THE ASCENDANCY OF ASSISTED LIVING: THE CASE FOR FEDERAL REGULATION

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The assisted living industry is rapidly expanding as an increasing number of seniors are seeking alternative long-term housing options. In this note, Mr. Bruce argues that the federal government has promulgated no regulations of the assisted living industry and that the patchwork of state regulations is too inconsistent to provide sufficient protection for the health and safety of elderly residents. He further argues that the federal government should provide uniform regulation of assisted living standards, including staffing levels, staff training requirements, the scope and quality of care facilities offer, and move-in and move-out requirements. Finally, he argues that a uniform set of federal regulations are in the best interest of assisted living residents and the assisted living industry.

I. Introduction

In 2000, a mere seven weeks after being admitted to Forest Hill Manor, an assisted living facility located in

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Virginia, emergency found Theresa Buford, clammy and unresponsive on a bare mattress.[1] Ms. Buford arrived at the hospital in a coma.[2] The doctors determined that she was suffering from hypothermia with a body temperature fifteen degrees below normal.[3] She died two weeks later, the official cause of death cited as complications from hypothermia.[4]

Forest Hill Manor had a history of providing negligent care to its residents.[5] Virginia state officials had issued numerous violation notices to Forest Hill Manor for inadequate staffing and heating problems.[6] Nevertheless, a state supervisor renewed the facility's license based solely on promises that the facility would correct all problems.[7]

In the immediate aftermath of Ms. Buford's death, Virginia revoked Forest Hill Manor's license, and the Buford family sued, alleging that the assisted living facility allowed Ms. Buford to freeze to death.[8] Attorneys for Forest Hill Manor suggested that the hypothermia resulted from Ms. Buford's health problems, but Robert Cosby, a nurse's aide at Forest Hill Manor, testified in a deposition that "it was so cold in the home that 'you're shivering . . . and you're losing feeling in your fingers.'"[9] Eventually, the facility settled out of court with the family for $345,000.[10]

Unfortunately, Ms. Buford's death is not an isolated incident. Inadequate care and oversight plague assisted living facilities throughout the United States.[11] This note proposes that the current assisted living regulatory scheme, implemented state-by-state, is inef-

1. David S. Fallis, *As Care Declines, Cost Can Be Injury, Death; Lapses by Home Operators, State Create Perilous Conditions*, WASH. POST, May 23, 2004, at A01.
2. *Id.*
3. *Id.*
4. *Id.*
5. *See* David Ress, *Appointee's Adult Homes Had Troubles; Doctor Named to Mental Health Board*, RICH. TIMES DISPATCH, Aug. 5, 1998, at A-1.
6. Fallis, *supra* note 1, at A01.
7. *Id.*
8. *Id.*
9. *Id.*
10. *Id.*
11. *See, e.g.*, Eden Laikin, *State Inspections; Condition Critical for Care Facilities; Inspections at 3 LI Assisted Living Centers Find Residents' Health Suffered from a Lack of Medical Monitoring*, NEWSDAY, Aug. 6, 2004, at A02 (describing an assisted living resident whose bedsore went untreated and burrowed down to the hip bone, and another resident who was suffering from diarrhea and given medication for diarrhea and constipation); Kevin McCoy, *Patchwork of Laws, Few Inspections Can Spell Trouble*, USA TODAY, May 25, 2004, at 11A (describing an assisted living resident who died with bruises running down his left side after being kicked by a caregiver for soiling his bed).

fective due to the piecemeal and varied state regulation. Consequently, federal regulation is necessary to ensure the safety of the rapidly growing assisted living population.

Part II of this note will briefly explore the history of long-term elder care in the United States, providing a background to the current popularity of assisted living compared to other elder care options. Part III will examine the varied state regulation of assisted living and the consequences wrought upon the assisted living population by generally inadequate state regulation. Finally, part IV will offer a solution to the problem of inconsistent regulation by proposing the implementation of a federally mandated baseline for assisted living regulation.

II. The History of Long-Term Elder Care in the United States

Care for the elderly is a dynamic and constantly evolving societal effort. The past two centuries have seen rapidly changing social, political, and economic hurdles challenging the manner in which the United States addresses elder care. This section will briefly examine the evolution of elder care through the past 200 years, focusing on the poorhouse, Social Security, nursing homes, and assisted living.[12]

A. The Poorhouse

In terms of life expectancy, early America was a young society.[13] Moreover, the social demographics of the typical American family ensured the availability of long-term care for the elderly by their children. Most married couples had "widely spaced offspring" where an "aging colonial couple might be both parents of infants and grandparents at the same time."[14] As a result, "the elderly of colonial America

12. By necessity, this section will provide a very basic background to a complicated historical subject. For anyone interested in the subject, Karen Stevenson's website, ElderWeb, available at http://www.elderweb.com, is a wonderful resource. She comprehensively examines the history of elder care in the United States with many links to primary source documents.

13. In 1800, the mean age at death for men and women was fifty-six. In 1850, the mean age at death was sixty-two for men and sixty-one for women. CAROLE HABER, BEYOND SIXTY-FIVE: THE DILEMMA OF OLD AGE IN AMERICA'S PAST 11 (1983).

14. *Id.* at 10.

rarely lived apart from their children."[15] Inevitably, a segment of the elderly population was childless and penniless, and such situated persons were forced to rely on the public welfare system as devised by the local authorities.[16] Originally, local churches and municipalities took on the burden of providing for those elderly persons who had no family.[17] However, in the early nineteenth century, local authorities began to rely almost exclusively on "indoor relief" for the indigent, including the elderly indigent.[18]

Indoor relief, or institutional care, was primarily provided through the poorhouse.[19] Rural poorhouses, often called poor farms due to their location on private farm land, were "managed by a single 'matron,'" the wife of the superintendent of the farm.[20] Urban poorhouses were much larger than their rural counterparts but had limited budgets, providing nothing that could be labeled "services" for residents.[21] Poorhouses sheltered a diverse cross section of society under one roof, becoming the location of last resort for mentally handicapped persons, orphans, the elderly, and even criminals.[22]

Throughout the nineteenth century, the percentage of elderly persons in the poorhouse population increased.[23] Unsurprisingly, the poorhouse was not considered an attractive option for living out one's life. A 1925 Department of Labor study reported that most poorhouses were distinguished by dilapidation, inadequacy, and inde-

15. *Id.* at 11.

16. Karen Stevenson, ElderWeb: LTC Backwards and Forwards, http://www.elderweb.com/history/?PageID=2806 (last visited Oct. 24, 2005).

17. OFFICE OF DISABILITY, AGING & LONG-TERM CARE POLICY, CARING FOR FRAIL ELDERLY PEOPLE: POLICIES IN EVOLUTION (1996).

18. *Id.*; HABER, *supra* note 13, at 24–25 (Some communities provided "outdoor relief," similar to a pension system whereby financial support was provided to elderly persons able to care for themselves for purposes of paying rent or heating their dwellings.); *see also* BRUCE C. VLADECK, UNLOVING CARE: THE NURSING HOME TRAGEDY 33 (1980).

19. OFFICE OF DISABILITY, AGING & LONG-TERM CARE POLICY, *supra* note 17.

20. VLADECK, *supra* note 18, at 33. "The rationale for country farms was rooted in the fallacious illusion that they could be self-supporting through the labor of their inmates, even though admission was generally reserved for those incapable of participating in the labor force." *Id.*

21. *Id.*

22. Stevenson, *supra* note 16.

23. HABER, *supra* note 13, at 83–84 (In 1904, 43% of the national poorhouse population was over the age of sixty; in Massachusetts, the percentage of elderly persons constituting the poorhouse population jumped from 26% in 1864 to 48% in 1904; in San Francisco the average age of the city's poorhouse population rose from 36 1/6 in 1870 to 59 1/8 in 1894.).

cency.[24] Poorhouse conditions were so notorious that nineteenth century popular culture began memorializing the indoor relief system.[25]

The gradual demise of the poorhouse system was spurred by pension supporters who argued "that it was unjust and inhumane to subject the elderly to poorhouse living."[26] Pension proponents were vindicated with the passage of the Social Security Act of 1935.

B. Social Security

The Great Depression, arguably the era that had the greatest influence on the emergence of the modern regulatory state, wiped out the wealth of most Americans, including the elderly.[27] The newly destitute elderly were unable to rely on their children, who had nothing to provide their parents.[28] Reflecting this rapid loss of wealth, in 1935, the Commission on Economic Security estimated that at least "one-half of the approximately 7,500,000 people over [sixty-five] years [of age] now living are dependent."[29]

This growing crisis led to the passage of the Social Security Act in 1935.[30] The modern view of Social Security focuses on the pool of money paid into the program by employees and employers, which provides a form of insurance for the elderly after retirement.[31] However, at the time of original passage, the primary focus was on Old Age Assistance (OAA), "a temporary transitional measure [designed] to meet the income needs of the elderly until the contributory, non-means-tested system of old age insurance . . . could be fully imple-

24. VLADECK, *supra* note 18, at 33.

25. JOHN N. CHADSEY, *Out from the Poorhouse* (Canaan: Chadsey & Smith, 1879) (The first verse lyrics: "Out from the Poorhouse—its oft dreaded door / Will cause me no pangs of the heart ev-er-more / It seems years have linger'd since I first became a poor wretched pauper, a-weary and lame / Oh! How my children have wrung my poor heart! / God knows I work'd hard to give them a start / But they drove me at last—when I would I'd ne'er been born—Off to the poorhouse, alone and forlorn.").

26. VLADECK, *supra* note 18, at 34.

27. Stevenson, *supra* note 16.

28. *See* SOC. SEC. ADMIN., COMM. ON ECON. SEC., REP. TO THE PRESIDENT OF THE COMM. ON ECON. SEC., *available at* http://www.ssa.gov/history/reports/ces/ces5.html (last visited Oct. 24, 2005) (as transmitted to the President in Jan. 1935) ("18,000,000 people, including children and aged, are dependent upon emergency relief for their subsistence and approximately 10,000,000 workers have no employment other than relief work. Many millions more have lost their entire savings, and there has occurred a very great decrease in earnings.").

29. *Id*.

30. VLADECK, *supra* note 18, at 35.

31. Stevenson, *supra* note 16.

mented."[32] OAA provided "cash payments to elderly poor people, regardless of their work record."[33] While there were few federal requirements to qualify for OAA, the most significant was a prohibition on such payments if the elderly person was living in a public institution.[34] Implicit in the restriction on providing funds for persons in public institutions was societal disfavor with public institutions.[35]

One consequence of the newly available government funding to the elderly was the emergence of proprietary convalescent homes. These homes were the precursors to nursing homes, as enterprising, cash-strapped home owners opened their residences to the elderly in exchange for money.[36] By the mid-1940s, "[p]rivate entrepreneurs were offering nursing and personal care services over and above what boarding homes had traditionally provided."[37] The driving force behind the rapidly developing nursing and personal care services was the Social Security Act, "which had injected a substantial new flow of income into the hands of older people and those who sold services to them."[38]

C. Nursing Homes

In 1950, Congress amended the Social Security Act by adding three provisions that directly affected nursing homes and provided the avenue for development over the next thirty-five years. First, Congress lifted the prohibition on governmental payments to residents of public institutions.[39] Second, Congress condoned federal matching of payments made by state and local welfare agencies to the suppliers of health services.[40] Third, Congress required that states

32. VLADECK, *supra* note 18, at 36.
33. Stevenson, *supra* note 16.
34. 42 U.S.C. § 306 (2000) ("[O]ld-age assistance means money payments to, or . . . medical care in behalf of or any type of remedial care recognized under State law in behalf of, needy individuals who are 65 years of age or older, but does not include any such payments to or care in behalf of any individual who is an inmate of a public institution . . . .").
35. VLADECK, *supra* note 18, at 36 ("[T]he [poorhouse] had no defenders.").
36. *Id.* at 37.
37. *Id.* at 39.
38. *Id.*
39. *Id.* at 40. "It was the clear hope of Congress that counties and municipalities would convert what remained of the almshouse/county hospital system into public facilities providing some level of health care along with custodial services." *Id.*
40. *Id.* at 40–41.

making payments to residents of public institutions establish regulations to license public nursing homes.[41] The government consequently became a primary buyer of nursing home care.[42]

The advent of Medicare and Medicaid provided a new wrinkle in the regulation of nursing homes. Long-term care providers that qualified and elected to use Medicare and Medicaid funds had to follow federally mandated guidelines.[43] However, there were very few nursing homes "that met the statutory requirements for extended care. . . . [M]ost of those originally brought into the Medicare program came in under the aegis of 'substantial compliance.'"[44] An Institute of Medicine study of nursing homes in the early 1980s resulted in the enactment of the federal Nursing Home Reform Law, which tightened federal standards by "requir[ing] that [each] facility provide each patient with care that will enable the patient 'to attain or maintain the highest practicable physical, mental and psychosocial well-being.'"[45] Nevertheless, many persons still look upon the nursing home industry with distrust, primarily because the nursing home trade associations have pressured Congress to insert significant loopholes into the enforcement procedures of the Nursing Home Reform Law.[46]

D. Assisted Living

The most recent innovation in long-term care, assisted living, is a consequence of the rapidly changing demographics of the United States and the general distrust of the nursing home industry. Greater

41. *Id.* at 41.
42. Stevenson, *supra* note 16.
43. Nursing Home Abuse Resource, History of Nursing Homes, http://www.nursing-home-abuse-resource.com/nursing_home_abuse/history.html (last visited Oct. 24, 2005).
44. VLADECK, *supra* note 18, at 54.
45. Nursing Home Abuse Resource, *supra* note 43.

> OBRA 87 requires that [Skilled Nursing Facilities] and [Intermediate Care Facilities] provide [twenty-four]-hour licensed practical nurse care seven days a week, and have at least one [registered nurse] on duty at least [eight] hours per day, seven days a week. Nurse's aides are required to undergo special training. OBRA 87 makes it the State's responsibility to establish, monitor and enforce state licensing and federal standards. States are required to maintain investigatory units and Ombudsman units, and to fund and staff them adequately.

Id.
46. Eric M. Carlson, *Siege Mentality: How the Defensive Attitude of the Long-Term Care Industry Is Perpetuating Poor Care and an Even Poorer Public Image*, 31 MCGEORGE L. REV. 749, 753–54 (2000).

mobility, a high divorce rate, a declining birth rate, and the advancement of women in the workplace have contributed to a severe decline in the number of family settings available to care for elderly relatives.[47] In addition, the aging of the baby boom generation has led to a rapid rise in the elderly population.[48] In 2000, there were thirty-five million Americans over the age of sixty-five,[49] and that number is expected to surpass seventy-five million by 2030.[50] Over the next two decades, experts anticipate the number of people needing long-term care to double to fourteen million.[51] Meeting the needs of this exploding population will continue to fall largely on the assisted living industry.[52]

Originally, the assisted living phenomenon was an unregulated market response to emerging demographic trends (namely, the aging population) and consumer demands.[53] In 2000, one-third of assisted living facilities had been in business for five years or less, and sixty percent had been in business for ten years or less.[54] In 1998, there were an estimated 11,500 assisted living facilities with just over 600,000 beds, as compared with an estimated 17,000 nursing homes with 1,600,000 beds in 1996.[55]

47. Michael A. Keslosky & Dr. Glenn L. Stevens, *The Assisted Living Industry: An Industry Overview and Performance of Public Firms* 4–5 (May 1, 1999), *available at* http://server1.fandm.edu/departments/BusinessAdministration/FinanceHome/StudentWork/Keslosky/Keslosky.html.

48. *Id*. "Baby boom generation" refers to the generation of Americans born shortly after the end of World War II. *Id.*

49. LISA METZEL & ANNETTA SMITH, THE 65 YEARS AND OVER POPULATION: 2000, CENSUS 2000 BRIEF 1 (2001), *available at* http://www.census.gov/prod/2001pubs/c2kbr01-10.pdf.

50. Keslosky & Stevens, *supra* note 47, at 4–5; Stephanie Edelstein, *Assisted Living: Recent Developments and Issues for Older Consumers*, 9 STAN. L. & POL'Y REV. 373, 374 (1998) (By the year 2030, the percentage of the population aged sixty-five and older is expected to be twenty percent.).

51. CATHERINE HAWES ET AL., U.S. DEP'T OF HEALTH & HUMAN SERVS., HIGH SERVICE OF HIGH PRIVACY ASSISTED LIVING FACILITIES, THEIR RESIDENTS AND STAFF: RESULTS FROM A NATIONAL SURVEY (Nov. 2000), *available at* http://aspe.os.dhhs.gov/daltcp/reports/hshp.htm#chap1.

52. *Id*.

53. *Id*.; Edelstein, *supra* note 50, at 374 (The primary consumer demands were a desire "for alternatives to the high cost and institutional setting of nursing homes, demands for more personal autonomy, the increase in the number of widows aged sixty-five to seventy-five seeking affordable residential programs, and the desire of older persons to age in place.").

54. HAWES ET AL., *supra* note 51.

55. *Id*.

Assisted living did not remain regulation-free for long, as states began promulgating rules for such facilities.[56] However, the assisted living definition and regulatory scheme varies from state to state.[57] Despite the varied definitions, common elements unite assisted living facilities and distinguish them from nursing homes. Assisted living facilities generally provide a residential setting, twenty-four-hour supervision, scheduled and unscheduled assistance, three meals a day, housekeeping, social activities, and assistance with eating, bathing, dressing, and walking.[58] The typical resident is a woman in her eighties with a range of ailments from incontinence to Alzheimer's disease.[59]

Assisted living facilities provide a level of care between independent living and nursing homes.[60] However, assisted living facilities are not designed for persons requiring twenty-four-hour skilled nursing care or constant medical monitoring.[61] Yet, the assisted living industry is providing medical services to an increasing number of rapidly aging elderly residents with physical ailments.[62]

A number of differences exist between nursing homes and assisted living facilities. The primary difference is that assisted living facilities are not federally regulated.[63] In contrast to assisted living facilities, nursing homes are subject to strict federal guidelines because they rely on Medicaid and Medicare funds.[64] A second major difference between assisted living facilities and nursing homes is their re-

56. *See, e.g.*, 55 PA. CODE §§ 2620.1–.83 (2005); 40 TEX. ADMIN. CODE §§ 92.2–.616 (2005); WASH. ADMIN. CODE 388-78A-2010 to -3230 (2005). The first regulations regarding assisted living were passed in Oregon in 1989, and by 1998, thirty states had passed legislation or issued regulations. HAWES ET AL., *supra* note 51.

57. *Compare* ALA. ADMIN. CODE r. 420-5-4-.01 (2005) ("'Assisted Living Facility' means . . . any other entity that provides or offers to provide residence and personal care to individuals who are in need of assistance with activities of daily living."), *with* LA. ADMIN. CODE tit. 48, § 8813 (1999) ("Assisted Living Home/Facility [is] an Adult Residential Care Home/Facility that provides room, board, and personal services, for compensation.").

58. *See* THE ASSISTED LIVING FEDERATION OF AMERICA, WHAT IS ASSISTED LIVING? (2004), http://www.alfa.org/public/articles/details.cfm?id=126.

59. *Id*.

60. GEN. ACCOUNTING OFFICE, ASSISTED LIVING: EXAMPLES OF STATE EFFORTS TO IMPROVE CONSUMER PROTECTIONS 2 (2004) [hereinafter GAO REPORT #1].

61. *Id*. at 5.

62. CTR. FOR MEDICARE ADVOCACY ET AL., POLICY PRINCIPLES FOR ASSISTED LIVING (Apr. 2003) [hereinafter MEDICARE ADVOCACY], *available at* http://medicareadvocacy.org/SNF_AsstLivingPolicyPaper.htm#paper.

63. *See* Michael J. Stoil, *Assisted Living: On the Slippery Slope to Regulation?*, NURSING HOMES LONG TERM CARE MGMT., June 2002, at 8.

64. *Id.*; *see also* 42 U.S.C. § 1395i-3 (2000 & Supp. II 2002).

spective costs. Assisted living facilities typically cost less than nursing homes.[65] However, the relative cost of assisted living is misleading because assisted living residents use private funds to pay for their expenses while eligible persons can use Medicaid to cover nursing home costs.[66]

The United States has come a long way since wealth and family were the sole support system for the elderly. However, the latest revolution, assisted living, raises many concerns, especially in light of the aging population. An examination of state regulation will provide a necessary background for determining if federal regulation would provide a safer, more efficient framework for assisted living facilities.

III. Analysis of State Regulation

The states purport to regulate an enormous amount of activity when it comes to assisted living facilities. This section will examine how the states regulate these facilities and will provide a guidepost for a more thorough examination of specific regulations regarding disclosure, scope of care, and staffing (training and quantity). In addition, this section will examine why states, even when these regulations are in place, seem unable to effectively monitor assisted living facilities.

A. State Regulation Schemes

The states' statutory schemes have much in common upon cursory examination. Most states regulate the following areas to varying degrees: disclosure items; facility scope of care; third-party scope of care; move-in and move-out requirements; medication management; physical facility requirements; number of residents allowed per room; bathroom requirements; staff and administrator training requirements; staffing levels; continuing education requirements; and Medicaid waiver policy.[67] A brief summary of each regulated area will illuminate the general statutory framework.

65. THOMAS D. BEGLEY, JR. ET AL., NAELA PUB. POLICY COMM'N, WHITE PAPER ON ASSISTED LIVING 3 (2001) (In 1998, the average per diem of an assisted living room was $71, compared with an average per diem of $111 for a nursing home room).

66. *Id*. (Medicaid waivers can be used in some instances for assisted living.).

67. NAT'L CENTER FOR ASSISTED LIVING, ASSISTED LIVING STATE REGULATORY REVIEW 2005 (2005) [hereinafter NCAL].

Regulation of disclosure items concerns what information a facility must provide to a prospective resident prior to executing a residence or service contract.[68] Consumers rely on the information that providers supply.[69] Because assisted living facilities are not subject to federal regulations, they have considerable flexibility in determining what services to provide.[70] For example, some facilities "would admit or retain a resident who has an ongoing need for nursing care while [others] would discharge a resident who developed that need."[71] As a result, consumers must rely on the facilities to provide the necessary information to make informed decisions on which assisted living facility can and will meet their individual needs.[72]

Scope of care regulations involve the personal, medical, and nursing services that individual facilities may provide.[73] Most state regulations allow assisted living facilities to adopt scope of care levels on a continuum from minimal (providing meals and limited supervision) to comprehensive (e.g., caring for residents suffering from dementia).[74] Currently, three regulatory models dominate state regulation with regard to scope of care.[75] Under the first model, coined "board and care," facilities generally refuse residents who are eligible for nursing homes and provide minimal assistance with activities and medications.[76] The second model requires the state to license facilities and services that meet defined requirements in their laws and regulations.[77] The third model requires the state to license the provider of the services, whether that is the facility or an outside service provider.[78]

Move-in and move-out requirements are closely tied to the scope of care allowed with respect to the administration of medication. These regulations control certain situations, such as lack of money or

68. *Id*.
69. GEN. ACCOUNTING OFFICE, ASSISTED LIVING: QUALITY-OF-CARE AND CONSUMER PROTECTION ISSUES IN FOUR STATES 13 (1999) [hereinafter GAO REPORT #2].
70. *Id*.
71. *Id*. at 3.
72. *Id*. at 13.
73. NCAL, *supra* note 67, at 5.
74. *See generally* MEDICARE ADVOCACY, *supra* note 62.
75. BEGLEY ET AL., *supra* note 65, at 8–9.
76. *Id*. at 9.
77. *Id*.
78. *Id*. Within this model of regulation, a state may create different levels of care for assisted living facilities, and as a result, most states follow this model as it provides increased flexibility. *Id*.

deterioration of health, that require an assisted living facility to reject a prospective resident or force a current resident to move out.[79]

Medication management addresses the proper administration of medication within assisted living facilities.[80] State regulation controls who can administer medicine and the extent to which assistance is permitted.[81] In many states, staff can help a resident self-administer medicine, but only registered nurses can actually administer medicine.[82]

Physical facility regulations govern the various infrastructure requirements for assisted living facilities. A small sample of regulated physical characteristics include the maximum number of residents per room, the number of bathrooms per resident, and the overall square footage requirement for facilities.[83]

Staffing requirement regulations cover a number of different items, including: the number of staff members required to be in assisted living facilities at all times; the minimum staff member qualifications; the minimum administrator qualifications; and annual continuing education requirements for all staff members.[84]

Another vitally important regulated area is whether states allow assisted living facilities to obtain waivers to receive Medicaid funds for their residents.[85] Such waivers allow lower-income persons to use assisted living facilities and explicitly invite more federal involvement in assisted living.

The above-mentioned categories are the primary areas that states regulate when licensing assisted living facilities. In an effort to determine if those regulations are both stringent enough and effective, the next few sections will closely examine state regulatory schemes for disclosure, scope of care, and staff requirements.

1. DISCLOSURE REGULATIONS

The varying approaches that states take to regulate assisted living creates a disclosure problem. Specifically, the scattered regulations raise the possibility that future residents will not be aware of

79. *See generally* NCAL, *supra* note 67.
80. *See generally id*.
81. *See generally id*.
82. *See, e.g.*, *id*. at 2, 6, 9, 13.
83. *See generally id.*
84. *See generally id.*
85. *See generally id.*

what level of care they will receive or the qualifications of those who will care for them.

In 2004, the General Accounting Office (GAO) released a report indicating that consumers had problems choosing assisted living facilities because providers gave prospective residents vague, incomplete, and misleading information.[86] When making important selection decisions, consumers primarily rely on the marketing materials (e.g., brochures and tours) of the individual facility.[87] Nevertheless, "key information, such as a description of services not covered or available at the facility, the staff's qualifications and training, circumstances under which costs might change, assistance that residents would receive with medication administration, facility practices in assessing needs, or criteria for discharging residents if their health changes" often go unreported to consumers.[88] A report commissioned by the American Bar Association expressed additional nondisclosure concerns such as, "the kind, frequency, and cost of services offered by the facility, resident rights, and discharge policies and procedures."[89] The American Association of Retired Persons (AARP) also discovered significant discrepancies between assisted living facility marketing materials and the contracts actually signed by prospective residents.[90] The vague nature of assisted living marketing can perhaps be attributed to marketing strategies that focus on making the sale rather than "helping consumers make informed decisions."[91]

Nonetheless, many states do not require any disclosure,[92] including many of the most populous states.[93] However, a number of states, such as Idaho, do regulate disclosure.[94] Specifically, Idaho regulates

86. *See* GAO REPORT #1, *supra* note 60, at 7.
87. *Id*.
88. *Id*. at 8.
89. BEGLEY ET AL., *supra* note 65, at 15 (examining thirteen assisted living contracts); Edelstein, *supra* note 50, at 375 (Of even greater concern are the marketing techniques promoted in assisted living provider literature, some suggesting avoiding set rules and creating a sense of urgency when attempting to make a sale to a prospective customer.).
90. BEGLEY ET AL., *supra* note 65, at 15 (Marketing materials frequently provide more information than the contracts, and the contracts often contain a clause indicating that the contract supersedes any verbal representations made to the consumer.).
91. Edelstein, *supra* note 50, at 375.
92. *See generally* NCAL, *supra* note 67.
93. California, Florida, Ohio, and Virginia do not require any disclosure items from assisted living facilities. *Id*. at 12, 26, 104, 144.
94. *Id*. at 32.

admission policies, requiring assisted living facilities to "develop and follow a written admission policy . . . [to be] shown to any potential resident, his legal guardian/conservator, or both."[95] The written admission policy must disclose the purpose, quantity, and characteristics of service.[96] Prior to admission, the facility and prospective resident must review and understand the proposed fee schedule.[97] In addition, Idaho lists a number of conditions that prohibit admission to assisted living facilities.[98]

Lack of disclosure can have severe consequences for consumers.[99] Assisted living facilities often "promise more than they deliver as part of their basic fees, while others use contracts that obscure the true cost of care."[100] Critics charge that financial difficulties "are the product of an industry in which prices are unregulated and key players are eager for rapid profits."[101] Even assisted living industry advocates, who are generally zealous in efforts to avoid federal regulation, admit that disclosure problems plague the industry.[102]

2. SCOPE OF CARE

A second pitfall for many state statutory schemes concerns the ambiguity of scope of care regulations. Oregon passed the first state regulation concerning the licensing of an assisted living facility in 1989.[103] In the ensuing rush among the states to license and regulate assisted living, states began to allow facilities to house residents who

95. IDAHO ADMIN. CODE r. 16.03.22.422.01 (2005).
96. *Id*.
97. *Id.* at r. 16.03.22.422.02.
98. *Id*. at r. 16.03.22.422.07 (including, but not limited to, residents requiring skilled nursing care on a twenty-four-hour basis and residents whose physical, social, or emotional needs are not compatible with the current residents).
99. *See* Amy Goldstein, *Assisted Living: Paying the Price; Extra Fees Drive Up the Cost and Drive Away Some Patients*, WASH. POST, Feb. 20, 2001, at A01 (For example, when Keith Stauffer admitted his mother into an assisted living community in Virginia, the facility's marketing director assured him that when his mother's money ran out, there would be no problems. Four years later, Ms. Stauffer's bank account was drained, and her son had $20,000 in unpaid bills.).
100. *Id*.
101. *Id*.
102. *Assisted Living Reexamined: Developing Policy and Practices to Ensure Quality Care: Hearing Before the Senate Special Comm. on Aging*, 107th Cong. 4–5 (2002) [hereinafter *2002 Hearing*] (statement of Larry Minnix, Chief Executive Officer of American Association of Homes and Services for the Aging).
103. HAWES ET AL., *supra* note 51.

needed more intensive assistance.[104] The licensure system applied a "one-size-fits-all" approach to assisted living facilities, essentially reducing standards to the lowest common denominator and allowing individual facilities to provide higher levels of care based on individual contracts.[105]

Currently, every state has a level of licensure model, whereby states establish one, two, or three levels, with each level having a certain set of requirements.[106] The general dividing line between the licensure levels is the amount of medical care a facility will provide.[107] For example, Maryland has a three-level system (low, moderate, and high), and the levels are defined by varying service requirements pertaining to health and wellness, medication assistance, and social and recreational concerns.[108] Maryland requires strict separation between its three tiers, and, thus, if a facility resident develops the need for a higher level of care, then the facility must seek a resident-specific waiver within thirty days if the facility wishes to continue caring for the resident.[109]

Other states, such as Illinois, have a two-tiered licensure system. Illinois' two levels of licensing are classified as assisted living and shared housing.[110] The separate classification is misleading, however, as the only tangible difference between the two is how many people can be cared for in each facility.[111] There is a stark contrast, however, between Illinois' purported two-level system and Arkansas' two-level system.[112] In Arkansas, Level I facilities must provide twenty-four-

104. *See id*. (By the mid-90s, most state licensing agencies allowed facilities to admit chair-ridden residents or wheelchair bound residents, one-third of state agencies allowed facilities to retain bed-ridden residents, and some states opened up assisted living to skilled nursing care for residents with severe impairments.).

105. MEDICARE ADVOCACY, *supra* note 62.

106. *Id*.

107. *See id*.

108. MD. CODE REGS. 10.07.14.04 (2006).

109. *Id*.

110. NCAL, *supra* note 67, at 35.

111. *Id*. (The NCAL defines the two as follows: Assisted Living—"provides community-based residential care for at least three unrelated adults . . . who need assistance with activities of daily living (ADLs), including personal, supportive, and intermittent health-related services available [twenty-four] hours per day, if needed to meet the scheduled and unscheduled needs of a resident." Shared Housing—"provides community based residential care for [twelve] or fewer unrelated adults . . . who need assistance with housing, ADLs, and personal, supportive, and intermittent health-related services. This care must be available [twenty-four] hours per day, if needed, to meet the scheduled and unscheduled needs of a resident.").

112. *Id*. at 8.

hour staff supervision, assistance with social and recreational activities, and limited medication assistance.[113] By contrast, Level II facilities may directly assist residents with medication if administered by licensed nursing personnel and must assist residents with activities of daily living.[114]

Most states have one level of licensure or a misleading two-level system similar to Illinois. Oregon's regulations provide a prime example of the one-level system. Oregon's system of licensure can be summarized as follows: "Facilities may care for individuals with all levels of care needs."[115] Oregon allows residents to remain in a facility as their health declines, provided the facility can meet the resident's needs.[116] California's regulations provide a further example of the slippery nature of scope of care regulations. These regulations list specific services that assisted living staff may not perform. Specific contractual clauses, however, may supersede the regulatory prohibition.[117] Such situations appear ripe for exploitation. The contractual agreement can set up a negotiated-risk system whereby the contract will release the facility from liability for certain actions in return for allowing a resident to remain in a facility with a condition that would otherwise be barred.[118] The result is a wildly variable scope of care standard within individual facilities, exposing residents to dangers, including substandard care.

3. STAFFING

A joke among assisted living industry experts highlights this third requirement: Why are you in better hands with a Maryland manicurist than a Maryland assisted living employee? The answer—because in Maryland, you need 300 hours of training to be a manicurist and only three hours of training to work in an assisted living facility.[119] The most critical safeguards to quality assisted living care are staffing and training requirements. All states require staff to be present on-site twenty-four hours a day, although some smaller facilities

113. *Id*.
114. *Id*.
115. *Id*. at 111.
116. GAO REPORT #2, *supra* note 69, at 19.
117. *Id*. at 19–20.
118. BEGLEY ET AL., *supra* note 65, at 7.
119. McCoy, *supra* note 11, at 11A.

do not require staff to always be awake.[120] In addition, all states have training requirements for their assisted living staff and administrators, though the requirements vary from state to state. Nevertheless, many staff training and staffing level requirements are wholly inadequate.

a. Staff Training States use one of three training methods: hourly, topical, or programmatic.[121] As a general rule, relatively little training is required.[122] Hourly training requirements can range from seven hours[123] to forty hours total.[124] Topical training programs provide specific instruction in various areas, such as first-aid, emergency evacuation plans, and procedures for detecting elder abuse.[125] The third method of training, programmatic, is very similar to the topical training method because it requires staff to participate in an orientation session.[126] Preservice topical training and on-the-job training comprise programmatic training, focusing on the specific area in which the employee will have responsibilities.[127] However, as a whole, only eleven percent of incoming staff members complete their training before beginning work.[128]

Perhaps the most remarkable aspect of the training requirements is the age minimums promulgated by many states. For example, in

120. GAO REPORT #2, *supra* note 69, at 10 n.12.

121. *See* Robert Mollica, STATE ASSISTED LIVING POLICY: 2002, at 145 (Portland, Maine: National Academy for State Health Policy, Nov. 2002).

122. HAWES ET AL., *supra* note 51.

123. 651 MASS. CODE REGS. 12.07 (2004) ("Prior to active employment, all staff and contracted providers . . . must receive a seven-hour orientation which includes the following topics: (a) Philosophy of independent living in an Assisted Living Residence; . . . (d) Safety and Emergency Measures; . . . (k) General overview of the job's specific requirements.").

124. Mollica, *supra* note 121, at 145.

125. *See* 2620 PA. CODE § 73 (2004) ("Staff persons and volunteers used as staff persons shall receive orientation to the general operation of the home and training in fire prevention, operation of safety equipment, emergency planning and evacuation procedures within [thirty] days of employment or volunteer services."); 6 PA. CODE § 11.33(a) ("Providers shall . . . provide program staff persons with the following: (1) A general orientation in the following areas: . . . (iv) Health and safety precautions, including infection control . . . (v) information on fire and safety measures/codes . . . (xi) The center's policies and regulations . . . [and] (xii) The center's emergency procedures."); 22 VA. ADMIN. CODE § 40-71-80 (2004) ("All personnel shall be trained in the relevant laws, regulations, and the facility's policies and procedures sufficiently").

126. N.M. CODE R. § 7.8.2.17 (Weil 2004) ("Staff training, appropriate to staff responsibilities, including at a minimum, an orientation . . . .").

127. HAWES ET AL., *supra* note 51.

128. *Id*.

Pennsylvania, a sixteen-year-old teenager can directly care for assisted living residents.[129] In many states, staff must be eighteen years old to provide direct care for residents.[130] Even more remarkably, administrators need only be twenty-one years old in almost every state, and some jurisdictions do not even require a college degree to run an assisted living facility.[131]

A 1999 GAO Report to Congress discovered that one-fourth of the studied assisted living facilities were cited for consumer protection or quality of care deficiencies or violations in 1996 and 1997.[132] One of the most frequently cited problems was "insufficient, unqualified, and untrained staff."[133]

In testimony before Congress, Ms. Emilia-Louise Kilby, an assisted living resident, raised numerous concerns about the training and quality of staff at her assisted living facility.[134] Her concerns ranged from the staff not providing residents with enough water to swallow their pills to the inability of the staff to recognize the health deterioration of its residents.[135] Moreover, Karen Love, the Executive Director of the Consumer Consortium on Assisted Living, also testified that "the [assisted living] industry ha[d] allowed an unacceptable margin of error for itself" with regard to staff training and levels.[136]

129. *See* 55 PA. CODE § 2600.54 (2005) (A sixteen-year-old staff member is not allowed to perform tasks related to mediation administration.).

130. *See* NCAL, *supra* note 67, at 5, 7, 22, 70, 85, 87, 91, 132, 135, 138, 142, 163 (naming Alaska, Arizona, Delaware, Mississippi, Nevada, New Hampshire, New Mexico, Tennessee, Texas, Utah, Vermont, and Wisconsin).

131. *See* 651 MASS. CODE REGS. 12.06 (2005) ("The Manager of an Assisted Living Residence shall be at least [twenty-one] years of age and . . . must have a Bachelors degree or equivalent experience in human services management, housing management and/or nursing home management.").

132. GAO REPORT #2, *supra* note 69, at 4.

133. *Id*. at 4, 5. In one egregious example highlighting the problem associated with lack of training, Grover McCurdy, who suffered from dementia, was admitted by his family into a Florida assisted living facility. One night he began choking after dinner, and the residents called for Michelle Cuevas, the lone caregiver on duty. She attempted to help Mr. McCurdy by calling his name and lifting his arms, but in the end, her efforts failed. After his death, the state investigated and determined that Cuevas did not have the required first aid or CPR training, nor did six of the facility's other eight staff members. Julie Appleby & Kevin McCoy, *Problems with Staffing, Training Can Cost Lives*, USA TODAY, May 26, 2004, at 1B.

134. *See Assisted Living in the 21st Century: Examining Its Role in the Continuum of Care: Hearing Before the Senate Special Comm. on Aging*, 107th Cong. 14–20 (2001) [hereinafter *2001 Hearing*] (statement of Emilia-Louise Kilby, assisted living resident).

135. *Id*. at 14.

136. *Id*. at 33 (statement of Karen Love).

b. Staff Levels A recent investigation conducted between 2000 and 2002 found persistent problems with staffing levels at assisted living facilities. This investigation revealed that one in five facilities inspected by regulators had "at least one staffing violation, ranging from too few employees on a work shift to lack of a certified facility manager."[137] Actual staffing violations are likely to be even higher, but violations often go unreported by the involved facility and undetected by the state regulators.[138] Staffing shortages can be attributed to a number of causes, such as an extremely high turnover rate (forty percent) and salaries that are rarely over the minimum wage.[139] Some states, such as Oregon, do not even have specific staffing level requirements.[140] When there are not enough adequately trained staff members, serious problems develop.[141]

The story of Ruth Cecil illustrates the dangers of inadequate staffing. Ms. Cecil suffered from Alzheimer's disease, but was nevertheless admitted into an Arizona assisted living facility that catered to persons requiring minimal attention.[142] One afternoon, Ms. Cecil wandered into the 100-degree heat and fell in the outdoor exercise courtyard.[143] At the time, all but one of the staff members was in a meeting,[144] and the sole staff member on duty had been hired two days prior to the incident.[145] The on-duty staff member had not been told to keep the gate to the exercise courtyard locked.[146] Ms. Cecil was found forty minutes later, with a body temperature of 108 degrees, her skin burned and already beginning to peel.[147] She died at the hospital.[148] State regulators imposed a $3,000 fine on the facility for inadequate staff levels.[149] Arguably, this fine is the best evidence that state

137. Appleby & McCoy, *supra* note 133, at 1B.
138. *Id*.
139. *Id*.
140. GAO REPORT #2, *supra* note 69, at 20 (indicating that other states, such as California and Ohio, have similarly vague guidelines that require staffing to be sufficient to meet the needs of the residents).
141. *Id*. at 24.
142. Appleby & McCoy, *supra* note 133, at 1B.
143. *Id*.
144. *Id*.
145. *Id*.
146. *Id*. The exercise courtyard had been the subject of a complaint because it was not visible to staffers inside the facility. The complaint was dismissed by Arizona regulators. *Id*.
147. *Id*.
148. *Id*.
149. *Id*.

regulation is failing. If the death of a resident, due to an easily correctable staffing level mistake, only brings what amounts to a slap on the wrist, then the industry is not adequately regulated.

Despite the staff training and staffing level regulatory requirements, many assisted living facilities do not provide adequate levels of competent care. Whether this failure can be attributed to low wages, massive turnover, or ignorance, the state regulatory scheme is clearly having problems within this area of assisted living regulation.

B. State Monitoring

The above exploration of state regulation provides a broad overview of what the states purport to regulate. It is equally important to examine a state's ability to conduct effective oversight of the assisted living industry in enforcing its regulations.

The rapidly expanding assisted living industry creates a problem for state regulatory oversight because most states lack sufficient resources.[150] The most common methods of oversight are periodic licensing inspections and complaint investigations.[151] Licensing inspections consist of "meeting with the facility's administrator, touring the facility, reviewing facility and resident records, and interviewing residents and staff."[152] Complaint investigations generally involve resident and staff interviews and an examination of facility records.[153] If inspectors discover a deficiency, then the facility might be sanctioned in a number of different ways, including written plans of correction, reinspection, monetary fines, license revocation, criminal sanctions, or admission restrictions.[154]

In addition to investigation by the state licensing agencies, state ombudsmen also play a role in monitoring assisted living facilities.[155] Ombudsmen are assigned to facilities, and through residents, family members, staff, or their own observation, they too can initiate a com-

150. GAO REPORT #1, *supra* note 60, at 15.
151. GAO REPORT #2, *supra* note 69, at 3.
152. *Id*. at 21.
153. *Id*.
154. *Id*. at 22.
155. *Id*. State ombudsmen are advocates for long-term care residents, and receive and attempt to resolve individual complaints and pursue resident advocacy via laws, regulations, and administration. CAL. DEP'T OF AGING, LONG-TERM CARE OMBUDSMAN PROGRAM (2005), http://www.aging.state.ca.us/html/programs/ombudsman.html.

plaint.[156] The complaint will name the facility and identify the problem.[157] Following an investigation, the ombudsman can attempt to either resolve the issue with appropriate staff members or refer the facility to the state licensing agency.[158] In Florida, for example, ombudsmen inspect facilities annually in an attempt to have consistent evaluations regarding residents' quality of care and quality of life.[159] Upon completion, the ombudsman discusses his or her findings with the facility administrator and "negotiate[s] a resolution" to any identified problems.[160] Unresolved problems are reported to the state licensing agency.[161]

Required periodic inspections vary greatly between the states, from California's purported annual inspection to Oregon's biannual inspection.[162] Although state regulatory agencies' best intentions are to inspect assisted living facilities and ensure compliance, the reality is much different.

Even when facilities are inspected annually, regulators generally oppose shutting down assisted living facilities except in the most severe of circumstances.[163] Not only do states avoid shutting down facilities, but also many states are currently cutting back on oversight because of budget crises. In July 2003, for example, California dropped its pretense of annual inspections, and switched to on-site inspections for twenty percent of its facilities per year.[164] Similarly, in 2002, Illinois budgeted $700,000 for the oversight of its assisted living facilities, but less than a year later, it cut funding to $230,000.[165] Rick Harris, Director of the Bureau of Health Provider Standards in Alabama, testified before Congress that state regulators "do not have enough resources" to monitor assisted living facilities adequately.[166] In Alabama, state regulators spend $5.5 million inspecting 244 nursing

156. GAO REPORT #2, *supra* note 69, at 22.
157. *Id*.
158. *Id*.
159. *Id.* at 23.
160. *Id*.
161. *Id*.
162. *Id*. at 4.
163. McCoy, *supra* note 11, at 11A.
164. *Id*. California's switch to annual inspections of only twenty percent of its assisted living facilities means that institutions will go five years without a single on-site inspection. *Id*.
165. *Id*.
166. *2002 Hearing*, *supra* note 102, at 22 (statement of Rick Harris, Director, Bureau of Health Provider Standards, Alabama Department of Public Health).

homes, compared with $500,000 spent inspecting 330 assisted living facilities.[167] The foregoing examples vividly illustrate the woefully inadequate resources that states have to monitor the assisted living industry.

Comparing assisted living oversight with nursing home oversight helps illuminate assisted living's oversight deficiencies. Federal protocol for nursing homes requires unannounced annual inspections conducted by multidisciplinary teams. In 2000–2001, for example, Wisconsin nursing homes were visited an average of 4.4 times.[168] State inspections of assisted living facilities, on the other hand, generally involve one inspector, and nearly half of the assisted living facilities in Wisconsin did not receive a single visit in the same period that nursing homes were visited an average of 4.4 times.[169]

State oversight of the assisted living industry is spotty at best. Yet, even if state oversight does catch an assisted living facility violating regulations, the sanctions levied are essentially nonexistent. In Virginia, for example, the maximum fine for violating state standards is $500—hardly a deterrent.[170] In fact, some states are completely unwilling to use the most drastic sanctions.[171] Likely, the states will become even less capable of monitoring assisted living in the coming years as the elderly population continues to increase.

IV. Recommendation

The state regulatory scheme governing assisted living is chaotic, disorderly, and largely ineffective. Thus, the question remains, what can be done to ensure the safety of the elderly and to curb the abuses that occur under the current statutory scheme? Federal regulation, although not a cure-all, is the answer if implemented in a smart, well-defined manner.

167. *Id*.

168. CTR. FOR MEDICARE ADVOCACY, ENFORCEMENT IN THE ASSISTED LIVING INDUSTRY: DISPELLING THE INDUSTRY'S MYTHS [hereinafter MEDICARE ADVOCACY REPORT #2], *available at* http://medicareadvocacy.org/SNF_AsstLiv_Enforcement.htm.

169. *Id*.

170. Fallis, *supra* note 1, at A01.

171. GAO REPORT #2, *supra* note 69, at 22. A Florida facility with repeated severe deficiencies in medication or dietary services would be required to add a consultant pharmacist or dietician until the problem is corrected. *Id*.

A. Federal Regulation of Assisted Living Facilities and the Commerce Clause's Reach

The U.S. Congress has legislative authority under the Commerce Clause of the U.S. Constitution.[172] In using the Commerce Clause power, the U.S. Supreme Court has identified three categories of activity that Congress may regulate:[173] (1) Congress may regulate the use of the channels of interstate commerce;[174] (2) Congress may regulate the instrumentalities of interstate commerce, or persons or things in interstate commerce, even if the perceived threat comes only from intrastate activities;[175] and (3) Congress may regulate those activities having a substantial relation to interstate commerce.[176]

Assisted living falls squarely within congressional power under the third category, that is, activities having a substantial relation to interstate commerce. Alterra, one of the leading U.S. providers of assisted living, has facilities in twenty-one states.[177] The multistate providers of assisted living, of which there are many,[178] substantially affect interstate commerce. For example, out-of-state children frequently pay for their parents to enter an assisted living facility. In addition, the federal government already has an important role in other areas of assisted living regulation. The Federal Trade Commission, for example, protects consumers from false advertising and unfair trade practices, relevant to the marketing materials of assisted living facilities.[179] Further, Medicaid waivers increasingly subsidize assisted living resident fees.[180] Current reports estimate that "federal Medicaid waivers pay for assisted living services for 102,000 residents in forty-

172. U.S. CONST. art. I, § 8, cl. 3. "To regulate Commerce with foreign Nations, and among the several States, and with the Indian Tribes." *Id*.

173. United States v. Lopez, 514 U.S. 549, 558 (1995) (citing Heart of Atlanta Motel v. United States, 379 U.S. 241, 256 (1964)).

174. *Id*. at 558 (citing Heart of Atlanta Motel v. United States, 379 U.S. 241, 256 (1964); United States v. Darby, 312 U.S. 100, 114 (1941)).

175. *Id*. at 558 (relying on Houston, E. & W. Tex. Ry. v. United States (Shreveport Rate Cases), 234 U.S. 342 (1914)).

176. *Id*.

177. *See* ALTERRA HEALTHCARE CORP., ASSISTED LIVING RESIDENCES, http://www.assisted.com/locate_r.asp (last visited Oct. 24, 2005).

178. Examples include: (1) Sunrise Senior Living, which operates in twenty-five states with an annual revenue of $1.26 billion; and (2) Emeritus Corp., which operates in thirty-three states with an annual revenue of $206.7 million. Kathleen Vickery, *Conditions Improve in 2003, but Challenges Lie Ahead*, PROVIDER, June 2004, at 49.

179. 15 U.S.C. §§ 45(a), 52–54, 57(a), 57(b) (FTC authority); MEDICARE ADVOCACY, *supra* note 62.

180. MEDICARE ADVOCACY, *supra* note 62.

one states, establishing the federal government as a major purchaser of assisted living services."[181] Federal regulation of nursing homes is often justified in that Medicare and Medicaid provide funding, and the government has a right to regulate the quality of care that it is helping to purchase.[182] In sum, little doubt exists that the federal government has the authority to regulate an industry that so greatly affects the well-being of its citizens now and into the future.

B. Regulation, Not Strangulation

Idaho Senator Larry Craig, Chairman of the Senate Special Committee on Aging (Aging Committee), acknowledged in the summer of 2004 that Congress would likely regulate the assisted living industry unless the state regulatory system drastically improved.[183] Assisted living providers, desperate to avoid federal regulation, believe "there is no justification for federal interference in the private, state-regulated contracts between assisted living facilities and residents."[184] The argument between the assisted living industry and those who champion federal regulation in this area is primarily centered on whether federal regulation would improve consumer access to quality care.[185]

1. FEDERAL REGULATORY SCHEME V. STATE REGULATORY SCHEME: WHICH WOULD BE MORE EFFECTIVE IN THE ASSISTED LIVING INDUSTRY?

Experts use two terms, deterrence and compliance, to describe the paradigms within which government implements regulatory schemes.[186] The deterrence paradigm is formal and sanction-oriented, seeing the regulated industry as an actor attempting to exploit the system.[187] The compliance paradigm, on the other hand, expects the regulated actor to comply with regulations if the enforcement mecha-

181. *Id*. (citing Robert L. Mollica, *Coordinating Services Across the Continuum of Health, Housing, and Supportive Services*, 15 J. AGING & HEALTH 165, 172 (2003)).
182. Stoil, *supra* note 63, at 8.
183. Kevin McCoy, *Senator Fears Feds May Have to Regulate Assisted Living*, USA TODAY, June 1, 2004, at 1B (Senator Craig, in talking about possible federal action said, "I'm not going to close that out as not being a reasonable option . . . if this industry can't develop a standard level of care.").
184. Stoil, *supra* note 63, at 8.
185. *Id*.
186. Kieran Walshe, *Regulating U.S. Nursing Homes: Are We Learning from Experience?*, 20 HEALTH AFFAIRS 128, 134 (2001).
187. *Id*.

nism is informal and developmental, with a reduced focus on sanctions.[188]

Generally, state regulations are based on the compliance paradigm. The assisted living industry wants a system that "work[s] collaboratively with facilities, providing . . . technical assistance and help."[189] The industry opposes an adversarial system that focuses on sanctions.[190] Despite a steady stream of GAO reports finding fault with state regulations, congressional hearings threatening federal intervention, and lawsuits, the states continue to use the compliance paradigm for their regulation of assisted living facilities.

2. ARGUMENTS IN FAVOR OF STATE REGULATION

Assisted living industry members adamantly oppose federal regulation of the industry.[191] Industry advocates employ three arguments in their battle against federal regulation. The first argument raises a particularly attractive rallying cry to Americans—choice.[192] Assisted living is most effective, they argue, when it is a market-driven response to consumer preferences in long-term care.[193] Margaret Thompson, an executive for Thompson White & Associates, a group that runs nine assisted living facilities, testified before the Aging Committee that national standards would "restrict . . . the kind of choices and the kind of innovation that we have been blessed to have under the current regulatory system."[194] The second argument, a corollary to the first, is that state regulation is closer to the consumer and therefore more efficient in responding to the consumer's and the industry's needs.[195] The third argument is that federal regulation of assisted living facilities will fare no better than the federal regulation of nursing homes, which are still fraught with quality of care problems

188. *See id*. at 134–35.
189. MEDICARE ADVOCACY REPORT #2, *supra* note 168, at 9.
190. *Id.* Iowa did not impose a single penalty of any type against an assisted living facility between 1996 and 2002. *See, e.g.*, Fallis, *supra* note 1, at A01 (The assisted living industry appears to be effectively lobbying in states for the compliance system, as in Virginia, where the maximum fine for violating its standards is $500.).
191. *See* Stoil, *supra* note 63, at 8.
192. *See generally 2001 Hearing*, *supra* note 134, at 45–55 (statement of Margaret Thompson, Executive Vice President, Thompson White & Associates).
193. *Id*. at 54.
194. *Id*. at 68.
195. *Id*. at 42.

despite, and primarily because of, federal regulation.[196] These three arguments may resonate with the American public, but all are challengeable.

3. ARGUMENTS IN FAVOR OF FEDERAL REGULATION

Consumer advocates and even state regulators acknowledge that some form of federal regulation would not only be helpful, but in many cases is necessary for the assisted living industry. Karen Love, Co-Chairman of the Consumer Consortium on Assisted Living, has been the most active in arguing for federal regulation. In prepared testimony before the Aging Committee, Ms. Love countered the industry argument that regulations need to be tailored to states individually, remarking, "consumers, regardless of where they live, have the same concerns about receiving good quality and appropriate care."[197]

Additionally, Ms. Love challenged the charge that national standards would stifle innovation, as well as the argument purporting to highlight the failure of nursing home regulation.[198] With respect to the latter, nursing home regulation has improved the quality of life for many residents.[199] Evidence indicates that the inappropriate use of physical and chemical restraints, rates of urinary incontinence and catheterization, and most importantly, hospitalization rates have all declined.[200] In addition, the national nursing home trade associations "came to consensus with consumers and advocates on the current standards in the law."[201] Accordingly, the federal regulation of nursing homes is not to blame for lack of quality resident care, but rather poor management combined with spotty state oversight has led to increased complaints.[202] In cases where nursing home providers and industry advocates complain about federal regulation, "they are speaking of important standards relating to fire safety or sanitation, or outdated, state-specific regulations, not standards or requirements in

196. MEDICARE ADVOCACY REPORT #2, *supra* note 168.
197. *2001 Hearing*, *supra* note 134, at 40 (statement of Karen Love, Co-Chairman, Consumer Consortium on Assisted Living).
198. *Id*. at 71 (remarking that national standards with respect to automobiles have not brought innovation to a halt).
199. *See id*.
200. Walshe, *supra* note 186, at 131.
201. *2001 Hearing*, *supra* note 134, at 39 (statement of Karen Love, Co-Chairman, Consumer Consortium on Assisted Living).
202. *Id*.

federal law or regulation."[203] As a general rule, health professionals and nursing home providers are easily in step with national standards.[204]

Perhaps most fatal to the assisted living industry's reliance on the alleged shortcomings of federal regulation of nursing homes is the testimony of Rick Harris, the Director of Alabama's Bureau of Health Provider Standards. While testifying about nursing home regulation, Mr. Harris acknowledged "controversy over the survey and enforcement methodology that is used," but also noted that he had "never heard anybody really come forward and argue that nursing home standards, the care standards, need to be changed in any significant way."[205] Both sides in the debate over federal regulation of assisted living make valid points. However, the arguments in favor of federal regulation are more persuasive, primarily because they come from individuals such as Rick Harris, whose sole job is to ensure the safety of the elderly community in assisted living and nursing home environments.

4. FEDERALLY REGULATED ASSISTED LIVING

State regulation lacks the uniformity and consistency that federal regulation would provide. The vast differences between states can leave consumers who move to another state in a position where it is more difficult than it should be to make an informed decision about assisted living facilities.[206] National federal standards setting norms for training, disclosure to prospective consumers, and scope of care with respect to the level and training of staff members would provide a "predictable setting for consumers, providers, and payers."[207]

The federal government is better positioned than state governments to implement and monitor such regulations. The consistency

203. *Id*.
204. *Id*.
205. *See 2002 Hearing*, *supra* note 102, at 22 (statement of Rick Harris, Director, Alabama Bureau of Health Provider Standards).
206. *2001 Hearing*, *supra* note 134, at 37–38 (statement of Karen Love, Co-Chairman, Consumer Consortium on Assisted Living). The states use over two dozen designations to refer to assisted living and some states have facilities that do not even fall under existing state law. *Id*.
207. Traci Little, *Regulating Assisted Living for Older Americans: Ensuring Access to Quality, Cost-Effective Supportive Health Care Through Uniform Definition and Regulation of Assisted Living Services* 5 (Program on Law and State Govt. at Indiana University School of Law—Indianapolis, Working Paper), *available at* http://indylaw.indiana.edu/programs/Law_State_gov/assistedliving.pdf.

and adequacy of state funding is likely to be less certain than what the federal government would bring to bear to implement and monitor regulation of assisted living facilities, as shown by the drastic cuts of such funding in numerous states.[208] The funds needed to inspect assisted living facilities will admittedly increase the national budget, but that is far better than ignoring the exploding elderly population in unmonitored assisted living facilities.[209] Though many companies that offer assisted living facilities operate in numerous states, assisted living industry advocates continue to argue that state regulations and standards need to be designed specifically for the state in question.[210] Consumers, though, tend to have the same concerns about quality care, wherever they live. Federal regulation will facilitate uniformity and certainty, and will reduce concerns and uncertainty about the extent of coverage and quality of care. Furthermore, assisted living corporations with wide-ranging operations in various states will be aided by not having to navigate multiple sets of regulations.

V. Conclusion

The current regulatory state of the U.S. assisted living industry can, at best, be characterized as disorganized. Despite prodding by the federal government, consumer advocacy groups, and consumers, the assisted living industry seems unable to develop an adequate strategy for dealing with its numerous problems.

The states, currently responsible for regulating the assisted living industry, are overwhelmed by the exploding elderly population and the parallel growth of the assisted living industry. The result of

208. *See, e.g.*, McCoy, *supra* note 11, at 11A (showing how some states' budgetary cuts curtail nursing home oversight).

209. Is there any industry that would not love the opportunity to police itself? By default in some states, and by a patchwork of regulations in other states, this is in effect happening all too often in the assisted living industry. According to a founder of Kapson Senior Quarters, a chain of assisted living facilities that is now part of Atria Inc., "the industry is doing one hell of a good job policing itself." Many consumers, long term care ombudsman, state regulators, geriatric care managers, elder law attorneys and other advocates would beg to differ . . . .

2001 Hearing, *supra* note 134, at 38 (statement of Karen Love, Co-Chairman, Consumer Consortium on Assisted Living).

210. *Id*. at 47–49 (statement of Margaret Thompson, Executive Vice President, Thompson White & Associates); *2002 Hearing, supra* note 102, at 4–8 (statement of Larry Minnix, CEO of American Association of Homes and Services for the Aging).

the states' oversight failures is an increasing number of deaths and reports of inadequate care and abuse.

Thus, assisted living regulations should be federalized because the federal government is in a better position to police this industry effectively. The assisted living industry overstates concerns about federal regulation, perhaps because it is intent on keeping its relative freedom and minimizing oversight. Federal regulation will provide needed consistency when it comes to assisted living standards, including staffing level requirements, training, scope of care, and quality of care. The failure to do so will ensure that this conversation continues with increasingly tragic consequences.