

**AMERICAN BAR ASSOCIATION**  
**COMMISSION ON LEGAL PROBLEMS OF THE ELDERLY**  
**COMMISSION ON MENTAL AND PHYSICAL DISABILITY LAW**  
**SENIOR LAWYERS DIVISION**  
**REPORT TO THE HOUSE OF DELEGATES**  
**RECOMMENDATION**

- 1 **RESOLVED**, that the American Bar Association supports uniform and comprehensive state and  
2 territorial standards, regulation, and oversight of facilities and programs, commonly referred to as  
3 “assisted living,” offering to persons in a residential setting some degree of supervision or assistance  
4 with personal services and health care, sufficient to:
- 5 (a) enable consumers to make informed choices about their care options;  
6 (b) provide residents’ rights and legal protections; and  
7 (c) ensure resident safety and appropriate, high quality care.
- 8 **FURTHER RESOLVED**, that the American Bar Association opposes state, territorial, or federal  
9 agencies granting “deemed status” (the recognition of private accreditation as meeting government  
10 regulatory standards) to assisted living programs or providers accredited by private organizations  
11 unless:
- 12 (a) state and territorial monitoring and enforcement functions are effectively integrated and  
13 strengthened under the deeming process;  
14 (b) results of the state and territorial monitoring and enforcement process are fully accessible to the  
15 public; and  
16 (c) the deeming process is closely monitored and evaluated.
- 17 **FURTHER RESOLVED**, that the American Bar Association supports initiatives to increase the  
18 availability of affordable assisted living options and access to those options by persons of low and  
19 moderate means.

## REPORT

### I. INTRODUCTION

Advertisements for assisted living facilities offer comfortable residences, social opportunities, freedom from housekeeping and health care worries, and the prospect of never having to move again. However, consumers seeking a residence to meet both their current and future needs face a daunting task. Those looking at programs in more than one state are likely to be even more confused. Unlike nursing homes, there are no federal regulations governing assisted living, no uniform standards, and no mechanism for ensuring resident safety and quality of care. Each state has its own definition of assisted living, its own guidelines for resident eligibility and for the services that can be offered, and its own system of regulating facilities. In most states, oversight of assisted living is minimal; in some states, it is non-existent.

Broadly defined, assisted living offers supervision, assistance with some activities of daily living and other personal services, and sometimes health care, in a residential setting, to persons who can no longer live independently. The following definition is one of the more comprehensive, although variations abound:

Assisted living is a residential setting that provides or coordinates flexible personal care services, 24-hour supervision and assistance (scheduled and unscheduled), activities, and health-related services; 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; has an organizational mission, service programs and a physical environment designed to maximize residents' dignity, privacy and independence; and encourages family and community involvement."<sup>1</sup>

The Assisted Living Federation of America (ALFA) estimates that approximately one million people live in an assisted living environment today (compared to an estimated 1.5 million who live in nursing homes).<sup>2</sup> The majority of these residents are female and very frail, with an average age of 84. Indeed, one in four assisted living residents requires the same level of assistance as the typical nursing home resident.<sup>3</sup> Consumer demand for assisted living is expected to continue, as the number of older Americans is projected to more than double by 2030, when people age 65 and older will make up 20% of the population.<sup>4</sup>

Assisted living providers may be individuals who were formerly in the board and care industry; entrepreneurs with real estate backgrounds but no health care expertise; owners of nursing

---

<sup>1</sup> Keren Brown Wilson, ASSISTED LIVING: RECONCEPTUALIZING REGULATION TO MEET CONSUMERS' NEEDS AND PREFERENCES 10 (AARP 1996).

<sup>2</sup> Assisted Living Federation of America, <http://www.alfa.org>.

<sup>3</sup> Catherine Hawes, A NATIONAL STUDY OF ASSISTED LIVING FOR THE FRAIL ELDERLY: RESULTS OF A NATIONAL SURVEY OF FACILITIES, DHHS/ASPE, 2000.

<sup>4</sup> U.S. ADMINISTRATION ON AGING, DHHS, A PROFILE OF OLDER AMERICANS: 2000, <http://www.aoa.gov>.

homes or hospitals adding assisted living within existing buildings or converting entire buildings; or former nursing home or other health care providers. They may be for-profit or not-for-profit. They may also be members of the 'hospitality' industry – the Hyatts and Marriotts. Assisted living facilities range in size from "mom-and-pop" homes with fewer than five residents, to apartment-style complexes housing several hundred persons. They may be freestanding, or one part of a continuing care retirement community.<sup>5</sup> Costs vary depending on size, location and services, as well as the particular facility's pricing plan. Such a plan may be all-inclusive, *a la carte*, or a combination of the two in which residents pay a basic monthly fee plus additional charges for other services. Some plans also require a substantial down payment. Most residents pay out of personal resources.

Assisted living first emerged in the late 1980s as a housing option for older people who were generally healthy and financially comfortable. At that time, it was virtually unregulated. Providers objected to regulation, contending that the market would direct what services were provided in assisted living, and the quality of those services. However, the industry burgeoned, resident needs changed, and the issues grew more complex. In recent years, states have responded to those changes and have taken steps to regulate these facilities. The problem is that state approaches differ considerably, and significant issues of uniformity, consistency, safety and quality of care remain. In 1999, the U.S. General Accounting Office studied 721 assisted living facilities in four states with very different systems (California, Florida, Ohio and Oregon). The GAO reported that in general, state regulation of assisted living focuses on three main areas: living accommodations, admission and retention criteria, and the types and levels of services that may be provided. Investigators observed that even within these three categories, states rarely address how services are to be provided, how quality is to be ensured, or what legal protections should be given to residents.<sup>6</sup>

## II. NEED FOR UNIFORM AND COMPREHENSIVE REGULATION

### **Lack of Uniform State Definitions**

For consumers, the inconsistency and confusion in assisted living begins with terminology. In developing regulations for assisted living, some states renamed as assisted living, such facilities as residential care, personal care, board and care, domiciliary care, sheltered housing, adult congregate living or rest homes. Some added assisted living to the existing scheme. Others developed new definitions and regulations for the emergent models, either to replace existing programs or as a separate program. There are currently more than two dozen designations for facilities that could be called assisted living, with more than one such designation in some states. In California, for example, these programs are known as residential care facilities; in New Mexico, they are called adult residential shelter care facilities. Michigan licenses homes for the aged and adult foster care. New York licenses assisted living programs, adult care facilities, adult homes, and enriched housing programs. This range of designations can be particularly confusing for people

---

<sup>5</sup> Continuing care retirement communities offer independent living, assisted living and skilled nursing home care on a single campus.

<sup>6</sup> U.S. GEN. ACCT. OFFICE, ASSISTED LIVING: QUALITY-OF-CARE AND CONSUMER PROTECTION ISSUES IN FOUR STATES, GAO/HEHS-99-27 (1999) [hereinafter GAO Report].

considering a move to an assisted living facility in a state other than where they currently reside, or for family members exploring assisted living options for an out-of-state parent.

To further complicate matters, some states permit certain categories of assisted living to operate unlicensed and without oversight. Kentucky's new assisted living regulations exempt facilities that existed when the new law took effect in July 2000. In Michigan and New York, some assisted living programs do not fit within the categories that are licensed and regulated, and are therefore not subject to state oversight. It is highly unlikely that the average consumer would understand these distinctions.

#### **Lack of Consumer Protection in Marketing and Contracts**

More confusion derives from the services that are offered, or that appear to be offered, and their costs. Sales pitches and marketing materials may lead consumers to believe that they can remain in a facility for the rest of their lives, glossing over the fact that either facility policy or state regulation may require discharge if the resident's needs exceed certain limits, or that the cost of services will increase far beyond the basic fees originally quoted. Marketing claims may conflict with the terms of the contract, or fall short of what is actually provided. No state statutory and regulatory schemes address marketing issues; none require use of a standard contract; and of those states that even require a written contract, few specify what disclosures that contract should make. Accordingly, assisted living contracts range from single, sparsely worded pages that commit a facility to providing nothing more than a roof over the resident's head, to multi-page documents packed with detailed, often confusing, and sometimes inconsistent information.

In a 1995 examination of 13 assisted living contracts, the ABA Commission on Legal Problems of the Elderly found vague language and stark omissions on issues as important as the kind, frequency, and cost of services offered by the facility, resident rights, and discharge policies and procedures.<sup>7</sup> The situation had changed little by 1999, when the GAO reported that contracts lacked essential information, were vague or even misleading, and were not routinely provided to prospective residents. The GAO findings were reinforced recently by the AARP Foundation, which compared marketing materials and admission contracts from 80 facilities. AARP discovered that significant discrepancies between marketing materials and contracts are common; that marketing materials frequently provide more information than contracts; and that many contracts include a caveat that the contract supercedes any other oral or written representations made to the consumer. The most frequent discrepancies between marketing and contracts involved supervision, nursing care, assistance with medication, and transportation. For example, marketing materials promised 24-hour nursing care, or assistance with taking medication three times a day, but the contract itself was vague, or even silent, on these issues.<sup>8</sup>

Unfortunately, consumers are likely to believe what they read in brochures and what they are told by sales representatives, whom they may mistakenly assume to be nurses or social workers.

<sup>7</sup> See, John Buck, *Assisted Living: An Uncharted Course*, BIFOCAL, Winter 1996, at 1.

<sup>8</sup> This information was gathered in preparation of the consumer education brochure, NAVIGATING YOUR WAY TO A QUALITY ASSISTED LIVING FACILITY, AARP, 601 E. Street, NW, Washington DC 20049 (D17037-1200).

It is not until later that consumers discover that the services they expected are unavailable, or that they are available but only for an additional fee. For example, a facility may offer “assistance with medication” which to a consumer is likely to mean hands-on help taking medicine in the doses prescribed (opening the container, removing the appropriate amount, and handing it to the resident to swallow), at the appropriate times. The facility, however, may be licensed only to give reminders, not to administer the medication.

#### Need for Recognition of Resident Rights and “Aging in Place”

In some respects, assisted living residents have fewer legal rights than nursing home residents or apartment dwellers. Some states, *e.g.*, Mississippi, provide no rights at all in the regulations, leaving this issue to the discretion of the facility. In other states, different rights attach in different programs, although consumers are unlikely to realize this distinction because the facilities appear so be so similar.<sup>9</sup> Even in states where residents do have legal rights and protections, inconsistency reigns. Some regulations give residents only a right to privacy. Others provide for specific protections, such as freedom from abuse and restraints, privacy, confidentiality, accommodation of individual needs. Still others establish a full set of rights more akin to those of a nursing home resident, plus a grievance procedure.

Almost all states require regulated facilities to provide residents with notice of a pending transfer or discharge, although that notice may be as little as 5-10 days. Some states have established, or require facilities to establish, guidelines and procedures by which residents can object to the action. Few states specify that the notice should contain the grounds for discharge, and not all states direct how notice is to be provided, or to whom.<sup>10</sup> There is also little uniformity in the degree to which residents may challenge a discharge. In at least two states (Massachusetts and Minnesota), assisted living discharges fall under landlord-tenant law. Some states require facilities to establish their own appeals mechanisms – which could result in nothing more than a meeting with the staff member or administrator who made the initial decision. Other states have established guidelines for internal procedures, and/or provided recourse to an outside agency (usually the agency that licenses the facility).

What about those advertisements that claim a facility will care for residents for the rest of their lives? Unfortunately, they are not always accurate, and they create more confusion. Although assisted living is frequently touted as enabling people to “age in place,” in reality many residents do not live out their lives in the facility of their choosing. They may need services beyond those the facility is licensed to provide, or they may not be able to meet the costs of their care. Sometimes, the resident’s own behavior might be the basis for discharge. The rate at which residents move out of

<sup>9</sup> *E.g.*, in Hawaii, residents of Adult Residential Care Homes (housing plus personal and health care services “to residents who do not need the professional health services [of] an intermediate, skilled nursing or acute care facility”) may be discharged with two weeks notice because “the operator wishes to ... discharge the resident.” Haw. Rev. Stat. Tit. 19, § 321-15.1, Haw. Admin. R., 11-100-19. This reason is not acceptable in Assisted Living facilities (housing plus “health care ... personalized support services ... health monitoring... and routine nursing tasks...”). Haw. Admin. R. 11-90-10(b). Consumers, however, might not realize the difference.

<sup>10</sup> Common grounds include nonpayment, resident behavior, and resident health needs. States that regulate the content of the discharge notice may require the reason for the action, effective date of the transfer or discharge, where the resident is to be moved, appeal rights, and a contact for the long-term care ombudsman.

assisted living, and the reasons for these moves, are difficult to determine. They vary significantly from one state to the next due to differences in state law, limits on allowable conditions or services, and facility choice of whom to serve, which services to provide, or which to make available through outside programs, *e.g.*, home health and other community-based care.

Some states prohibit facilities from providing certain services, but allow residents to obtain the same services from an outside agency. Mechanisms to ensure the quality of care for residents who remain in a facility under these circumstances vary from non-existent to relatively involved. In Maryland, for example, the licensing agency must approve retention of residents with needs higher than a facility's licensure would permit.<sup>11</sup> Michigan's homes for the aged may retain residents who need care beyond that which the facility is licensed to provide, if the resident, resident's family, physician, and facility agree, and the facility assures the state that the resident will receive the necessary services.<sup>12</sup>

#### Need for Comprehensive State Regulation

Unlike nursing homes, which must meet staffing standards and other strict regulations, and submit to regular inspections, there are no uniform standards or federal regulations to protect assisted living residents.<sup>13</sup> The industry has argued that resident autonomy and flexibility can be attained only if providers do not have to comply with the kind of extensive regulations governing nursing homes. Many providers contend that the contract, and the market, should direct what services are provided, and the quality of those services. Consumer advocates respond that providers have significantly greater bargaining power than elders made vulnerable by physical frailty, diminished mental capacity, or anxiety about an impending move to a new environment, or by families under pressure to find a quick placement for a parent. Moreover, they argue that the history of resident abuse and neglect in the board and care and nursing home industries lend strong support for government oversight of the services and care provided.

States have begun to examine issues of oversight and enforcement, but regulations vary tremendously in the frequency and content of inspections, and in mechanisms for enforcement. States are more likely to focus on required disclosures of information, *e.g.*, living arrangements, admission and retention criteria, scope of services, and facility design, than on the quality of services and care provided. They rarely prescribe staffing ratios or specific staff training. The result is that services and quality vary from one state to the next and even from one facility to the next.

Each of the four states investigated by the GAO in 1999 licensed some form of assisted living, and inspected or surveyed the licensed facilities. The licensing agency or other appropriate state program, such as adult protective services or the long-term care ombudsman program, also responded to complaints about potential violations or allegations of abuse or neglect. Even so, there

<sup>11</sup> Code Md. Reg. 10.07.14.10 (2000).

<sup>12</sup> MAC §333.21325 (Jan.9, 2001).

<sup>13</sup> Nursing homes provide residents with room, board, nursing services, and assistance with activities of daily living. Nursing homes participating in the Medicare or Medicaid programs must comply with the federal Nursing Home Reform Law, 42 U.S.C. §1395i-3 (Medicare certified facilities) and 42 U.S.C. §1396r (Medicaid certified facilities). For a discussion of nursing home law, see Eric Carlson, *LONG-TERM CARE ADVOCACY* (1999).

was great variation in the rate and content of inspections, and in tools for ensuring compliance with the regulations. Moreover, those states still experienced inadequate or insufficient resident care; insufficient, unqualified, and untrained staff; and inappropriate medication administration.<sup>14</sup>

In states where unlicensed facilities are permitted to operate, the issue is further complicated. Testifying before the U.S. Senate Special Committee on Aging, Sen. Hillary Clinton (D. NY) described how consumer misunderstanding can lead to disaster. In New York, unlicensed assisted living “look-alike” facilities contract with a licensed home care organization for provision of health services to residents. In this case, the resident’s daughter, unaware that she was dealing with two separate providers, gave instructions about her mother’s medication only to the assisted living program. The instructions were not followed, and the mother died.<sup>15</sup>

Other serious incidents have been reported recently in the national media.

- In New York, an 82-year-old assisted living resident died from congestive heart failure a few days after an inexperienced aide (the only staff member on duty despite promises of 24-hour care) walked him down a long hallway to a waiting ambulance.<sup>16</sup>
- Residents of a Minnesota assisted living facility resorted to calling 911 on behalf of residents who needed help the staff was not providing. When one resident was taken by ambulance to the emergency room, hospital workers telephoned the facility for her medical history, but no one answered. Police who went to the facility were met by the sole staff person on duty – a cook who barely spoke English and who had not been taught how to use the phone.<sup>17</sup>
- For the second time in a month, an 80-year-old man with Alzheimer’s Disease wandered out of an unlocked door in a North Carolina assisted living facility marketed as providing dementia care. By the time staff realized the man was gone, he had walked half a mile down a dark highway, been hit by a car, and died.<sup>18</sup>
- An 83-year old frail female resident of a Virginia assisted living facility died two days after being assaulted in a day room by a 55-year old male resident.<sup>19</sup>

Although these incidents may not be the norm, they cannot be ignored. While assisted living regulations may establish minimum guidelines and parameters within which facilities are to operate,

---

<sup>14</sup> See, GAO Report.

<sup>15</sup> Testimony of Hillary Rodham Clinton (D. NY) before U.S. Senate Special Committee on Aging, April 26, 2001.

<sup>16</sup> Jennifer Steinhauer, *As Assisted Living Centers Boom, Calls for Regulation Are Growing*, NEW YORK TIMES, Feb. 12, 2001, at A1.

<sup>17</sup> Amy Goldstein, *Assisted Living: Helping Hand May Not Be Enough*, WASH. POST, Feb. 18, 2001, at A1.

<sup>18</sup> *Id.*, at A1.

<sup>19</sup> Ian Shapira, *Fauquier Patient’s Death Ruled a Homicide*, WASH. POST, Mar. 28, 2001 at B1.

few states have mechanisms for monitoring quality, or holding assisted living providers accountable for poor care. Providers may appreciate a hands-off approach, but lack of oversight makes it more likely that they will not be held accountable for meeting resident expectations, or worse, that resident safety will be compromised by a failure to meet minimum care standards.

Unrestrained advertising hype, opaque – or missing – contracts, the lack of standards and oversight of assisted living leads to confusion for frail older consumers, their families, and those who seek to advise them, and may even put residents at risk of harm. For the reasons described above, there is a need for state standards, regulation, and oversight of assisted living facilities and programs that will allow consumers to make informed choices about their options, give residents legal rights and protections, and ensure that residents receive appropriate, high quality care.

### III. ACCREDITATION AND DEEMED STATUS

As an alternative to regulation, the assisted living industry encourages private accreditation as a tool for measuring quality. Two industry-sponsored groups are offering to accredit assisted living facilities, in much the same way that hospitals and nursing homes are accredited. The Assisted Living Federation of America and the American Association of Homes and Services for the Aging have designated the Rehabilitation Accreditation Commission (CARF) as the accrediting body for their member facilities. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has also entered the assisted living accreditation arena.

The JCAHO standards are organized around six functions on resident care (consumer protection, rights and ethics; continuity of services; assessment and reassessment; resident services; resident education; and health and wellness) and six on management (improving performance; managing the environment; leadership; managing human resources; managing information; and infection control). To earn and maintain JCAHO accreditation, a facility must have an on-site survey by Joint Commission surveyors at least every three years.<sup>20</sup> The CARF standards include: assisted living core values and mission; input from residents, families and other stakeholders; disclosure of information; outcomes management; individual-centered planning, design and delivery of services; and resident rights.<sup>21</sup> Neither the CARF nor the JCAHO criteria are specific. Rather than setting measurable requirements for key areas, they offer a more general objective, are designed for flexibility, and focus on quality improvement.

In some circumstances, when facilities meet private accreditation standards, they are considered to meet government licensure or regulatory requirements. This process is known as deeming.<sup>22</sup> Deeming, or deemed status, has existed since 1965 as an option for certifying hospitals for the Medicare program. In 1982, when the Health Care Financing Administration proposed to extend deemed status to nursing homes participating in the Medicare program, advocates for

<sup>20</sup> JCAHO website at <http://www.jcaho.org>.

<sup>21</sup> CARF website at <http://www.carf.org>.

<sup>22</sup> PRESIDENT'S ADVISORY COMMISSION ON CONSUMER PROTECTION AND QUALITY IN THE HEALTH CARE INDUSTRY, QUALITY FIRST: BETTER HEALTH CARE FOR ALL AMERICANS, 1998.

nursing home residents identified such significant problems that the proposal was withdrawn. Similar concerns arise in the assisted living context.

While accreditation is fine as an industry tool for quality improvement, it becomes problematic when states substitute what is essentially self-evaluation, for compliance with regulatory standards and state oversight. Moreover, the assisted living accreditation is performed by a private organization supported by facility fees; licensure is undertaken by a government agency not subject to outside influence. Accreditation visits are usually announced; licensing agency inspections are not. Accreditation is based on a set of private criteria developed by the industry without public input; licensure is based on regulations adopted by the state. Accreditation takes an educational and consultative approach; licensure aims to determine compliance with state regulation and to identify and remedy deficiencies. Accreditation criteria leave much to the subjective opinion of surveyors, offer little opportunity for facility comparisons by consumers and others, and detract from accountability. They should not substitute for uniform standards with measurable requirements to guide consumers and ensure high quality care, and they should not be the basis for granting of deemed status.

Industry standard setting and accreditation are certainly to be encouraged, but they are not adequate substitutes for public accountability, especially given the vulnerability of assisted living residents. Accordingly, accreditation and deemed status should not be a substitute for regulation by state or federal agencies, unless state monitoring and enforcement functions are effectively integrated and strengthened under the deeming process, results of the state monitoring and enforcement process are fully accessible to the public, and the deeming process is closely monitored and evaluated.

#### IV. NEED FOR AFFORDABLE OPTIONS

The cost of assisted living depends on the facility and the needs of the resident. Costs vary not only from one facility to the next, but from one resident to the next. Common fee arrangements include a substantial entrance deposit, or none at all, plus 1) a basic rate for room and board, with services available on an *à la carte* basis, or 2) a basic rate for room, board and a standard package of services, with other packages or additional services available at extra charge. In a 1993 AARP survey of 63 assisted living residences, only seven utilized a single rate within the same facility.<sup>23</sup>

The cost of assisted living ranges from approximately \$1,000 to more than \$4,000 per month.<sup>24</sup> Costs are generally paid out of personal resources by residents and their families, which places this option beyond the reach of many older Americans. For those without families to help, the situation is even more acute. The U.S. Bureau of the Census reports that in 1997, 84 percent of persons aged 75 and older had incomes less than \$25,000 per year, and 40 percent had incomes of less than \$10,000 per year.<sup>25</sup> There is no way that they will be able to afford assisted living without

<sup>23</sup> Rosalie A. Kane & Keren Brown Wilson, ASSISTED LIVING IN THE UNITED STATES: A NEW PARADIGM FOR RESIDENTIAL CARE FOR FRAIL OLDER PERSONS? 48 (1993).

<sup>24</sup> CRS REPORT FOR CONGRESS, ASSISTED LIVING: BACKGROUND AND ISSUES, April 6, 2001, at 3.

<sup>25</sup> See, NCB DEVELOPMENT CORPORATION: AFFORDABLE ASSISTED LIVING BACKGROUNDER, <http://ncbdc.org>, citing U.S. Bureau of the Census, <http://www.census.gov>.

some assistance. Unfortunately, some people find out after they have moved in, that they cannot afford the cost of the care they need, and they must leave. As many as two-thirds of current residents have incomes that are too low to cover the typical cost of a year's stay without using up their savings.<sup>26</sup>

For those who can afford the premiums, long-term care insurance may subsidize the cost, although coverage is limited and premiums are high unless the policy is purchased well in advance. Medicare does not pay for assisted living. It may, however, cover skilled nursing care or services provided to assisted living residents by licensed home health care agencies. Some residents receive financial assistance through state Medicaid waivers.<sup>27</sup> These Medicaid waivers are of limited value, however, as coverage is limited, facilities must agree to participate in the program, and residents must meet income and medical eligibility guidelines.

The U.S. Department of Housing and Urban Development offers some federal funding for the development of assisted living for low-income persons age 62 and older who need assistance with at least three activities of daily living, *e.g.*, eating, dressing, bathing.<sup>28</sup> Another source of assistance is the Supplemental Security Income state supplement for persons with mental or developmental disabilities.<sup>29</sup> States may also offer their own subsidies to individuals directly to pay for care. Some segments of the assisted living industry are exploring affordable options. One church-affiliated group is structuring fees so that the market rent covers an in-house subsidy for low-income residents. The Robert Wood Johnson Foundation and a non-profit lender have joined forces with some non-profit senior housing and service providers to develop affordable assisted living for very low-income (Medicaid eligible) persons in several states.<sup>30</sup>

Despite the significant growth of the assisted living industry, opportunities are limited for persons of modest means. The high cost of market-rate facilities forces many people who need long-term care to forgo services, to move away from their communities, to rely on family members, or to enter the more restrictive setting of a nursing home unnecessarily. Others are forced to leave their assisted living homes when they can no longer pay the cost of their care. Initiatives to increase the availability of affordable assisted living options and to support access to those options by persons of low and moderate means will help to alleviate this situation.

## V. EXISTING ASSOCIATION POLICY

---

<sup>26</sup> Amy Goldstein, *Assisted Living: Paying the Price*, WASH. POST, Feb. 20, 2001, at A1.

<sup>27</sup> At least 38 states cover some assisted living services through Medicaid waivers and/or other state-funded programs. See Mollica, STATE ASSISTED LIVING POLICY 2000, at <http://www.nahsp.org>.

<sup>28</sup> The HUD Assisted Living Conversion Program (ALCP) provides grants to convert Section 202, 202/8 and 202 Project Rental Assistance Contract projects to Assisted Living Facilities for the frail elderly. 42 U.S.C. 3545.

<sup>29</sup> See, Eric Carlson, LONG-TERM CARE ADVOCACY §5.05[2] (1999).

<sup>30</sup> See David Nolan & John Rimbach, *A Model of Affordable Assisted Living*, PROVIDER, Oct. 1997, at 73.

The American Bar Association has a long history of support for consumer protections and quality in health and long-term care.

In 1983, the Association went on record in support of effective enforcement mechanisms to ensure adequate quality of care in nursing homes participating in the Medicare and Medicaid programs, and expressed concern over proposals that included granting of deemed status to nursing homes.<sup>31</sup> In 1987, the House of Delegates supported federal and state legislative and regulatory standards to improve the quality of home care, including provisions to involve consumers directly in the evaluation and monitoring of home care, provide them with clear and consistent information about services, consumer rights, and simple and effective means of redress should problems arise. This resolution also included support for monitoring systems and enforcement mechanisms aimed at ensuring quality of care for older persons and persons with disabilities. It opposed the granting of "deemed status" under federal and state programs to home health providers who are accredited by private accrediting bodies unless certain conditions are met.<sup>32</sup> These conditions are included in the recommendation under consideration at this time.

In 1989, the Association expressed support for federal oversight and state legislation requiring licensure and regulation of board and care facilities for adults who need personal assistance, lodging and meals, consistent with eight specified principles, (state licensing, contractual protections and resident rights, regulation to prevent abuse and neglect, minimum standards to ensure resident safety and protection, enforcement to assure quality, development of a plan of care, sanctions against unlicensed homes, and living arrangements consistent with principles of least restrictive environment and treatment).<sup>33</sup> While this policy stills stands with regard to board and care homes, assisted living covers a wider range of facilities and provides a higher level of care than the institutions that were the subject of the 1989 policy.

Also in 1989, the Association recommended that federal and state legislation provide a coordinated and comprehensive system of care for Americans of all ages with long-term care needs, consistent with principles of equity and procedural fairness, and consumer choice with respect to the

<sup>31</sup> ABA Resolution No. 104 (February 1983). This resolution urged retention of effective enforcement mechanisms to ensure adequate quality of care in nursing homes participating in the Medicare and Medicaid programs, and expressed "concern over possible changes which may substantially weaken existing enforcement procedures and limit public access to the enforcement process." It responded to proposed regulations that would have allowed accreditation by the Joint Commission on Accreditation of Hospitals (JCAH, later to become JCAHO) to be sufficient to demonstrate compliance with Medicare/Medicaid standards. The accompanying report argued that deemed status would "place an accreditation body into an enforcement role which can only be properly carried out by the state survey agency and HHS." Report at 2.

<sup>32</sup> ABA Resolution No. 106 A (August 1987). The conditions are identical to those listed in the attached Recommendation. They would require that a) state monitoring and enforcement functions [be] effectively integrated and strengthened under the deeming process; b) results of the state monitoring and enforcement process [be] fully accessible to the public; and c) the deeming process [be] closely monitored and evaluated.

<sup>33</sup> ABA Resolution No. 121 (August 1989). The accompanying report describes board and care homes as including a "wide variety of nonmedical, community-based residential facilities." These homes are defined in the Older Americans Act as institutions regulated by the states pursuant to 42 U.S.C. 1382(e). While there is some overlap, board and care and assisted living are not always the same. For example, depending on the state, assisted living may provide medical care to residents.

nature and setting for delivery of care.<sup>34</sup> The Association supported universal access to quality health care that includes, among other characteristics, mechanisms for assuring the quality and appropriateness of care.<sup>35</sup>

The recommendation under consideration fits squarely within Goal III of the Association's Mission and goals – to provide ongoing leadership in improving the law to serve the changing needs of society. It builds upon the foundation created by existing policies, extending their principles to assisted living, the newest and fastest growing member of the continuum of long-term care. It would permit the Association to advocate for standards, regulation, licensure and oversight, to improve the current patchwork of laws affecting assisted living, to enable consumers to make informed choices, to protect the rights of residents, and to ensure that they receive appropriate, high quality care. It would also allow the Association to raise concerns about deemed status, and to promote affordable assisted living options for those for who cannot afford to pay the high costs of most facilities.

#### VI. CONCLUSION

The assisted living industry has received a great deal of negative publicity in recent months, which has led to increased activity at the federal and the state levels. At the federal level, Rep. Fortney Pete Stark (D. CA) has introduced H.J. Res. 13, calling for a White House Conference on Assisted Living. While there are several co-sponsors, as of this writing no action has been taken on the bill. At an April 26, 2001 hearing convened by the U.S. Senate Special Committee on Aging, several senators expressed concern about quality of care and a great deal of interest in working with consumer advocates and provider organizations to develop model standards that could be adopted by states.<sup>36</sup> Most of the activity has been at the state level, and states that were initially reluctant to regulate assisted living, are beginning to consider mechanisms for addressing quality of care and consumer protection. The Association's involvement would be particularly timely.

Respectfully submitted,

F. Wm. McCalpin  
Chair, Commission on Legal Problems of the Elderly

---

<sup>34</sup> ABA Resolution No. 106A (August 1989).

<sup>35</sup> ABA Resolution No. 105 (February 1994).

<sup>36</sup> See, U.S. Senate Special Committee on Aging, <http://www.senate.gov/~aging>

## GENERAL INFORMATION FORM

To Be Appended to Reports with Recommendations  
(Please refer to instructions for completing this form.)

**Submitting Entity:** Commission on Legal Problems of the Elderly

**Submitted By:** F. Wm. McCalpin

**1. Summary of Recommendation(s).**

Supports uniform and comprehensive state and territorial standards, regulation, and oversight of facilities and programs, commonly referred to as "assisted living," offering to persons in a residential setting some degree of supervision or assistance with personal services and health care, sufficient to enable consumers to make informed choices about their care options; provide resident rights and legal protections; and ensure resident safety and appropriate, high quality care.

Opposes state, territorial, or federal agencies granting "deemed status" (the recognition of private accreditation as meeting government regulatory standards) to assisted living programs or providers accredited by private organizations unless certain conditions are met.

Supports initiatives to increase the availability of affordable assisted living options and access to those options by persons of low and moderate means.

**2. Approval by Submitting Entity.**

Approved April 28, 2001, by the Commission on Legal Problems of the Elderly.

Co-sponsorship approved:  
Commission on Mental and Physical Disability Law (June 1, 2001)  
Senior Lawyers Division (June 6, 2001).

**3. Has this or a similar recommendation been submitted to the House or Board previously?**

No.

**4. What existing Association policies are relevant to this recommendation and how would they be affected by its adoption?**

Support for effective enforcement mechanisms to ensure adequate quality of care in nursing homes participating in the Medicare and Medicaid programs, and concern over proposals to grant deemed status to nursing homes (2/83).

Support for federal and state legislative and regulatory standards to improve the quality of home care, including involving consumers directly in evaluation and monitoring of home care, and providing them with clear and consistent information about services, consumer rights, and simple and effective means of redress (8/87).

Support for home care monitoring and enforcement mechanisms aimed at ensuring quality of care for older persons and persons with disabilities. Opposition to deemed status under federal and state programs to home health providers accredited by private accrediting bodies unless certain conditions are met (8/87).

Support for federal oversight and state legislation requiring licensure and regulation of board and care facilities for adults who need personal assistance, lodging and meals, consistent with eight specified principles (8/89).

Support for federal and state legislation providing a coordinated and comprehensive system of care for Americans of all ages with long-term care needs, consistent with principles of equity and procedural fairness, and consumer choice with respect to the nature and setting for delivery of care (8/89).

Support for universal access to quality health care that includes mechanisms for assuring the quality and appropriateness of care (2/94).

This recommendation builds upon existing policies, extending their principles to assisted living, the newest and fastest growing segment of long-term care.

**5. What urgency exists which requires action at this meeting of the House?**

The assisted living industry is burgeoning, media coverage of problems encountered by residents is mounting, state legislative activity is increasing, and federal interest is growing. Since June 1998, at least 44 states have revised or begun revising their regulations to address issues of assisted living. However, states differ in how they define and regulate assisted living, and the extent to which they monitor quality of care. The lack of consistency and oversight puts residents at risk. At an April 26, 2001 hearing convened by the U.S. Senate Special Committee on Aging, several senators expressed concern about quality of care in assisted living, and interest in working with consumer advocates and provider organizations to develop model standards that could be adopted by states.

**6. Status of Legislation. (If applicable.)**

At the federal level, Rep. Fortney Pete Stark (D. CA) has introduced H.J. Res. 13, calling for a White House Conference on Assisted Living. While there are several co-sponsors, as of this writing no action has been taken.

## 102

Almost all legislative and regulatory activity to date has been at the state level.

**7. Cost to the Association. (Both direct and indirect costs.)**

None

**8. Disclosure of Interest. (If applicable.)**

None

**9. Referrals.**

Commission on Homelessness and Poverty  
Commission on Mental and Physical Disability Law (co-sponsorship approved June 1, 2001)  
Commission on Women in the Profession  
Section of Real Property, Probate, and Trust Law  
Family Law Section  
General Practice, Solo and Small Firm Section  
Health Law Section  
Senior Lawyers Division (co-sponsorship approved June 6, 2001)  
Young Lawyers Division

**10. Contact Person. (Prior to the meeting.)**

Stephanie Edelstein, ABA Commission on Legal Problems of the Elderly, 740 15<sup>th</sup> Street NW,  
Washington DC 20005. Phone: 202/662-8694. Fax: 202/662-8698.  
E-Mail: [sedelstein@staff.abanet.org](mailto:sedelstein@staff.abanet.org)

**11. Contact Person. (Who will present the report to the House.)**

F. Wm. McCalpin, Chair, Commission on Legal Problems of the Elderly