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The Blurred Line Between Nursing Homes & Assisted Living Facilities: How Limited Medicaid Funding of Assisted Living Facilities Can Save Tax Dollars While Improving the Quality of Life of the Elderly

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**THE BLURRED LINE BETWEEN NURSING HOMES &
ASSISTED LIVING FACILITIES: HOW LIMITED MEDICAID
FUNDING OF ASSISTED LIVING FACILITIES CAN SAVE
TAX DOLLARS WHILE IMPROVING THE QUALITY OF LIFE
OF THE ELDERLY**

JENNIFER RAE FLEMING*

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I. INTRODUCTION

Growing old is something that is generally anticipated with some trepidation in America. The “anti-aging industry,” which currently reaps in \$56 billion per year, preys on this fear with doctors claiming to have the keys to not only staving off the aesthetic signs of aging, but the physiological ones as well.¹ With no reliable fountain of youth in sight, Americans are left with one certainty besides taxes—getting older and dying. One of the more uncomfortable aspects of aging is planning for one’s own long-term care. Many, if not most, people avoid dwelling on their own mortality; the idea of contemplating their final years seems rather distasteful. However, unlike decades past when the elderly were limited to relying on nursing homes, one’s family, or merely one’s self, recently things have markedly changed. Those who decide to leave their own private home because they need assistance with their day-to-day care now have a myriad of options.

For those who can afford it, Assisted Living Facilities (“ALFs”) offer an attractive alternative for those who can no longer live alone, but who do not require the skilled medical care of a nursing home. Due to a marketing frenzy, ALFs have become one of the fastest growing housing options for seniors.² Glossy brochures advertise homey, attractive living quarters—a stark contrast to the sterile, hospital-like atmosphere of nursing homes.

Despite their promise of helping residents age with ease and dignity, ALFs can pose more problems than they can answer. The expense of living in an ALF can be staggering, and like other rental properties, the proprietor can evict a resident who can no longer afford to live there. The threat of eviction is a major concern for the elderly, who may be unable to cope with the physical and mental demands of changing residences. Evictions from the ALFs most often result in the elderly being forced into nursing homes. Nursing homes offer a level of care far greater than ALFs with an increased cost to match, however Medicaid, rather than the residents, pays for this

¹ Arlene Weintraub, *Selling the Promise of Youth*, BUS. WK., March 20, 2006, available at http://www.businessweek.com/magazine/content/06_12/b3976001.htm.

² See Robert G. Schwemm & Michael Allen, *For the Rest of their Lives: Seniors and the Fair Housing Act*, 90 IOWA L. REV. 121, 137 (2004).

expense when the residents have run out of assets.³ The result is that the residents must move to a more expensive, yet less comfortable environment in order for the government to help them financially.

This article will examine ALFs and the problems that arise for their residents who exhaust their financial resources and must then move into nursing homes. While the federal government regulates nursing homes, states regulate both ALFs and Medicaid requirements.⁴ Nevertheless, most states treat ALFs and Medicaid as separate issues and fail to enact legislation that ties them together. Rather than allowing the elderly to age in a desired place with the help of Medicaid, most states will not allow it to pay for a resident to stay in an ALF.⁵ Illogically, states will instead pay for these residents to live in nursing homes, despite the fact that they not only cost much more, but that these residents' do not require twenty-four hour skilled nursing. A few states have recognized this tension, and have enacted legislation allowing Medicaid to pay for ALFs as well as nursing homes in certain situations.⁶

Several issues surrounding ALFs require further exploration. The first concern is the problem of defining assisted living adequately. The definition of an ALF is significant because of the interplay between ALFs and nursing homes; the definition helps to identify the upper limits of care that an ALF may provide. An ALF that provides a high level of care may be subject to federal regulation as a de facto nursing home. Since ALFs are state-regulated each state legislature decides how to define them. This lack of uniformity creates a complex problem of comparing facilities among states, and makes it more difficult for states to borrow ideas from others to improve their own regulations. If the definition of ALF changes across state lines, then the regulations that govern them are difficult to translate from one state to another. This not only causes difficulty for legislators, but for seniors themselves. Potential ALF residents may face a choice of facilities in multiple states for a variety of reasons: wanting to move closer to their families, believing that the local ALF facilities are unacceptable, or desiring to live in a different climate.

The second problem, examining the different state regulations as compared to the national standards for nursing homes, poses obvious difficulty. Since there is no standard definition for ALFs, there likewise are no national standards for ALF regulations. Nevertheless, most states regulate several areas to varying degrees. All states that license ALFs must decide

³ See discussion *infra* Part IV.C.

⁴ See discussion *infra* Part IV.

⁵ See discussion *infra* Part III.

⁶ See discussion *infra* Part VII.A-C.

whether to employ a single-level or multi-level system.⁷ Single-level systems do not differentiate between ALFs with high and low levels of care; multi-level systems do. States also vary in their requirements concerning the obligation of an ALF to meet the needs of residents.⁸ This obligation is closely tied to the licensing system the state employs, as an ALF generally has no obligation to meet needs that exceed the scope of its license.⁹ Most states impose mandatory minimum staffing requirements for ALFs to ensure resident safety.¹⁰ One of the most common features of ALFs, the administration of medicine to residents by the staff, is also regulated by the state.¹¹ These regulations attempt to establish minimum standards in an industry that occupies a nebulous area of quasi-medical care in a landlord-tenant environment. These regulations provide support for allowing the elderly to stay in ALFs rather than prematurely moving into skilled nursing facilities.

The third issue is the relevant federal legislation that affects the modern history of the nursing home and the recent rise of ALFs. Social Security, Medicare, Medicaid, and the Nursing Home Reform Act of 1987¹² each form the pieces of a large puzzle that can affect every aspect of seniors' housing choices. The relationship between government funding, state and federal regulations, and the senior's ability to pay plays a large role in determining whether an ALF is an appropriate housing option.

The fourth section of this article deals with an examination of the arguments against allowing those medically eligible for nursing home care to remain in ALFs. Opponents argue that ALFs must retain their image of an active senior lifestyle that is not conducive to allowing the frailer residents to remain. The safety of other residents and the difficulty of dealing with the required higher standards of care as a result of the proposed changes are examined in turn. The fifth section contains arguments supporting the use of Medicaid to pay for residents in ALFs, from both an individual and a governmental perspective.

The sixth and final area covered by this article is a review of different solutions created to address the problem of seniors' premature relocation to nursing homes. For example, Home Health Care involves Medicaid paying for in-home care that can be administered wherever the recipient

⁷ See discussion *infra* Part III.A-B.

⁸ See discussion *infra* Part III.B.

⁹ See discussion *infra* Part III.

¹⁰ See discussion *infra* Part III.C.

¹¹ See discussion *infra* Part III.D.

¹² The Nursing Home Reform Act of 1987 is codified at 42 U.S.C. § 1395i-3 et seq., 42 U.S.C. § 1396r et seq., and 42 C.F.R. § 483 et seq.

lives—including ALFs.¹³ Oregon has a mandate to ensure that all seniors live in the least restrictive environment that is practicable, and employs case managers to guide the elderly through the quagmire of long-term care facilities.¹⁴ New York created a plan in which ALFs may be certified in a special program that enables them to receive Medicaid funding.¹⁵

II. THE DIFFICULTY IN DEFINING “ASSISTED LIVING”

A. *What ALFs Are*

The description that ALFs fall between independent living and nursing care is accurate, yet vague. Since federal law does not regulate ALFs, each state chooses its own definition, resulting in no one standard that transcends state lines.¹⁶ To complicate matters further, most states do not use the term Assisted Living Facility at all; in fact, there are over 26 different official terms used in the 50 states to describe the same general housing arrangement.¹⁷ As a result, in 1999 the General Accounting Office concluded that it was not possible to determine the precise number of individuals living in ALFs because of the lack of definition of assisted living.¹⁸

In addition, there are varying levels of care within facilities that do not correspond from state to state, and sometimes even from facility to facility within a single state.¹⁹ For the elderly or adult children exploring housing options for their parents, these significant differences make comparisons extremely difficult, and make the facility operators themselves the only ones capable of differentiating their facility from their competitors. This informational imbalance is clearly not in the best interests of consumers and can lead to inappropriate living arrangements, which in turn can create the need to switch housing again in the future, even if a resident has their own financial resources.

¹³ See discussion *infra* Part VI.A.

¹⁴ See discussion *infra* Part VI.B.

¹⁵ See discussion *infra* Part VI.C.

¹⁶ Eric M. Carlson, *Critical Issues in Assisted Living: Who's In, Who's Out, and Who's Providing the Care*, NATIONAL SENIOR CITIZENS LAW CENTER, May 2005, at 14, available at <http://www.nslc.org/publications/manuals>.

¹⁷ Consumer Consortium on Assisted Living, available at http://www.ccal.org/consumers_care.htm (last visited Feb. 1, 2007).

¹⁸ *Assisted Living: Quality-of-Care and Consumer Protection Issues in Four States: Before the Special Comm. on Aging*, 106th Cong. GAO/HEHS-99-2, at 1 (1999) (statement of Kathryn G. Allen, Associate Director, Health, Education, and Human Services Division).

¹⁹ See Carlson, *supra* note 16, at 8.

Overall, assisted living is a loosely defined combination of housing and care.²⁰ For the purposes of this article, the term “assisted living facility” refers to a residential setting that (1) provides or coordinates flexible personal care services, 24-hour supervision and assistance, and activities and health-related services; (2) has a service program and physical environment designed to minimize the need for tenants to move within or from the setting to accommodate changing needs and preferences; (3) has an organizational mission, service programs and a physical environment designed to maximize residents dignity, autonomy, privacy, and independence; (4) and encourages family and community involvement.²¹ ALFs promise dignity, independence, privacy, and a host of services that cater to residents’ individual social and physical needs.²² However hazy the definition, the concept of an ALF is clearly attractive; over an estimated 1 million Americans are now residents of these facilities.²³

B. *What ALF's Are Not: Other Housing Options for Seniors*

To understand the ALF concept, it is first helpful to know what it is not. Although there is still no exact definition, there are other existing housing arrangements that can help identify the limits of care an ALF can offer. Although the different options of living arrangements that the elderly have available to choose from do not fall along a precise continuum, they do offer increasing levels of services that help to differentiate between choices.

1. INDEPENDENT LIVING

Independent living is the most self-explanatory—seniors may either remain in their own homes and continue to care for themselves as they did previously, or they can move to a new home that offers them modest services. Services provided by independent living housing are limited to simple aid, such as housekeeping, group dining, and transportation.²⁴ Several factors distinguish ALF services from this more traditional arrangement. For one, ALFs provide residents with assistance with the “activities of daily living,” a term for personal care support, which includes bathing or showering, dressing, getting in or out of bed or a chair, using the bathroom,

²⁰ *Id.*

²¹ *Assisted Living Options Hawaii*, available at <http://www.assistedlivinghawaii.com/what.htm> (last visited February 22, 2007) (citing Keren Brown Wilson, *Assisted Living: Reconceptualizing Regulation to Meet Consumers' Needs and Preferences*, AARP, 1996, at 10).

²² Carlson, *supra* note 16, at 7.

²³ *Id.* at 8.

²⁴ See Schwemm & Allen, *supra* note 2, at 136-37.

and eating.²⁵ In addition, ALFs generally assist residents with self-administration of medication.²⁶ Independent living arrangements provide neither personal-care support nor any medical services.²⁷ This arrangement offers the lowest level of care available to seniors.

2. CONTINUING CARE RETIREMENT COMMUNITIES

Continuing Care Retirement Communities (“CCRCs”) are a more specific type of housing arrangement than ALFs—they ensure that residents age in place²⁸ by offering levels of care ranging from the low level of independent living to the high level of skilled nursing care.²⁹ This arrangement offers stability and peace of mind because elders have the assurance that their care will be handled until the end of their life. CCRCs require a substantial upfront entrance fee as well as a monthly fee tied to an objective index.³⁰ ALFs, in contrast, generally only require a monthly fee, on average ranging from \$2,524 a month, or \$30,288 a year.³¹ Even without the financial consideration, skilled nursing care is something that many elderly eventually require, and ALFs cannot meet that need. CCRCs attempt to fill this segment of the market, but the large entrance fee makes them a feasible option only for the wealthy. Those seniors who are at risk of exhausting their financial resources likely cannot afford the large upfront payment that CCRCs require, and consequently must explore other alternatives. Thus, ALFs offer the middle class of seniors their most realistic option for paid elder care outside a nursing home.

3. NURSING HOMES

Nursing homes provide skilled nursing care for those who require full-time medical and related services, but do not require the acute care provided by hospitals.³² The major difference between ALFs and nursing homes is

²⁵ National Center for Health Statistics, Activities of Daily Living (ADL), <http://www.cdc.gov/nchs/data/wh/nchsdefs/adl.htm>. (last visited Mar. 5, 2007)

²⁶ See discussion *infra* Part III.D.

²⁷ See *id.*

²⁸ The term “age in place” refers to a senior living in a single residence as they grow older, rather than moving into facilities with progressively high levels of care as the ability to take care of himself or herself decreases.

²⁹ See Schwemm & Allen, *supra* note 2, at 140.

³⁰ Stuart D. Zimring, *Housing for the Elderly, Housing Options for the Elderly: Opportunities and Challenges*, 31 EST. PLAN. 321, 323 (July 2004).

³¹ The MetLife Market Survey of Nursing Home & Home Care Costs, (Sept. 2004), available at <http://www.metlife.com/WPSAssets/13288174261105724366V1FMetLife%20Market%20Survey.pdf>.

³² Schwemm & Allen, *supra* note 2, at 138 (citing Lawrence A. Frolik and Melissa C. Brown,

that ALFs do not offer extensive medical care, and they have an increased emphasis on privacy.³³

Federal law defines a nursing facility as:

[A]n institution (or a distinct part of an institution) which—(1) is primarily engaged in providing to residents—(A) skilled nursing care and related services for residents who require medical or nursing care, (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or (C) on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities.³⁴

The federal Nursing Home Reform Act of 1987 requires a pre-admission screening by a registered nurse guaranteeing that the nursing home is appropriate for the potential resident, and a reassessment must be conducted every three months throughout their stay.³⁵ A registered nurse must be on duty at least eight hours a day, and a licensed nurse must be in charge at all times.³⁶ Nursing homes also must have an agreement with a hospital regarding the transfer of patients as necessary based on their medical needs.³⁷ ALFs have relatively little regulation as to who they may accept as residents, and often rely more on the contract between the resident and the facility to determine what levels of care will be provided.³⁸

These different housing options offer seniors a wide variety of housing opportunities. ALFs cater to residents with a broad range of physical needs, but it is the emotional need that they fulfill that makes them so attractive. ALFs offer a chance for independence, privacy, and self-determination that nursing homes cannot.

ADVISING THE ELDERLY OR DISABLED CLIENT 15.01, at 15-1 (1997 & Supp. 2002)).

³³ Teresa Modnick, Robert Segal, M.A., and Tina de Benedictis, Ph.D., *Assisted Living Facilities for Seniors*, available at http://www.helpguide.org/elder/assisted_living_facilities.htm (last visited Feb. 3, 2007).

³⁴ 42 U.S.C. § 1396r(a).

³⁵ 42 U.S.C. § 1396r(b)(3)(B)(iii).

³⁶ 42 C.F.R. § 483.30.

³⁷ 42 U.S.C. § 1395x(l).

³⁸ See Carlson, *supra* note 16, at 17.

C. Comparing Assisted Living Facilities to Nursing Homes: Areas Generally Regulated by State Law

All fifty states and the District of Columbia have some form of assisted living regulations.³⁹ As a result, there are as many different state models for regulating ALFs as there are states.⁴⁰ Many state statutes are written in vague terms, allowing the ALF and the resident to negotiate a contract defining the standard of care.⁴¹ This type of regulation gives facilities substantial flexibility in outlining what services they will provide residents. It also overvalues the negotiation aspect of contracting—the personal care contract in ALFs is generally a take-it-or-leave-it, with no ability to negotiate over terms or conditions. Thus, elders rely heavily on what little regulation states offer. Generally, there are two areas states regulate; (1) the structure of the licensing system employed by the state, i.e., multi-level or single-level and (2) the day-to-day operations, namely a facility's obligation to meet needs and accommodate health conditions, and training and staff requirements.

D. The Structure of the Licensing System

There are two ways that a state can structure their ALF licensing system. One solution is to have a single system that encompasses all levels of care from independent living up to nursing homes. The second way is to break the single system into multiple levels of care, with each higher level of care having more stringent requirements.

1. THE SINGLE-LEVEL LICENSING SYSTEM

States with a single level of care only license one type of ALF.⁴² Thus, ALFs are licensed to accept and retain any resident so long as they do not have a state-specified disqualifying disorder.⁴³ States with single-level systems stress the benefits of allowing ALFs to be flexible in catering to their residents' needs.⁴⁴ Without a set of criteria to which an ALF must conform, each facility is free to set its own criteria so long as it is in conformity with

³⁹ *Id.*

⁴⁰ See Eric M. Carlson, *Critical Issues in Assisted Living: Who's In, Who's Out, and Who's Providing the Care: State Summaries*, NATIONAL SENIOR CITIZENS LAW CENTER, May 2005 [hereinafter *State Summaries*].

⁴¹ Carlson, *supra* note 16, at 8.

⁴² *Id.* at 19.

⁴³ *Id.*

⁴⁴ *Id.* at 21.

the general statute. In theory, the single-level system is ideal, with each ALF providing dynamic individualized care as the resident ages in place. In practice, however, residents rarely stay in a single-level ALF due to their changing needs.⁴⁵ As such, the single-level license is what the state provides, but multiple levels of care are effectively practiced by individual facilities that either accept or reject residents based on their changing needs. This makes it difficult to compare different ALFs within a state, since each facility effectively sets its own standards.

2. THE MULTI-LEVEL LICENSING SYSTEM

States with multi-level systems license at least two types of ALFs.⁴⁶ Facilities are licensed for maximum levels of care, such that a patient who resides in the lowest level of ALF could also be admitted to any other level in the state.⁴⁷ This system specifies different quality of care standards that a facility must possess to care for residents at each level.⁴⁸ Those standards include minimum staffing levels and specific training requirements, and bar certain patients, such as those with dementia, from residing in lower level facilities.⁴⁹ The result simplifies the comparison of different facilities, since all of the ALFs in the state must be licensed under one of the multiple care levels. Elders also receive some increased protection from negligent care because facilities cannot provide care they are not qualified to give. For ALFs that choose to house residents with more specialized problems, such as dementia and Alzheimer's, further licensing requirements are appropriate to protect both the residents and the staff. Forty-four states now have special requirements for ALFs that serve people with dementia.⁵⁰

Multi-level licensing has many benefits, but the flaws are so potentially harmful to residents that the system needs additional work before it should be elevated to a national standard. Although the multiple levels create more appropriate minimum staffing and training requirements, they also create an easy way for facilities to evict residents as soon as their needs extend beyond the scope of a facility's license. This licensing structure also helps create a loophole for getting around the Fair Housing Act (FHA)⁵¹ which bans

⁴⁵ See discussion *infra* Part III.A.1.

⁴⁶ Carlson, *supra* note 16, at 19.

⁴⁷ *Id.*

⁴⁸ *Id.* at 8.

⁴⁹ See *id.* at 19-20.

⁵⁰ National Academy for State Health Policy, *Long Term and Chronic Care: Assisted Living* (2003), available at http://www.nashp.org/_docdisp_page.cfm?LID=3CBEF3B3-F1A6-4791-99A0052670C89F09 (last visited Feb. 2, 2007).

⁵¹ 42 U.S.C. § 3604(f)

housing discrimination based on handicap. In a single level licensing system, facilities have a harder time showing that the eviction was not in violation of the ADA, since accommodating the resident would not require them to change their license—a change which would constitute an exempt fundamental alteration.⁵²

ALF residents are often vulnerable to eviction as soon as their condition worsens, and the facility determines that they cannot (or will not) care for them any longer.⁵³ Requiring that ALFs obtain a license for different levels of care would protect residents from facilities exercising their considerable discretion in ordering premature evictions. Most state laws allow involuntary discharge when a facility cannot meet a resident's needs, and generally allow facilities the right to determine themselves whether they can meet particular needs.⁵⁴ This is an uncomfortable situation akin to players refereeing their own games. Although an ALF is in a unique position to know its own limitations, there is a strong incentive to save money by evicting those residents who begin to require additional care. ALFs are private businesses, not charitable organizations, and the cost of caring for the elderly can be high. State licenses that specify what level of care a facility may provide simplifies the matter considerably by taking discretion away from the facility operators. If a facility owner does not wish to care for residents that require a certain level of care, they can opt for running a facility with a lesser license (and likely collecting less in rent per resident).

E. *The Obligation of the Facility to Meet Needs & Accommodate Conditions*

ALFs are popular in part because of the perceived ability of an elder to age in place rather than move constantly as their condition deteriorates. Most states outline certain conditions that are a threshold for requiring an ALF to deny admission and/or continued residence. Generally, these conditions would cause a resident to be medically eligible for nursing home placement.⁵⁵

Most ALFs enjoy significant discretion in discharging patients against their will.⁵⁶ Thirty-nine states allow a facility to discharge a resident against his will whenever the facility determines that the facility cannot meet the resident's needs.⁵⁷ This setup gives broad latitude to individual facilities in

⁵² See *Assisted Living Associates of Moorestown, L.L.C. v. Moorestown Tp.*, 996 F. Supp. 409 (D.N.J. 1998); *Judy B. v. Borough of Tioga*, 889 F. Supp. 792, 10 A.D.D. 586 (M.D. Pa. 1995); *Liddy v. Cisneros*, 823 F. Supp. 164, 2 A.D.D. 1243 (S.D.N.Y. 1993).

⁵³ Carlson, *supra* note 16, at 9

⁵⁴ See *id.*

⁵⁵ *State Summaries*, *supra* note 40.

⁵⁶ See generally *supra* Part III.

⁵⁷ Carlson, *supra* note 16, at 33.

determining when a resident can be evicted. The problem with such discretion is that often residents are discharged either "too early" or "too late."⁵⁸ A discharge that is "too early" is likely a violation of the resident's rights under the Fair Housing Act; a discharge that is "too late" can be dangerous to both the resident and to others. The best solution to this problem is diligent monitoring of residents' condition by ALF staff and discussions with their physicians concerning any changes in condition. Although most state laws direct ALFs to supervise physician-directed health care, clear directives on the frequency of updates and the sharing of patient information with the facility helps to avoid untimely discharges.

The legal community has been slow to recognize the dangers surrounding the evictions of the elderly from ALFs. In *Potomac Group Home v. Montgomery County*⁵⁹ the court held that a county ordinance requiring an ALF resident to move out if unable to exit the facility unassisted violated the Fair Housing Act. However, twenty-three states have laws requiring ALF residents to be ambulatory (not bedridden) or risk eviction.⁶⁰ These laws are often enforced by the ALFs' own election, however there are many common exceptions ultimately allowing the facility to choose which residents can stay despite their worsening condition.⁶¹ This creates an additional problem, because ALFs have different standards for those residents who they have already admitted versus those who are seeking to become residents. Allowing flexibility regarding exceptions for existing residents seems appropriate, since the ALFs themselves tout the ability of residents to age in place. By allowing elders with pre-existing needs in, it would burden the ALF more than allowing its current residents to reach that point over time.

F. *The Minimum Care & Staffing Requirements*

State laws give significant discretion to individual ALFs in determining their own staffing levels.⁶² Forty-three states require ALFs to use staffing levels "appropriate to meet the needs of residents," but they do not specify what those levels should be.⁶³ Federal law requires that nursing homes must have "sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual

⁵⁸ See *id.* at 9.

⁵⁹ *Potomac Group Home Corp. v. Montgomery County*, 823 F. Supp. 1285, 1299-1301 (D. Md. 1993).

⁶⁰ See Carlson, *supra* note 16, at 39-42.

⁶¹ See *id.* at 25.

⁶² *Id.* at 60.

⁶³ *Id.*

plans of care.”⁶⁴ Specifically, a licensed nurse must be on duty at all times, and one must serve as a full-time director of nursing. Clearly, the residents of an ALF are far more autonomous than the residents of nursing homes, and are able to rely on themselves to fulfill many of their own needs. Residents are, however, living in an ALF because of their inability to live on their own, so some enumeration of what needs a facility is required to provide is likely appropriate. Without specific laws, residents are left to rely on the agreement they signed with the ALF, or on oral promises that the operators used in marketing the facility to them to determine their expected level of care.

The role of physicians in ALFs is minor. There is no requirement that an ALF have an affiliated physician, with the sole exception of ALFs offering specialty care in Alabama.⁶⁵ The role of nurses is even more staggering—only twenty-six states require that ALFs employ, or at a minimum, contract with nurses.⁶⁶ Nursing requirements appear more frequently in states that use multi-level licensing, with nurses generally being required as a part of care for the highest licensing levels.⁶⁷

States’ regulations specify initial and ongoing training requirements for staff and administrators, but the level of specificity in those requirements varies considerably among states. “Some states specify only general requirements, while others specify topics to be covered, the number of training hours required, the completion of approved courses, or some combination thereof.”⁶⁸ Unfortunately, mandating certain *quantities* of training does little to ensure that staffs receive *quality* training. Given that the elderly are more likely to be sick than the population as a whole,⁶⁹ it is surprising that only slightly more than half of the states require staff training in first aid or CPR. A small minority of states requires a certain minimum number of hours for initial training, and even fewer states require that the person conducting initial training must have certain qualifications.⁷⁰ Legislation that requires training for staff but does not specify what must be covered or who must provide the training is an empty gesture. Seniors rely on ALFs not only as a place to live, but also as a place where they are provided with some level of care. ALFs are far more expensive than apartments because of their service component, and part of that service is

⁶⁴ 42 C.F.R. § 483.30 (2005).

⁶⁵ ALA. ADMIN. CODE r. 420-5-20-.04(4) (1975).

⁶⁶ Carlson, *supra* note 16, at 57.

⁶⁷ *Id.*

⁶⁸ *State Residential Care and Assisted Living Policy: 2004*, (March 31, 2005), available at <http://aspe.hhs.gov/daltcp/reports/04alcom1.htm> (hereinafter *Overview of Care*).

⁶⁹ See generally Administration on Aging: Evidenced-Based Disease Prevention Program, available at http://www.aoa.gov/press/fact/pd/f/fs_EvidencedBased.doc (last updated Aug. 27, 2003).

⁷⁰ See generally *Overview of Care*, *supra* note 68, at 32-33.

supposed to be an educated staff that is trained to provide basic assistance. Without a professional, or at a minimum, an educated staff, the relative value of ALFs compared to apartment or dormitory-style living is diminished.

In comparison, under the Nursing Home Reform Act, a nurse aide in a nursing home must complete seventy-five hours of initial training, at least sixteen of which must be completed before having any direct contact with a resident.⁷¹ In addition, a registered nurse with a minimum of one year of experience with long-term care facilities must provide or supervise training.⁷² Although nursing homes in general provide higher-level care than an ALF, personnel in many ALFs are providing care that is analogous to that of a nurse's aide in a nursing home.⁷³ Therefore, minimum staffing requirements for ALFs are necessary to protect residents from mistakes caused by ignorant staff.

G. *The Administration of Medicine to Residents*

The trend of delegating nursing duty to non-nurses is the result of the financial burden of ALFs using registered nurses and favorable state law. In a nursing home, only an LPN or RN may administer medications, yet ALFs permit unlicensed personnel to distribute medications.⁷⁴ Twenty-one states authorize non-nurses to administer medication to residents; however, all states allow some form of delegation of duties to non-nurses.⁷⁵ Oregon's ombudsman reports that there is an epidemic breakdown in the medication administration system in ALFs.⁷⁶ Many states allow non-nurses to help residents self-administer medication by placing pills inside residents' mouths.⁷⁷ The line between helping a resident with their medication and actually administering the medication is a very fine one, and is one that states have not adequately addressed.

The distinction between the state ALF regulations and federal nursing home requirements makes little sense. A 2002 study by the U.S. Department of Health and Human Services found that there was only a slight variation in the complexity of the drug regimes between the average ALF resident and nursing home resident.⁷⁸ ALFs argue that allowing non-nurses to administer

⁷¹ 42 C.F.R. § 483.152(a) (2007).

⁷² 42 C.F.R. § 483.152(a)(5)(i) (2007).

⁷³ See Carlson, *supra* note 16, at 56.

⁷⁴ Jules B. Olsman, *Risks of Assisted Living*, ANN.2003 ATLA-CLE 917 (2003).

⁷⁵ Carlson, *supra* note 16, at 58-59.

⁷⁶ *Id.*

⁷⁷ *Id.* at 59.

⁷⁸ U.S. Dept. of Health and Human Serv., *Medication Use by Medicare Beneficiaries Living in Nursing Homes and Assisted Living Facilities*, (June 5, 2002), available at <http://aspe.hhs.gov/daltcp/reports/meduse.htm>.

medication is no different from a family member performing the same act, which would be unregulated,⁷⁹ however, given the number of ALFs that advertise and promote their “professional care,” this argument becomes somewhat specious. The problem is not in the delegation of duties, but in the lack of training and education. A son or daughter can help their parent with their medication; the difference is that their actions are not for financial gain. Clear issues of negligence arise when untrained or otherwise ignorant staff members assume duties typically reserved for nurses.

“Oregon has the most liberal nurse delegation act in the nation.”⁸⁰ Under the law, nurses can train unlicensed staff to perform numerous medical tasks.⁸¹ “For example, staff in assisted living facilities can take blood sugar levels (by sticking the client’s finger to get a blood sample).”⁸² “As a result, unlicensed (but trained) staff can be responsible for more patients” and community-based residences can accommodate more people.⁸³ The key in Oregon is that the unlicensed staff is properly trained by a registered nurse. Oregon law specifies that a nurse supervising staff can be held liable if the ALF staff member is acting pursuant to specific instructions from the nurse, or if the nurse fails to leave instructions when the nurse should have done so.⁸⁴ Since Oregon requires nurses to train the staff, the risk of liability creates a strong incentive for nurses to properly train staff members and ensure that they are up to date on resident needs.

III. THE RELEVANT FEDERAL LEGISLATION & PROGRAMS AFFECTING ASSISTED LIVING & NURSING HOMES

A. Social Security

Social Security is most commonly thought of as a retirement benefit. The amount of the monthly benefit to which a worker is entitled depends upon their earnings record and upon the age that they choose to begin receiving benefits. Workers can also receive Social Security if they become disabled and meet certain criteria set forth by the federal government. Another component of Social Security is SSI—Supplemental Security Insurance. SSI is a program run by Social Security that pays monthly checks to the elderly, the blind, and people with disabilities who do not have many

⁷⁹ Carlson, *supra* note 16, at 59.

⁸⁰ Michael S. Sparer, *Health Policy for Low Income People in Oregon*, URBAN INST. (Sept. 24, 1999), available at <http://www.urban.org/publications/309092.html>.

⁸¹ OR. REV. STAT. § 678.445 (2005).

⁸² Sparer, *supra* note 80.

⁸³ *Id.*

⁸⁴ OR. REV. STAT. § 678.036(3) (2005).

assets or much income.⁸⁵ SSI recipients usually receive food stamps and Medicaid.⁸⁶ A person is entitled to SSI if they qualify as disabled, blind, or elderly, and they are able to meet a means-test which determines if their assets and income fall below a certain threshold.⁸⁷ Effective January 2006, the SSI payment for an eligible individual is \$603 per month.⁸⁸

While eligibility for Social Security disability is based on prior work under Social Security, SSI payments are made based on financial need. Recipients usually cannot receive SSI while in a public institution such as a nursing home.⁸⁹ ALFs are by definition private institutions, however, and their residents can qualify for SSI.

B. Medicare

Medicare is a federally funded health insurance program that covers 95% of the elderly population.⁹⁰ It is composed of Hospital Insurance (HI) and Supplementary Medical Insurance (SMI). The HI portion will fully cover nursing home care for twenty days; additional coinsurance payments are required for coverage days twenty-one through one hundred.⁹¹ After one hundred days, Medicare does not cover long-term care.⁹² SSI helps pay for doctors, outpatient care, and medically necessary doctor services.⁹³ Together, someone receiving both HI and SMI will generally only be responsible for prescription drugs, routine care, dental care, and hearing aids.⁹⁴

⁸⁵ Social Security Online, <http://www.ssa.gov/d&s1.htm>

⁸⁶ *Id.*

⁸⁷ *Id.*

⁸⁸ Social Security Online, *Find an Answer to Your Question: How much will I receive in SSI benefits?*, available at http://ssa-custhelp.ssa.gov/cgi-bin/ssa.cfg/php/enduser/std_adp.php?&p_lva=&p_faqid=85 (last updated Feb. 13, 2006).

⁸⁹ Social Security Online, *Understanding Supplemental Security Income: Living Arrangements* (2006), available at <http://www.socialsecurity.gov/notices/supplemental-security-income/text-living-ussi.htm>.

⁹⁰ Ctrs. for Medicare & Medicaid Servs., Dept of Health & Human Serv., *Brief Summaries of Medicare & Medicaid: Title XVIII and Title XIX of The Social Security Act as of November 1, 2006*, at 16, available at <http://www.cms.hhs.gov/medicareprogramratesstats/downloads/medicare%20medicaidsummaries2006.pdf>. [hereinafter *Brief Summaries of Medicare & Medicaid*].

⁹¹ *Id.* at 12.

⁹² *Id.*

⁹³ *Id.* at 19-20.

⁹⁴ *Id.* at 24.

C. Medicaid

Medicaid was created on July 30, 1965 through Title XIX of the Social Security Act.⁹⁵ The Medicaid provisions of the Social Security Act provide that for “categorically needy” persons, participating states must provide minimal services consisting of inpatient hospital services, outpatient hospital services, other laboratory and x-ray services, skilled nursing facility services, screening and diagnosis of children, family planning services, and physician's services.⁹⁶ For people who are eligible for full Medicaid coverage, the Medicaid program supplements Medicare coverage by providing services and supplies that are available under their states' Medicaid program.⁹⁷ Services covered by both programs will be paid first by Medicare; Medicaid pays the difference up to the states' payment limit.⁹⁸ Medicaid also covers additional services (e.g., nursing facility care beyond the 100 day limit covered by Medicare, prescription drugs, eyeglasses, and hearing aids).⁹⁹

Each state administers its own Medicaid program while the federal Centers for Medicare and Medicaid Services (CMS) (formerly the Health Care Financing Administration) in the United States Department of Health and Human Services monitors the state-run programs and establishes requirements for service delivery, quality, funding, and eligibility standards.¹⁰⁰ It is a jointly-funded, cooperative venture between the federal and state governments that operates as a matching entitlement program.¹⁰¹

In some states, Medicaid pays private health insurance companies that contract with the state Medicaid program, while other states pay providers (i.e., doctors, clinics and hospitals) directly to ensure that individuals receive proper medical attention.¹⁰² Although Medicaid is a federal program, each state individually decides who it will cover under the program and also sets the guidelines for what procedures are covered. While states do not have to fund all medical services within those five categories, they must establish “reasonable standards ... for determining ... the extent of medical assistance

⁹⁵ 42 U.S.C. § 1396 (2003).

⁹⁶ *Roe v. Ferguson*, 515 F.2d 279, 281 (6th Cir. 1975).

⁹⁷ Centers for Medicaid & Medicare Services, *Dual Eligibility Overview*, available at <http://www.cms.hhs.gov/DualEligible> (last modified Dec. 14, 2005).

⁹⁸ *Id.*

⁹⁹ *Id.*

¹⁰⁰ See *Brief Summaries of Medicare & Medicaid*, *supra* note 90.

¹⁰¹ *Id.*

¹⁰² Centers for Medicare & Medicaid Services, *Medicaid Program - General Information Overview*, available at <http://www.cms.hhs.gov/MedicaidGenInfo> (last updated Mar. 8, 2006) [hereinafter *Ctrs. for Medicare & Medicaid Serv.*].

under the plan which . . . are consistent with the objectives” of Title XIX.¹⁰³ Once a state plan is approved by the federal Department of Health and Human Services, “the federal government partially reimburses the state for the state’s expenditures in subsidizing medical services for needy citizens covered by its plan.”¹⁰⁴

The Medicaid statute does not provide coverage for the residential or room-and-board charges of an ALF—it simply limits the payment of benefits to certain facilities.¹⁰⁵ Furthermore, federal law is clear that there is no fundamental right to receive Medicaid benefits at all, let alone to receive them for a particular facility.¹⁰⁶ Thus, a now-penniless resident who must leave an ALF for a nursing home that is covered by Medicaid has no federal grounds on which to stand in challenging an eviction.

Despite this lack of a fundamental right to care from a facility that the resident chooses, if ALF care is significantly less expensive than the same care at a nursing home, it is illogical to move a patient into the nursing home. The large disparity between an apartment’s rental rate and an ALF’s fees reflects the heavy service component of each payment. A feasible arrangement would be for states to elect for Medicaid to cover the hefty service component of ALFs, while residents use their own Social Security income to pay for the boarding component.

D. *The 1987 Nursing Home Reform Act*

The Nursing Home Reform Act of 1987¹⁰⁷ created strict federal regulations governing the nursing home industry. Prior to the Act, there were separate intermediate care facilities (ICF) and skilled nursing facilities. Intermediate care facilities offered less intensive care than nursing facilities; they are generally focused more on aiding “activities of daily living,” such as feeding, grooming, and toileting, rather than medical help.¹⁰⁸ The 1987 Act eliminated the distinction, and raised the minimum standards of care for ICFs to the same strict level as skilled nursing facilities.¹⁰⁹ Today, nursing

¹⁰³ 42 U.S.C. § 1396a(a)(17) (2003).

¹⁰⁴ *Lewis v. Thompson*, 252 F.3d 567, 570 (2d Cir.2001).

¹⁰⁵ *Leocata ex rel. Gilbride v. Wilson-Coker*, 343 F. Supp. 2d 144, 151 (D.Conn. 2004).

¹⁰⁶ *Id.*

¹⁰⁷ 42 U.S.C. § 1396r (2006).

¹⁰⁸ Mark W. Swanson, *Optometric Care of Nursing Home Residents*, AMERICAN OPTOMETRIC ASS’N 3 (1998), available at <http://www.aoa.org/documents/NursingHomeResidents.pdf>.

¹⁰⁹ See 42 U.S.C. § 1396r (2006).

homes typically offer both levels of care under one roof, and patients can shift from one level of care to the other as needed.¹¹⁰

The basic objective of the Nursing Home Reform Act was to ensure that residents of nursing homes received quality care that would result in their achieving or maintaining their “highest practicable” physical, mental, and psychosocial well-being.¹¹¹ To secure quality care in nursing homes, the Nursing Home Reform Act requires the provision of certain services to each resident and establishes a Residents’ Bill of Rights.¹¹² Nursing homes receive Medicaid and Medicare payments for long-term care of residents only if they are certified by the state to be in substantial compliance with the requirements of the Nursing Home Reform Act.¹¹³

To qualify for Medicaid reimbursement, the Nursing Home Reform Act required providers to make these reforms: (1) combine intermediate care facilities and skilled nursing facilities by bringing the level of care of intermediate care facilities to that of skilled nursing facilities; (2) provide 24-hour nursing coverage; (3) employ physicians as designated medical directors for each facility; (4) employ a social worker for each nursing facility with more than 120 beds; and (5) provide standardized assessments of residents.¹¹⁴

IV. THE OPPOSITION: THE ARGUMENTS AGAINST DIVERTING NURSING HOME RESIDENTS TO ALFs

Allowing Medicaid to help pay for ALFs would increase the facilities’ need for stringent regulation. There are strong arguments against increasing regulation of ALFs, both from consumers and ALF operators. ALFs thrive on their distinctions from nursing homes—the “homey” feeling that institutional nursing homes lack, and privacy from both the staff and other residents. Some states that are placing residents in ALFs who traditionally would have ended up in a nursing home face opposition. ALF operators argue that this new setup will threaten not only the active senior image that the industry has relied on for so long, but also the health and safety of residents.

Although evicting elderly residents of ALFs is an unfortunate occurrence, an equally distressing concern is the allowance of more and more

¹¹⁰ Swanson, *supra* note 108.

¹¹¹ Martin Klauber & Bernadette Wright, *The 1987 Nursing Home Reform Act: Fact Sheet* (Feb. 2001), available at <http://www.aarp.org/research/legis-polit/legislation/aresearch-import-687-FS84.html>.

¹¹² *Id.*

¹¹³ *Id.*

¹¹⁴ *Kansas Health Care Ass’n. v. Kansas Dept. of Soc. & Rehab. Serv.*, 958 F. 2d 1018 (10th Cir. 1992).

increasingly disabled elders to stay in ALFs. There is a danger that ALFs are becoming more like the intermediate care facilities that the federal Nursing Home Reform Law in 1990 eliminated.¹¹⁵ The basis for eliminating these institutions was that the Institute of Medicine found them to be inadequate; although the residents of intermediate institutions were the same as those in nursing homes, the standard of care was much lower.¹¹⁶ Many states allow ALFs to accept seniors with complex health needs if the resident and his or her doctor and family agree, but with this increased choice comes the danger that states are giving the industry too much self-regulation.¹¹⁷ When the boundary between an ALF and nursing home is unclear, it looks increasingly like one of the intermediate care facilities from the 1980s.

States license nursing homes, but they are also subject to federal regulation if residents receive Medicaid and Medicare benefits.¹¹⁸ Most nursing homes accept Medicare, and are thus subject to federal regulations that attempt to standardize a minimum level of care for residents.¹¹⁹ ALFs are generally private-pay and thus do not accept Medicare reimbursement, although this trend is changing in some states.¹²⁰ An increasing number of states are placing Medicaid-eligible adults in assisted living residences as an alternative to traditional placement in nursing homes.¹²¹ An estimated 100,000 ALF residents receive at least partial care paid for by the Medicaid program.¹²²

Many states are diverting Medicaid recipients from nursing homes to ALFs, which pushes these facilities to the limit of, and sometimes beyond, their care capabilities.¹²³ In some states, Medicaid may pay for the service component of assisted living.¹²⁴ Many of these facilities receive federal money for residents who would otherwise be living in nursing homes subject to federal regulation and the strict standards that are expected in a facility that

¹¹⁵ Janet Grady Sullivan, *Redefining Long Term Care*, 21 CONTEMP. LONG TERM CARE 60, 62 (Aug. 1998).

¹¹⁶ Carlson, *supra* note 16, at 23.

¹¹⁷ See Kevin McCoy & Julie Appleby, *Many Facilities Accept People Who Are Too Ill*, USA TODAY (Mar. 31, 2005), available at http://www.usatoday.com/money/industries/health/2004-05-26-assist-too-sick_x.htm

¹¹⁸ Dept. of Health & Human Serv., *Nursing Homes: About Nursing Home Inspections*, available at <http://www.medicare.gov/Nursing/AboutInspections.asp> (last updated July 25, 2005).

¹¹⁹ Olsman, *supra* note 74.

¹²⁰ See discussion *infra* Part VI.

¹²¹ Dept. of Health & Human Serv., U.S. Admin. on Aging, *Aging Internet Information Notes: Assisted Living*, available at http://www.aoa.gov/prof/notes/notes_assisted_living.asp (last updated Sept. 9, 2004).

¹²² Carlson, *supra* note 16, at 8.

¹²³ See *id.*, at 24.

¹²⁴ Dept. of Health & Human Serv., U.S. Admin. on Aging, *Fact Sheet*, available at http://www.aoa.gov/prof/notes/notes_assisted_living.asp (last updated Sept. 27, 2004).

provides health care.¹²⁵ For many, ALFs are a welcome option for the time between living independently and requiring skilled care. However, there are a growing number of ALF residents whose needs overlap with those of a nursing home resident, and the disparities between the regulation regimes of the facilities are significant.¹²⁶ Many ALF models were designed to care for far healthier seniors than those who have ultimately become residents.¹²⁷ Since the industry has expanded at a compounded annual rate of 10% throughout the 1990s, some ALFs have struggled with mounting debt in their rush to meet the expected demand. As a result, the need for additional residents to fill beds resulted in more residents with additional needs being admitted.¹²⁸ Many ALFs could not increase staffing to sufficient levels to provide additional care because their costs would increase, and rates were already considered too high and could not rise any further.¹²⁹

Money is unfortunately the deciding factor for many of those who leave an ALF for a nursing home. When a resident's assets run out, the ALF can evict them just like any other residence when the tenant is unable to pay. "Because Medicaid only covers categorically needy persons, individuals do not become eligible for Medicaid assistance until they 'spend down' their private assets below a[n] income ceiling set by state statute."¹³⁰ For the elderly who need assistance, often the only place they can go is a skilled nursing facility for which Medicaid will pay. "Medicaid regulations signaled the willingness of government to pay the full cost of long-term care for poor older persons in nursing homes, but not in other settings."¹³¹

V. GOVERNMENT FUNDING: THE ARGUMENTS FOR KEEPING NURSING HOME ELIGIBLE RESIDENTS IN ASSISTED LIVING FACILITIES

The federally mandated minimum level of care at a skilled nursing facility is much higher than at a state-regulated ALF. These regulations are necessary and protect those who belong in skilled nursing facilities due to serious health problems, however, for those who end up at a skilled nursing

¹²⁵ Stacey L. Bradford, *10 Things Your Assisted Living Facility Won't Tell You*, SMART MONEY, available at <http://www.smartmoney.com/consumer/index.cfm?story=200104192> (last visited Feb. 12, 2007).

¹²⁶ See *id.*

¹²⁷ *Id.*

¹²⁸ *Id.*

¹²⁹ *Id.*

¹³⁰ *Leocata ex. rel. Gilbride v. Wilson-Coker*, 343 F. Supp.2d 144, 149 (D. Conn. 2004).

¹³¹ Peter Uhlenberg, *Replacing the Nursing Home*, PUBLIC INTEREST (Summer 1997), available at http://www.findarticles.com/p/articles/mi_m0377/is_n128/ai_19726633.

facility rather than an ALF, not because of care concerns but because it is the only government-funded option, the heightened level of care comes with a sharp decrease in freedoms and quality of life. Where ALFs strive to mimic a communal or apartment style of living, nursing homes are generally institutional, with a hospital-like atmosphere. Nursing home administrators make virtually all of the residents' daily living decisions—how to furnish their rooms, when to eat and bathe, where to go, whom to socialize with, what medical treatment to receive—leaving little if any autonomy for the residents.¹³² Those who have reached old age, only to have their freedom and privacy effectively taken from them, deserve legislation that improves their situation.

Nearly a third of the over-85 population is just above the poverty line, yet most assisted living facilities are being marketed to the estimated 20% of the elderly population that is considered affluent.¹³³ That 20% does not require the financial assistance of Medicare and Medicaid in order to survive, but the majority of the elderly do. Despite the fact that ALFs are 40% to 50% cheaper than a nursing home, Medicare and Medicaid will not cover residents' expenses.¹³⁴ If these residents could stay in the ALF with care subsidized by the government, the costs would be significantly less than moving them to a skilled nursing facility. Many ALF residents leave in order to receive a higher level of care.¹³⁵ ALFs that provide a level of care that would prevent elders from being sent unnecessarily to nursing homes would not only improve the individual's quality of life, but it would ultimately save the government money. Medicaid pays for skilled nursing facilities (not custodial or long-term care), and helps cover hospice care and some home health care.¹³⁶ Interestingly, the level of care provided at an ALF is not covered, yet a patient who must transfer to a skilled nursing facility because they run out of money—despite no change in their medical condition—often ends up at a nursing home and is covered there by Medicaid. By increasing the flexibility of Medicare and Medicaid guidelines for supporting persons in assisted living, it would be possible to facilitate expansion of this alternative to nursing homes.¹³⁷

¹³² *Id.*

¹³³ Mary Zahn, *Case Study: Alma Guinness, 92, Out of Money and a Home*, MILWAUKEE J. SENTINEL, Aug. 26, 2001, available at <http://www.jsonline.com/news/state/aug01/care2sid26082501a.asp>.

¹³⁴ Mark Tatge, *The Old Folks Home*, FORBES, Dec. 12, 2005, available at http://www.forbes.com/personalfinance/retirement/free_forbes/2005/1212/156.html.

¹³⁵ Consumer Consortium on Assisted Living, *Frequently Asked Questions*, http://www.ccal.org/consumers_care.htm (last visited Feb. 12, 2007).

¹³⁶ Ctrs. for Medicare & Medicaid Serv., *supra* note 102.

¹³⁷ Uhlenberg, *supra* note 131.

VI. ATTEMPTING A SOLUTION: INNOVATION BY STATE GOVERNMENTS

Some states have responded to these problems by allowing Medicaid dollars to go toward ALFs in providing services to those residents who would otherwise be in a nursing home for financial reasons. This section explores a few of the different options that have been cultivated in different states.

A. Home Health Care

Home Health Care is an option where the elderly are able to stay in their homes and receive nursing care. It has surged in popularity over the last few years, spurred in part by the increasing willingness of Medicare and Medicaid to pay for it.¹³⁸ Medicare expenditure on home health care grew from \$1.9 billion in 1988 to \$9.7 billion in 1994.¹³⁹ Part of the concern surrounding Home Health Care is that quality controls become less feasible because the care is provided in the home, rather than at a monitored facility. This argument becomes moot when applied to the ALF model—if residents are in need of skilled care but not 24-hour a day care of a nursing home, home care at ALFs would be the ideal solution.

B. The Oregon Program

“The Oregon health care system of long-term care is a national model.”¹⁴⁰ Over the last 20 years, state lawmakers have enacted policies designed to encourage the elderly and disabled to receive home- and community-based services rather than entering a nursing home.¹⁴¹ The state employs case managers whose jobs are to ensure that the elderly are aware of the available alternatives to institutionalization. There is an ongoing state effort to work with the assisted living industry to place Medicaid enrollees in community-based facilities.¹⁴² As a result, Oregon is the only state that spends more Medicaid dollars on home- and community-based services than on nursing home care.¹⁴³ It is also one of only two states that can boast a

¹³⁸ *Id.*

¹³⁹ *Id.*

¹⁴⁰ Sparer, *supra* note 80.

¹⁴¹ *Id.*

¹⁴² *Id.*

¹⁴³ *Id.*

decline in the number of nursing home beds between 1980 and 1995.¹⁴⁴ As a result, Oregon is the only state where more than 25 percent of ALF residents are Medicaid beneficiaries.¹⁴⁵ “Between 1981 and 1997, the number of Medicaid beneficiaries residing in nursing homes declined from 8,400 to 6,800, despite a substantial increase in the elderly population of Oregon.”¹⁴⁶

“The linchpin for the state’s long-term care system is legislation enacted in 1981¹⁴⁷ mandating that long-term care services be delivered in the least-restrictive and least-institutional environment possible.”¹⁴⁸ That legislation designated an agency to be responsible for supervising and coordinating the various long-term care programs for the elderly.¹⁴⁹ It also delegated the responsibility of developing a single point of entry for persons seeking long-term care so that they are informed of all available options.¹⁵⁰ This gateway to long-term care alleviates many of the problems with ALFs in other states – the case manager can distinguish different facilities, and prospective residents can have questions answered by an uninterested party. States that rely on the ALFs themselves to be the primary disseminators of information give control to the facility operators, while providing little guidance to seniors.

C. *The New York Program*

New York regulates adult care by classifying facilities into three groups: Adult Homes, Enriched Housing Programs (EHP), and Assisted Living Programs (ALP).¹⁵¹ Adult Homes offer the lowest level of care, providing only personal care services such as housekeeping, meals, supervision, and assistance with medication.¹⁵² EHPs are similar to Adult Homes but cater primarily to those 65 years or older.¹⁵³ An ALP is an Adult Home or EHP that the New York State Department of Health certifies to provide Medicaid-funded home care services.¹⁵⁴

¹⁴⁴ *Id.*

¹⁴⁵ *Id.*

¹⁴⁶ *Id.*

¹⁴⁷ O.R.S. § 410.040

¹⁴⁸ Sparer, *supra* note 80.

¹⁴⁹ *Id.*

¹⁵⁰ *Id.*

¹⁵¹ THE EMPIRE STATE ASS’N OF ADULT HOMES & ASSISTED LIVING FACILITIES, THE FACTS ABOUT . . . ASSISTED LIVING IN NEW YORK (2002), available at <http://www.ny-assisted-living.org/pdf/assistedliving.pdf>. [hereinafter Ass’n of Adult Homes].

¹⁵² *Id.*

¹⁵³ *Id.*

¹⁵⁴ *Id.*

Programs like New York's ALP are a promising solution for those residents that are eligible for nursing care. The ALP bridges the gray area between ALFs and nursing homes, utilizing existing programs to help pay for care. Seventy-four percent of residents in all of New York State's assisted living facilities have incomes of less than \$25,000 (well below the reported average cost of care per year).¹⁵⁵ This situation leaves a great number of people in the situation where their expenses outpace their income; if they live long enough, they will eventually spend down all of their savings and require government assistance such as the ALP.

The ALP is designed to help those seniors who are medically eligible for nursing home care but do not require placement in such a medically intensive setting.¹⁵⁶ Participants in the ALP receive home health care services provided by an on-site licensed home care agency and a community certified home health agency under contract.¹⁵⁷ New York accepts Medicaid for this program with the approval of social services.¹⁵⁸ As of 2002, the ALP included 54 facilities providing care for 3,014 residents.¹⁵⁹ Qualified participants are those who are not bedridden, do not require continual nursing care, and who do not endanger the safety of others.¹⁶⁰ Services provided include personal care, room and board, housekeeping, supervision, home health aides, personal emergency response services, nursing, physical therapy, occupational therapy, speech therapy, medical supplies and equipment, adult day health care, a range of home health services, and the case management services of a registered professional nurse.¹⁶¹ This program fills the void for those who medically require nursing assistance, but who do not wish or need to move into an institutional home.

VII. CONCLUSION

The United States is facing a crisis in the coming years regarding elder housing and care. The current laws that allow ALF residents to be evicted and sent to nursing homes after their funds are depleted are inadequate given the number of baby boomers that will soon require care. It is impractical for

¹⁵⁵ NURSING HOME COMMUNITY COALITION OF NEW YORK STATE, ASSISTED LIVING IN NEW YORK STATE: A SUMMARY OF FINDINGS (2001), available at http://www.ltccc.org/papers/assisted_living_project.htm.

¹⁵⁶ N.Y. State Dept. of Health, Assisted Living Program, http://www.health.state.ny.us/health_care/medicaid/program/longterm/alps.htm (last visited Feb. 12, 2007).

¹⁵⁷ Ass'n of Adult Homes, *supra* at 151.

¹⁵⁸ N.Y. State Dept. of Health, *supra* at 156.

¹⁵⁹ Ass'n of Adult Homes, *supra* at 151.

¹⁶⁰ N.Y. State Dept. of Health, *supra* note 156.

¹⁶¹ *Id.*

the government to send people to live in nursing homes who do not require a highly skilled level of care, from both a financial and a quality of life standpoint. States that do not allow ALFs to receive Medicare funding to subsidize those who would otherwise be in nursing homes should examine the cost difference between the two housing options and reevaluate their statutes accordingly.

Facilities that accept Medicaid would be attractive choices to the middle class of seniors who are vulnerable to their assets depleting over years of residing in an ALF. Those facilities would be more marketable by offering peace of mind to residents who do not want to risk the possibility of having to move into a nursing home prematurely. When prospective residents are able to easily choose which facility best matches their needs, ALFs will be able to better tailor their services to a population that best matches their level of care, and that is what ALFs have marketed as their greatest asset from the beginning.

Flexibility is the greatest strength of ALFs, but it is also their greatest weakness. The industry defends flexibility as key to offering residents the services that they desire, by enabling different facilities to tailor their procedures to meet the needs of their particular residents.¹⁶² However, that flexibility is the result of what is often minimal government regulation, and that can have serious consequences for residents, including inadequate staffing and eviction, when a facility decides it can no longer care for a resident.¹⁶³ Home Health Care is an attractive option for those residents who wish to stay in the ALF rather than moving on to a nursing home. Allowing ALFs to become certified as Medicaid-eligible, such as in New York, also allows residents the choice to stay in their new home as long as they can medically, instead of as long as they can financially. Oregon's use of case managers and its commitment to placing seniors in the least restrictive environment that is practicable also has proved successful from both a financial and an individual standpoint.

The tension between the need for ALFs to maintain their signature flexibility and the need to ensure that appropriate care standards are met creates a significant challenge in drafting state laws regulating these popular entities. A national standard in ALF regulation is still premature—different states continue to create innovative solutions, and forcing states to adopt a single standard too soon may stifle new ideas. Setting a national standard for ALF regulation would also upset the existing Medicaid laws that leave setting eligibility requirements up to the states. As the population continues to age,

¹⁶² Carlson, *supra* note 16, at 12.

¹⁶³ *Id.*

however, the need for a system that is easier to compare both within a state and across state lines will become more and more urgent. States should begin the process now by improving their licensing requirements so that ALFs are not only safer for current residents, but also allow prospective residents to make informed choices.

