158/ Other private accreditation organizations, such as the National Committee on Quality Assurance (NCQA), have also developed standards for managed care companies. /159/ In addition, Congress has proposed a private accreditation model to regulate publicly funded managed care systems such as those being implemented under waivers to transform state Medicaid programs. /160/

Without consumer input and advocacy to counter industry's aggressive lobbying, private accreditation models are likely to prevail. Also, states and facilities will likely continue attempting to use both private accreditation and public certification to counter allegations of inadequate care, as they did in the recent round of Wyatt litigation. But, as Wyatt demonstrates, advocates may successfully combat such assertions with legal precedent, factual development, and the opinions of respected health care professionals. While private accreditation may have some merit, it can never be an adequate substitute for objective, consumer-oriented oversight and regulation of the health care industry.

Footnotes

/1/ Eleanor D. Kinney, Private Accreditation as a Substitute for Direct Government Regulation in Public Health Insurance Programs: When Is It Appropriate?, 57 Law & Contemp. Probs. 47, 50 (1994).

/2/ Timothy S. Jost, Medicare and the Joint Commission on Accreditation of Healthcare Organizations: A Healthy Relationship?, 57 Law & Contemp. Probs. 15, 16 (1994).

/3/ Kinney, supra note 1, at 52.

/4/ Hospital Survey and Construction Act, Pub. L. No 79-725, 60 Stat. 1040 (1946) (codified at 42 U.S.C. Secs. 291a -- 291o (1988)).

/5/ 42 U.S.C. Sec. 291d, g (1991) (originally enacted as Act of July 1, 1944, ch. 373, tit. VI, Sec. 604).

/6/ Kinney, supra note 1, at 52.

/7/ Id.

/8/ Joint Comm'n on Accreditation of Healthcare Orgs. (JCAHO), Understanding the Hospital Performance Report 1 (1994); Jost, supra note 2, at 16; Kinney, supra note 1, at 58 -- 60.

/9/ Kinney, supra note 1, at 52; Clark C. Havighurst, Private Accreditation in the Regulatory State, 57 Law & Contemp. Probs. 1, 6 (1994).

/10/ Kinney, supra note 1, at 71.

/11/ Jost, supra note 2, at 15 (1994); JCAHO, supra note 8.

/12/ Kinney, supra note 1, at 71; Jost, supra note 2, at 29 n.104 (citing the high cost of JCAHO accreditation: in 1991, the basic, initial triennial survey fee was $6,052; however, hospital administrators estimated that the total survey cost, including preparation, runs well over $100,000 depending on the size and nature of the facility).

/13/ Jost, supra note 2, at 15 n.11. See also Joan Steiber & Sidney M. Wolfe, Public Citizen's Health Research Group, Who's Watching Our Hospitals? (1994); Havighurst, supra note 9, at 9 ("[T]he Joint Commission for many years appeared to be more interested in organizational issues in hospitals than the outcomes of patient care -- that is, to be more concerned about how well a hospital treats its physicians than about how well it treats its patients.").

/14/ JCAHO, supra note 8, at 3; Jost, supra note 2, at 16. See also Plaintiffs' Reply to Defendants' Post-Trial Brief at 15, Wyatt v. Poundstone, No. 3195-N (M.D. Ala. filed July 11, 1995) (Clearinghouse No. 6874-Z-25).

/15/ Hearings Before the Subcomm. on the Handicapped of the S. Comm. on Labor & Human Resources and the Subcomm. on Labor, Health & Human Educ. & Related Agencies of the S. Comm. on Appropriations, 99th Cong. 1st Sess. at 87 -- 91 (1985) [hereinafter Senate Report].

/16/ Id. at 91.

/17/ Id. at 91 -- 92.

/18/ Jost, supra note 2, at 33.

/19/ See also Plaintiffs' Reply to Defendants' Post-Trial Brief at 12 n.43, Wyatt, No. 3195-N (Clearinghouse No. 6874-Z-25).

/20/ Id. at 11; Senate Report, supra note 15, at 92.

/21/ Plaintiffs' Reply to Defendants' Post-Trial Brief at 12, Wyatt, No. 3195-N (Clearinghouse No. 6874-Z-25).

/22/ Id.

/23/ Id. at 6; Senate Report, supra note 15, at 96 -- 97.

/24/ E.g., JCAHO standards provide that patients in mental health facilities have the right to impartial access to treatment regardless of race, religion, sex, ethnicity, age, and handicap. Each patient's personal dignity must also be recognized and respected in providing care and treatment, and each patient is entitled to receive individualized treatment. Joint Comm'n on Accreditation of Healthcare Orgs., 1993 Accreditation Manual for Mental Health, Chemical Dependency and Mental Retardation/Developmental Disabilities Services, Standards, vol. 1, at 31 (1993). To determine compliance with these standards, however, the protocol for JCAHO surveyors is to review patient rights policies and procedures, statement of rights, clinical records and the facility's written plan for professional services. Id., Scoring Manual, vol. 2; see also Plaintiffs' Reply to Defendants' Post-Trial Brief at 6, Wyatt, No. 3195-N (Clearinghouse No. 6874-Z-25).

/25/ JCAHO, supra note 8, at 3.

/26/ Senate Report, supra note 15, at 90.

/27/ JCAHO standards require facilities to post notices 30 days before the date of a scheduled survey to inform the public about the opportunity to request a public information interview with a JCAHO field representative. JCAHO's written notice states:

> Anyone believing that he or she has pertinent and valid information about . . . matters may request a public information interview with the Joint Commission's field representatives at the time of the survey. Information presented at the interview will be carefully evaluated for relevance to the accreditation process. Requests for a public information interview must be made in writing and should be sent to the Joint Commission no later than five working days before the survey begins. The request must also indicate the nature of the information to be provided at the interview. . . . The Joint Commission will acknowledge such requests in writing or by telephone and will inform the organization of the request for an interview. The organization, will in turn, notify the interviewee of the date, time and place of the meeting. [Emphasis added.]

Joint Comm'n on Accreditation of Healthcare Orgs., Public Notice Regarding Greil Memorial Psychiatric Hospital (Feb. 6, 1996).

/28/ Plaintiffs' Reply to Defendants' Post-Trial Brief at 12 -- 13, Wyatt, No. 3195-N (Clearinghouse No. 6874-Z-25).

/29/ Joint Comm'n on Accreditation of Healthcare Orgs., Sample Hospital Performance Report (1995). According to JCAHO, "there may be no real difference between a hospital that scores 88 in one area and a hospital that scores 81 in the same area. . . . Therefore, in assessing the difference in

scores between hospitals, it is appropriate to consider a range of scores rather than the absolute number."

/30/ Id. at 2.

/31/ Joint Comm'n on Accreditation of Healthcare Orgs., 1993 Accreditation Manual for Mental Health, Chemical Dependency and Mental Retardation/Developmental Disabilities Services, Scoring Guidelines, vol. II (1993); Plaintiffs' Reply to Defendants' Post-Trial Brief at 13 -- 14, Wyatt, No. 3195-N (Clearinghouse No. 6874-Z-25).

/32/ Jost, supra note 2, at 17; Plaintiffs' Reply to Defendants' Post-Trial Brief at 14, Wyatt, No. 3195-N (Clearinghouse No. 6874-Z-25) (scores are aggregated using complex algorithms to reach an accreditation decision).

/33/ Plaintiffs' Reply to Defendants' Post-Trial Brief at 9 -- 10 & n.30, Wyatt, No. 3195-N(Clearinghouse No. 6874-Z-25). One of Searcy Hospital's type 1 recommendations was for inadequate staffing in all levels of professional staff, including physicians, psychiatrists, psychologists, social workers, activity therapists, and nursing staff. At the survey, registered nurse staffing at Searcy Hospital was 73 percent. JCAHO subsequently lifted the type 1 recommendation regarding registered nurse staffing upon Searcy's submission of a written progress report indicating that the hospital had increased nurse staffing to 80 percent of budgeted positions.

/34/ Id.

/35/ Id. at 26.

/36/ Hamil R. Harris, Boiler Failure Limits Heat at St. Elizabeth's, Wash. Post, Dec. 12, 1995; Valerie Strauss, As St. Elizabeth's Crumbles, Many Advise Closing It, Wash. Post, Jan. 23, 1996 ("Freezing wards, sporadic hot water, medications shortages and inadequate staffing have devastated care at the District's St. Elizabeth's Hospital.").

/37/ Jost, supra note 2, at 40 -- 41.

/38/ Id. at 40.

/39/ Steiber & Wolfe, supra note 13, at 21.

/40/ Senate Report, supra note 15, at 89 -- 90.

/41/ Plaintiffs' Reply to Defendants' Post-Trial Brief at 10 & n.30, Wyatt, No. 3195-N (Clearinghouse No. 6874-Z-25).

/42/ Id. at 9 n.28; JCAHO, supra note 8, at 3.

/43/ Steiber & Wolfe, supra note 13, at 30.

/44/ 42 U.S.C. Sec. 1396.

/45/ See Pub. L. No. 92-223, 85 Stat. 802, Sec. 4 (codified at 42 U.S.C. Secs. 1396a(a)(31), 1396d(a)(15), 1396d(d)). When the Medicaid program was enacted in 1965, it excluded persons in public mental retardation facilities from Medicaid coverage. The 1965 statute also created an incentive for states to convert public institutions into "medical institutions" or skilled nursing facilities (SNFs) in order to receive Medicaid funding for individuals in such facilities. After states began to designate public mental retardation facilities as SNFs, Congress learned that many SNF residents were receiving far more medically intensive care than they needed, at more expense than was needed, due to the incentive created by the possibility of Medicaid funding. In 1971, Congress combined the SNF program with the less expensive and less medically intense intermediate care facility Medicaid reimbursement program for private providers and specifically authorized Medicaid funding for the "intermediate care" of individuals in public mental retardation facilities. See K. Charlie Lakin et al., Univ. of Minn. Inst. on Community Integration Report No. 31, Intermediate Care Facilities for Persons with Mental Retardation (ICFs-MR): Program Utilization and Resident Characteristics 3 -- 5 (1990); Sally Bachman et al., Univ. of Minn. Inst. on Community Integration Report No. 46, Residential Services for Persons with Developmental Disabilities: Status and Trends Through 1994 at 73 (Robert Prouty & K. Charlie Lakin eds., 1995). In addition to public facilities, the intermediate care facilities for the mentally retarded (ICF/MR) program provides Medicaid funding to certified publicly and privately operated facilities that serve as few as four individuals. See id. at 73 -- 74.

/46/ 42 C.F.R. Sec. 483.400 -- .480.

/47/ See Lelsz v. Kavanaugh, 673 F. Supp. 828, 837 -- 38 (N.D. Tex. 1987) (Clearinghouse No. 36,937) (describing a variety of ICF/MR regulations).

/48/ 42 C.F.R. Sec. 483.420.

/49/ Id. Sec. 483.430.

/50/ Id. Sec. 483.440. The "active treatment" regulation requires that each ICF/MR resident "receive a continuous . . . program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services . . . directed toward the acquisition of the behaviors necessary for the client to function with as much self-determination as possible and the prevention or deceleration of regression or loss of current optimal functional status." Id. Sec. 483.440(a). The regulations provide that an individual who is not in need of "active treatment" should not be admitted to an ICF/MR facility. Id. Sec. 483.440(b)(1).

/51/ Id. Sec. 483.460.

/52/ Id. Sec. 483.470.

/53/ See Margaret P. Sparr & Wayne Smith, Regulating Professional Services in ICF/MRs: Remembering the Past and Looking to the Future, 28:2 Mental Retardation 95, 96 (1990); see also

Lakin, supra note 45, at 6 (Health Care Financing Administration [HCFA] responsibilities include developing ICF/MR standards and monitoring state efforts to ensure facility compliance).

/54/ Sparr & Smith, supra note 53, at 97.

/55/ See 42 C.F.R. Sec. 442.109.

/56/ See Sheryl A. Larson & K. Charlie Lakin, Univ. of Minn. Inst. on Community Integration Report No. 47, Status and Changes in Medicaid's Intermediate Care Facility for the Mentally Retarded (ICF-MR) Program: Results from Analysis of the Online Survey Certification and Reporting System 1 (1995); Bachman et al., supra note 45, at 73 -- 74.

/57/ Lakin et al., supra note 45, at 7.

/58/ During a 1995 evidentiary hearing in the Wyatt litigation, the former state director of licensure and certification testified as plaintiffs' expert that she was aware of "less than probably ten facilities in the nation that were decertified." See Plaintiffs' Reply to Defendants' Post-Trial Brief at 14, Wyatt, No. 3195-N (Clearinghouse No. 6874-Z-25). See also Lakin et al., supra note 45, at 7 ("In practice, few terminations of [Medicaid] provider agreements have resulted from the intensified review of ICF-MR programs since 1985.").

/59/ As one commentary on this legislation noted:

> Three primary outcomes of the ICF-MR legislation appear to have been intended by Congress: (1) to provide substantial federal incentives for upgrading the physical environment and the quality of care and habilitation being provided in public [mental retardation and developmental disabilities (MR/DD)] institutions; (2) to neutralize . . . incentives for states to place persons with [MR/DD] in nonstate nursing homes and or to certify their state institutions as [SNFs in order to receive Medicaid reimbursement]; and (3) to create a program for care and habilitation ("active treatment") specifically focused on the needs of persons with MR/DD rather than upon medical care.

Bachman et al., supra note 45, at 73 -- 74.

/60/ Sparr & Smith, supra note 53, at 97; see also Lelsz, 673 F. Supp. at 836 -- 37 (describing this process).

/61/ E.g., during a 1995 evidentiary hearing in Wyatt, one of plaintiffs' experts -- a former state director of licensure and certification -- testified that in Title XIX surveys "the message [to state surveyors] is always clear that we all work for the same governor, and that if you're going to move on a state facility that is run, essentially by the governor of that state, . . . you really think hard before you make that kind of decision." See United States Proposed Findings of Fact and Conclusions of Law at 48 & n. 216, Wyatt, No. 3195-N (Clearinghouse No. 6874-Z-22).

/62/ In Wyatt, plaintiffs' expert witness testified that survey teams often have "a limited amount of time" and that in her four years as a state licensure director the licensing agency was responsible for

"hundreds" of additional facilities but was given no additional staff. See Plaintiffs' Reply to Defendants' Post-Trial Brief at 16 & n.68, Wyatt, No. 3195-N (Clearinghouse No. 6874-Z-25).

/63/ See United States Proposed Findings of Fact and Conclusions of Law at 48 -- 49, Wyatt, No. 3195-N (Clearinghouse No. 6874-Z-22) (noting the results of a Title XIX survey in an Alabama public facility that failed to document serious injuries, including ongoing self-injurious behavior and a recent rape, to institutional residents whose cases were also reviewed by the United States' expert witness).

/64/ Plaintiffs' Reply to Defendants' Post-Trial Brief at 13 & nn.51 -- 53, Wyatt, No. 3195-N (Clearinghouse No. 6874-Z-25).

/65/ The look-behind program was established after 1984 congressional hearings documented inadequate and even abusive conditions in public facilities that had been state certified as eligible for Medicaid reimbursement. Smith & Sparr, supra note 53, at 97; Lakin et al., supra note 45, at 6 -- 7.

/66/ These include cases (1) concerning unconstitutional conditions in Title XIX -- certified facilities, see, e.g., Lelsz, 673 F. Supp. 828; United States v. Illinois, 803 F. Supp. 1338 (N.D. Ill. 1992), Wyatt v. Poundstone, No. 3195-N (M.D. Ala. Mar. 3, 1995) (Clearinghouse No. 6874); (2) specifically alleging violations of Title XIX standards in institutions that are Title XIX certified, see, e.g., Messier v. Southbury Training School, 916 F. Supp. 133 (D. Conn. 1996) (granting plaintiffs the right to sue under 42 U.S.C. Sec. 1983 to vindicate alleged violations of Title XIX's "active treatment" requirement); and (3) combining these claims, see, e.g., Homeward Bound v. Hissom Memorial Center, No. 85-C-436-E (N. D. Okla. July 24, 1987) (Clearinghouse No. 42,759). Cf. Sparr & Smith, supra note 53, at 98 ("Today, despite all of the research and technological advances described in the . . . literature, it is still not uncommon for HCFA surveyors to come across lay and professional staff in facilities who do not have the most basic notion of how to do the job!").

/67/ See United States v. Tennessee, 798 F. Supp. 483 (W.D. Tenn. 1992). See also discussion of the evidence on this issue in the Wyatt litigation.

/68/ See Dennis H. Reid et al., Evaluation of Components of Residential Treatment by Medicaid ICF-MR Surveys; A Validity Instrument, 24:2 J. of Applied Behav. Analysis 293, 296 -- 300 (1991).

/69/ Id. at 300 -- 2. In a survey of public facility residential services directors (1) 21 percent of respondents characterized survey teams' interpretation of compliance with ICF/MR standards as "very" or "extremely" inconsistent; (2) 20 percent of respondents indicated that Title XIX surveyors do a poor job of differentiating between high-quality and low-quality care; and (3) 25 percent responded that survey decisions were "very" or "extremely" subjective, with 51 percent characterizing survey decisions as "only somewhat objective."

/70/ See Halderman v. Pennhurst State School & Hosp., 446 F. Supp. 1295 (E.D. Pa. 1977), aff'd in part & rev'd in part, 612 F.2d 84 (3d Cir. 1979), rev'd on other grounds, 451 U.S. 1 (1981) (Clearinghouse No. 12,902).

/71/ Plaintiffs' Reply to Defendants' Post-Trial Brief at 10 -- 11, Wyatt, No. 3195-N (Clearinghouse No. 6874-Z-25). See Evans v. Washington, 459 F. Supp. 483 (D.D.C. 1978) (Clearinghouse No. 17,574) (consent decree agreeing to close Forest Haven in light of allegations of inadequate care; Forest Haven finally closed in October 1991); United States v. Pennsylvania, No. 93-CV-2094 (E.D. Pa. 1994) (settlement agreement); Homeward Bound, No. 85-C-437-E.

/72/ As plaintiffs argued during the 1995 Wyatt proceedings, "With advances in the field, a consensus has developed that all individuals with mental retardation can and should be served in community settings." See Plaintiffs' Proposed Findings of Fact and Conclusions of Law at 57, Wyatt, No. 3195-N (Clearinghouse No. 6874-Z-23); see also id. at 56 -- 80 (reciting generally plaintiffs' mental retardation evidence regarding community placement issues). Perhaps most significantly, The Arc (formerly known as the Association for Retarded Citizens), the nation's largest advocacy organization on behalf of people with mental retardation and their families, has taken the position that "[a]ll people with mental retardation . . . have a right to live in their local community with non-disabled citizens and be fully included. . . . Large congregate care facilities (institutions) are no longer necessary or appropriate for anyone, regardless of the type or severity of a person's disabilities." The Arc, Where People Live (199
5).

/73/ See, e.g., United States Proposed Findings of Fact and Conclusions of Law at 50 & n.230, Wyatt, No. 3195-N (Clearinghouse No. 6874-Z-22) (citing trial testimony by one of plaintiffs' expert witnesses, who contended that ICF/MR standards regarding admission to mental retardation facilities were not the same as provisions of court-devised "Wyatt standards," which require, inter alia, that no mentally retarded individual shall be admitted to an Alabama institution unless a prior determination has been made that residence in the institution is the "least restrictive habilitation setting feasible" and that mentally retarded individuals should not be admitted to an institution if services and programs in the community can provide the individual with adequate habilitation. See also Wyatt v. Stickney, 344 F. Supp. 387, 396 (M.D. Ala. 1972) (setting out the requirements of Wyatt Standards 3(a) and 3(b)). One commentary characterized the ICF/MR program itself as essentially detached from current advocacy and profes
sional trends that focus on community-based care:

> Congress noted in the 1987 Developmental Disabilities Act that "it is in the national interest to offer persons with developmental disabilities the opportunity, to the maximum extent feasible, to make decisions for themselves and to live in typical homes and communities where they can exercise their full rights and responsibilities as citizens." It is difficult to see the present ICF-MR program as reflecting a serious commitment to advance this national interest. The current policy was developed in 1971 primarily to assure minimum standards of care and treatment to residents of large state institutions. Two decades later it seems essentially out of step with contemporary goals and standards for services to persons with mental retardation and related conditions, the vast majority of whom today receive those services while living in community-based residential settings or their own homes.

Lakin et al., supra note 45, at 73.

/74/ See Sparr & Smith, supra note 53, at 98 (acknowledging criticisms that Title XIX surveyors have used "inconsistent criteria" in measuring compliance with ICF/MR requirements for "active treatment." These regulations indicate that any individuals who are not in need of "active treatment," including those who are "generally independent" and can "function with little supervision or in the absence of a continuous active treatment program," are inappropriately admitted to an ICF/MR facility. See 42 C.F.R. Sec. 483.440(a), (b); see also supra note 50 (discussing this regulation).

/75/ Pub. L. No. 89-97, Sec. 1861(f), (g), 79 Stat. 286, 315 -- 16 (requiring accreditation for psychiatric hospitals), repealed by Deficit Reduction Act of 1984, Pub. L. No. 98-369, Secs. 2335(b)(1), 2340(a)(1)(4), 98 Stat. 499, 1091, 1093 (codified as amended at 42 U.S.C. Sec. 1395x (1988 & Supp V 1993)). Based on JCAHO accreditation, psychiatric hospitals were deemed in compliance, even after repeal, with the Medicare conditions of participation. Id.

/76/ 42 U.S.C. Sec. 1395x(e)(9), 1395bb (1988).

/77/ 42 U.S.C. Sec. 1395bb (1988 & Supp. III 1991); 42 C.F.R. Secs. 401, 488, 489. Facilities eligible for deemed status include psychiatric hospitals, SNFs, home health agencies, ambulatory surgical centers, rural health clinics, comprehensive outpatient rehabilitation facilities, hospices, laboratories and clinics, rehabilitation agencies, or public health agencies providing outpatient physical therapy, occupational therapy, or speech pathology services.

/78/ Omnibus Consolidated Rescissions and Appropriations Act, Pub. L. 104-134, Sec. 516(b), 110 Stat. 1321 [512] (Apr. 26, 1996).

/79/ Id. Sec. 516(b)(1), 110 Stat. 1321 [512 -- 13] (Apr. 26, 1996); Kinney, supra note 1, at 60 -- 61. Extension of deemed status to SNFs has long engendered strong opposition due to a legacy of substandard care within the industry. In 1981, the Reagan Administration proposal to permit deemed status certification of Joint Commission-accredited nursing homes was derailed by consumer groups concerned about quality care and inadequate monitoring. Congress not only imposed a six-month moratorium on the use of private accreditation of nursing homes but also commissioned a study to look comprehensively at the need for regulatory reform of the nursing home industry. Because nursing homes provide long-term care to a vulnerable and dependent population, it has been repeatedly suggested that the deeming mechanisms, in lieu of government regulation, are inappropriate. See also Omnibus Budget Reconciliation Act of 1987, 42 U.S.C. Secs. 1395i-3 (Medicare), 1396r (Medicaid) (Supp. 1991) (enacting sweeping reform legislatio n that not only raised the quality standards that Medicare- and Medicaid-certified nursing homes had to meet but also substantially strengthened the survey and enforcement process).

/80/ See also Omnibus Consolidated Rescissions and Appropriations Act, Pub. L. 104-134, Sec. 516(b), 110 Stat. 1321 (Apr. 26, 1996); H.R. Conf. Rep. No. 236, 104th Cong., 2d Sess. 3 (1996).

/81/ Kinney, supra note 1, at 58 ("As of 1982, at least thirty-eight states had [already] incorporated JCAHO accreditation into their licensure program in some capacity."); Jost, supra note 2, at 21 (as of 1994, two-thirds of states still utilized JCAHO accreditation in their licensure policy).

/82/ Timothy S. Jost, Confidentiality and Disclosure in Accreditation, 57 Law & Contemp. Probs. 171, 178 (1994); Kinney, supra note 1, at 54 -- 55.

/83/ States Not Waiting for Federal Deemed Status Action, McKnight's Long Term Care News, Apr. 8, 1996. In its final version, implementation of the Iowa law was made contingent on the passage of federal legislation authorizing deemed status for SNFs. Telephone interview with Carl McPherson, Iowa Department of Elder Affairs (July 1, 1996).

/84/ Kinney, supra note 1, at 56; Jost, supra note 2, at 18.

/85/ Jost, supra note 2, at 2 n.24.

/86/ Self-Help for the Elderly v. Richardson, No 2016-71 (D.D.C. 1972) (Clearinghouse No. 5918).

/87/ Cospito v. Heckler, 742 F.2d 72 (3d Cir. 1984), cert. denied, 471 U.S. 1131 (1985) (Clearinghouse No. 27,184); O'Bannon v. Town Court Nursing Center, 447 U.S. 773 (1980) (Clearinghouse No. 25,468).

/88/ Jost, supra note 2, at 18 -- 19; Kinney, supra note 1, at 61.

/89/ 42 U.S.C. Sec. 1395bb(e)(2) (Supp. III 1991).

/90/ 42 C.F.R. Sec. 488.6(d) (1993).

/91/ Id. Sec. 489.53(b)(2).

/92/ Id. Sec. 488.28.

/93/ Jost, supra note 2, at 41.

/94/ Id. at 41 -- 42.

/95/ 42 U.S.C. Sec. 1395bb(a) (1992); 42 C.F.R. Sec. 401.126(b)(2) (1992).

/96/ Kinney, supra note 1, at 58 -- 59. Deemed status for home health agencies was adopted despite widespread opposition. As a result, the home health industry is subject to extensive look-behind provisions to validate JCAHO accreditation findings. In addition, accreditation reports are subject to full public disclosure. See 42 U.S.C. Sec. 1395bb(a)(4).

/97/ Jost, supra note 2, note 83, at 179.

/98/ Id. at 171 -- 72.

/99/ Niven v. Siqueira, 487 N.E.2d 937 (Ill. 1985).

/100/ Zion v. New York Hosp., 590 N.Y.S.2d 188, 190 (N.Y 1992).

/101/ See In re International Horizons, Inc., 689 F.2d 996, 1003 (11th Cir. 1982); Hancock v. Hobbs, 967 F.2d 462, 467 (11th Cir. 1992).

/102/ See ACLU of Miss. v. Finch, 638 F.2d 1336, 1343 (5th Cir. 1981).

/103/ Id. at 1343 (citing Carr v. Monroe Mfg. Co., 431 F.2d 384, 388 (5th Cir. 1970), cert. denied, 400 U.S. 1000 (1971)).

/104/ See Lora v. Board of Educ., 74 F.D.R. 565 (E.D.N.Y. 1977) (Clearinghouse No. 15,768); see also Finch, 638 F.2d at 1344 ("there is a 'special danger' in permitting state governments to define the scope of their own privilege when the misconduct of their agents is alleged") (quoting Carr, 431 F.2d at 389).

/105/ Order at 15, Wyatt, CA 3195-N (M.D. Ala. Sept. 12, 1994) (Clearinghouse No. 6874); see also Plaintiffs' Opposition to Defendants' Motions for Reconsideration of Orders Regarding Peer Review Information and Tours of the Kidd, Allen and Box Facilities at 3 -- 8, Wyatt, No. 3195-N (Clearinghouse No. 6874-Z-18).

/106/ Patients of Philadelphia State Hosp. v. Pennsylvania, 417 A.2d 805 (Pa. 1980) (Clearinghouse No. 24,694).

/107/ Georgia Hosp. Ass'n v. Ledbetter, 396 S.E.2d 488 (Ga. 1990).

/108/ Id. at 490.

/109/ JCAHO, supra note 8, at 2 -- 4. Telephone interview with Margaret Van Ameringe, Director of Federal Relations, JCAHO (June 26, 1996).

/110/ JCAHO is reportedly reevaluating this practice. Telephone interview with Van Ameringe, supra note 109.

/111/ Wyatt, No. 3195-N (originally Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971)).

/112/ Wyatt v. Stickney, 344 F. Supp. 373, 379 (M.D. Ala. 1972) (mental illness standards); Wyatt, 344 F. Supp. 387, 395 (mental retardation standards). These standards reflect constitutional concerns. In a consent decree signed in 1986, the parties agreed that the Wyatt standards would be insulated from any "challenges because of present and future changes in the law." See Order at 8 -- 9, Wyatt v. Wallis, No. 3195-N (M.D. Ala. Sept. 22, 1986) (Clearinghouse No. 6874-Z-14) (approving consent decree).

/113/ Wyatt, 1986 WL 69194 (M.D. Ala. Sept. 22, 1986) at *7, enjoining the defendants to "make all reasonable efforts to achieve full accreditation of Alabama's mental health facilities by the Joint Commission on the Accreditation of Hospitals [JCAHO] and full certification of Alabama's mental retardation facilities under Title XIX of the Social Security Act." At the time the consent decree was signed, all of defendants' mental retardation facilities were Title XIX certified as ICF/MRs, but three of the six psychiatric facilities had yet to obtain JCAHO certification. All of defendants' psychiatric facilities were JCAHO certified by the time of the 1995 evidentiary hearing. The 1986 consent decree also required that all Wyatt standards "remain in effect," id. at *7, and that the defendants "continue to make substantial progress in placing members of the plaintiff class into community facilities and programs." Id.

/114/ See Youngberg v. Romeo, 457 U.S. 307 (1982) (Clearinghouse No. 19,650).

/115/ 42 U.S.C. Sec. 12101. Plaintiffs amended their complaint to add Americans with Disabilities Act claims in 1993.

/116/ E.g., defendants' primary expert witness on mental illness issues testified that JCAHO standards were "two to three generations past the Wyatt standards." This expert characterized the Wyatt standards as "general," in contrast with JCAHO standards, which he said "talk about . . . how . . . you actually operationalize that standard and apply it on a day-to-day basis." See Defendants' Post-Trial Brief at 18, Wyatt, No. 3195-N (Clearinghouse No. 6874-Z-24). Defendants' primary expert witness on mental retardation testified that Title XIX regulations were superior to the Wyatt standards because, in his view, Title XIX regulations were more detailed. This expert also asserted that while Wyatt standards could conceivably "be substantially out of date sooner or later with best practices," Title XIX regulations "will not become so" because they are periodically revised. Id. at 25 -- 26. On cross-examination, however, plaintiffs obtained admissions from these experts about the limits of the JCAHO and Title XIX processes. Defendants' mental illness expert acknowledged that "[I] would never suggest to any state system that they relied exclusively on any one measure of compliance. . . . JCAHO is not necessarily the only thing one should use if one is going to function as a credible expert." See Plaintiffs' Reply to Defendants' Post-Trial Brief at 17 -- 18 & nn.72 -- 73, Wyatt, No. 3195-N(Clearinghouse No. 6874-Z-25). Defendants' mental retardation expert conceded that Title XIX surveyors rarely saw institutional life as it really was during their visits to mental retardation facilities. Id. at 12 & n.46.

/117/ Order, Wyatt v. Hanan, No. 3195-N (M.D. Ala. Mar. 3, 1995) (Clearinghouse No. 6874-Z-20). This order denied defendants' motion for summary judgment regarding facilities that the plaintiffs had not visited at the time the motion was written. The defendants contended that they should be granted summary judgment regarding these facilities because, inter alia, they were accredited by JCAHO or Title XIX certified by HCFA.

/118/ Wyatt v. Poundstone, 892 F. Supp. 1410 (M.D. Ala. 1995), appeal dismissed as moot, 1996 WL 446249 (11th Cir. 1996), injunction dissolved as moot, No. 3195-N (M.D. Ala. Aug. 13, 1996).

/119/ Order at 7, Wyatt, No. 3195-N (M.D. Ala. Mar. 3, 1995) (Clearinghouse No. 6874-Z-20).

/120/ Wyatt, 892 F. Supp. at 1419.

/121/ Order at 8, Wyatt, No. 3195-N (M.D. Ala. Mar. 3, 1995) (Clearinghouse No. 6874-Z-20); Wyatt, 892 F. Supp. at 1419 -- 20.

/122/ Illinois, 803 F. Supp. 1338, 1341.

/123/ Lelsz, 673 F. Supp. 828, 840 -- 41.

/124/ Robbins v. Budke, 739 F. Supp. 1479, 1481 (D.N.M. 1990) (Clearinghouse No. 45,784).

/125/ Tennessee, 798 F. Supp. 483, 498.

/126/ Id.

/127/ Woe v. Cuomo, 729 F.2d 96, 106 (2d. Cir.), cert. denied, 469 U.S. 936 (1984) (Clearinghouse No. 18,399).

/128/ Thomas S. v. Flaherty, 902 F.2d 250, 252 -- 53 (4th Cir.), cert. denied, 498 U.S. 951 (1990) (Clearinghouse No. 36,533).

/129/ Order at 8, Wyatt, No. 3195-N (M.D. Ala. Mar. 3, 1995) (Clearinghouse No. 6874-Z-20); see also Wyatt, 892 F. Supp. at 1419 -- 20 (Thomas S. and Woe held that accreditation and certification created "only a rebuttable prima facie presumption").

/130/ Order at 8 -- 10, Wyatt, No. 3195-N (M.D. Ala. Mar. 3, 1995) (Clearinghouse No. 6874-Z-20); Wyatt, 892 F. Supp. at 1420 (since plaintiffs had rebutted any presumption of adequate care created by the JCAHO accreditation of defendants' psychiatric facility for children, "while JCAHO accreditation may be evidence to be considered by the court in determining whether there is compliance with certain minimum standards, the weight it should be accorded is limited"). See also discussion of plaintiffs' evidence, infra.

/131/ Defendants' Post-Trial Brief at 20 -- 21, 29 -- 30, Wyatt, No. 3195-N(Clearinghouse No. 6874-Z-24).

/132/ Id.

/133/ Order at 4 -- 5 n.5, Wyatt, No. 3195-N (M.D. Ala. Aug. 8, 1995) (Clearinghouse No. 6874-Z-27) (refusing to stay the court's preliminary injunction regarding defendants' children's psychiatric facility pending appeal). Moreover, the court noted that the variety of evidence regarding unsafe conditions at this facility "is overwhelming that JCAHO has allowed its standards to fall below the floor required" by the Constitution and the Wyatt standards. Id.

/134/ Woe, 729 F.2d at 106 -- 7 & n.11.

/135/ Id. at 106 & n.11. In addition, Woe made no findings regarding whether JCAHO standards themselves had fallen below constitutional requirements.

/136/ Thomas S. v. Flaherty, 699 F. Supp. 1178, 1197 -- 98 (W.D.N.C. 1988), aff'd, 902 F.2d 250, 253 (4th Cir. 1990).

/137/ Plaintiffs' Reply to Defendants' Post-Trial Brief at 8, Wyatt, No. 3195-N (Clearinghouse No. 6874-Z-25).

/138/ Plaintiffs' Proposed Findings of Fact and Conclusions of Law at 45 -- 47, Wyatt, No. 3195-N (Clearinghouse No. 6874-Z-23).

/139/ Plaintiffs' Reply to Defendants' Post-Trial Brief at 9, Wyatt, No. 3195-N (Clearinghouse No. 6874-Z-25).

/140/ Id. at 16.

/141/ Id. The peer review committee charged with evaluating behavioral programming in defendants' mental retardation facilities was also critical of Title XIX surveyors. This committee found that "Title XIX surveyors . . . continue to render interpretations of regulations that are sometimes antithetical to good programming practices and unsupported by the letter of regulatory language." Id. at 17.

/142/ Id. at 19 -- 22.

/143/ Id. at 22.

/144/ Id. at 22 -- 23.

/145/ Id. at 23.

/146/ Id. at 25.

/147/ Id. at 26.

/148/ Wyatt, 892 F. Supp. 1410. The court found that violations of Wyatt standards regarding safety at this facility "are pervasive and severe and . . . as a result, the very health and safety of the children at [the facility] are threatened." Id. at 1412. The court also found that defendants' treatment of children at this facility contravened the guarantees of the Fourteenth Amendment to the Constitution. Id. at 1420, n.65 (citing Youngberg, 457 U.S. 307, 324).

/149/ Plaintiffs' Reply to Defendants' Post-Trial Brief at 26 -- 27, Wyatt, No. 3195-N (Clearinghouse No. 6874-Z-25).

/150/ See Wyatt, 868 F. Supp. 1356 (describing the role of the United States as amicus in the litigation).

/151/ Memorandum Regarding the United States' Position on Whether Title XIX Regulations Are the Equivalent of Minimum Constitutional Standards and the Significance to Be Ascribed to HCFA Certification at 1, Wyatt, No. 3195-N (Clearinghouse No. 6874-Z-21).

/152/ Id. at 3. At trial the United States' mental retardation expert, a private, state-contracted service provider, testified that "Title XIX doesn't have anything to do with professional standards of practice. . . . Those are just . . . things you have to do to do business. . . . [W]e have to meet HCFA to get paid . . . but we would never assume HCFA has anything to do with professional standards." See Plaintiffs' Reply to Defendants' Post-Trial Brief at 6 n.16 and 17 n.71, Wyatt, No. 3195-N (Clearinghouse No. 6874-Z-25).

/153/ Memorandum Regarding the United States' Position on Whether Title XIX Regulations Are the Equivalent of Minimum Constitutional Standards and the Significance to Be Ascribed to HCFA Certification at 3 -- 4, Wyatt, No. 3195-N (Clearinghouse No. 6874-Z-21).

/154/ Id. at 5 -- 6.

/155/ Id. at 6.

/156/ Id. at 7.

/157/ Id. at 8 -- 9; see also id. at 9 ("Just since 1992, the Department of Justice has filed five lawsuits against states alleging unconstitutional conditions in mental retardation facilities which are -- and continue to be -- HCFA certified.").

/158/ As of July 1, 1996, JCAHO had rendered accreditation decisions on seven health care networks and had another four scheduled for survey. Several more networks are in the process of applying for JCAHO accreditation. JCAHO anticipates completing a total of about 20 such surveys in 1996. Telephone interview with Alice Brown, Public Affairs Division, JCAHO (July 2, 1996).

/159/ The National Committee on Quality Assurance is also developing industrywide accreditation standards for managed behavioral health companies. See Accreditation Standards for Managed Behavioral Healthcare Organizations (draft) (Apr. 1, 1996) (available from National Committee on Quality Assurance, 2001 L St. NW, Suite 500, Washington, DC 20036).

/160/ See Medicaid Managed Care Act of 1995, S. 839, 104th Cong., 1st Sess. (May 22, 1995) (permitting private accreditation of Medicaid managed care plans in lieu of an annual external independent review of the quality and timeliness of and access to health services specified in the state's contract with the plan).