Nursing Home Admission Contracts: Undermining Rights the Old-Fashioned Way

by Charles P. Sabatino

I. Introduction

To entering nursing home residents and their families, an admission contract is often treated as one of many incomprehensible forms in a mass of admission materials. Often, these admission agreements are hurried through (or even ignored altogether) because the admission time is one of considerable emotional pressure for all concerned. The admission contract’s terms will lie dormant until the resident or the family has a question or complaint about the nursing home. When the contract is then consulted, if it contains misleading or inappropriate provisions, it may significantly distort the resident’s understanding of his or her legal rights, and subsequently chill the exercise of those rights and privileges by both the resident and the family.1

To evaluate fully the legality of admission contract provisions in any state, one must be aware of (1) applicable Medicare and Medicaid law and regulations; (2) state licensure laws and regulations; and (3) state regulations specific to Medicare- and Medicaid-certified facilities. If a facility does not participate in Medicare or Medicaid, then only state licensure laws and regulations will apply.

Existing federal regulations governing nursing homes are in the process of major change, brought about by the passage of the 1987 Nursing Home Reform Amendments (NHR Amendments), which were passed by Congress as part of the Omnibus Budget Reconciliation Act of 1987 (Pub. L. No. 100-203), and scheduled to be phased in over time.2 Some of the major reforms mandated by the amendments include (1) the elimination of the distinction between skilled nursing facilities (SNFs) and intermediate care facilities (ICFs); (2) enhancement of resident rights; (3) required training and registration of nurse’s aides; (4) development of survey procedures designed to measure outcomes and quality of care better; and (5) enhanced enforcement authority, including a range of intermediate sanctions for facilities that fail to comply with standards.

While effective dates for certain provisions have already been revised more than once, most of these provisions are now to be implemented by October 1, 1990.3 Be aware that the federal standards are minimum requirements; states are free to impose more stringent resident rights standards.

II. The Most Common Problems

Admission contract studies have fairly consistently revealed problems in six areas affecting resident rights.

A. Poor Form and Readability

Identifying which papers actually constitute the contract often poses a formidable problem for both the resident and the family. Usually, the resident receives at least one document entitled “Agreement” or “Contract,” but any number of collateral materials may be incorporated into that contract. Especially important are statements of patients’ rights and grievance procedures. It is preferable for these documents to be expressly incorporated into the contract document. Even though federal and state residents’ rights provisions are binding upon facilities regardless of the contract language, the advantage of incorporating such provisions into the contract is that this may give the resident a contractual right of enforcement against the facility. Most but not all states lack a private right of enforcement for resident rights violations, outside of contract or tort.

Readability problems typically include small print size, awkward and lengthy sentence construction, use of obscure legal language, poor formatting, and unclear reproduction.

B. Unclear References to Services and Costs

Frequently, the basic services to which residents are entitled are described in overly general language such as “nursing care and personal care as may be required for the health, safety, comfort, and well-being of the patient.” Without a detailed itemization of covered services and costs, and of services and costs explicitly not covered, the resident will be unsure about who has financial responsibility. This uncertainty may leave the resident totally dependent on the facility’s interpretation of who bears financial responsibility.

The problem is further complicated because covered services and costs differ depending upon whether the resident is private-pay, Medicare-eligible, or Medicaid-eligible. Contracts may confusingly mingle provisions for all three situations. The preferable practice is to use a separate contract or service/fee schedule for each payment situation.

State Medicaid coverage regulations and practices vary tremendously in content and level of detail concerning covered items and services. Therefore, one needs to research state regulations in order to ascertain specifically what services Medicaid covers. Because of state variation and inconsistency in coverage definitions, the NHR Amendments require the Health Care Financing Administration (HCFA) to define those items and services to be included in the Medicare and Medicaid rates, as well as those that may be charged to the resident’s personal funds.4 In an attempt to comply, HCFA published a proposed rule on March 20, 1990, listing five broad categories of required services (personal hygiene, nursing and specialized rehabilitative services, dietary services, activities program, and room/bed maintenance), but declining to define any items or services covered within these categories.5

C. Financial Responsibility

I. The Responsible Party

Perhaps the most widespread questionable admission prac-
tice has been that of requiring a "responsible party" or "guarantor" to the contract. It has been a common practice for facilities to require someone, usually a family member, to cosign the contract and to assume joint and several personal financial liability for payment. The NHR Amendments expressly prohibit third-party guarantors. These amendments apply to any nursing home participating in the Medicare or Medicaid program. Apart from the NHR Amendments, existing federal regulations at 42 C.F.R. § 442.312 (concerning the delegation of resident rights to guardians, next of kin, or sponsoring agency) have been interpreted in some states to prohibit anyone from signing admission contracts on behalf of patients, unless the patient has been adjudicated incompetent or is certified by a physician to be incapable of understanding rights and responsibilities.

2. Private-Pay Duration-of-Stay Clauses

Private-pay duration-of-stay clauses require residents to pay for care out of their own or their families' funds for a stated period of time (usually one or two years) before applying for Medicaid coverage. The benefit to the facility is that private-pay rates are usually higher than state Medicaid reimbursement rates. The legality of these provisions has been successfully challenged in several states and finally expressly proscribed by HCFA in 1987 in an unpublished letter to all nursing home administrators. The 1987 NHR Amendments have eliminated any remaining doubt about these clauses by expressly prohibiting them.

Unfortunately, in states that clearly prohibit private-pay duration-of-stay clauses, oral or "secret" agreements by residents to pay privately for a stated period of time are still common. Discrimination against Medicaid-eligible applicants places tremendous pressure on family members to enter "voluntarily" into private pay arrangements. Significantly, in the absence of state prohibitions, federal law allows nursing homes to give admissions preference to private pay persons over Medicaid-eligible persons.

3. Solicitation of Contributions

Requiring "voluntary" contributions as a condition of admission or continued stay in a nursing home has long been illegal with respect to Medicare- or Medicaid-eligible residents. Under Medicare and Medicaid antifraud and antitrust provisions, it is a felony willfully to charge Medicaid residents "any gift, money, donation, or other consideration" as a condition for admission or continued stay. The illegality of the practice has been reiterated in the NHR Amendments with respect to Medicaid-eligible residents.

Note, however, that this federal prohibition does not apply to private-pay residents. Moreover, even for Medicaid residents, bona fide voluntary contributions to nonprofit nursing homes are permissible. Consequently, the voluntariness of a contribution and its practical influence in securing a resident's admission may create troublesome legal and practical grey areas for the legal advisor. Contribution requirements seldom appear in the written contract. The mere knowledge that the institution seeks contributions may be inherently coercive upon the family in light of bed shortages and the tremendous stress attendant to seeking nursing home admission.

The federal government took an aggressive position on the issue of coercive contribution requirements in United States v. Downtown Jewish Home for the Aged, a civil fraud action in which the U.S. charged a nursing home with unlawfully soliciting contributions of $1,000 to $20,000. The case was settled by a consent decree, and the facility subsequently filed for bankruptcy.

D. Liability Waivers for Personal Injury or Property Damage

Among the more common provisions found in admission contracts are waivers or limitations of liability for loss or damage to personal property. Waivers for personal injury are somewhat less frequent but still common. Waivers take many forms, but the following example is typical:

The home shall not be responsible for loss or theft of any money, valuables, or personal effects brought into the home by the patient or relatives or friends unless delivered to the custody of the business office for safe keeping and for which a receipt will be issued.

Such a provision eliminates any meaningful use of one's personal property. Federal law addresses this issue only in generalities. The original residents "'Bill of Rights'" grants the resident a right "to retain and use his personal possessions and clothing as space permits." The NHR Amendments require facilities to care for residents "in an environment that will promote maintenance or enhancement of the quality of life of each resident," and "to make reasonable accommodation of individual needs and preferences." Query whether either the quality of life or accommodation is promoted by requiring residents to waive liability for loss of personal property.

Broadly worded waivers of liability for personal injury are likely to be unenforceable and void as a matter of public policy in most states. Residents are most commonly asked to consent to absolute waivers for injury caused by other patients or by independent contractors in the facility, or for injury occurring outside of the facility, such as on a field trip.

Federal and state nursing home laws have not squarely addressed personal injury waivers, even though the whole thrust of the regulatory framework is expressly intended to set standards for the protection of residents' health, safety, and welfare.

E. Restrictions on Personal Rights and Freedoms

Two kinds of problems occur in the admission process concerning restrictions of resident rights: (1) incomplete or inaccurate statements of resident rights, and (2) contract provisions that contravene or limit resident rights under state or federal law. Examples of the second problem include contrac-
tual limitations on personal belongings that may be brought into the facility, food restrictions, limits on visitors, broadly worded medical treatment consents, and blanket consents to be photographed.

A related practice is the incorporation by reference of a “Residents’ Handbook,” or some other statement of house policies, into the admission contract. If the house policies or handbook provisions are more restrictive than the residents’ bill of rights, then their validity is likewise suspect.

The only way to advise clients in this context is to be fully aware of the federal and state residents’ bills of rights. Existing federal rules and the new NHR Amendments set minimum standards that may be further strengthened by state law. 14

F. Transfer and Discharge

1. Permissible Grounds

Federal regulations recognize only three permissible grounds for transfer or discharge: (1) medical reasons; (2) the welfare of the resident or other residents; and (3) nonpayment. 15

The NHR Amendments articulate six acceptable reasons for transfer or discharge, but they are substantively similar to the original three. 16 Admission contracts frequently either omit any statement of grounds for transfer or discharge, or the stated grounds conflict with federal or state standards.

Perhaps the most outrageous example found of improper grounds for transfer or discharge is the following provision: “This contract may be terminated immediately by either party upon showing of negligence, lack of due diligence, untemperance, immorality, incompetency, cruelty, mental derangement, willful violation of laws or governmental regulation, or willful violation of explicit rules and regulations of the Facility.”

More typically, improper discharge provisions may be inserted into various clauses describing conduct unacceptable to the nursing home. An example of this type of provision is as follows: “Failure of the patient to accept and to pay for special nursing care when deemed necessary and proper by the home shall be sufficient reason for immediate removal.” This provision not only exceeds permissible grounds, it also restricts the resident’s right to refuse treatment.

2. Notice of Transfer or Discharge

In the past, federal regulations have required only “reasonable notice” of involuntary transfer or discharge. 17 The NHR Amendments require a 30-day notice in most cases, with fairly stringent due process safeguards attached. 18 Many states already impose a specific notice period. Admission contracts should track the relevant federal or state rule language. However, it is not uncommon to find either no reference to an advance notice time period or a notice provision shorter than regulations permit.

3. Intrafacility Transfers

Transferring a resident from one room to another within the same facility occurs fairly routinely in nursing homes, because administrators try to accommodate residents’ needs and preferences while maintaining administrative efficiency. However, such transfers can be as traumatic to residents as transfers to another institution. Therefore, the grounds and procedures for intrafacility transfer are important to examine in admission contracts. State studies indicate that admission contracts usually avoid addressing the question of intrafacility transfers, or they include rather broad statements of facility authority, as in the following illustration: “In order to maintain efficiency and tranquility in its operation, the Facility may, in its discretion, change the Patient’s accommodation.”

Federal law has been unclear about facility obligations in intrafacility transfer and discharge, although a number of states have set specific guidelines and procedures. The NHR Amendments articulate a resident’s right only “to receive notice before the room or roommate of the resident in the facility is changed.” 19

4. Bed-Hold Policies

When a Medicaid resident leaves the nursing home to be hospitalized or to visit family on a therapeutic leave, states are permitted to use Medicaid funds to pay for the resident’s bed for an additional number of days. This “bed-hold” period is set by state policy and may range from zero days paid, as in Virginia (with some exceptions), to 20 days paid, as in New York.

Existing admission contracts seldom explain facility bed-hold policies. However, under the NHR Amendments, facilities will be obligated to inform Medicaid residents of state bed-hold policies before transfer and at the time of transfer. Moreover, if the period of hospitalization or leave exceeds the bed-hold limit, the facility must give the resident priority in readmission. 20

III. Conclusion—The Attorney’s Role

If an attorney is contacted prior to nursing home admission to review a facility’s admission contract, he or she has a valuable opportunity to identify questionable provisions and provide accurate information about the extent of resident rights. Given the lack of bargaining power in nursing home admissions, however, it is usually not worth advocating changes in the contract unless the administrator is known to be approachable.

Legal counsel is more likely to be involved in defensive actions than in predmission negotiation. However, before one reaches the posture of defensive litigation, other actions are possible. At a minimum, the attorney could notify the nursing home before admission that certain contract provisions are of questionable legality. This step may be enough to deter the facility from attempting to enforce the provisions. However, a difficult judgment call is required when a family has already agreed to private-pay arrangements, even though the resident

Private-pay duration-of-stay clauses have now been expressly prohibited by the NHR Amendments.
may be eligible for Medicaid. Should the attorney tell the family to apply for Medicaid on behalf of the resident and stop paying the facility? Perhaps the best answer is a cautious yes. If considerable money is involved and state case law precedent is lacking, both the attorney and the client need to be prepared for possible litigation. Although chances of success may be good, the process understandably frightens many clients and families because of potential costs and fear of facility retaliation against the resident.

Another litigation alternative is filing a complaint with the state long-term care ombudsman and the state agency responsible for nursing home licensing and certification (usually the state health department). The ombudsman is responsible for problem resolution and is frequently active in recommending policy reform. The licensing and certification agency is responsible for enforcement of state and federal nursing home standards. If violations are established based upon illegal contract clauses, the state can take corrective steps.

If litigation seems inevitable, then the attorney should consider a variety of causes of action. A private right of action to enforce state standards is available in a minority of states. Contract and tort theories may be feasible, as may be often overlooked state consumer protection laws. The use of contract provisions that are legally unenforceable has been held to be inherently deceptive and misleading in several states under consumer protection laws. An important advantage of consumer protection acts is that they commonly provide for statutory damages and attorney fees. Antitrust law and Federal Trade Commission (FTC) rules concerning misleading trade practices may also be applicable to facility chains that operate interstate. Finally, if facility policies are discriminatory, consider claims under title VI of the Civil Rights Act or section 504 of the Rehabilitation Act of 1973.

Because facility practices invariably affect more than one resident, consider class relief. A class action also has the advantage of reducing the fear of retaliation felt by single litigants. Still, residents and families tend to be reluctant litigants, regardless of their numbers.

In the end, success in remedying unfair contract practices will be measured not so much by the extent to which contract language changes, but by the extent to which facility practices become more client-friendly. Advocates sometimes see the former change without the latter. Be wary of contract reform that becomes an exercise in legal treatise writing, as illustrated by a "model" contract drafted by the California Association of Health Facilities. It apparently comports with the letter of recently enacted state requirements, but it is also more than 40 pages long, including attachments!

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Endnotes

1. Studies in at least five states—Maine, Louisiana, California, North Dakota, and Maryland—have demonstrated fairly widespread use of misleading and legally suspect contractual provisions. All five of these studies are reviewed in D. AMBROGI & F. LEONARD, NURSING HOME ADMISSION AGREEMENTS: STATE STUDIES, NATIONAL RECOMMENDATIONS (California Law Center on Long Term Care 1988). See also AMERICAN ASSOCIATION OF RETIRED PERSONS, LEGAL COUNSEL FOR THE ELDERLY, DECISION-MAKING, INCAPACITY, AND THE ELDERLY: A PROTECTIVE SERVICES PRACTICE MANUAL 119-25 (1987).


3. The Health Care Financing Administration (HCFA) published purportedly "final" regulations prescribing new requirements for long-term care facilities on February 2, 1989 (54 Fed. Reg. 5316 et seq.), but the effective date of these regulations was pushed back once by HCFA, and then by Congress, to October 1, 1990. It is likely that HCFA will republish a revised final rule in mid-1990.


7. See id. at §§ 1395i-3(c)(5)(A)(ii), 1396r(c)(5)(A)(ii).

8. Id. at § 1320b-7(b)(d).

9. Id. at § 1396c(c)(5)(B).


11. 42 C.F.R. § 442.311(k).


13. Id. at §§ 1395i-3(c)(1)(A)(v), 1396r(c)(1)(A)(v).

14. The applicable federal rights regulations are found at 42 C.F.R. § 405.1121(k) for skilled nursing facilities and 42 C.F.R. § 442.311 for intermediate care facilities. The two versions are substantially the same. The NHR Amendments rights provisions are found at 42 U.S.C. § 1395i-3(c) (Supp. 1990) (Medicare) and 42 U.S.C. § 1396c(c) (Supp. 1990) (Medicaid).

15. 42 C.F.R. §§ 405.1121(k)(4), 442.311(c).


19. Id. at §§ 1395i-3(c)(1)(A)(v), 1396r(c)(1)(A)(v).

20. Id. at § 1396c(c)(2)(D).

