# HISTORY OF ELDER LAW

Wroten & Associates, Inc.

5510 Trabuco Road • Irvine • CA • 92620 • (949) 788-1790 • www.wrotenlaw.com

# HISTORY

## History Behind the Development of the Long Term Care Industry & Development of Regulatory Oversight

The Social Security Act was initially enacted in 1935 to provide old-age assistance to aged needy individuals. Medicare and Medicaid were subsequently adopted in 1965 as Title XVIII and XIX of the Social Security Act with a design to extend Social Security services to include healthcare coverage to all Americans aged 65 and older (Medicare) and to provide health care services to low-income families and individuals with disabilities (Medicaid). Initially, the Department of Health, Education, and Welfare (HEW) maintained oversight over both the Medicare and Medicaid programs through the Social Security Administration (SSA) and the Social and Rehabilitative Service Administration (SRS), respectively. Today, the Centers for Medicare & Medicaid Services administer both of these federal programs. Over the decades since 1965 there have been many changes to these programs as is demonstrated in the following timeline.

### Advent of Government Programs for the Elderly

There is a complex hierarchy of legal principles that weave together to create the laws and rules that impact long term care. From the roots of common law has evolved a constellation of statutory laws enacted through the votes of our elected state and federal government legislators. Payment for long term and skilled nursing care has evolved over the last eight decades as a result of a variety of federal legislative Acts. These same laws oftentimes provide the gravamen for statutory claims in civil litigation brought against healthcare providers.

#### The Social Security Act

In 1935 Franklin D. Roosevelt signed into law the original Social Security Act. The Social Security Act as initially legislated did not contain any provisions for healthcare, let alone the expansive entitlement program in place today. Although lacking any provision for healthcare the Social Security Act did establish a federal-state public assistance program for the elderly through the Old Age Assistance program (OAA). Although created to provide assistance to the elderly, OAA specifically prohibited the distribution of any funds to residents living in public institutions. As a result of this prohibition, the seed for the growth of private proprietary nursing homes was planted.

Fifteen years later, in 1950, the Social Security Act was amended to allow for direct payment of OAA funds to healthcare providers for the first time. To monitor this new payment system and the need for participation rules, the amended law included a "standard setting amendment" which mandated the creation of state licensing programs for nursing facilities.

In 1956 the availability of OAA funding was significantly expanded such that by 1960 OAA payments had skyrocketed from $35.9 million (1950) to $280.3 million (1960), thereby setting the stage for today's broader healthcare entitlement programs.

## The Medicare Act (Creation of Medicare and Medicaid)

On July 30, 1965 another round of amendments to the Social Security Act were signed into law by President Lyndon Johnson. Through these 1965 amendments, Medicare (healthcare for the elderly) and Medicaid (healthcare for the poor) were established. The Medicare Act specifically established a cooperative financial program between states and the federal government to pay for medical services provided to the elderly and poor. The Act created a joint enterprise of sorts that made federal funds available to states agreeing to participation mandates established by the federal government.[2]

The Centers for Medicare and Medicaid Services (CMS) is the federal agency charged with determining whether any state is qualified to receive Federal Financial Participation (FFP) dollars.

## State Plans Create Cooperative Agreements to Support Receipt of Federal Medicare Dollars

Independent state legislative action is required to authorize a state's agreement to participation mandates established under the Medicare Act. State compliance with federal participation mandates seeded the need for the creation of state agencies to oversee the administration of federal healthcare dollars received under the Act.

In California, the Medicaid State Plan sets forth the requirements of Title XIX of the Social Security Act. This state plan is a comprehensive written document created by California legislators that describes the nature and scope of California's Medicaid (Medi-Cal) program and serves as a contractual agreement between the State of California and the federal government for the use and administration of federal dollars. Requirements include conformity with Title XIX of the Social Security Act and regulations outlined in Chapter IV of the Code of Federal Regulations.

## Federal Regulations

In addition to funding, the 1965 Medicare Act also provided the Department of Health Education and Welfare (HEW) authority to establish program participation standards for healthcare providers. In 1967 this authority was expanded to include

[2] See Medicare Provision in Title XVIII, 42 USC 1935i-3(b)(4); and Medicaid Provision in Title XIX, 42 USC 1396r(b)(4).

development of nationwide regulations designed to create uniformity between independently developed state standards.

In 1971 President Nixon published his eight-point plan to improve nursing homes and in 1972 Congress passed laws which for the first time provided full funding for state nursing facility certification programs. Regulations setting certification standards were published in 1973 (interim) and finalized in January 1974.

Through the years there were many failed efforts to institute changes in the provider certification process. Ultimately, in 1982 the Health Care Financing Administration (HCFA) announced planned changes to facility participation certification designed to ease the certification process. Under pressure from state and public groups however, HCFA's plan was shelved, and in 1983 HCFA contracted with the Institute of Medicine (IoM) for a study designed to "serve as a basis for adjusting federal policies and regulations governing the certification of nursing homes so as to make those policies and regulations as appropriate and effective as possible". The IoM thereafter stated their goal was "to ensure that any person requiring nursing home care be able to enter any certified nursing home and receive appropriate care, be treated with courtesy, and enjoy continued civil and legal rights." This base line goal set the bar for the provision of adequate healthcare services funded by the government.

When regulations are utilized to support claims in civil litigation it is important to determine the appropriateness of their use as per se evidence establishing liability. By design, regulations establish administrative department rules that are not required to meet more stringent constitutional evidentiary standards that apply in civil and criminal courts. Therefore, regulations do not necessarily carry the same force and effect of statutes when applied to civil and criminal claims. In the event that evidentiary rules do not support their use as per se evidence of liability, they still may be considered as being instructive for the purpose of evaluating the reasonableness of conduct under review. The determination of the appropriate use of regulations as well as all other aspects of the government's administrative oversight of healthcare participation requirements is therefore an important consideration when managing civil or criminal actions.



## Regulatory Administration: Historical Milestones

**1972** – The Federal Supplemental Security Income program (SSI) which is funded through U.S. Treasury general funds was enacted. Through this program Medicare eligibility was expanded to cover individuals under the age of 65 with long-term disabilities as well as individuals with end-stage renal disease. Eligibility is linked to Medicaid low income thresholds and is available for the elderly, blind, and disabled U.S. residents.

**1977** – The Health Care Financing Administration (HCFA) was established within the Department of Health, Education and Welfare (HEW) to administer Medicare

and Medicaid programs. HEW was renamed in 1979 and those agencies providing public health services were placed into the Department of Health and Human Services (HHS).

**1985** – The Emergency Medical Treatment and Labor Act (EMTALA) were enacted. EMTALA requires Medicare participating hospitals having emergency rooms to provide appropriate medical screenings and stabilizing care.

**1987** – The Omnibus Budget Reconciliation Act of 1987 (OBRA87) adopted nursing home reforms.

**1995** – The Social Security Administration is made an independent agency of the executive branch of the United States federal government.

**1996** – Health Insurance Portability and Accountability Act of 1996 (HIPAA) was enacted establishing (1) the requirement for creation of rules to improve continuity of healthcare coverage, (2) the Medicare Integrity Program, (3) national administrative simplification standards for electronic healthcare transactions, and (4) a mandate to adopt privacy regulations.

**2001** – HHS announced the renaming of HCFA, now known as the Centers for Medicare & Medicaid Services (CMS).

**2009** – The Affordable Care Act (ACA) is enacted. Amongst the provisions of the ACA are new rules designed to combat health care fraud, waste, and abuse. Increased sentencing rules and state-of-the-art technology utilizing advanced predictive modeling technology is touted by HHS as providing powerful tools for combating health care fraud, waste, and abuse.

The Health Care Fraud Prevention and Enforcement Action Team (HEAT) were created through a joint effort by HHS and the Department of Justice (DOJ). HEAT is directed by the Secretary of HHS and the U.S. Attorney General.

The Health Information Technology for Economic and Clinical Health Act (HITECH) was enacted to address privacy and security concerns related to electronic transmission of protected health information. HITECH strengthens HIPAA protections.

**2013 –** Final regulations to support enhanced HIPAA privacy and security protections and enforce HITECH were adopted.

## Institute of Medicine Report Spurs the Development of the Regulatory Framework In Place Today

The Institute of Medicine (IoM) is an independent, nonprofit organization that serves as the health arm of the National Academy of Sciences which was originally chartered by President Abraham Lincoln in 1863. The Academies collectively

include the National Academy of Sciences, the National Academy of Engineering, the National Research Council, and the Institute of Medicine. The Institute of Medicine works "outside of government to provide unbiased and authoritative advice to decision makers and the public" about "the nation's most pressing questions about health and health care."

In 1983 the Institute of Medicine contracted to conduct a study of the then current system of enforcing nursing home regulatory policies and procedures in a manner to assure the provision of "satisfactory" care. Their report "Improving the Quality of Care in Nursing Homes" was released on January 1, 1986 and concluded that an overhaul of the regulatory system was needed. The IoM criticized federal policies that required surveyors to consult with facility operators in an effort to return them to regulatory compliance and the limitation of formal sanctions to cases where violations remained uncorrected beyond deadlines set by surveyors. To assure regulatory compliance it was determined that surveyors required enforcement authority that allowed them to impose punishment for regulatory violations.

Prompted by the 1986 IoM report, legislators began working on the Federal Nursing Home Reform Act which was ultimately adopted as part of the more comprehensive Omnibus Budget Reconciliation Act of 1987 (OBRA) signed into law by President Ronald Reagan. OBRA revised the standards by which nursing homes are evaluated for Medicare and Medicaid funding participation and created the minimum expectation that care would be sufficient to support the ability of patients to "attain and maintain the highest *practicable* physical, mental, and psychosocial well-being." Enforcing the OBRA provisions required the evolution of state and federal regulations which today establish the rules on which federal Medicare and Medicaid dollars are funded. OBRA requirements are codified in the Code of Federal Regulations, Title 42 (Public Health), Part 483 (Requirements for States and Long Term Care Facilities).

## The Growth of Regulatory Oversight

Compliance with the constellation of complex rules and regulations that apply to long term care operations is overseen by both state and federal administrative agencies granted quasi executive branch authority to interpret and enforce legislatively enacted statutory mandates through the respective agency's adoption of administrative regulations. At the Federal level, the Department of Health and Human Services maintains oversight of long term care operations. In California, the Department of Public Health, Licensing and Certification, maintains oversight over skilled nursing facilities while the California Department of Social Services, Community Care Licensing Division, oversees Residential Care Facilities for the Elderly.[3]

[3] In California, a Residential Care Facility for the Elderly (RCFE) is a voluntarily chosen housing arrangement where 75% of the residents are aged 60 or older. Varying levels of care and supervision are provided. RCFEs may also be known as assisted living communities, retirement homes, or board and care homes.

## Federal Administrative Agencies

**Where To Find Them**

Centers For Medicare & Medicaid Services
http://www.cms.gov/

Department of Health & Human Services
http://www.hhs.gov/

The Health Care Financing Administration (HCFA) was established in 1977 as part of HEW to coordinate Medicare and Medicaid programs. HCFA's responsibility included oversight of medical provider standards that require compliance with healthcare provider certification rules. In 2001 HCFA was renamed the Centers for Medicare & Medicaid Services (CMS). CMS is an agency of the US Department of Health and Human Services (DHHS) and continues to have responsibility for the administration of Medicare and Medicaid's health financing program.

## HHS Organization

- Various agencies falling under the oversight of the HHS Secretary include CMS, the Centers for Disease Control and Prevention (CDC), and the National Institutes of Health (NIH). Additional offices include the Office for Civil Rights (OCR), the Departmental Appeals Board (DAB), and the Office of Inspector General (OIG). CMS has its headquarters in Woodlawn, Maryland and has ten regional offices located throughout the United States. Following is the organization chart published by the Department of Health and Human Services.
  Region I - Boston, Massachusetts
  Connecticut, Massachusetts, Maine, New Hampshire, Rhode Island and Vermont.
- Region II - New York City, New York
  New Jersey, New York, as well as the U.S. Virgin Islands and Puerto Rico.
- Region III - Philadelphia, Pennsylvania
  Delaware, Maryland, Pennsylvania, Virginia, West Virginia and the District of Columbia.
- Region IV - Atlanta, Georgia
  Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina and Tennessee.
- Region V - Chicago, Illinois
  Illinois, Indiana, Michigan, Minnesota, Ohio and Wisconsin.
- Region VI - Dallas, Texas
  Arkansas, Louisiana, New Mexico, Oklahoma and Texas.
- Region VII - Kansas City, Missouri
  Iowa, Kansas, Missouri, and Nebraska.
- Region VIII - Denver, Colorado
  Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming.
- Region IX - San Francisco, California
  Arizona, California, Hawaii, Nevada, the Territories of American Samoa, Guam, and the Commonwealth of the Northern Mariana Islands.
- Region X - Seattle, Washington
  Alaska, Idaho, Oregon, and Washington

**Where To Find Them**

California Department of Health Care Services (DCHS) dhcs.ca.gov

California Department of Public Health cdph.ca.gov

California Department of Social Services, Community Care Licensing Division ccld.ca.gov

## California Administrative Agencies

In 2007 the California Department of Health Services (CDHS) reorganized to *create two related agencies, the Department of Health Care Services (DHCS)* which finances and administers the California Medical Assistance Program (Medi-Cal) and the California Department of Public Health (CDPH) which oversees the Licensing and Certification Program for health care facilities. Licensing and Certification is responsible for monitoring the compliance of health care facilities with state laws and regulations. In addition, Licensing and Certification cooperates with CMS in monitoring Medicare and Medi-Cal (in California Medicaid is referred to as Medi-Cal) payments which must meet federal requirements. Licensing and Certification also oversees the certification of nurse assistants, home health aides, hemodialysis technicians, and the licensing of nursing home administrators.[4]

## Assisted Living

Assisted Living is a licensed residential setting that provides 24 hour care and supervision to seniors who need assistance, but do not require around the clock nursing care. Assisted Living communities provide assistance with activities of daily living, medication management, social activities, housekeeping, meals, transportation, and may offer dementia care programs and health-related services.

Assisted Living communities in California are referred to as licensed Residential Care Facilities for the Elderly (RCFEs) and are regulated by the California Department of Social Services. RCFEs operate under laws specific to assisted living. Although Medi-Cal does not generally cover assisted living expenses, state inspections, staff training and certification requirements unique to RCFEs are in force.[5]

### Use of Regulations to Support Civil Litigation

Long term care litigation has been significantly impacted by the legislative adoption of a plethora of plaintiff friendly laws designed to encourage attorneys to take on the causes of the elderly. Through the last 15 years these laws have effectively been explored by attorneys nationwide leading to a profusion of mega verdicts against long term care providers. In response to these verdicts, long term care providers complain that courts have seemingly disregarded fundamental legal protections owed to any defendant as courts appear to perceive their role as being protectors of the vulnerable rather than protection of the litigation forum.

To maintain a stable and fair litigation environment for both sides, it is important to understand the history and purpose behind the development of the cache of laws that

[4] Please refer to the Nursing Home Administrators Act, California Health & Safety Code section 1416 for law relating to Administrator education, training, and certification.
[5] A state by state compendium of state agencies having oversight over state assisted living facilities is located in Appendix A.

has evolved over the last eight decades. It is within this history we find the roots of long term care responsibility and the special laws to be considered when managing these unique cases.