SHADOW NURSING HOME OWNERSHIP: HOW A FAILURE IN GOVERNMENT OVERSIGHT OF FOR-PROFIT NURSING HOMES IN NEW YORK HAS ALLOWED PROFITS TO BALLOON AND STANDARDS OF CARE TO PLUMMET

Marissa Espinoza[†]

[†] J.D. Candidate, Brooklyn Law School, 2023; B.A. Hofstra University, 2015. Thank you to Professor Frank Pasquale for his invaluable mentorship and guidance throughout this paper, to Professor Loreen Peritz for her tremendous research and editing assitance, and to Dean Karen Porter for allowing me the opportunity to undertake this research as a Brooklyn Law School *Health Law and Policy Fellow*. I am deeply grateful to my family, friends, and colleagues for their unconditional support throughout three demanding years of law school and full-time employment. Lastly, I thank my former boss, Senator Jim Gaughran, for his unwavering support and encouraging me to always pursue more.

Abstract: *Complex corporate nursing home structures have become commonplace in for-profit nursing home ownership. These structures, designed to shield owners from regulation and liability, allow owners to evade public scrutiny by obscuring the identify of true owners and allow the true owners to direct revenue to other companies they own or benefit from, such as staffing agencies, payroll businesses, and management companies. This has led to a deterioration in the standard of care for nursing home residents, society's most vulnerable population, while providing a boon in profits for the true owners. Money that should be spent on care is instead diverted to high-overhead contractors and above-market rents, which further enriches the beneficial owners of the nursing homes.*

To address the crisis, states are beginning to legislatively require nursing homes to spend a minimum percentage on direct care of residents, known as a "direct care ratio." While commendable, these laws may easily be evaded if they are not interpreted and enforced in a wise and effective way. Based on New York's experience, states should adopt a revenue-focused regulatory approach to the implementation of direct care ratio laws. To prioritize residents' care and safety, states should narrowly define costs allowed to count towards the direct care ratio and closely scrutinize those costs. They must also regulate and cap the expenses nursing homes pay in transactions where there is common ownership between the nursing home owner and the contractor. These steps will greatly improve care and safety for vulnerable nursing home residents.

I. INTRODUCTION

The COVID-19 pandemic has brought to the forefront of public attention the crisis brewing inside nursing homes. While the pandemic ravaged the global community, bringing cities to a standstill, shuttering businesses, overloading hospitals, and forcing the deceased to await burials in freezer trucks, another crisis was unfolding inside nursing homes across the United States.

For decades, government officials and regulators have inadequately regulated and overseen the nation's nursing homes, which are more than just a residential space; nursing homes are medical facilities that care for the elderly and the sick in their most vulnerable moments.[1] Yet, too many nursing home residents endure shocking living conditions while experiencing the impacts of chronic staffing shortages, issues worsened by private equity firms' mass purchases of nursing home facilities and subsequent establishment of obscure ownership structures.[2] Residents have suffered severe and life-threatening neglect in facilities, had their conditions worsened by poor medical care, and faced flagrant mistreatment by nursing home management.[3]

While the pandemic did not cause many of the underlying issues in nursing homes the public has borne witness to this past year, the pandemic certainly exacerbated and exposed existing problems. For the last two decades, good government groups, advocates for nursing home residents, and investigative journalists have highlighted the issues that accompany for-profit nursing home ownership and the complex corporate structures these owners create to evade liability.[4] In New York, decades of ineffective government oversight and regulatory failures, compounded by the unprecedented challenges of responding to a global pandemic, has brought nursing homes to a crisis point, with public outrage forcing a flood of legislative action to address and fix the chronic shortcomings plaguing New York's nursing home industry.[5]

At the Cold Spring Hills Center for Nursing & Rehabilitation ("Cold Spring Hills") in Woodbury, New York, 116 residents died from March through May 2020, representing nearly 20% of the facility's bed capacity,

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[1] Joe Eaton, *Who's to Blame for the 100,000 COVID Dead in Long-Term Care?*, AARP (Dec. 3, 2020), https://www.aarp.org/caregiving/health/info-2020/covid-19-nursing-homes-who-is-to-blame.html.

[2] *See id*.; *see also* THE DEADLY COMBINATION OF PRIVATE EQUITY AND NURSING HOMES DURING A PANDEMIC, AMERICANS FOR FINANCIAL REFORM 5 (2020) (discussing how the profit incentive behind private equity ownership of nursing homes "generates profits but compromises cares").

[3] *See* Matt Sedensky & Bernard Condon, *Not Just COVID: Nursing Home Neglect Deaths Surge in Shadows*, AP NEWS (Nov. 19, 2020), https://apnews.com/article/nursing-homes-neglect-death-surge-3b74a2202140c5a6b5cf05cdf0ea4f32.

[4] *See, e.g., Non-Profit vs. For-Profit Nursing Homes: Is there a Difference in Care?*, CTRS. FOR MEDICARE ADVOC. (Mar. 15, 2012), https://medicareadvocacy.org/non-profit-vs-for-profit-nursing-homes-is-there-a-difference-in-care/; Charles Duhigg, *At Many Homes, More Profit and Less Nursing*, N.Y. TIMES (Sept. 23, 2007), https://www.nytimes.com/2007/09/23/business/23nursing.html.

[5] *See* Susan Arbetter, *New York: A Rich State With Poor Nursing Homes*, SPECTRUM NEWS (Feb. 12, 2021), https://spectrumlocalnews.com/nys/capital-region/news/2021/02/12/new-york—a-rich-state-with-poor-nursing-homes; *see also* Marina Villeneuve, *Reforms Follow Deadly Year in New York Nursing Homes*, ASSOCIATED PRESS (Apr. 10, 2021), https://apnews.com/article/new-york-andrew-cuomo-legislation-coronavirus-pandemic-state-budgets-f3d86162837392af618f44644932fdb5.

during the height of the COVID-19 pandemic.[6] This number was reflected in death certificates filed with the local township, while the facility simultaneously underreported COVID-related deaths to the New York State Department of Health, the agency charged with oversight of New York's nursing homes, a reporting discrepancy that has yet to result in monetary fines levied or enforcement action.[7]

Family members recall receiving no communication from the facility about the presence of COVID-19 inside Cold Spring Hills, despite an Executive Order from New York's then-Governor requiring communication with family members, and notwithstanding staff members awareness of the presence of the virus within the facility .[8] One resident's daughter learned from a nurse practitioner that residents were suspected of dying from COVID-19 after a phone call notified her that her mom had a fever.[9] Three days later, the facility reported to her that her mother was improving.[10] Two days after that, her mother died, with COVID-19 listed as the cause of death on the death certificate filed with the Town of Oyster Bay.[11]

Cold Spring Hills operates through a limited liability company ("LLC"), with common ownership between the LLC set up to operate the nursing home and the LLC that acts as the nursing home's landlord.[12] Cold Spring Hills is part of the largest nursing home network in New York.[13]

Complex ownership structures, like that used by Cold Spring Hills, help obscure a facility's true owner and allow money to be siphoned from the nursing home into expensive management fees, administrative costs, and contracts with companies that share common ownership with the facility's

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[6] Jim Baumbach, Matt Clark, Paul LaRocco, Sandra Peddie, and David Schwartz (hereinafter "Baumbach et al.")., *Crisis, Care and Tragedy on LI*, NEWSDAY (Aug. 15, 2020).

[7] *Id.*; *NYS Health Profile: Cold Spring Hills Center for Nursing and Rehabilitation*, N.Y. DEP'T OF HEALTH, https://profiles.health.ny.gov/nursing_home/view/150464#inspections (last visited Apr. 14, 2022).

[8] Baumbach et al., *supra* note 6; N.Y. Exec. Order No. 202.18 (Apr. 16, 2020), https://www.governor.ny.gov/sites/default/files/atoms/files/EO_202.18.pdf; N.Y. Exec. Order No. 202.19 (Apr. 17, 2020), https://www.governor.ny.gov/sites/default/files/atoms/files/EO_202.19.pdf.

[9] Baumbach et al., *supra* note 6.

[10] *Id.*

[11] *Id.*

[12] *See Cold Spring Hills Center for Nursing and Rehab*, MEDICARE.GOV, https://www.medicare.gov/care-compare/details/nursing-home/335555?id=7fd81e27-0a94-438a-b3ca-28d161981497&city=Woodbury&state=NY&zipcode= (last visited Apr. 5, 2022).

[13] Press Release, SENTOSACARE, SentosaCare's Benjamin Landa and the Philipson Family Announce Major Investment in the Redevelopment of Woodmere Rehabilitation & Health Care Center in Woodmere, NY (Sept. 8, 2015) (https://www.prnewswire.com/news-releases/sentosacares-benjamin-landa-and-the-philipson-family-announce-major-investment-in-the-redevelopment-of-woodmere-rehabilitation—health-care-center-in-woodmere-ny-300139026.html); Baumbach et al., *supra* note 6.

owner.[14] This extraction of revenue reduces nursing homes' investments into staffing and care.[15]

These structures are not unique to Cold Spring Hills, nor are they new. The issue of nursing homes functioning as a labyrinth of LLCs has been a focus of advocates since the early 2000's, when the "general trend toward giving nursing home organizations corporate names and structures" with private equity investment groups buying up nursing homes attracted public attention.[16] For the last two decades, advocates and investigations have tied issues of nursing home quality to this structure of for-profit nursing homes.[17] Horror stories have come to light that depict what life is like within some for-profit nursing homes, including the shocking case of a 55-year-old resident suffering from dementia who froze to death days before Thanksgiving in 2011, after his for-profit nursing home "failed to ensure that each resident assessed and identified at risk for elopement/wandering was provided adequate supervision."[18]

The difference now, in 2022, is public outrage over the crisis within nursing homes has brought government oversight to a turning point, with recently enacted laws in New York and elsewhere aimed at improving the standard of care for residents.[19]

To address the issues that the use of complex corporate structures by for-profit nursing homes raise, this Article will offer a revenue-focused regulatory approach for the implementation of New York's new *Direct Care Ratio* law. This approach focuses on driving nursing homes to spend more on direct patient care, and includes regulatory recommendations to ensure interpretation and enforcement of the law that prioritize the care and safety of residents. These recommendations will address the issues raised in this Article by arguing that New York's regulatory approach should move in the

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[14] *See* Ted Sherman, *Who is Responsible When a Nursing Home is Providing Poor Care? Sometimes it's Hard to Find Out.*, NJ.COM (Feb. 15, 2022), https://www.nj.com/politics/2022/02/who-is-responsible-when-a-nursing-home-is-providing-poor-care-sometimes-its-hard-to-find-out.html.

[15] *See* AMERICANS FOR FINANCIAL REFORM, *supra* note 3, at 5 (discussing how the profit incentive behind private equity ownership of nursing homes "generates profits but compromises cares").

[16] Michael Amon & Ridgely Ochs, *A Business Built On Timing, Smarts and Contacts*, NEWSDAY (Sept. 22, 2007,12:15 PM), https://www.newsday.com/long-island/a-business-built-on-timing-smarts-and-contacts-1.876949.

[17] *See id.*; Duhigg, *supra* note 5; Allegra Abramo & Jennifer Lehman, *How N.Y.'s Biggest For-Profit Nursing Home Group Flourishes Despite a Record of Patient Harm*, PROPUBLICA (Oct. 27, 2015, 8:00 AM), https://www.propublica.org/article/new-york-for-profit-nursing-home-group-flourishes-despite-patient-harm.

[18] N.Y. DEP'T OF HEALTH, Detailed Deficiency Report: Woodmere Rehab & Health Care Center (Dec. 1, 2011).

[19] N.Y. PUB. HEALTH LAW § 2828 (2021); N.J. STAT. § 30:4D-7cc (2020); 101 MASS. CODE REGS. 206.12 (2021).

direction of requiring nursing homes to reinvest revenue into residential care, not profits.

This Article proceeds in the following parts. Part II will first provide a broad overview of New York's legal landscape for nursing homes, including the licensure process for facilities, relevant laws and regulations, and accountability measures like fines and tort liability available to hold negligent facilities accountable. Part III will examine two case studies of for-profit nursing homes in New York that have exploited residents while maximizing profit extraction from their facilities. Lastly, Part IV proposes a revenue-focused regulatory approach that will prioritize residents' care over nursing home owners profits.

II. NEW YORK'S LEGAL LANDSCAPE FOR NURSING HOMES

The New York State Department of Health ("DOH") oversees the licensure and regulation of nursing homes and the safety of the 117,000 people residing in New York nursing homes.[20] Of the 621 nursing homes in New York, 65% are for-profit, compared with 70% nationally.[21] Nursing home operators are required to obtain a DOH license to run the facility.[22] The DOH reviews applications and grants licenses, promulgates regulations that govern the minimum standards of care nursing homes must provide residents, and issues fines and other penalties to non-compliant operators.[23] The DOH operates alongside federal regulators, which also govern nursing homes. The DOH is charged with overseeing and monitoring nursing homes on behalf of the State and the federal government.[24] Nursing homes must comply with federal law in order to participate in lucrative Medicaid and Medicare programs, which fund 62% and 12% respectively, of nursing home residents nationally.[25]

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[20] About Nursing Home Reports, N.Y. DEP'T OF HEALTH, https://www.health.ny.gov/facilities/nursing/about_nursing_home_reports.htm (last visited Apr. 14, 2022).

[21] N.Y. DEP'T OF HEALTH, *615 Nursing Homes in New York with Total Number Of Beds*, https://profiles.health.ny.gov/nursing_home/bed_type/Total+number+of+beds; N.Y. ATT'Y GEN., *Nursing Home Response to COVID-19 Pandemic*, at 22 (last revised Jan. 30, 2021); *Nursing Home Care*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/nchs/fastats/nursing-home-care.htm (last visited Apr. 5, 2022).

[22] N.Y. PUB. HEALTH LAW § 2896 (2021); N.Y. PUB. HEALTH LAW § 2896-e (2021).

[23] N.Y. PUB. HEALTH LAW § 2896-e (2021); N.Y. PUB. HEALTH LAW § 2803 (2021).

[24] INST. OF MED., IMPROVING THE QUALITY OF CARE IN NURSING HOMES ch. 4 (1986).

[25] MaryBeth Musumeci & Priya Chidambaram, *Key Questions About Nursing Home Regulation and Oversight in the Wake of COVID-19*, KFF, (Aug. 3, 2020), https://www.kff.org/coronavirus-covid-19/issue-brief/key-questions-about-nursing-home-regulation-and-oversight-in-the-wake-of-covid-19/; The federal legislation enacted new minimum requirements for nursing homes to be eligible for Medicare and Medicaid payments and put in place added enforcement systems; *see* Omnibus Budget Reconciliation Act of 1987, H.R. 3545, 100th Cong. (1987) (enacted).

In addition to government regulation and fines for violators, tort law provides aggrieved nursing home residents and their families with a private cause of action, with potential awards of punitive and compensatory damages available to successful litigants.[26] Litigants or their kin may plead multiple causes of action, including wrongful death suits, negligence, and intentional torts.[27]

A. Licensure

Federal law requires nursing home facilities "be licensed under applicable State and local law."[28] Following the Medicaid fraud and patient abuse scandals that shocked the public throughout the 1970s, New York state legislators enacted a law requiring all nursing home investors be vetted by the State.[29] New York requires that nursing homes may not operate unless "under the supervision of an administrator who holds a currently valid nursing home administrator's license and registration."[30] Nursing home administrators act as the chief executive officer of the facility.[31] The DOH sets educational and experience requirements for applicants, including an examination that is subject to review by a board of examiners within the DOH comprised of medical professionals and experienced nursing home administrators.[32]

Nursing home administrators are vested with significant responsibility over the affairs of the facility.[33] They are responsible for managing operations of the facility, supervising staff, continually evaluating "the care and services provided," and ensuring "the health and safety of the residents."[34] Nursing home administrators can be held professionally and

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[26] David J. Hoey, *The Intersection of Tort Law and Nursing Home Abuse and Neglect Litigation*, 14 NAT'L ACAD. OF ELDER L. ATT'YS 2-17 (2018).

[27] *See id*.

[28] 42 C.F.R. § 483.70 (2019).

[29] *See* Amon & Ochs, *supra* note 17; N.Y. PUB. HEALTH LAW § 2896 (2021); Press Release, N.Y. ATT'Y GEN., Medicaid Fraud Unit Created In Wake Of 1970's Nursing Home Scandal Commemorates 25th Anniversary At Brooklyn Marriott (Apr. 11, 2000), https://ag.ny.gov/press-release/2000/medicaid-fraud-unit-created-wake-1970s-nursing-home-scandal-commemorates-25th.

[30] N.Y. DEP'T OF HEALTH, *Nursing Home Administrator* (last revised June 2017), https://health.ny.gov/professionals/nursing_home_administrator/; N.Y. COMP. CODES R. & REGS. tit. 10 § 415.26 (2019).

[31] N.Y. DEP'T OF HEALTH, *supra* note 31.

[32] N.Y. DEP'T OF HEALTH, *Licensure Process* (last revised July 2017), https://www.health.ny.gov/professionals/nursing_home_administrator/licensure_program/licensure_process.htm; N.Y. PUB. HEALTH LAW § 2896-a (2021).

[33] N.Y. PUB. HEALTH LAW § 2895-a (2021).

[34] N.Y. DEP'T OF HEALTH, *supra* note 31.

personally liable for failure to comply with applicable laws, including license suspension, revocation, censure, or subject to civil penalty.[35]

While nursing home administrators act as day-to-day managers of nursing homes, they have a role distinct from the owners of nursing homes. Decisions regarding ownership of a nursing home facility are made by the DOH's Public Health and Health Planning Council, a 24-member regulatory body charged with "broad" powers to make decisions about the establishment, acquisition, and transfer of ownership of nursing home facilities.[36] Nursing home ownership is strictly regulated; facilities must disclose the identity of the owner and promptly notify the DOH of any change in ownership or the corporation.[37] To establish a new facility or change ownership of an existing facility, a Certificate of Need must be submitted to the DOH, which then performs a character and competence review of the applicant, and examines his or her existing facilities.[38]

The character and competence review has an important and valid public policy purpose; it grants the DOH and the Public Health and Health Planning Council latitude to deny bad actors with histories of providing sub-standard care and violations from acquiring a license.[39] This review allows the Council to deny licensure to operators who are found to have not provided "a substantially consistent high level of care."[40] The statute that lays out the process for the character and competence review specifically states "there shall not be a finding that a substantially consistent high level of care has been rendered where there have been violations of the state hospital code, or other applicable rules and regulations, that (i) threatened to directly affect the health, safety or welfare of any patient or resident, and (ii) were recurrent or were not promptly corrected."[41]

The DOH submits this review, along with a summary of violations and fines for the applicant's other facilities and the DOH's recommendations, to the Public Health and Health Planning Council for a final determination.[42] The 24-member Council includes nursing home industry representatives and officials from the health care industry.[43] The Council is afforded *great*

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[35] N.Y. PUB. HEALTH LAW § 2897 (2021).

[36] N.Y. DEP'T OF HEALTH, *Public Health and Health Planning Council*, https://health.ny.gov/facilities/public_health_and_health_planning_council/; N.Y. PUB. HEALTH LAW § 220 (2021); N.Y. PUB. HEALTH LAW § 2801-a (2021).

[37] N.Y. COMP. CODES R. & REGS. tit. 10 § 401.3 (2021).

[38] *Id.*; N.Y. PUB. HEALTH LAW § 2801-a (2021).

[39] *See* Abramo & Lehman, *supra* note 18; N.Y. DEP'T OF HEALTH, *supra* note 37; N.Y. PUB. HEALTH LAW § 2801-a (2021).

[40] N.Y. PUB. HEALTH LAW § 2801-a (2021).

[41] *Id.*

[42] *Id.*

[43] N.Y. PUB. HEALTH LAW § 220 (2021).

discretion to grant or deny ownership decisions.[44] Despite State law providing the Council with the authority to deny licensure to owners with problematic histories, the Council tends to approve applications "[u]nder a narrow interpretation of the rules…if violations aren't strictly identical or were promptly addressed."[45] A ProPublica investigation into the trouble-plagued nursing home network examined in Part III, and all nursing home ownership applications submitted before the Council from 2010-2015, revealed that no applications "were rejected because of lapses in… patient case" and "[i]n most cases, the council…follows the [DOH] recommendations."[46]

Despite the State's efforts to monitor and control nursing home ownership, and the autonomy afforded to the Council and the DOH to deny licensure to individuals with histories raising red flags, sophisticated owners have developed complex strategies to evade strict State scrutiny and obtain licensure, as discussed in Part III.[47] In addition to regulating ownership changes, New York State requires nursing home owners to submit an annual report detailing the facility's assets, liabilities, revenues, and expenses.[48] In apparent defiance of New York law, not all nursing home owners are compliant; the first case study examined in Part III details a facility's change of ownership that went unreported to the DOH, yet seemingly resulted in no fines or penalties issued.[49] This annual report also requires disclosure of aggregate transactions exceeding $500 to any person with an ownership stake in the facility, or an affiliate of any person with an ownership stake.[50] The DOH cost report mirrors the cost report required by the federal Centers for Medicare & Medicaid Services (CMS), but is not identical. Both the federal and New York state cost reports are difficult to publicly access and read; the New York cost reports require a FOIL request to obtain.[51] These disclosure requirements operate alongside federal requirements for participation in the Medicare and Medicaid programs, and mandate nursing homes disclose payments to specified affiliates, including where States have "determined

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[44] *See* Abramo & Lehman, *supra* note 18; N.Y. PUB. HEALTH LAW § 224-B (2021) (emphasis added).

[45] Abramo & Lehman, *supra* note 18.

[46] Abramo & Lehman, *supra* note 18.

[47] *See infra* Part III for a discussion of how sophisticated nursing home owners use complex strategies to evade State scrutiny and obtain licensure.

[48] N.Y. PUB. HEALTH LAW § 2805-e (1) (2021).

[49] N.Y. COMP. CODES R. & REGS. tit. 10 § 401.3 (2021); *see infra* Part III subsection b.

[50] N.Y. PUB. HEALTH LAW § 2805-e (1)(g) (2021).

[51] CMS, Cost Reports by Fiscal Year, https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports/Cost-Reports-by-Fiscal-Year; N.Y. STATE DEP'T OF HEALTH, Institutional Cost Reports (ICRs), https://www.health.ny.gov/facilities/hospital/rate_setting/centers/index.htm. To access the federal data set requires a download and is not available in an easily digestible format. To access the state data set requires a FOIL, and the data is similarly not available in an easily digestible format.

that the … provider may have" such an affiliation, a related party transaction.[52]

B. Regulation

DOH regulations largely govern nursing home oversight and standards, supplementing statutes that lay a broad framework, and establish the baseline of standards for the quality-of-care nursing homes must provide residents. Regulations include staffing levels, communication with residents' families, standards of care, and more.[53] Regulations dictate the number of registered nurses required each day, the legal rights of residents who lack the capacity to make decisions about their medical treatment, and requirements for nursing homes' emergency preparedness plans.[54] State regulations supplement, and live alongside, federal statutes and regulations, providing a detailed regulatory scheme for nursing home operations.

The COVID-19 pandemic highlighted disturbing problems rampant in nursing homes, though many of the problems predated the pandemic and have long been on the radar of policy makers.[55] The most alarming issues made visible by the pandemic are inadequate staffing levels and poor preparations for providing sufficient standards of care.[56] Despite comprehensive regulations that enumerate detailed rules governing nursing homes in New York, the issues of staffing levels and standard of care were notorious problems pre-pandemic. The COVID-19 pandemic did not cause these issues; safe staffing levels and appropriate standards of care for residents have long been pervasive problems within the nursing home industry.[57] Rather, the COVID-19 pandemic highlighted these systemic issues and brought them to the forefront of public discourse.

Federal law requires nursing homes be equipped "to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each

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[52] 42 C.F.R. § 455.107 (2021); 42 C.F.R. § 455.107(b)(2)(i) (2021); 42 C.F.R. § 455.101 (2021).

[53] N.Y. COMP. CODES R. & REGS. tit. 10 § 415.13 (2021); N.Y. COMP. CODES R. & REGS. tit. 10 § 415.3 (2021); N.Y. COMP. CODES R. & REGS. tit. 10 § 415.5 (2021).

[54] 42 C.F.R. § 483.73 (2021); N.Y. COMP. CODES R. & REGS. tit. 10 § 415.13 (2021); N.Y. COMP. CODES R. & REGS. tit. 10 § 415.2(f) (2021); N.Y. COMP. CODES R. & REGS. tit. 10 § 415.26(f) (2021).

[55] *See, e.g.,* Deborah Gastfreund Schuss, *COVID-19's Deadly Lesson: Time to Revamp Long-Term Care,* HEALTH AFFS. (Nov. 17, 2020), https://www.healthaffairs.org/do/10.1377/hblog20201110.707118/full/; Duhigg, *supra* note 5; Katie Thomas, *In Race for Medicare Dollars, Nursing Home Care May Lag*, N.Y. TIMES (Apr. 14, 2015), https://www.nytimes.com/2015/04/15/business/as-nursing-homes-chase-lucrative-patients-quality-of-care-is-said-to-lag.html.

[56] *See* Brian E. McGarry et al., *Severe Staffing and Personal Protective Equipment Shortages Faced by Nursing Homes during the COVID-19 Pandemic*, 39 HEALTH AFF. 7 (2020).

[57] Leah Judge, *Three States Impose Profit Limits on Nursing Homes*, CONSTANTINE CANNON LLP (Oct. 29, 2021), https://www.lexology.com/library/detail.aspx?g=8a2a79e9-b815-4c51-8972-f9aaf79fb9c8.

resident."[58] New York State DOH regulations are more specific, establishing minimum nursing home staffing standards.[59] A facility must employ the services of a registered professional nurse for at least eight consecutive hours every day of the week.[60] In addition, DOH regulations establish requirements for certified nurse aides, who perform the majority of direct residential care, as well as for feeding assistants and other nursing personnel.[61]

Despite these requirements, well-documented examples of violations of staffing standards exist. In the second case study examined in Part III, the New York State Attorney General not only investigated, but also successfully charged and prosecuted, the owner and manager of a nursing home for failing to provide enough staff and adequate care for residents under its care.[62] The Attorney General's investigation revealed a complex ownership maze, with the owner of the nursing home officially listed as the owner of the facility, and also listed as profiting, along with the facility's manager and their relatives, from various companies with business contracts with the nursing home facility.[63] The facility was predominantly funded by Medicaid, Medicare, and private insurance payments.[64] Over a three-year period, $14,480,275 was paid directly to the owner, the manager, their relatives, or entities related to the owner or manager.[65] The Attorney General's office successfully made the case that the owner, upon obtaining ownership control of the facility, reduced staffing "and other necessary services and supplies needed to provide safe and adequate care … to the approximately 174 residents."[66]

In addition to setting staffing standards, federal and state regulations set minimum standards of care that facilities must provide residents.[67] Federal law requires facilities provide necessary services "to ensure that a resident's

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[58] 42 C.F.R. § 483.70 (2019).

[59] N.Y. COMP. CODES R. & REGS. tit. 10 § 415.13 (2021).

[60] *Id.*

[61] *Id.*

[62] Anthony Borrelli, *Former nursing home officials plead guilty to endangering charges in neglect case*, PRESSCONNECTS (Sept. 13, 2018), https://www.pressconnects.com/story/news/public-safety/2018/09/13/otsego-nursing-home-neglect-ny-ag-endangering/1287960002/; *see infra* Part III subsection c.

[63] N.Y. ATT'Y GEN., *supra* note 22, at 66.

[64] *Id.*

[65] *Id.*

[66] *See* Borrelli, *supra* note 63; Press Release, N.Y. ATT'Y GEN., A.G. Underwood Announces Guilty Pleas of Former Focus Ostego Nursing Home Operators For Endangering Resident (Sept. 12, 2018), https://ag.ny.gov/press-release/2018/ag-underwood-announces-guilty-pleas-former-focus-otsego-nursing-home-operators.

[67] 42 C.F.R. § 483.25 (2021); 42 C.F.R. § 483.35 (2021); N.Y. PUB. HEALTH LAW § 2895-b (2021); N.Y. COMP. CODES R. & REGS. tit. 10 § 415.13 (2021); N.Y. COMP. CODES R. & REGS. tit. 10 § 415.5 (2021).

abilities in activities of daily living do not diminish" unnecessarily.[68] Activities of daily living encompass a wide range of the traditional routines one would perform if living independently, including personal hygiene habits, dining, community, and mobility.[69] This is the *minimum* care a nursing facility must afford its residents.[70]

Federal law also requires nursing homes to annually conduct a facility-wide assessment to evaluate what resources it needs to adequately care for its residents.[71] This comprehensive review looks at the number of residents and the care each resident requires, staff capacity and their ability to provide the care each resident requires, and the facility's resources.[72]

In addition to regulating staffing levels and the standard of care that must be provided to residents, as discussed in the prior section on licensure, New York State attempts to strictly regulate ownership.[73] This extends to management consultants hired by nursing homes and the extent to which decisions are delegated to such consultants.[74] Nursing homes are permitted to hire management consultants, but the nursing home operator must remain "the party responsible for the operation" of the facility.[75] This prevents nursing home operators from ceding major management and operational decisions to third-party consultants, but as Part III will discuss, some owners disregard, or fail to fully comply, with this regulation.[76]

There are legitimate business reasons for contracting with a management consultant, particularly consultants with vast experience across nursing home operations. Economies of scale suggest that outsourcing certain decisions to management consultants with particularized expertise may bring efficiency to a nursing home's operations and can assist the nursing home with implementing best practices.[77] For comparison, the practice of outsourcing management is common in the real estate industry where property management is outsourced to specialized management companies, rather than the real estate company performing management

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[68] 42 C.F.R. § 483.24 (2021).

[69] *Id*.

[70] 42 C.F.R. § 483.24(b) (2021) (emphasis added).

[71] 42 C.F.R. § 483.70 (2019).

[72] *Id*.

[73] N.Y. COMP. CODES R. & REGS. tit. 10 § 401.3 (2021).

[74] N.Y. COMP. CODES R. & REGS. tit. 10 § 600.9 (2021).

[75] *Id*.

[76] *Id*.; *see infra* Part III subsection b.

[77] *See* Daniel Markovits, *How McKinsey Destroyed the Middle Class*, THE ATLANTIC (Feb. 3, 2020), https://www.theatlantic.com/ideas/archive/2020/02/how-mckinsey-destroyed-middle-class/605878/ (discussing the general benefits management consultants can bring to a businesses operations).

operations in-house, a business decision made by real estate companies based on which option is cheaper.[78]

However, New York State regulations prohibit a nursing home operator from ceding "an improper delegation…of its responsibilities" to a management consultant.[79] The regulation provides criteria for determining whether an improper delegation of responsibilities has occurred, including examining whether the management consultant has hiring or firing ability of the nursing home administrator or "other key management employees"; control of the facility's records and books; authority over the facility's assets and liabilities; and the ability to establish and enforce a facility's operational policies.[80]

Beyond regulations, the federal government offers the public, state regulators, and prospective residents a supposedly powerful tool to help guide choices when selecting a nursing home: the Five-Star Quality Rating System run by CMS.[81] The ratings are comprised of grades for on-site inspections, time nurses spend with residents, and the quality of care afforded to residents.[82] These three grades are then combined into a star rating that purports to reflect the objective quality of a nursing home.[83]

This rating system was revamped in 2008 amid a spike in private equity firms purchasing nursing homes.[84] Changes to the rating system sought to address concerns about the deleterious impacts on quality of care that followed private equity acquisition of a nursing home.[85] Despite the

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[78] SIGRID KATZLER, BJÖRN BERGGREN & CHRISTINA GUSTAFSSON, WILL OUTSOURCING OF COMMERCIAL PROPERTY MANAGEMENT FUNCTIONS ADD TO PERFORMANCE? A QUANTITATIVE ANALYSIS OF THE SWEDISH MARKET 2 (2017), https://www.diva-portal.org/smash/get/diva2:1095009/FULLTEXT01.pdf; ECONOMISTS ADVISORY GROUP LTD, ECONOMIES OF SCALE 123 (1997).

[79] N.Y. COMP. CODES R. & REGS. tit. 10 § 600.9 (2021); N.Y. COMP. CODES R. & REGS. tit. 10 § 405.2-405.3 (2021).

[80] N.Y. COMP. CODES R. & REGS. tit. 10 § 600.9 (2021).

[81] *Five-Star Quality Rating System*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Oct. 7, 2019), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/FSQRS; *see* Robert Gebeloff et al., *How Nursing Homes' Worst Offenses Are Hidden From the Public*, N.Y. TIMES (Dec. 9, 2021), https://www.nytimes.com/2021/12/09/business/nursing-home-abuse-inspection.html (discussing how safety issues at nursing homes are not factored into the Five-Star system).

[82] CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 82.

[83] *Id.;* Jessica Silver-Greenberg & Robert Gebeloff, *Maggots, Rape and Yet Five Stars: How U.S. Ratings of Nursing Homes Mislead the Public*, N.Y. TIMES (Mar. 31, 2021), https://www.nytimes.com/2021/03/13/business/nursing-homes-ratings-medicare-covid.html.

[84] Charles Duhigg, *Washington Scrutinizes Nursing Homes*, N.Y. TIMES (Nov. 16, 2007), https://www.nytimes.com/2007/11/16/business/16care.html; Press Release, CTRS. FOR MEDICARE & MEDICAID SERVS., CMS Issues Historic Star Quality Rating System for Nursing Homes (Dec. 18, 2008), https://www.cms.gov/newsroom/press-releases/cms-issues-historic-star-quality-rating-system-nursing-homes.

[85] *Id.*

government's intention to create an objective metric, sophisticated facilities have identified ways to manipulate their ratings, including submitting of inaccurate or inflated data.[86] This—combined with systematic failings that include CMS' reliance on self-reported data, a lack of truly surprise inspections, facilities' financial incentive to manipulate data, and limited government auditing of data—challenges the reliability and objectivity of these ratings, the very ratings regulators rely on when examining ownership changes.[87] Moreover, owners of nursing home rely on high-ratings to advertise their facilities to the public and regulators, and as a shield to combat allegations that subpar care was provided.[88]

C. Fines

Nursing home facilities and management may face various enforcement actions for violating applicable laws, including fines, civil liability, criminal penalties, and license suspension.[89] DOH uses a system of inspections and surveys to evaluate the quality of care provided by nursing home facilities.[90] Facilities that fail to comply with federal or state regulations may be fined per violation cited.[91] The maximum fine allowable under state law for a violation is capped at $2,000 per violation, though the DOH may increase the fine to $5,000 if the same violation is repeated within twelve months and is a serious threat to resident's health and safety.[92] In 2008, the state legislature amended the law to allow DOH to assess a $10,000 fine if serious physical harm to a resident occurs as a result of a violation, and while the law was renewed, it is slated to expire in 2023.[93] DOH may assess fines for violations of State regulations, such as where a nursing home failed "to have robust infection prevention and control policies," which could constitute resident negligence under 10 NYCRR § 81.1(c) as a "failure to provide timely, consistent, safe, adequate and appropriate services, treatment, and/or care to a patient or resident of a residential health care facility."[94]

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[86] T. Edelman, *Don't be Fooled by the Federal Nursing Home Five-Star Quality Rating System*, CTR. FOR MEDICARE ADVOC. (Oct. 5, 2016), https://medicareadvocacy.org/dont-be-fooled-by-the-federal-nursing-home-five-star-quality-rating-system/; *see* Silver-Greenberg & Gebeloff, *supra* note 84.

[87] *See* Silver-Greenberg & Gebeloff, *supra* note 84; N.Y. DEP'T OF HEALTH, *supra* note 88; *see also* Abramo & Lehman, *supra* note 18.

[88] N.Y. DEP'T OF HEALTH, *supra* note 88; *see* Abramo & Lehman, *supra* note 18.

[89] N.Y. DEP'T OF HEALTH, *supra* note 21; *see* N.Y. ATT'Y GEN., *supra* note 22, at 65, 68; N.Y. PUB. HEALTH LAW § 2897 (2021).

[90] N.Y. DEP'T OF HEALTH, *supra* note 21.

[91] N.Y. DEP'T OF HEALTH, *supra* note 21.

[92] N.Y. PUB. HEALTH LAW § 12 (2021).

[93] OFF. OF THE N.Y. STATE COMPTROLLER, DIV. STATE GOV'T ACCOUNTABILITY, 2015-S-26, NURSING HOME SURVEILLANCE (2016); N.Y. PUB. HEALTH LAW § 12-b (2021).

[94] N.Y. ATT'Y GEN., *supra* note 22, at 70; N.Y. COMP. CODES R. & REGS. tit. 10 § 81.1 (2021).

Despite fines and a number of other tools at regulators disposal to hold nursing homes accountable, advocates and State officials have criticized enforcement as subpar and not aggressive enough.[95] An audit in 2016 by the New York State Comptroller found that DOH "frequently inspect[ed] nursing homes and act[ed] quickly on serious complaints," but the audit criticized the "problems and delays with how [the DOH] is assessing fines to nursing homes after violations are found."[96]

The audit highlighted that some facilities with repeat violations can see problems perpetuate and escalate into more serious and threatening problems inside their facilities.[97] Moreover, similar to many government-issued fines, the penalties levied against nursing homes may be incorporated as the cost of doing business, rather than as punitive measures used to deter bad behavior.[98]

D. Tort Liability

When statutes and regulations prove insufficient to protect residents from negligent care, or worse, intentional harm, some argue that "tort law has become the most effective vehicle for ensuring that systemic nursing reform occurs," though this is a trend that courts have pushed back on.[99] Nevertheless, residents and their families have successfully sued for wrongful death actions, negligence claims, and intentional torts.[100]

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[95] *See* Abramo & Lehman, *supra* note 18; Press Release, OFF. OF THE N.Y. STATE COMPTROLLER (Feb. 22, 2016) (https://www.osc.state.ny.us/press/releases/2016/02/state-health-department-should-improve-enforcement-nursing-home-violations).

[96] OFF. OF THE N.Y. STATE COMPTROLLER, *supra* note 96; OFF. OF THE N.Y. STATE COMPTROLLER, 2015-S-26, *supra* note 94.

[97] OFF. OF THE N.Y. STATE COMPTROLLER, 2015-S-26, *supra* note 94.

[98] In 2017, following the Trump administration's relaxation of penalties levied against nursing homes, residential advocates criticized the move as coming at a time when penalties and fines were finally being used against nursing homes in a way to effectuate change, rather than being incorporated by nursing homes as the cost of doing business. *See* Jordan Rau, *Trump Administration Eases Nursing Home Fines in Victory for Industry*, N.Y. TIMES, (Dec. 24, 2017), https://www.nytimes.com/2017/12/24/business/trump-administration-nursing-home-penalties.html; Toby S. Edelman, *Deregulating Nursing Homes*, 39 BIFOCAL A J. OF THE ABA COMM'N ON L. AND AGING 31, 31-33 (Jan. – Feb. 2018).

[99] In 1991, a California court rejected the claim that a personal injury lawsuit is an adequate substitute for pre-injury enforcement by a public agency and described the state police power to protect public health. *See* Kizer v. City of San Mateo, 53 Cal.3d 139 (1991); Steven M. Levin & John M. Rushing, *Litigating Nursing Home Malpractice*, GPSOLO (July/Aug. 2008).

[100] *See, e.g.*, Leah Shields, *Family Wins Lawsuit Against Nursing Home 4 Years After Woman's Death*, WSPD LOCAL 6 (Aug. 12, 2019), https://www.wpsdlocal6.com/news/family-wins-lawsuit-against-nursing-home-4-years-after-womans-death/article_63089a82-bd4c-11e9-801b-d7370171b8af.html; Jaci Smith, *Jury Awards $6M to Family of Woman Who Died in Buffalo Center Nursing Home*, GLOBE GAZETTE (June 17, 2021), https://globegazette.com/news/local/jury-awards-6m-to-family-of-woman-who-died-in-buffalo-center-nursing-home/article_5b9f617c-1f4f-565d-8e56-28d8a429f18a.html; *Nursing Home Abuse & Neglect*, LEVIN & PERCONTI, https://www.levinperconti.com/nursing-home-abuse-neglect.html (last visited Apr. 5, 2022).

Litigation often begins with an examination of traditional negligence issues, including whether the duty of care owed to the resident was breached, and a determination of causation.[101] Since many residents in nursing home facilities have underlying conditions, are elderly, or are in declining health, examining whether the nursing home's actions caused their harm requires a close analysis. The underlying issue examined in these lawsuits is what duty of care was owed to nursing home residents, including common law duty of care, statutory duty of care, and contractual duty of care.[102]

Government regulation intertwines with tort liability, because federal and state laws and regulations set forth the standards of care owed to residents, and litigants may rely on a nursing home's alleged violation of a regulation to support their lawsuit.[103]

While licensure, tort liability, regulation, and fines seek to ensure a baseline of quality within nursing homes, sophisticated nursing homeowners have designed complex corporate ownership structures to evade regulation and liability. Part III presents two case studies of for-profit nursing homes that have exploited the use of complex corporate structures to evade liability, disguise the true owner of their nursing homes, and maximize profits, while overseeing facilities with serious issues and declining standards of care.

III. CASE STUDIES OF FOR-PROFIT NURSING HOMES WITH COMPLEX CORPORATE STRUCTURES

New York State regulates nursing home ownership, including the establishment of new facilities, and the acquisition or transfer of existing facilities.[104] Despite New York's efforts to regulate the industry, sophisticated nursing home owners have successfully designed complex mazes of ownership structures that use LLCs to disguise the true owners and evade responsibility and liability.[105]

Complex corporate structures enable the evasion of regulations by disguising the true owners of nursing homes. When true owners establish a separate LLC to operate a facility, the LLC obscures what parties are the true owners. This presents a challenge for government regulators with limited resources in performing oversight and enforcement over nursing homes. Complex corporate structures also enable the evasion of liability for torts.

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[101] *Elements To Prove In A Nursing Home Abuse Or Neglect Claim*, EMERSON STRAW LAW, https://emersonstraw.com/blog/elements-to-prove-in-a-nursing-home-abuse-or-neglect-claim (last visited May 25, 2021); *Tort Law: Nursing Home Liability*, BERMAN & SIMMONS, (last visited May 25, 2021), https://www.bermansimmons.com/law-articles/tort-law-nursing-home-liability/.

[102] *Id*.

[103] *See* Hoey, *supra* note 27, at 10.

[104] N.Y. DEP'T OF HEALTH, *supra* note 37; N.Y. PUB. HEALTH LAW § 2801-a (2021).

[105] *See* Baumbach et al., *supra* note 6; *See* Amon & Ochs, *supra* note 17.

When true owners register LLCs as the operators rather than the true owners, protection behind the LLC ostensibly limits an owner's liability to aggrieved parties for tort claims.[106] For-profit nursing homes that legally separate their facility from the underlying real estate holdings and from the LLCs that provide management, staffing, or other services use this separation to assist true owners in acquiring facilities and increasing profits, while limiting the financial and legal liability they may face.[107]

The prevalence of complex corporate structures in for-profit nursing homes highlights two major issues that governments face. First, nursing homes and regulators are working at cross-purposes: because nursing homes rely heavily on government reimbursement rates to operate, including Medicare and Medicaid, they have a financial incentive to fill facility beds and to advocate for increasing reimbursement rates, while regulators, in their watchdog role, are charged with ensuring the appropriate spending of public funds. Second, obscuring the true owners of nursing homes allows true owners to evade legal and financial liability, including from government regulators, law enforcement, and aggrieved parties. It also conceals the real profits that nursing homes earn, as these complex structures limit the transparency of the flow of funds from nursing homes to beneficiary companies via lease payments, management companies, and more. This makes it challenging to determine the actual need for increasing reimbursement rates.

While DOH regulations explicitly prohibit owners of nursing homes from extracting equity from a facility unless certain criteria are met, and require disclosure of certain transactions that redirect revenue to the true owners, this section will first provide an overview of how for-profit nursing homes maximize profit extraction, and then will examine two case studies where the for-profit owners exploited their facilities to maximize profit extraction, while seemingly complying with state regulations.[108]

A. Overview of How For-Profit Nursing Homes Maximize Profit

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[106] N.Y. PUB. HEALTH LAW § 2801-d (2021); *see* Jerauld E. Brydges & John M. Jennings, Appellate Division Solidifies Legal Protections for Receivers, NYSBA HEALTH L. J., 1, 65-7 (Winter 2006). (noting a nursing home industry group submitted an *amicus curiae* brief regarding the "protective benefits of doing business in the corporate form" for nursing home owners). While LLCs provide true owners some protection, New York State law allows aggrieved parties to pursue a true owner for tort liability where they are a "controlling person;" *see infra* Part III subsection b(ii) for a discussion of New York's private cause of action where nursing home owners are "controlling persons."

[107] *See infra* Part III for two case studies of nursing homes that employ complex corporate structures.

[108] Nursing homes "seemingly" comply with regulations, as Case Study 1 illustrates how true owners apparently skirt State regulations governing nursing home operators and the outsourcing of core management operations, and Case Study 2 illustrates a true owner indicted for violating State law; N.Y. COMP. CODES R. & REGS. tit. 10 § 415.26 (2021); N.Y. PUB. HEALTH LAW § 2805-e (1) (2021); N.Y. PUB. HEALTH LAW § 2805-e (1) (g) (2021).

Extraction

There are various practices owners of for-profit nursing homes employ to maximize profit extraction from owned facilities. One crucial point to note, though ostensibly obvious, is that owners of for-profit nursing homes maintain a profit motive in each business decision they make, whereas owners of not-for-profit nursing homes generally lack that incentive. For years, academic researchers, advocacy groups, and the media have published extensive findings concluding not-for-profit nursing homes provide a greater quality of care than their for-profit counterparts do, and that acquisition of a facility by a for-profit owner leads to a notable decline in the quality of care provided.[109]

New York State seeks to regulate the amount of capital that a nursing home owner may extract from a facility, enumerating strict criteria that must be satisfied before facilities extract equity, including approval of the DOH Commissioner.[110] The criteria dictate that facilities may not "withdraw or reduce a facility's equity so as to create or increase a negative net worth by means of a withdrawal," so as to prevent facilities from drawing down the nursing home's equity and creating an artificial negative net worth.[111] Creating an artificial negative net worth would allow the nursing home industry to validate ensuing requests to government bodies for increasing Medicaid reimbursement rates.[112] Trade groups and associations representing nursing home facilities regularly advocate for increasing reimbursement rates.[113]

There are various other schemes for-profit owners use to exploit nursing home facilities in order to extract profit. These include (1) structuring ownership of the facility to disguise the true owner, which also allows the true owner to evade strict government oversight and regulation; (2) structuring ownership of the nursing home facility in a manner that limits the true owner's financial or legal liability from lawsuits; and (3) the

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[109] CTR. FOR MEDICARE ADVOC., *supra* note 5; Charlene Harrington et al., *Hidden Owners, Hidden Profits, and Poor Nursing Home Care: A Case Study*, 45(5) INT'L J. OF HEALTH SERV. 779, 779-82 (2015); Atul Gupta et al., *Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes*, NYU STERN SCHOOL OF BUSINESS, Nov. 12, 2020; Charlene Harrington at al., *Does Investor Ownership of Nursing Homes Compromise the Quality of Care?*, 91(9) AM J. PUBLIC HEALTH 1452, 1452-5 (2001).

[110] N.Y. COMP. CODES R. & REGS. tit. 10 § 415.26(h)(7) (2021).

[111] *Id.*

[112] An artificial negative net worth would make a nursing home appear unprofitable, and thereby justify the nursing home industry's regular requests for increasing Medicaid reimbursement rates. *See, e.g., Testimony Before The Joint Fiscal Committees Of The N.Y. State Leg.: Hearing on Health & Medicaid, N.Y State Leg. Joint Hearing* (Feb. 16, 2017) (Statement of Michael A. L. Balboni on behalf of Greater New York Health Care Facilities Ass'n); Press Release, CONTINUING CARE LEADERSHIP COALITION ET AL., (Mar. 23, 2018) (https://www.crainsnewyork.com/assets/pdf/CN114808323.PDF).

[113] *Id.*

establishment of LLCs or related companies. This third option creates LLCs that are distinct from the nursing home facility corporation, with the LLCs contracted to provide services to the nursing home. Services include providing payroll services; management or administrative services; mortgage services; staffing agencies; laundry services; food services; PPE or other equipment; and rehabilitation services.[114] When there is common ownership between the nursing home and the LLCs contracted to provide services, the rates charged are both set by, and paid to, the true owner.

True owners can extract profit directly from the nursing home facility. In addition, they can establish additional companies to provide the facility various services such as management services or staffing assistance, and then direct payments from the facility to these companies at a rate set by the true owner.[115] In the case studies discussed below, the true owner is also a principal in other companies providing services to the facility, or has relatives with ownership stakes in the other companies. Common ownership between a facility and the companies providing services to the facility raises questions about the rates charged for the services, since the dominant form of funding for nursing homes remains government funding.

The following section examines two case studies, one, a former nursing home owner successfully prosecuted by the New York State Attorney General, and the second, the self-described "largest nursing home network in the state of New York."[116] These case studies demonstrate how for-profit nursing home owners benefit from, and exploit, the nursing homes they are entrusted with running.

B. Case Study 1: Cold Spring Hills Center for Nursing and Rehabilitation

Cold Spring Hills Center for Nursing and Rehabilitation is a for-profit nursing home located across eleven acres in Woodbury, New York. Federal and state records list "Cold Spring Acquisition, LLC" as the licensed operator of the facility, and "Cold Spring Realty Acquisition, LLC" as the property owner.[117] When the nursing home was purchased in 2016 by two business partners, Bent Philipson and Benjamin Landa, the gentlemen had already

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[114] *E.g.*, N.Y. ATT'Y GEN., *supra* note 22, at 66.

[115] *See id*.

[116] SENTOSACARE, *supra* note 14.

[117] N.Y. DEP'T OF HEALTH, Public Health and Health Planning Council, *Committee Day Agenda Exhibits*, (Jan. 28, 2016); Medicare Find & compare nursing homes, hospitals & other providers near you., MEDICARE FIND & COMPARE NURSING HOMES, HOSPITALS, AND OTHER PROVIDERS NEAR YOU, https://www.medicare.gov/care-compare/ (last visited Apr. 14, 2022).

amassed what they described as the "largest nursing home network in the state of New York," Sentosa Care.[118]

Sentosa Care's website describes it as owning and operating nursing facilities throughout the region.[119] In a lawsuit Sentosa Care brought against journalists who wrote an unfavorable article about the care provided to residents by Sentosa Care's nursing home network, the court stated that Sentosa Care "is a consulting company that provides services to skilled nursing facilities" and has "contractual relationships with all of the SentosaCare affiliated nursing facilities."[120] Despite Sentosa Care's website describing it as owning and operating facilities, Sentosa Care's lawyer stated in response to a 2015 investigative report into Sentosa Care's network that "SentosaCare does not have 'ownership or control' over the facilities in its network and only contracts with them to provide administrative and rehabilitation consulting, regulatory advice and purchasing services."[121] However, DOH records dispute this accounting, supporting the assertion that Landa, Philipson, or their relatives retain ownership stakes in facilities owned by Sentosa Care.[122] Sentosa Care's business model utilizes individual LLCs to purchase and operate nursing home facilities, allowing Sentosa Care, Philipson, and Landa to be a step removed from direct operations of a facility. Though a step removed, Sentosa Care profits and benefits from its nursing home network. In 2013, Sentosa Care was paid "more than $11.5 million for financial, staffing and other services" from nursing homes within its network.[123]

In accordance with State requirements during the application to acquire ownership of the nursing home facility, Cold Spring Hills submitted the names and ownership stakes for the operator and the property owner, with Philipson, Landa, or their relatives listed as majority stakeholders in both entities.[124] The diagram in Appendix 1 shows the common ownership between facility's operator and the facility's landlord; Landa, Philipson, or their direct relatives control at least 50% ownership in the LLC that operates Cold Spring Hills, and at least 50% ownership in the LLC that is the landlord to Cold Spring Hills.[125]

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[118] SENTOSACARE, *supra* note 14.

[119] SentosaCare, http://www.sentosacarellc.com/about-sentosa-care-ny/ (last visited May 25, 2021).

[120] SentosaCare LLC v. Lehman, 2018 NY Slip Op 50134(U), 58 Misc. 3d 1216(A), 95 N.Y.S.3d 126 (Sup. Ct.).

[121] *See* Abramo & Lehman, *supra* note 18.

[122] N.Y. DEP'T OF HEALTH, *supra* note 88.

[123] *See* Abramo & Lehman, *supra* note 18.

[124] N.Y. DEP'T OF HEALTH, *supra* note 88.

[125] *See infra* Appendix 1.

Listed as principals for Cold Spring Acquisition, LLC, the operator of the facility, were Joel Leifer with a 25% ownership stake, Esther Farkovitz with a 25% ownership stake, Avi Philipson with a 25% ownership stake, Rochelle David with a 12.5% ownership stake, and Leah (Leaya) Friedman with a 12.5% ownership stake.[126] In documents filed with the DOH, Leifer is listed as the administrative director of Atrium Center for Rehabilitation, a Brooklyn-based nursing home; Farkovitz is Benjamin Landa's daughter; Philipson is Bent Philipson's son; and David and Friedman are human resources officials at Confidence Management Systems, a New Jersey housekeeping services company.[127] Records filed with the New York State Department of State ("DOS"), the state agency charged with keeping records such as business licensing and incorporation records, list Bent Philipson as the individual who will accept mail process on behalf of Cold Spring Acquisition, LLC.[128]

Cold Spring Realty Acquisition, LLC, the property owner, functions as the landlord for Cold Spring Hills.[129] Listed as principals for Cold Spring Realty Acquisition, LLC are Cheskel Berkowitz; Benjamin Landa; Philipson Family Limited Liability Trust Co; and Lifestar Family Holding LLC, which lists with the DOS an address for their entity in Rockland County NY that is the home of David Zahler, listed on LinkedIn as the "Founder and CEO" of Central Care Solutions, a company that "streamline[s] the supply ordering process for healthcare facilities."[130]

While Cold Spring Acquisition, LLC and Cold Spring Realty Acquisition, LLC are separate LLCs with different principals, Landa and Philipson made no concerted effort to hide themselves as the true owners of Cold Spring Hills when seeking approval by the DOH Public Health and Health Planning Council for their 2016 purchase of the facility. Documentation submitted to the DOH Public Health and Health Planning Council clearly stated the overlapping relationships between the principals of the LLC seeking to operate Cold Spring Hills, and the principals of the LLC seeking to be the property owner.[131] In fact, documentation submitted also shows the principals' affiliations with other nursing homes, and that the principals have been involved with other nursing home purchases together.[132]

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[126] N.Y. DEP'T OF HEALTH, *supra* note 88.

[127] *Id*.

[128] *Entity Information: Cold Spring Acquisition, LLC*, N.Y. DEP'T OF STATE, https://apps.dos.ny.gov/publicInquiry/EntityDisplay (last visited Apr. 14, 2022).

[129] N.Y. DEP'T OF HEALTH, *supra* note 88.

[130] *Id*.; Central Care Solutions, LinkedIn (last visited Apr. 7, 2022), https://www.linkedin.com/company/central-care-solutions/ (last visited May 25, 2021); Central Care Solutions, LinkedIn (last visited Apr. 7, 2022), https://www.linkedin.com/in/david-zahler-27193b58.

[131] N.Y. DEP'T OF HEALTH, *supra* note 118.

[132] N.Y. DEP'T OF HEALTH, *supra* note 88.

New York does not forbid the structure that Cold Spring Hills has established, with common ownership between both the operator and property owner, refered to as common ownership, a related party transaction, or a non-arms length transaction. However, this type of ownership is inherently problematic because this relationship allows the landlord to set the rent the facility operator pays. Here, the lease terms for Cold Spring Hills provided a $54.2 million thirty year mortgage paid by the operator to finance the 2016 purchase of the property.[133]

i. Disguises the True Owner, Enabling Evasion from Government Oversight or Regulation

It is hard to dispute that Landa and Philipson are the true owners of Cold Spring Hills. Though neither gentleman explicitly declares himself as such, tracing their ownership interests in documents filed with the DOH Public Health and Health Planning Council makes evident they, as business partners, are the owners.[134]

The way Landa and Philipson structured the Cold Spring Hills business venture illustrates how true owners attempt to evade strict government oversight and regulation, utilizing relatives and multiple LLCs as owners of the facility and of the property, and making it difficult to trace the true owners. This structure has allowed Landa and Philipson to be a step removed from the day-to-day operations of Cold Spring Hills, installing their children as the operators of the facility and installing an administrator, who is the party legally responsible for the affairs of the nursing home. Administrators can be held professionally and personally liable for failure to comply with governing regulations; landlords may only be liable to the extent they are a "controlling party," that is, someone "of a direct or indirect ownership interest," and even then, can be liable only to the same extent which the facility is liable.[135] Even where a nursing home owner has a facility found to incur violations or safety issues, this has not acted as a barrier for the DOH granting the owner permission to acquire another facility.[136]

Government oversight tends to focus on the annual inspections of nursing homes to determine the extent of a facility's compliance with state

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[133] *Id.*

[134] *See* N.Y. DEP'T OF HEALTH, *supra* note 118 (detailing Philipson statements to the DOH guaranteeing his son's equity contributions as well as both Philipson and Landa's affidavits declaring they are "willing to contribute equity to the operating entity."); *see also* Baumbach et al., *supra* note 6.

[135] N.Y. PUB. HEALTH LAW § 2897 (2021); N.Y. PUB. HEALTH LAW § 2808-a (2021).

[136] *See* Abramo & Lehman, *supra* note 18; N.Y. DEP'T OF HEALTH, *supra* note 37; N.Y. PUB. HEALTH LAW § 2801-a (2021).

and federal law.[137] Regulators focus on the quality of care within a facility, and it appears to a lesser extent, if at all, on the flow of funds from facilities into subsidiary companies.[138] While Cold Spring Hills has just a 2-star CMS rating, the facility has faced only one federal fine in the last three years, and there appears to be no fines levied against Landa or Philipson.[139]

Enforcement efforts have not been immune to criticism, with the average number of fines for nursing homes in New York, (0.20), falling at less than half of the national rate (0.47).[140] Prior to the Attorney General's scathing report in January 2021 into the handling of the COVID-19 pandemic by New York State and the nursing home industry, enforcement efforts by state officials were limited.[141] Officials with the jurisdiction to hold true owners accountable for wrongdoing in facilities, or for financial manipulation through exploitation of subsidiary companies, were limited, an issue the Attorney General blamed on "law enforcement agencies lack[ing] the resources to conduct such comprehensive investigations of the financial transactions and records."[142]

ii. Limited Financial or Legal Liability from Lawsuits

The structure of Cold Spring Hills obscures that Landa and Philipson are the true owners. Beyond the benefits described above, this structure has additional advantages. Structuring ownership of the facility in this manner aids true owners in attempting to limit their financial and legal liability from lawsuits, including those brought for negligent care or wrongful death.[143] Though true owners may seek this structure to limit their liability, New York State law provides a recourse, albeit narrow, for aggrieved parties to pursue action against true owners.

New York State Public Health Law Section 2801-d, which governs care in nursing home facilities, creates a private cause of action for patients injured

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[137] Institute Of Medicine, IMPROVING THE QUALITY OF CARE IN NURSING HOMES 147 (Nat'l Academies Press 1986).

[138] The Long Term Care Community Coalition, an advocacy group for nursing home residents, compiled a report showing government oversight and fines focuses on violations for standard and quality of care in nursing homes, as opposed to the potential misappropriation of funds. *See* Press Release, LONG TERM CARE CMTY. COAL. (Sept. 17, 2020) (https://nursinghome411.org/wp-content/uploads/2020/09/LTCCC-statement-enforcements.Sept_.2020.pdf).

[139] MEDICARE FIND & COMPARE NURSING HOMES, HOSPITALS, AND OTHER PROVIDERS NEAR YOU, https://www.medicare.gov/care-compare/ (last visited Apr. 10, 2022).

[140] *See, e.g.,* Press Release, LONG TERM CARE CMTY. COAL. (June 1, 2020) (https://nursinghome411.org/ltccc-alert-new-report-finds-significant-regional-variations-in-new-yorks-nursing-homes/); OFF. OF THE N.Y. STATE COMPTROLLER, *supra* note 96; Abramo & Lehman, *supra* note 18.

[141] N.Y. ATT'Y GEN., *supra* note 22, at 51, 65.

[142] *Id*.

[143] *See* Hoey, *supra* note 27, at 8-10.

in a residential health care facility.[144] Section 2808-a holds nursing home owners who are controlling persons, responsible for injuries and neglect which occur as a result of violations of the nursing home regulations, liable to the same extent as the nursing home.[145] Section 2808-a defines controlling person to be "any person who by reason of a direct or indirect ownership interest (whether of record or beneficial) has the ability, acting either alone or in concert with others with ownership interests, to direct or cause the direction of the management or policies of said facility."[146] This allows parties to bring an action against true owners, where a claim and recovery would otherwise be brought against the facility without naming the true owner as a defendant.[147] Bringing an action against the true owner brings the presumable benefit that the true owner has greater financial resources.[148]

This law has limitations; it is only truly effective in holding controlling parties accountable if the nursing home has no insurance or has a limited insurance policy. That is because in those scenarios, the controlling party would be exposed to liability for damages.[149] The statute states a controlling person can only be liable "to the same extent" as the facility.[150] Since the liability of a controlling person is not greater than the liability of the facility, if a facility's insurance policy is sufficient to cover the damages from the claim, the controlling person will have no personal liability.[151] On the other hand, nursing homes who frequently rely on their insurance policies for negligence or wrongful death claims will likely face policy cancellations or sharply increased premiums.[152] Thus, the law is most beneficial in lawsuits where a facility has no insurance or a limited insurance policy, by allowing for a controlling party to be held liable for damages.

iii. Separate LLCs Contracted to Provide Services to the Nursing

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144 N.Y. PUB. HEALTH LAW § 2801-d(2021).

145 N.Y. PUB. HEALTH LAW § 2808-a(1) (2021).

146 N.Y. PUB. HEALTH LAW § 2808-a(2) (2021).

147 Louis Adolfsen, *Dismissing Lawsuits Against Owners of New York Nursing Homes*, THE MELITO & ADOLFSEN LAW FIRM, (Sept. 2, 2016), https://www.jdsupra.com/post/contentViewerEmbed.aspx?fid=05b4039b-520c-4fc2-a71c-a5ea7122046b; Brydges & Jennings, *supra* note 107, at 65-67.

148 *See* Hoey, *supra* note 27, at 8.

149 Adolfsen, *supra* note 149.

150 N.Y. PUB. HEALTH LAW § 2808-a(1) (2021).

151 Adolfsen, *supra* note 149.

152 U.S. DEP'T OF HEALTH AND HUM. SERV. ASS. SEC. FOR PLANNING AND EVALUATION, OFF. OF DISABILITY, AGING AND LONG-TERM CARE POLICY, THE NURSING HOME LIABILITY INSURANCE MARKET: A CASE STUDY OF FLORIDA (2006).

Home

The third way that owners of for-profit nursing homes exploit facilities for profit extraction is through commonly owned or controlled transactions. LLCs separate from the facility's LLC are established, and are then contracted to provide services to the nursing home. When these LLCs share common ownership with the facility, the beneficiaries of the LLC providing the service contract are essentially paying themselves as owners of the nursing home. This happens when the principal of the nursing home LLC and the service provider LLC entirely overlap, as well as when there are related party transactions, such as between relatives or business partners.

In addition to land-lease transactions such as that between Cold Spring Acquisition, LLC and Cold Spring Realty Acquisition, LLC, for-profit owners use separate LLCs to provide various services to the nursing home facility, for which the LLCs are well-compensated.[153] Cold Spring Hills illustrates one example of this, with the nursing home operator and landlord sharing the same principals or relatives of the principals. State cost reports reveal the extent to which the principals associated with Cold Spring Acquisition, LLC and Cold Spring Realty Acquisition, LLC are principals in LLCs that Cold Spring Hills contracts with to provide various services.[154]

Joel Leifer, a named principal of the LLC that operates Cold Spring Hills, is listed in documents filed with the DOH Public Health and Health Planning Council as the administrative director of a Brooklyn-based nursing home.[155] Records with CMS list Leifer as involved with numerous various nursing homes across New York.[156] A press release from February 2018 sent out by Excelsior Care Group revealed that Cold Spring Hills hired Excelsior Care Group to run the facility.[157] Excelsior Care Group's website boasts that it is a "premier healthcare management firm that strategically provides management consulting services" to nursing homes across the region.[158] Despite State regulations explicitly prohibiting the "improper delegation to the management consultant," Cold Spring Hills seemingly outsourced critical

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153 *See* N.Y. ATT'Y GEN., *supra* note 22, at 66.

154 N.Y. DEP'T OF HEALTH, Nursing Home Cost Report 2952310N, (2020); N.Y. DEP'T OF HEALTH, Nursing Home Cost Report 2952310N, (2019); N.Y. DEP'T OF HEALTH, Nursing Home Cost Report 2952310N, (2018); N.Y. DEP'T OF HEALTH, Nursing Home Cost Report 2952310N, (2017).

155 N.Y. DEP'T OF HEALTH, *supra* note 88.

156 NursingHomeDatabase.com, https://www.nursinghomedatabase.com/ (under "People Search" search the name "Joel Leifer") (last visited on Apr. 6, 2022).

157 Press Release, COLD SPRING HILLS CENTER FOR NURSING & REHAB (2018) (https://patch.com/new-york/syosset/directory/listing/46153/cold-spring-hills-center-for-nursing-rehab;); Press Release, EXCELSIOR CARE GROUP (Feb. 16, 2018) (http://www.excelsiorcare.net/bringing-excelsiors-vision-of-healthcare-to-woodbury-new-york-and-brentwood-long-island/).

158 EXCELSIOR CARE GROUP, http://excelsiorcaregroup.com/ (last visited May 25, 2021); N.Y. COMP. CODES R. & REGS. tit. 10 § 600.9 (2021).

management decisions to Excelsior Care Group, and then later, to Philosophy Care Centers.[159] The diagram in Appendix 2 shows Cold Spring Hills' outsourcing of management operations, potentially in violation of State law.[160]

At the height of the COVID-19 pandemic, this outsourced management company, Philosophy Care Centers, communicated updates to residents' families, including changes the facility was making to policies to address residents safety as the pandemic ravaged New York.[161] In other written communications to families of Cold Spring Hills residents, Philosophy Care Centers wrote the facility was reducing communal gatherings and restricting residents to their individual rooms, key policies at that point in time, at the beginning of the pandemic, which were being promoted by public health experts as crucial to stemming the spread of COVID-19.[162] Criteria within DOH regulations look at "the adoption and enforcement of policies regarding the operation of the facility" as an indicator that a nursing home operator has improperly delegated its responsibilities to a management consultant.[163]

A 2020 media story featured Benjamin Landa telling the newspaper that Joel Leifer owns Excelsior Care Group.[164] That same story reported Bent Philipson's representative stated Philosophy Care Centers "succeeded Excelsior Care in June 2019."[165] Philosophy Care Centers website lists Bent Philipson as the founder and its Facebook page previously identified the company as "operating a network of Skilled Nursing Facilities located throughout NY."[166] The about section of Philosophy's Facebook now identifies it as a "Long Island, NY based consulting company."[167]

In 2019, media reports state a major business dispute led Landa and Philipson to split their joint business ventures.[168] In the memorandum of understanding dictating the split of Landa and Philipson's business interests, the agreement granted Philipson the interests in Cold Spring Hills.[169] Cold

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159 N.Y. COMP. CODES R. & REGS. tit. 10 § 600.9 (2021).

160 *Id.*; *see infra* Appendix 2.

161 *See* Baumbach et al., *supra* note 6.

162 *Id.*; Berkeley Lovelace Jr., *Dr. Anthony Fauci sees 'glimmers' that social distancing is 'dampening' coronavirus outbreak*, CNBC, (Mar. 31, 2020), https://www.cnbc.com/2020/03/31/us-health-official-fauci-sees-glimmers-that-social-distancing-is-dampening-coronavirus-outbreak.html.

163 N.Y. COMP. CODES R. & REGS. tit. 10 § 600.9 (2021).

164 *See* Baumbach et al., *supra* note 6.

165 *Id.*

166 Philosophy Care Centers , https://www.philosophycare.com/our-team (last visited May 25, 2021); *see* Baumbach et al., *supra* note 6.

167 Philosophy Care Centers (@philosophycarecenters), Facebook (May 25, 2021), https://www.facebook.com/philosophycarecenters.

168 *See* Baumbach et al., *supra* note 6.

169 *Id.*

Spring Hills retained Philosophy Care Centers in June 2019.[170] Although New York State requires prompt notification to the DOH of any change in ownership or the corporation,[171] the DOH stated Cold Spring Hills failed to alert the DOH to this change.[172]

Despite clear and easily accessible evidence that Landa and Philipson are the true owners of Cold Spring Hills, the byzantine network of LLCs the business partners have established has allowed them to apparently skirt State regulations and evade responsibility for what happens within Cold Spring Hills. Landa and Philipson's skilled use of commonly owned and controlled LLCs to own and operate Cold Spring Hills is not unknown to regulators; public records with the DOH, including those submitted when the partners sought DOH approval to purchase the facility, make clear they are the true owners of the facility. Yet, by obscuring their beneficial ownership of Cold Spring Hills, Landa and Philipson have evaded rigorous government oversight, limited their financial and legal liability, and maximized usage of subsidiary LLCs to extract profits from Cold Spring Hills nursing home. This case study of Cold Spring Hills provides a dramatic showcase of just how for-profit facilities maximize profits through complex mazes of affiliated entities, common ownership, and related parties.

C. Case Study 2: Focus Rehabilitation and Nursing Center

In 2018, the New York Attorney General announced a plea agreement with an owner and manager of Focus Rehabilitation and Nursing Center, ("Focus Otsego"), a for-profit nursing home in Cooperstown, New York.[173] The plea agreement centered on allegations of inadequate staffing and failure to provide safe standards of care for nursing home residents.[174] The Attorney General's investigation revealed an equally serious issue—the exploitation of subsidiary LLCs to maximize profit extraction.[175]

Upon assuming ownership of the facility in 2014, the owner, Joseph Zupnik, and the manager, Daniel Herman, slashed the staff from 298 to 225,

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[170] *Id*.

[171] At the time of Cold Spring Hills' change of ownership, the then-law required a notification to the DOH of "any proposed change in the membership of the partnership." *See* N.Y. COMP. CODES R. & REGS. tit. 10 § 600.1(b). Since then, the law has changed to require notification to the DOH, the Long-Term Care Ombudsman, residents, and staff. *See* N.Y. COMP. CODES R. & REGS. tit. 10 § 600.1(d).

[172] *See* Baumbach et al., *supra* note 6.

[173] Press Release, N.Y. ATT'Y GEN., A.G. Underwood Announces Guilty Pleas Of Former Focus Otsego Nursing Home Operators For Endangering Resident (Sept. 12, 2008), https://ag.ny.gov/press-release/2018/ag-underwood-announces-guilty-pleas-former-focus-otsego-nursing-home-operators.

[174] *Id*.

[175] N.Y. ATT'Y GEN., *supra* note 22, at 66.

and cut other services and supplies for the facility's 174 residents.[176] At the same time, the facility, which was mainly funded by Medicaid, Medicare, and private insurance payments, directed large contracts to related party subsidiary LLCs for a variety of consulting contracts.[177] From the period of October 2014 through December 2017, $320,000 was paid to the nursing home owner; $1,300,000 was paid to relatives of the owner; $675,900 was paid to entities related to the owner and manager; $2,420,970 was paid to related parties of the owner and manager; $4,228,325 was paid to a management company operated by the owner and manager; $5,535,080 was paid to a related company of the owner, manager, and relatives; and portions of nursing home payroll went to relatives of the owner and manager.[178]

The problems at Focus Otsego culminated in December 2016 when CMS placed the facility into its "Special Focus Facility Program," a probationary program for the most egregious nursing homes with "a history of serious quality issues."[179] Despite this public designation, until the Attorney General brought charges, the owner and manager extracted substantial profit from the facility virtually unchecked, while overseeing a decline in the care provided to residents entrusted in Focus Otsego's care.[180]

The case study of Focus Otsego illustrates a problem emblematic in the debate over for-profit nursing home ownership: governments are averse to taking over the ownership or operations of problem-plagued nursing home facilities.[181] Before Zupnik purchased Focus Otsego in 2014, the facility was a county-owned nursing home.[182] As policy makers grapple with how to address the quality of care provided by nursing homes, that governments are reluctant to take on the burden of running these facilities remains an underlying factor driving governmental decision making.[183]

The COVID-19 pandemic renewed interest in the oversight of nursing homes as public outrage and heightened media attention highlighted the suffering and treatment of nursing home residents. New York's passage of a

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[176] N.Y. ATT'Y GEN., *supra* note 175; *In Our Opinion: Focus Otsego is a sad story,* THE COOPERSTOWN CRIER, (June 21, 2018), https://www.coopercrier.com/opinion/in-our-opinion-focus-otsego-is-a-sad-story-that-goes-on-and-on/article_4577702b-4481-5a51-b7c7-e722edb1399f.html.

[177] N.Y. ATT'Y GEN., *supra* note 22, at 66.

[178] *Id*.

[179] CTR. FOR MEDICARE & MEDICAID SERVS., *Special Focus Facility ("SFF") Program* (Oct. 2017), https://chfs.ky.gov/agencies/dail/Documents/SFFList.pdf; CTR. FOR MEDICARE & MEDICAID SERVS., *Special Focus Facility ("SFF") Program* (last visited May 25, 2021), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/SFFList.pdf.

[180] *See* Borrelli, *supra* note 63; *see also* N.Y. ATT'Y GEN., *supra* note 22, at 64-66.

[181] Jim Kevlin, *Stuligross: Manor Sale To Be Complete In Week*, ALLOTSEGO, (Oct. 1, 2014), https://www.allotsego.com/stuligross-manor-sale-to-be-complete-in-week/.

[182] *Id*.

[183] *See* Kevlin, *supra* note 183.

law mandating a minimum percentage of revenue that a nursing home must spend on direct resident care is a culmination of this attention. The next section explores this new law and offers recommendations for its implementation, because how this law is interpreted and enforced will determine its impact on improving care within New York's nursing homes.

IV. TOWARD REVENUE-FOCUSED REGULATION OF NURSING HOMES

The case studies explored in Part III highlight only some of the complicated issues facing policy makers as they grapple with how to ensure the protection of society's most vulnerable population, nursing home residents. Over past year, the COVID-19 pandemic disproportionately impacted these residents, renewing legislators' interest in addressing nursing home oversight and regulation, and resulting in passage of a new law in New York establishing a Direct Care Ratio.[184] New York's new law, which mandates a minimum percentage of revenue to be spend directly on patient care, is similar to the direct patient spending requirements imposed on private insurance companies in the Affordable Care Act.

This section analyzes New York's new law from a revenue-focused perspective, meaning the recommendations offered are focused around examining nursing homes actual revenues, and driving facilities to spend more of their revenues on actual patient care. This section evaluates New York's new law and offers recommendations for its implementation to strengthen the interpretation and enforcement of the DCR. This section also offers other reforms New York can institute, such as careful implementation of the newly passed safe staffing law, and empowering the Public Health and Health Planning Council to conduct rigorous reviews of the applications that come before it.

A. New York's Direct Care Ratio and the Affordable Care Act's Medical Loss Ratio

In implementing the Affordable Care Act, the Department of Health and Human Services ("HHS") adopted a rule commonly referred to as the "medical loss ratio," ("MLR").[185] This rule largely requires health insurance companies to spend a minimum percentage of premium revenues on health care and quality improvement activities; 80% for individual and small group

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[184] *See* Susan Jaffe, *After Pandemic Ravaged Nursing Homes, New State Laws Protect Residents*, KAISER HEALTH NEWS (Aug. 20, 2021), https://khn.org/news/article/after-pandemic-ravaged-nursing-homes-new-state-laws-protect-residents/.

[185] Suzanne M. Kirchhoff, Cong. Research Serv., R42735, MEDICAL LOSS RATIO REQUIREMENTS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA): ISSUES FOR CONGRESS (2015).

market insurers and 85% for large group market insurers.[186] Looking at this in the alternative, the MLR caps the amount that can be spent on administrative costs and profits at 20% or 15%. Insurers who fail to meet the minimums are penalized by a requirement that the difference be rebated back to plan members.[187] During HHS' promulgation of rules to implement the MLR, of key interest to insurance companies were what activities or expenses qualified for "quality improvement activities," with HHS ultimately adopting that activities "capable of being objectively measured and of producing verifiable results and achievements" may be considered as quality improvement activities.[188]

Advocates for creation of the MLR argued it would direct more insurance premiums to patient care and less to insurance companies' overhead and profits.[189] In April 2021, the New York state legislature adopted a "minimum direct resident care spending" requirement, a state version of the MLR for nursing home facilities.[190] This followed a years-long push by advocates for adoption of a MLR for nursing homes similar to the Affordable Care Act's MLR.[191] New York's law follows a similar law enacted by New Jersey in late 2020, with New Jersey's requirement set at 90%, and a similar law enacted by Massachusetts in September 2020, with Massachusetts's requirement set at 75%.[192]

New York's Direct Care Ratio, ("DCR"), requires that nursing homes and other residential health care facilities spend a minimum of 70% of revenues on direct patient care, with 40% of this 70% be allocated to staffers who work directly with residents.[193] New York's DCR also instituted a profit cap, limiting nursing home profit margins, where excess revenue of 5% over expenses is to be remitted to a "nursing home quality pool" run by the state.[194]

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[186] Timothy Jost, *Implementing Health Reform: Medical Loss Ratios*, HEALTH AFFS, (Nov. 23, 2010), https://www.healthaffairs.org/do/10.1377/hblog20101123.008047/full/; 45 CFR § 158.210 (2021).

[187] 45 CFR § 158.210 (2021).

[188] *Id*.; *see* Jost, *supra* note 190.

[189] HealthLeaders Media Staff, *Legislating Medical Loss Ratio Leads To Unintended Consequences*, HEALTH LEADERS MEDIA, (May 6, 2009), https://www.healthleadersmedia.com/finance/legislating-medical-loss-ratio-leads-unintended-consequences.

[190] N.Y. PUB. HEALTH LAW § 2828 (2021).

[191] Press Release, LONG TERM CARE CMTY. COAL. AND THE CTR. FOR MEDICARE ADVOC. (Aug. 13, 2018) (https://nursinghome411.org/wp-content/uploads/2018/11/ltccc-cma-medical-loss-ratio-statement.pdf); Charlene Harrington, Leslie Ross, Dana Mukamel, & Pauline Rosenau, *Improving The Financial Accountability Of Nursing Homes*, THE KAISER COMM'N ON THE MEDICAID AND THE UNINSURED (June 2013).

[192] N.Y. PUB. HEALTH LAW § 2828 (2021); N.J. STAT. ANN. § 30:4D-7cc (2020); 101 MASS. CODE REGS. 206.12 (2021).

[193] N.Y. PUB. HEALTH LAW § 2828 (2021).

[194] *Id*.

New York's statute defines the type of activities allowable to meet the direct resident care requirement.[195] The new law explicitly prohibits administrative costs, other than nursing administration, from counting towards the 70% requirement.[196] This may help prevent administrative costs from being used to inflate a facility's DCR, because the DCR intends to increase the amount of money spent on direct resident care. New York's broad definition of direct resident care counts "nonrevenue support services," "ancillary services," and "program services;" these are services that for-profit nursing homes often contract for with subsidiary LLCs, such as laundry and linen, housekeeping, and medical staff services.[197]

Critically, New York's statute directs the Commissioner of the DOH to issue subsequent regulations to implement the DCR, leaving room for broad regulatory discretion as to what qualifies as an allowable cost towards the direct resident care requirement.[198]

B. Ensure that Interpretation and Enforcement of New York's Direct Care Ratio Reflect Patients' Interests

Key next steps for successful implementation of the DCR will be what limitations, if any, the DOH establishes in its forthcoming regulations. The federal government experience over the past decade with implementation of the MLR can inform New York's approach to interpreting and enforcing the DCR.

In November 2021 the DOH published proposed regulations for comment in the State Register to implement the DCR.[199] Yet, just prior to publishing the proposed regulations, in October 2021, the DOH testified before the DOH's Public Health and Health Planning Council that the DCR law adequately enumerated the requirements and subsequent regulations may not be necessary.[200] The DOH should reverse course and adopt regulations that narrowly define costs, strictly monitor and scrutinize costs, and regulate and cap expenses paid to related party transactions.

i. Narrowly Define Costs under the DCR, then Strictly Monitor

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[195] *Id*.

[196] *Id*.

[197] *Id*.; *see* N.Y. ATT'Y GEN., *supra* note 22, at 66.

[198] N.Y. PUB. HEALTH LAW § 2828 (2021).

[199] N.Y. COMP. CODES R. & REGS. tit. 10, § 415.34 (proposed Nov. 17, 2021).

[200] Archived Webcast: NY Department of Health Committee on Codes, Regulations and Legislation and Full Public Health and Health Planning Council Meeting (Oct. 7, 2021) (https://www.health.ny.gov/events/webcasts/archive/).

and Scrutinize Costs Submitted Towards the DCR

The DOH should narrowly define the costs allowed to meet the 70% DCR requirement, then strictly monitor and scrutinize the costs facilities submit towards the 70% requirement. The broad statutory definition New York legislators adopted for allowable activities to meet the 70% requirement provides facilities flexibility in determining eligible costs to satisfy the 70% requirement.[201] The statute's definition of direct resident care includes plant operation and management, medical education, activities program, and laundry and linen as eligible to count towards the 70% requirement.[202] To ensure implementation of the DCR satisfies the policy intent behind the law, first, the DOH should rely on stakeholder input to adopt regulations that narrowly enumerate what defines these activities, and second, the DOH should closely monitor and regularly scrutinize the costs facilities submit towards the 70% DCR requirement.

During implementation of the Affordable Care Act, Congress charged the National Association of Insurance Commissioners ("NAIC") with "establish[ing] uniform definitions of the [MLR activities] and standardized methodologies for calculating measures for such activities" that would count towards improving health care quality.[203] The NAIC is a trade group representing state and territorial insurance regulators in the United States.[204] The NAIC convened working groups, with the most testy task being that of deciding what would and would not count towards quality improvement activities.[205] Insurers aggressively lobbied to define would count towards the MLR, seeking as broad a definition as possible, so insurers could "more easily meet the minimum requirements."[206] The NAIC debated what elements would be eligible to count towards the MLR, including elements with seemingly no direct connection to what an insurer spends on patient care, like payroll taxes and broker commissions, as well as other elements with more logical connection to patient care spending, like wellness initiatives and disease management.[207]

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[201] *See id*. (giving the DOH the power to promulgate regulations in regard to the law and defining eligible costs towards the 70% requirement with the qualifier "and Other similar program services"—both of which allow flexibility in determining allowable activities towars the 70%).

[202] N.Y. PUB. HEALTH LAW § 2828 (2021).

[203] *See* Jost, *supra* note 190.

[204] *Our Story*, NAIC, https://content.naic.org/about (last visited Apr. 14, 2022).

[205] Jost, *supra* note 190.

[206] Shelby Livingston, *The Medical Loss Ratio's Mixed Record.*, 50 MOD. HEALTHCARE 26 (Mar. 14, 2020).

[207] Emily P. Walker, *Debate Heats Up Over Medical Loss Ratios*, MEDPAGE TODAY (Aug. 16, 2010), https://www.medpagetoday.com/washington-watch/reform/21706; Timothy Jost, *The NAIC's Effort To Find Balance In Its Medical Loss Ratio Regulation*, KHN, (Sept. 30, 2010), https://khn.org/news/093010jost/; Livingston, *supra* note 146.

The DOH should convene similar workgroups comprised of stakeholders including the Public Health and Health Planning Council, representatives of the DOH, medical experts, bioethicists, lawyers, regulators, long-term care advocates, representatives of nursing home staffers, and representatives of nursing home owners to make recommendations on clearly defining the activities that can count towards direct resident care. For example, the statute allows "housing" to count as direct resident care.[208] This broad term, housing, could allow a facility to submit their rent, property taxes, mortgage, insurance, fuel costs, and more towards the DCR. The statute does not speak to whether a mortgage loan counts,[209] and while a mortgage loan may fit within the traditional definition of housing costs, the facility in Case Study 1 presents a costly mortgage loan that, if found to be above fair market value, may help the facility artificially inflate its 70% DCR.[210] Stakeholders' experiences can help inform the DOH's regulations, then ultimately, the DOH should adopt narrow regulations that enumerate what specifically qualifies under each of the various costs that count towards the 70% direct resident care requirement. This will prevent facilities from artificially inflating their DCR, as well as, honor the state legislature's intent for the law, to increase spending on direct care for residents.

Under the new law, the DOH has the authority to waive the DCR requirement for facilities on a case-by-case basis, a power, which if utilized, would undercut the intent behind the law.[211] This waiver should be granted only in the most extreme cases where facilities demonstrate true hardship or extenuating circumstances and following a meticulous review by the DOH of the facility's financial reports. The DOH should publish its rationale for granting the exemption publicly on its website.

Additionally, the DOH should establish a system for monitoring what activities facilities are submitting towards the 70% requirement, and regularly scrutinize those submitted costs. The Affordable Care Act requires insurers to annually submit reports to HHS with the activities the insurer is counting towards the MLR, and an explanation of other "non-claims costs."[212] The DOH should similarly require facilities to submit detailed reports annually that list expenses the facility is counting towards the 70%

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[208] N.Y. PUB. HEALTH LAW § 2828 (2021).

[209] *Id.*

[210] *See supra* Part III subsection b. Since New York's DCR allows "Housing" eligible towards the 70% DCR, if a facility's mortgage were eligible as part of the housing cost and the mortgage loan was more than would be found at fair market value, an inflated mortgage would inflate that facility's true costs towards the DCR and allow the facility to more easily meet the 70% requirement.

[211] N.Y. PUB. HEALTH LAW § 2828 (2021).

[212] 42 U.S.C. § 300gg–18.

requirement. The DOH should require these reports to include a rigorous accounting of a facility's expenses, particularly where related party transactions are counted towards the 70% direct resident care requirement. For example, if a nursing home facility is counting its laundry and linen expenses towards direct resident care, DOH regulations should require the facility disclose the gross expense, the recipient company, and the principals of the recipient company. This can help identify related party transactions, an issue prominent in both case studies from Part III.[213]

CMS regularly reviews insurance providers' MLR reporting forms to ensure compliance, as well as, audits insurers to examine whether the elements being used to satisfy the MLR are appropriate.[214] The DCR law grants the DOH explicit authority to audit a facility's reports.[215]

The DOH should audit randomly selected facilities annually, and audit all facilities at least once every three years, to confirm the facility is submitting appropriate costs towards the direct resident care requirement. In 2016, CMS publicized the results of its first audits of insurers' compliance with the MLR. Following the CMS audits, the NAIC engaged in a review of eligible quality improvement expenses under the MLR.[216] The NAIC review sought to clarify ambigious language insurers encountered while quantifying expenses under the MLR.[217] Periodically, the DOH should review all nursing home facilities' DCR submissions to ensure compliance, and also to review whether further clarification is needed about what activities are appropriate to count towards the 70% requirement. These reviews and audits will also help ensure that facilities are not artificially inflating costs to meet the 70% requirement.

ii. Regulate and Cap Expenses Paid to Related Party Transactions

In addition to narrowly defining allowable costs to meet the DCR, and close monitoring and scrutinization of costs submitted towards the DCR, the DOH should regulate and cap the expenses that a facility can counts towards its DCR when the expenses are paid to related party transactions, meaning a transaction where there is common ownership or beneficiaries between the nursing home facility and the company contracted for services. The case studies in Part III detail how for-profit nursing homes direct revenue to LLCs

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[213] *See supra* Part III.

[214] CTRS. FOR MEDICARE & MEDICAID SERVS., *Programs and Initiatives, Health Insurance Market Reforms, MLR Examinations*, https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/MLR_examinations_reports (last visited May 25, 2021).

[215] N.Y. PUB. HEALTH LAW § 2828 (2021).

[216] Timothy Jost, *First Medical Loss Ratio Audits Suggest Need for Clearer Standards*, HEALTH AFFS. (Mar. 30, 2016), https://www.healthaffairs.org/do/10.1377/hblog20160330.054232/full/.

[217] *Id*.

for various services, companies which are commonly controlled or operated by the true owner of the nursing home.[218] Some of the services discussed in the case studies, such as mortgage payments, may be included as activities that count towards the direct resident care requirement.[219]

The DOH should regulate these expenses through rigorous disclosure requirements, mandating facilities to account for expenses counted towards their DCR. Regulation and capping these expenses will help ensure the amount of revenue spent on direct resident care increases, the intent of the DCR law. Facilities are already required to submit cost reports to the DOH detailing revenues, expenses, assets, liabilities, and statistical information.[220] In addition to the disclosure recommendation made earlier for expenses that count towards the 70% direct resident care requirement, the DOH should also require facilities to disclose expenses, the recipient company, and the principals of the recipient company for related party transactions. Such disclosures can help identify unreported related party transactions and will promote transparency. The DOH should make cost report details available in an Internet public database, rather than through the current process that requires interested parties to file a Freedom of Information Law request to the DOH. Such databases already exist in New York for campaign finance donations and expenditures, as well as for government contracts, and would help document the flow of funds through facilities and to companies of common ownership.[221] Disclosure through a public database would also aid governments in making objective determinations about Medicare and Medicaid reimbursement rates.

Furthermore, the DOH should cap the amount that a facility can spend on a contract with a related party, where the transaction is being counted towards the facility's 70% direct resident care requirement. The DOH should cap the transaction at a fair market value, pre-determined by the DOH, and set regionally. For instance, the DOH should set a cap on how much a facility can pay for laundry and linen services per resident if the contract is with a related party company. It may be unrealistic for the DOH, or even the state legislature, to cap *all* expenditures a nursing home facility may make in related party transactions. There may be unique scenarios where the company is the only available vendor, perhaps with rural nursing home facilities that may be limited in which transportation vendor they select. However, at a minimum, capping the *amount* that a facility can spend on a related party transaction has sound public policy justification, since nursing homes rely heavily on public funds, namely Medicaid and Medicare, for

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[218] *See supra* Part III.

[219] *See supra* Part III; *see also* N.Y. PUB. HEALTH LAW § 2828 (2021).

[220] N.Y. DEP'T OF HEALTH, *supra* note 52; N.Y. COMP. CODES R. & REGS. tit. 10, § 86-1.22 (2021).

[221] *See* NY OPEN GOV'T, https://nyopengovernment.com/NYOG/ (last visited Apr. 7, 2022).

revenue.[222] Governments often institute restrictions on the spending of public funds and capping expenses has precedent, such as in government procurement and contracting law.[223] For example, governments, which operate entirely from taxpayer dollars, face procurement restrictions when they are looking to contract with outside vendors, such as with a public relations company for communications services.[224] Such contracts must be transparently and competitively bid out in order to protect the spending of public funds.[225] A cap on the amount a facility can spend on a contract to a related party company will create the same guardrails regarding the spending of Medicare and Medicaid monies in the nursing home industry.

Lastly, the DOH should regularly review and audit these related party transactions to determine whether the facility paid fair market value for the service, or whether the cost was inflated. This regular review can help inform the DOH as to whether the pre-determined cap should be increased, such as if there are severe shortages of available vendors for certain services, or whether it should be lowered, such as if facilities are regularly paying inflated prices for services.

C. Additional Solutions: Safe Staffing Implementation and A Call to Revamp the Public Health and Health Planning Council

There are additional reforms New York can enact, beyond the DOH promulgating regulations, that will help improve oversight and care for the residents of New York's nursing home facilities. The DOH should carefully monitor implementation of New York's newly passed safe staffing legislation to ensure facilities are compliant and annually review whether the staffing ratios should be adjusted. Lastly, the DOH should revise the Public Health and Health Planning Council to empower the Council to conduct rigorous reviews of applications that come before it.

The New York state legislature passed a law requiring safe staffing standards, which set nurse-to-patient ratios in nursing home facilities, a policy seen by experts as directly correlating to a positive increase in nursing home quality and benefiting residential care.[226] The law allows the DOH to

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[222] *See Medicaid's Role in Nursing Home Care*, KFF (June 2017), https://files.kff.org/attachment/Infographic-Medicaids-Role-in-Nursing-Home-Care (explaining most nursing home revenue derives from taxpayer funds, through Medicare and Medicaid) (emphasis added).

[223] *See* OFF. OF THE N.Y.S. COMP., *The Legalities of Purchasing and Competitive Bidding* (Nov. 28, 2018), https://evansny.news/wp-content/uploads/2019/12/NYSOSC-Legalities-Of-Purchasing-And-Competitive-Bidding-2018-11-28.pdf.

[224] *Id*.

[225] *Id*.

[226] N.Y. PUB. HEALTH LAW § 2895-b (2021); Charlene Harrington et al., *The Need for Higher Minimum Staffing Standards in U.S. Nursing Homes*, 9 HEALTH SERV. INSIGHTS 13, 13-17 (2016);

set minimum staffing standards.[227] Safe staffing proposals in New York were long viewed as unpassable, largely due to fiscal concerns expressed by nursing home owners and echoed by the DOH. Nursing home owners argued that without a corresponding increase in government funding, that is Medicaid reimbursement rates, safe staffing policies ere unfeasible.[228] This concern was parroted by the DOH when it released a study at the height of the COVID-19 pandemic on staffing levels that set the safe staffing proposal's price tag at $3 billion, a figure the DOH deemed unworkable.[229] Public pressure and changing political dynamics led to passage of safe staffing, following outrage over nursing home deaths during the COVID-19 pandemic.[230] Policy makers should closely monitor facilities' compliance with the staffing ratios and annually review whether the staffing ratios should be adjusted.

Lastly, the DOH should empower the Public Health and Health Planning Council to conduct rigorous reviews of applications that come before it. The DOH could accomplish this by supplying the Council with staff, and by requiring the Council to engage in a rigorous review of applications that come before them, including a heightened investigation into the character and competence of operators. The Council should be empowered to deny applications to true owners that have a history of violations or problems at other facilities from acquiring additional facilities. While the Council currently has wide discretion to approve or deny applications, it often operates as a formality on behalf of the DOH, rather than engaging in a rigorous, independent review of applicants, and closely scrutinizing true owners history in other facilities. The facility in Case Study 1 exemplifies the tendency of the Council to approve applicants, even those with a history of violations or problems at other facilities the applicant is affiliated with.[231]

Charlene Harrington et al., *Appropriate Nurse Staffing Levels for U.S. Nursing Homes*, 13 HEALTH SERV. INSIGHTS 1, 1-14 (2020) [hereinafter *Staffing*].

[227] N.Y. PUB. HEALTH LAW § 2895-b (2021).

[228] Carl Campanile & Bernadette Hogan, *Bill would require minimum staffing levels in NY nursing homes, hospitals*, N.Y. POST, (Jan. 31, 2021), https://nypost.com/2021/01/31/bill-would-require-minimum-staffing-in-nursing-homes-hospitals/.

[229] N.Y. DEP'T OF HEALTH, Study of Nurse Caregiver Minimum Staffing Levels and Other Staffing Enhancement Strategies and Patient Quality Improvement Initiatives (Aug. 2020).

[230] Nina A. Kohn, *Covid awakened Americans to a nursing home crisis. Now comes the hard part.*, WASHINGTON POST (Apr. 28, 2021, 6:00 AM), https://www.washingtonpost.com/outlook/2021/04/28/nursing-homes-covid-pandemic-reform-staffing/; Dan Clark, *New York Lawmakers Expected To Set New Staffing Requirements At Nursing Homes*, WSKG (Apr. 27, 2021), https://wskg.org/news/new-york-lawmakers-expected-to-set-new-staffing-requirements-at-nursing-homes/.

[231] *See, e.g.,* Abramo & Lehman, *supra* note 18; Part III subsection b.

V. CONCLUSION

Nursing homes are entrusted with caring for the most vulnerable in our society: the elderly, and the sick. Nursing homes are medical facilities that should operate at the highest standards. As recently as 2014, New York had the most residents in the nation residing in nursing homes.[232] If moral reason alone is not enough for government to ensure nursing homes provide the highest quality care, then financial reasons should suffice.

74% of the payments for nursing home residents originate from taxpayer subsidized programs—Medicare and Medicaid—and substantial government resources are devoted to the oversight and regulation of facilities.[233] Nursing homes also received substantial aid from the federal government during the pandemic. For instance, Cold Spring Acquisition, LLC received $4,300,320 in federal funding in 2020 in the CARES Act allocation of relief for nursing home providers.[234] Nursing homes should face conditions in their use of public funds, and while the DCR is a good first step at the state level and states like New York with an already enacted DCR should take concrete steps to strengthening it, the federal government should act and pass a federal DCR for nursing homes as well. The MLR was enacted in states across the country before the federal government established a federal MLR through the Affordable Care Act.[235]

This Article explored some of the problems associated with complex corporate structures of for-profit nursing homes, but these issues extend far beyond the problems discussed here. Many of the core issues facing nursing homes surround a facility's staffing levels and staff expertise, whether the standard of care provided to residents is adequate, and criticism over the amount of funds funneled to management and administrative consultants. In addition to the primary recommendation proposed here—for a revenue-focused regulatory approach to New York's implementation of its new *Direct Care Ratio* law—government can, and should, swiftly and aggressively take further steps to ensure residents of nursing homes are adequately cared for.

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[232] DEP'T OF HEALTH AND HUM. SERV., OFF. OF INSPECTOR GEN., Audit (A-02-15-01024), *New York Did Not Always Verify Correction of Deficiencies Identified During Surveys Of Nursing Homes Participating In Medicare And Medicaid* 5 (Oct. 19, 2017), https://oig.hhs.gov/oas/reports/region2/21501024.pdf.

[233] Musumeci & Chidambaram, *supra* note 26.

[234] CTRS. FOR DISEASE CONTROL & PREVENTION, *HHS Provider Relief* Fund, https://data.cdc.gov/Administrative/HHS-Provider-Relief-Fund/kh8y-3es6 (last visited Apr. 8, 2022).

[235] *See LTCCC Policy Brief: New York's Direct Care Minimum Spending Ratio*, LONG TERM CARE CMTY. COAL. (Mar. 2022), https://nursinghome411.org/wp-content/uploads/2022/03/LTCCC-Policy-Brief-NY-Direct-Care-Min.-Spending-Ratio.pdf (noting that state-level MLRs have existed since 1990).

Opponents to reform, mainly the powerful nursing home lobby,[236] will argue these measures, with their onerous regulations and insurmountable costs, will close nursing homes. However, the government will have new data from the comprehensive cost reports mandated under the DCR that can help determine the truthfulness of these arguments, and regular reviews by the DOH of the impact of the DCR regulations will allow the law to be tailored, if necessary. Nursing home owners may argue these reporting measures are burdensome; but the cost reports required under the DCR are already required in the documentation that facilities submit annually to the DOH. The recommendations made in this Article simply seek to standardize, and make publicly available, these cost reports.

Society once, too, faced major industry opposition to healthcare reform. The cigarette lobby spent decades, and hundreds of millions of dollars, opposing the regulation of tobacco and fighting measures that would hold tobacco companies accountable.[237] Ultimately, medical research and government data supported laws to reign in the tobacco industry,[238] similar to the tide turning in nursing home governance.[239] The DCR policy is supported by research confirming that increases in spending on direct resident care, and strengthened government regulation and oversight, directly improve the quality of care for nursing home residents.[240]

Former Vice-President Hubert Humphrey said "The moral test of government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; and those who are in shadows of life, the sick, the needy, and the handicapped."[241] It is true then, that how, and whether, elected officials and policy makers respond in addressing these enduring, systemic issues will signal whether society is willing to prioritize people over profit. Otherwise, America's decades long crisis will persist and residents will suffer.

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[236] Maggie Severns & Rachel Roubein, *As Residents Perish, Nursing Homes Fight for Protection from Lawsuits*, POLITICO (May 26, 2020), https://www.politico.com/news/2020/05/26/nurising-homes-coronavirus-lawsuits-281654.

[237] *See* Michael S. Givel & Stanton A. Glantz, *Tobacco Lobby Political Influence on US state legislatures in the 1990s*, 10 TOBACCO CONTROL 124, 127 (2001).

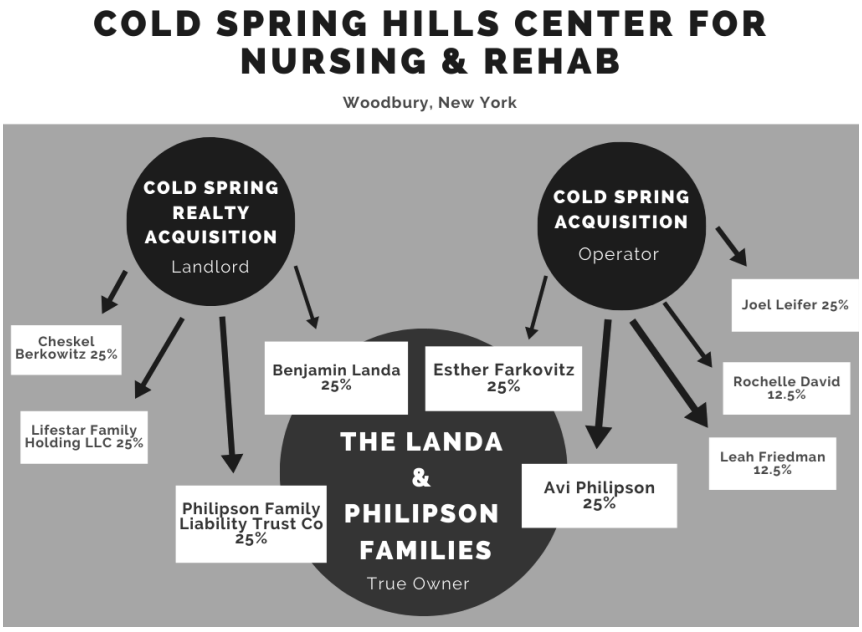
[238] Steve Jacob, *Surgeon General's Report 50 Years Ago Turned the Tide Against Smoking*, D MAGAZINE (Jan. 9, 2014), https://www.dmagazine.com/healthcare-business/2014/01/surgeon-generals-report-50-years-ago-turned-the-tide-against-smoking/.

[239] *See* Susan Jaffe, *3 States Limit Nursing Home Profits in Bid to Improve Care*, KAISER HEALTH NEWS (Oct. 25, 2021), https://khn.org/news/article/3-states-limit-nursing-home-profits-in-bid-to-improve-care/.

[240] *Staffing*, *supra* note 229, at 1.

[241] *Hubert Humphrey: Quotes*, BRITANNICA, https://www.britannica.com/quotes/Hubert-Humphrey (last visited Apr. 7, 2022).

Appendix 1



Appendix 2