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# Elder Law

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## **Consumer Advocacy in Assisted Living**

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### **I. Introduction**

A 70-year-old woman is in the midst of a health crisis and is trying to decide whether she can continue to live in the home in which she raised her family. She does not want to be a burden, but she is adamant that she does not want to move into a nursing home. An advertisement in the Senior Living section of the local newspaper offers "assisted living . . . privacy . . . independence . . . peace of mind . . . security . . . personalized attention . . . dignity . . . and assistance with activities of daily living, all in an idyllic home-like environment. . . ."

The assisted living industry is burgeoning, /1/ marketed as a new life-style option designed to provide comfort, autonomy, and security to older persons and their families at rates that are lower than the private-pay rates for nursing homes. More upscale facilities offer elegant decor and amenities that include ice cream parlors, bistros, and libraries. The typical resident is a single or widowed female, 85 years of age or older, who needs help with three activities of daily living. /2/ Forty-two percent of assisted living facility (ALF) residents have some form of dementia, and 27 percent use a wheelchair or walker. /3/

But what do potential consumers, or those already in such a residence, actually know about the legal implications of living in this relatively new housing phenomenon? Few people exploring assisted living are aware that, because ALFs are not licensed as nursing homes, residents do not have the rights and protections provided by federal or state nursing home laws. /4/ Moreover, ALF residents may not even be protected by state landlord-tenant laws. This article describes what assisted living is and is not, how it is marketed, and the issues that advocates should address in educating potential residents/ consumers and their families about assisted living and the problems they may face in choosing to move to an ALF.

### **II. What Is Assisted Living?**

The term "assisted living" is used to refer to many different types of facilities and settings. No agreed-upon model for assisted living and no federal standards or guidelines currently exist. Despite the lack of clarity, consumers exhibit strong acceptance of the ALF concept (e.g., a more flexible and homelike setting than the institutional environment of a nursing home). /5/ In general, ALF residents receive lodging, meals, and some housekeeping or other assistance in an environment that strives to be "residential" or "homelike." In reality there may be little difference between an ALF and a traditional board-and-care home except that board and care provides only the basics, that is, a room (frequently shared), group meals, and personal assistance, with little in the way of extras. In upscale ALFs, the building is designed for accessibility to promote independence. In addition, residents usually live in private rooms with full baths, individual temperature controls, and doors that lock, or in small apartments with kitchenettes. /6/

The Assisted Living Facilities Association of America (ALFAA) defines assisted living as

a special combination of housing and personalized health care designed to respond to the individual needs of those who need help with activities of daily living. Care is provided in a way that promotes maximum independence and dignity for each resident and involves the resident, family, neighbors, and friends. /7/

Depending on the state, facilities falling within the ALFAA definition could be known by a variety of appellations. The names and definitions of these facilities, used for the purpose of regulation or licensing, vary greatly. According to a 34-state review by the American Health Care Association, state regulatory agencies designate ALFs as residential care facilities, adult residential care homes, boarding homes, rest homes, adult congregate living facilities, sheltered care, homes for the aged, and basic care facilities. /8/

These designations do not indicate what services are available in a facility or in what setting the services are offered. These facilities may be freestanding or may be part of a continuing care retirement community or a nursing home. They may be built specifically for their purpose or converted from multiunit dwellings. They range in size from very small -- housing fewer than five residents -- to large facilities serving more than one hundred. Living units also vary markedly, from apartments with individual kitchens and bathrooms, to single and shared rooms with shared bathrooms. Sponsors may be private for-profit, not-for-profit, or public entities. Even large hotel chains such as Marriott and Hyatt are joining the market.

In most states, a facility can call itself an ALF even if it offers services very different from those described in the ALFAA definition. In addition, although a facility may claim to offer assisted living and espouse the philosophy of resident autonomy, in practice the facility may not live up to this claim. Consumers, therefore, cannot rely on the label "assisted living" to indicate a particular type of environment or quality of care.

### **III. Marketing Strategies**

A review of the assisted living industry and trade literature offers a glimpse at the strategies used to sell both the concept of assisted living and particular facilities. A major selling point for assisted

living is offering consumers the ability to "age in place." Advertisements frequently lead prospective residents to assume that they can remain in the ALF for as long as they want, no matter how frail they become. Yet 46 percent of ALF residents eventually move into nursing homes because they need more help than the facility can provide, 12 percent go into a hospital, and another 12 percent move to a second assisted living or retirement residence. /9/

"Aging in place" can be a misnomer. /10/ In some cases, although facilities claim to have the capacity to meet residents' needs, they do not actually have the staff to do so. Also, representations made to residents prior to entry into an ALF can differ from reality, especially as to costs; as a resident's needs increase, the costs of services may become prohibitive. Finally, some facilities evict residents who require a level of care that such facilities are not licensed to provide. /11/ In many states, the ALF may have sole discretion to evict a resident without providing the resident any notice or appeal rights. /12/

In states without ALF regulations, or in which "aging in place" is not regulatory policy, or in which ALFs are restricted by law to the number and degree of services they can provide, a resident's ability to remain in an ALF is dependent upon the services that the facility is able or willing to provide. Thus, although an ALF may market the concept of aging in place, its services may not include, for example, dispensing medicine and coordinating health care. In most states, although only a licensed nurse may dispense medication, the ALF may not be required to have a licensed nurse on staff. /13/ Confusion and misperceptions can have serious consequences.

In the Washington, D.C., area, a resident in a facility operated by a leader in the provision of luxury assisted living died as a result of a communication breakdown between the facility and health care providers on a medication issue. A medical laboratory notified the facility of test results with life-threatening implications, but the facility failed to notify the resident's physician of the test results in a timely manner, the physician delayed visiting the resident, and the resident died. The resident's family had assumed that monitoring of medical care would be part of the facility's medication supervision service. Although a state investigation stopped short of finding the facility responsible for the resident's death, the situation highlights the ambiguity over the responsibility for residents. /14/

Industry claims blur the distinction between which advertised attractive features an ALF is legally required to continue and which are offered simply because the market is favorable to those features at that time. An ALF may decide to discontinue a feature or service it is not legally obligated to provide if it is no longer profitable to do so. Even if the ALF is obligated to provide the feature or service, or the resident is protected against unilateral decision making by the ALF, a contractual obligation can be difficult to enforce, particularly if the ALF is financially unsound.

In any free-market enterprise, some degree of aggressiveness in marketing is to be expected. However, there is cause for concern when the industry doing the marketing operates virtually without restriction and when the marketing is aimed at a very vulnerable population. According to one consultant, seniors may consider assisted living because of a recent personal loss, the need for services to maintain independence, concern about housekeeping and home maintenance, a desire to live closer to family, concern about diminishing health and disability, and general loneliness. /15/ It

is toward this group of lonely, anxious, older consumers and their families that marketing is directed.

In addition to prospective residents, marketing is directed at those who influence them. Providers are advised to develop a referral base of families, health care providers, guardians, and even bank staff. /16/ Among the least intrusive of the suggested marketing strategies are advertisements in magazines and newspapers. /17/ Providers also are encouraged to earn the trust of "prospects" by giving them personalized attention designed to create a "warm fuzzy feeling." /18/ More worrisome are the recommendations for direct mail and telemarketing, which raise consumer protection issues. /19/ One author goes so far as to recommend "guerrilla-style techniques" -- avoid set rules, but be sure to "create a sense of urgency" and include "multiple face-to-face selling contact, a myriad of relentless, personalized, outrageous mailings and other creative selling initiatives that allow you to bond with prospects, gain their trust, and expedite their willingness to meet you face-to-face . . . . Your goal should be to do something for each of your '10 best leads' at least several times per week . . . before and/or after every face-to-face visit." /20/ How could the woman in the introductory example possibly withstand this onslaught and make an informed decision about whether the residence in the advertisement meets her health and social needs and her budget?

#### **IV. Regulation of Assisted Living**

In general, regulation of assisted living is minimal and certainly far less than that of nursing homes. Currently, no accepted industry standards have been established by an accrediting agency; nor have nationwide standards been set by the federal government. Rather, the individual states are responsible for overseeing ALFs. Some states have broadened the existing board-and-care licensing structure to include assisted living, some states are attempting to create new licensing categories and regulations for assisted living, and many states have not addressed the issue at all. Thus, the implementation of standards for and regulation of ALFs vary widely. The variations in state regulations governing ALFs affect every aspect of their operations from admission agreements to the physical plant. /21/

A survey conducted in 1995 by the National Academy for State Health Policy in Portland, Maine, found that 22 states had passed legislation, issued regulations, or implemented programs specifically targeted to assisted living, while an additional 6 states had issued draft regulations. /22/ In general, the survey found that states define assisted living as providing room and board and are moving toward designating the resident's living space as a unit containing a bathroom, kitchen or kitchenette, and lockable door. /23/ Further, although states tend not to regulate services offered, many limit the number of activities of daily living with which a facility can assist a resident and the number of days of skilled nursing care, if any, that can be offered. Many states also prohibit ALFs from admitting or keeping a bedridden resident. /24/

One factor that has been spurring states to begin to define standards and establish rules and regulations for ALFs was the Health Care Financing Administration (HCFA) 1994 decision officially to list and define assisted living in its Medicaid waiver application process. Although this development makes it easier for states to apply for a Medicaid waiver, it also requires states to have

firm standards and consistent regulations ensuring that ALFs receiving Medicaid money meet HCFA's requirements. /25/

Although Medicaid may provide assistance in some states, most assisted living residents pay privately. /26/ The cost of assisted living arrangements varies considerably depending on the community and the kind of facility. /27/

Assisted living regulation in Oregon, for example, is comprehensive relative to other states because of the state's Medicaid waiver program. According to a 1993 report by the American Association of Retired Persons, Oregon has "gone further than any other [state] in defining assisted living through regulations. . . ." /28/ For example, to support the concept of assisted living as a way of life providing older people with privacy, dignity, and independence, Oregon requires that ALFs demonstrate knowledge of and commitment to the assisted living philosophy /29/ as reflected in state-approved written policies and procedures. /30/ Oregon also requires that ALFs perform a comprehensive assessment of a resident's needs and develop a service plan for the resident prior to the resident's move into the ALF; the plan must be reviewed/ revised at least quarterly. /31/ Other criteria concern the management of ALFs (personnel requirements, handling of residents' funds, and contractual obligations of ALFs to their residents), /32/ licensing requirements, /33/ procedures for monitoring of ALFs by the state, /34/ and penalties for violations or noncompliance by an ALF. /35/ Despite this regulatory scheme, assisted living is the most loosely regulated of all of the long-term care options available in Oregon, and ALFs are subjected to considerably less oversight than, for example, nursing homes.

In contrast to Oregon, Minnesota provides little regulation of ALFs per se. Under Minnesota's home care licensure law, a provider can obtain either a Class E assisted living license, which enables the ALF to offer residents social support and "home aid" assistance (e.g., help with dressing, bathing, household tasks) but not "home health care" or nursing services, or a Class A professional home care agency license, which enables the facility to offer home health aid and nursing services (such as the administration of medicine), help with feeding, toileting, and ambulating, physical therapy, and nursing care. A facility may also offer home health aid and nursing services through a contract with a licensed home care provider.

While these licenses regulate the home care services that a facility can offer, Minnesota's 1995 Housing-with-Services Contract Act makes the contract between the resident and the facility the primary tool for determining the standards and quality of care that the resident will receive from the provider, as well as the legal rights of both parties. Under the Act, a contract between the housing-with-services provider and each resident or resident's representative is required. /36/ The contract must describe the services the resident will receive as part of the base rate as well as services available for an additional fee, include fee schedules for these additional services, describe the criteria used by the provider to determine who may continue to reside in the facility, describe the provider's referral procedures if the contract is terminated, and describe any complaint resolution process available to residents. /37/

The Minnesota statute does not require providers to assess a resident's service needs or to provide any particular service, does not restrict providers' discretion to determine when and why a resident may be required to leave an establishment, and does not impose living space requirements other

than to require the facility to meet fire safety, and building codes and food service license requirements established for board-and-lodging licenses, as well as landlord-tenant and fair housing laws. Providers are also required to inform residents that the home care ombudsman is a resource for complaint handling, although the ombudsman program has little legal clout. As a result, Minnesota's ombudsman explains, getting problems resolved depends upon "the ombudsman's negotiating skills and the good will of the provider." /38/

Although states and ALF providers differ with respect to the type and degree of ALF regulation, a 1995 survey conducted by the Research Triangle Institute and Brown University on behalf of the Department of Health and Human Services found that licensing and regulating board-and-care homes, including assisted living facilities, "substantially improved the safety of those facilities and the quality of care provided without creating an institutional type atmosphere." /39/

## **V. Assisted Living Contracts**

Because it is of critical importance in determining what services will be provided, their costs, and the obligations and responsibilities of the parties, consumers need to scrutinize carefully the assisted living contract (including all attachments and referenced documents) before signing it. In states (such as Minnesota) which have limited or no regulation to prescribe the types and level of services, quality of care, and residents' rights, these issues are in theory left to negotiation between the provider and consumer. Even in Oregon, the director of the Office of the Long-Term Care Ombudsman contends, "The essence of the commitment is embodied in the contract." /40/ However, ALFs may offer potential residents prepared form contracts that are not negotiable.

### **A. Inadequacies of Assisted Living Contracts**

Contract law presupposes equality of bargaining power between the contracting parties. However, because the demand for assisted living usually exceeds the supply and because those seeking assisted living services are often extremely vulnerable due to mental incapacity, physical frailty, or anxiety about their financial ability to provide for their needs until death, generally the bargainers to an assisted living contract do not have equal bargaining power. Knowing, intelligent choice is impossible when a party has little or no bargaining power.

Recently, the American Bar Association (ABA) Commission on Legal Problems of the Elderly reviewed assisted living contracts offered to potential residents in six different states. The ABA found that "many assisted living contracts are vague and confusing and rarely provided enough information about a facility to enable a consumer to make an intelligent, informed choice." /41/ Even more troubling, ABA found that the problem was less with what assisted living contracts contained than with what they left out. In many cases, the failure of such contracts to bind the facility to specific services, fees, accommodations, staff, procedures for contesting adverse actions taken by the facility, etc., created more problems for residents than the provisions that actually existed in the contracts. /42/ However, average consumers cannot anticipate the provisions that are needed to protect them and to rewrite a contract to include those provisions.

## **B. Negotiated Risk Agreements**

To further the goal of personal control or resident autonomy and responsibility, ALFs may include a negotiated risk agreement as part of the admission contract or as a separate option. Through a negotiated risk agreement, the resident agrees to absolve a facility of liability for injury that may result from the facility's inability to provide a service or accommodation that would protect the resident from risk of harm. In theory, a negotiated risk agreement provides greater choice and independence for residents by allowing them to remain in a place where they have greater autonomy and privacy than would be available in a more restricted setting such as a nursing home. Such an agreement may also permit an ALF to retain a resident whose level of care exceeds that which the facility can meet without the risk of a lawsuit if the resident suffers injury as a result of that lack of care. /43/

However, some advocates are concerned about negotiated risk agreements. As with the contract in general, it is likely that the parties to the negotiated risk agreement have unequal bargaining power. Potential residents may be unable to make knowing, intelligent choices about assuming risks in an ALF when the only alternative is entering a nursing home. Some people may sign such an agreement without fully understanding the rights they are giving up, or they may unwittingly subject themselves to a serious threat of harm out of fear that they will have no place to live if they are not admitted to or allowed to remain in that particular facility. Moreover, because of the absence of regulations concerning negotiated risk agreements, one ombudsman cautions that some providers may exploit residents by urging them or their representatives to enter into such agreements without their clear understanding of the concept of negotiated risk. /44/

## **C. Precautions Before Signing**

Although challenging a contract or particular provisions of a contract may be possible under several different theories, /45/ consumers bear the expense of going to court to enforce their rights, and getting a result in a reasonable period of time can be difficult. Therefore, a model contract or specific required contract clauses should be legislated in order to equalize the bargaining positions between ALFs and potential residents. To achieve this end, statewide efforts to analyze assisted living contracts and work toward standardization are needed.

Until more standardization occurs or stricter regulations are promulgated by all states, however, potential residents and family members or others assisting them must understand that, no matter what an ALF's marketing materials may say, the contract controls. Therefore, in order to ensure that potential residents and their family members make informed and knowing choices about the risks they are assuming, they should take the following precautions:

(1) Scrutinize the contract thoroughly;

(2) have an attorney who is experienced in long-term care and consumer issues review the contract and the facility's regulations;

(3) contact the long-term care ombudsman to learn if others have filed complaints or grievances against the facility;

(4) seek clarification of any terms in the contract that are vague or confusing; and

(5) become familiar with all facility rules or attachments referenced in the contract because these rules may be as binding as the contract. /46/

The resident and family members must ensure that the contract binds the facility to provide the services the resident is seeking at a cost that is affordable and adequately protects the resident's current and future interests.

## **VI. Conclusion**

The woman in the introductory example is in the midst of a crisis and needs adequately and clearly to evaluate her long-term care options and to find the most affordable quality care. Assisted living is one option often presented to those in her situation and may be an appropriate living situation for some. However, advocates need to assist consumers to make informed choices about whether a particular assisted living facility is right for them.

### Footnotes

/1/ Currently there are more than 40,000 providers in the United States, and the number is growing. Wayne L. Kaplan, *Alias: Assisted Living, A Guide Through the Maze of State Regulation*, Spectrum, Mar. -- Apr. 1996, at 7.

/2/ Susan Fitzgerald, *A Cost Effective Quality Alternative, Assisted Living Today*, Fall 1995, at 3A (citing an Assisted Living Facility Association of America (ALFAA) survey). Activities of daily living (ADLs) include bathing, dressing, toileting, eating, and medication management (reminders or dispensing).

/3/ *Id.*

/4/ See Nursing Home Reform Law, Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, 101 Stat. 1330 (amending 42 U.S.C. Secs. 1395i-3(a) -- (h) (Medicare) and 1396r(a) -- (h) (Medicaid)). The Nursing Home Reform Law was threatened with repeal during the 1995 session of Congress but at this writing remains in effect.

/5/ In urban areas particularly, in many apartment buildings, cooperatives, and condominium complexes, the population of older persons is growing more rapidly than that of other age groups. Referred to as naturally occurring retirement communities (NORCS), these residences have evolved not by design but because residents who came years earlier simply aged in place. In response to the predominantly older population, building owners and managers have installed grab

bars and handrails throughout buildings and, in some cases, sought to bring in different ranges of services to enable people to remain in their homes. Although these are not assisted living facilities or nursing homes, some older persons receive the care and companionship they need in such housing and insist that they intend to remain there until their death. See, e.g., Susan Levine, *As Tenants Age, High-Rises Become Retirement Havens*, Wash. Post, July 4, 1996, at A1, A18.

/6/ E.g., in Oregon, buildings must be designed for maximum accessibility to a frail population that is aging in place, and living units must be single occupancy and have full baths and kitchens, locking doors, and individual temperature controls. Or. Admin. R. 411-56-020. In Massachusetts, all units must be single or double with a lockable door, have a private full bath (newly constructed) or half bath (currently existing), have at least a kitchenette or access to cooking capacity, and meet all laws and regulations governing use and access by persons with disabilities. Mass. Regs. Code tit. 651, Sec.12.04(1).

/7/ ALFAA Advisor, June 28, 1991. The ALFAA can be contacted at 9401 Lee Highway, Suite 402, Fairfax, VA 22301. Others in the field define assisted living by pointing to a particular philosophy that emphasizes personal control or resident autonomy, aging in place, and dignity for older persons in homelike group settings. Usual characteristics include group or congregate housing arrangements that provide room and board as well as social and recreational opportunities; assistance to residents who need help with personal care needs and medications; availability of protective oversight or monitoring; and help around the clock or on an unscheduled basis. Rosalie Kane & Keren Brown Wilson, *Assisted Living in the United States: A New Paradigm for Residential Care for Frail Older Persons?* 6 -- 7 (1993).

/8/ Lynn Wagner, *What's in a Name?*, Provider, Oct. 1995, at 87.

/9/ Fitzgerald, *supra* note 2, at 4A.

/10/ Oregon is considered a pioneer in assisted living because the state created a Medicaid waiver program in 1989 that allows many Medicaid beneficiaries who qualify for admission to a nursing facility to be served instead in an assisted living facility. Oregon is also unique in making the decision to blur the line between assisted living and nursing care. Oregon requires assisted living facilities (ALFs) to adjust their services as needed to enable residents to age in place as their condition declines. Or. Admin. R. 411-56-000, 411-56-015. Thus, in addition to offering assistance with ADLs, three daily meals, housekeeping, and socialization activities, ALFs in Oregon must also be able to provide routine nursing care, including the administration of medication. Or. Admin. R. 411-56-015. However, despite the emphasis in Oregon's regulations on the concept of aging in place, Meredith Cote, the director of Oregon's Office of the Long-Term Care Ombudsman, has expressed concern that, for a number of reasons, aging in place may be a "broken promise" rather than a "realistic expectation" for ALF residents. E.g., Cote says, "As a population, people with advanced dementia are not well served by ALFs in Oregon." Telephone interview (July 18, 1996).

/11/ The average stay in an ALF across all surveyed by the American Association of Retired Persons (AARP) in 1993 was 26 months, and the most common cause for leaving was the resident's increased service needs. Kane & Wilson, *supra* note 7, at 28.

/12/ In Minnesota, e.g., an ALF is required only to disclose its discharge policy in its contract with residents. In Oregon, residents may not be asked to leave an ALF without 14 days' written notice stating the reasons for the request, and the resident has the right to object to the request; moreover, only five reasons may serve as grounds for requesting that a resident move. Or. Admin. R. 411-56-020. However, the allowable reasons for eviction are somewhat vague, and, unlike nursing home residents in Oregon, ALF residents have no right to a hearing.

/13/ Nurse Practice Acts in Oregon and some other states permit nonlicensed persons to be responsible for this service, under limited circumstances. See, e.g., Or. Admin. R. 851-47-000-851-47-030 (June 6, 1992).

/14/ Karl Vick, *Death Prompts Md. Probe of Assisted Living Facility*, Wash. Post, Jan. 9, 1995, at A1, A9.

/15/ M. David Vail, *Marketing and Selling Assisted Living*, Spectrum, Nov. -- Dec. 1995, at 36.

/16/ *Id.* See also Wendy S. Blumenstein & Arthur A. Bernandon, *Find Creative Ways to Market Hospitality*, Provider, Apr. 1996, at 23; David Peete, *Networking: Relationship Marketing That Works*, Spectrum, Nov. -- Dec. 1994, at 29 -- 31; Christy Fisher, *The Time Is Now*, Provider, Oct. 1995, at 77.

/17/ Fisher, *supra* note 16, at 80.

/18/ Robert Van Dyk, *Creating That Warm Fuzzy Feeling*, Provider, Jan. 1996, at 32.

/19/ Vail, *supra* note 15, at 38; Blumenstein & Bernandon, *supra* note 16, at 23.

/20/ David A. Smith, *Creative Prospect Follow Up*, Spectrum, Nov. -- Dec. 1994, at 41 -- 43.

/21/ Kaplan, *supra* note 1, at 7 -- 10. Differences exist in state regulations regarding licensing requirements, administrator's qualifications, staffing requirements, residential care and services required/prohibited, handling of medications, personal care services required/prohibited, activity services provided, Alzheimer's/dementia care, admission and retention criteria, food service, inspections, accommodations and furnishings, the physical plant, emergencies and disaster planning required, admission agreement/application form requirements, accounting requirements, resident rights, etc.

/22/ Markian Hawryluk, *Regulations in the Assisted Living Community*, Provider, Oct. 1995, at 71.

/23/ *Id.* at 72.

/24/ *Id.* at 74.

/25/ See Janet Grady Sullivan, *Medicaid Waivers Spur Assisted Living Regs*, *Contemporary Long Term Care*, May 1995, at 33; Susan Fitzgerald, *Increased Access or Costly Regulation?*, *Assisted Living Today*, Winter 1995, 15 -- 18. The Health Care Financing Administration (HCFA) defines

assisted living as "personal care and services, homemaker, chore, attendant care, companion services, medication oversight (as permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a licensed (where applicable) community care facility, in conjunction with residing in the facility." Assisted living also includes "24 hour on site response staff" to individuals who reside in their own single (or, with consent of both occupants, double) living units within a facility that has a central dining room, living room, and common activity centers. HCFA goes on to say that "care must be furnished in a way which fosters the independence of each consumer to facilitate aging in place," that "routines of care provision and services delivery must be client-driven to the maximum extent possible," and that nursing and skilled therapy services must be incidental, rather than integral, to the service package of an ALF. HCFA, Medicaid Bureau, Streamlined Waiver Application (June 1995). Although inclusion of assisted living by HCFA as a reimbursable Medicaid service does not translate into more federal dollars for a state, it enables states to offer a greater variety of long-term care options to Medicaid-eligible persons and gives states more flexibility and, potentially, more cost-effective ways of financing long-term care than nursing home placement. At the same time, states must be able to evaluate the effectiveness and to control the growth of this option. States are grappling with how to create a quality assurance system with the most limited, if any, regulations.

/26/ Some residents (typically those in board-and-care-type homes) receive financial assistance from supplemental security income, state supplements for persons with mental or developmental disabilities, or, as explained above, from Medicaid home and community-based care waivers. Medicare may cover services provided by licensed home health care agencies, and long-term care insurance may be a source of assistance to a very limited group.

/27/ Some facilities charge a basic rate for room and board, plus additional fees for services. Others charge a fee for a standard package of services and extra fees for services beyond those included in the package. Fees, however, can be a source of confusion. Of 63 assisted living residences surveyed in 1993 by AARP, only seven utilized a single rate within the same facility. Others charged different fees depending on room size and specific services needed. The lowest median rate for room, board, and services in the AARP survey was \$995 per month, and the median highest rate was \$1,639 per month. Kane & Wilson, *supra* note 7, at 48.

/28/ *Id.* at 51.

/29/ Or. Admin. R. 411-56-000(2), 411-56-010.

/30/ *Id.* 411-56-010.

/31/ *Id.* 411-56-015(1).

/32/ *Id.* 411-56-030.

/33/ *Id.* 411-56-050.

/34/ *Id.* 411-56-060.

/35/ Id. 411-56-090, 411-56-095.

/36/ Minn. Stat. Sec. 144D.04, subd. 1.

/37/ Id. subd. 2.

/38/ Telephone interview with Sharon Zoesch, Office of Ombudsman for Older Minnesotans (July 24, 1996).

/39/ Hawryluk, *supra* note 22, at 72.

/40/ Telephone interview with Cote, *supra* note 10.

/41/ John Richard Buck, *Assisted Living: An Uncharted Course*, Bifocal, Winter 1996, at 7.

/42/ Id. at 2.

/43/ E.g., in Oregon, included in the list of resident rights that ALFs are required to uphold is "assurance that the resident and/or significant other is free to select or refuse service and to accept responsibility for the consequences." Or. Admin. R. 411-56-010.

/44/ Telephone interview with Cote, *supra* note 10.

/45/ Courts may refuse to enforce contracts or provisions of contracts that contain the elements of an adhesion contract, i.e., contracts that (1) are offered on a standardized form (2) on a take-it-or-leave-it basis and that (3) provide no realistic opportunity for the consumer to bargain because of the superior bargaining position of the party offering the contract. See, e.g., *Madden v. Kaiser Found. Hosp.*, 552 P.2d 1178 (Cal. 1976), *Guthmann v. La Vida Llena*, 709 P.2d 675 (N.M. 1985), *Broemmer v. Abortion Serv. of Phoenix, Ltd.*, 840 P.2d 1013 (Ariz. 1992). Courts will not enforce provisions that limit the duties or liability of the stronger party, that defeat "the reasonable expectations" of the weaker party, and that are "unconscionable." *Madden*, 552 P.2d at 1184, *Guthmann*, 709 P.2d at 678, *Broemmer*, 840 P.2d at 1016. The leading case, *Williams v. Walker-Thomas Furniture Co.*, 350 F.2d 445 (D.D.C. 1965), defined "unconscionable" as "an absence of meaningful choice on the part of one of the parties together with contract terms which are unreasonably favorable to the other party." "Absence of meaningful choice" encompasses employment of sharp practices, use of fine print and convoluted language, lack of understanding, and inequality of bargaining power. Courts may also refuse to enforce a contract on grounds of public policy to discourage undesirable conduct or to avoid the use of the judicial process to uphold an unsavory agreement. Courts may find the agreement or some part of it unenforceable as against public policy for a myriad of reasons, e.g., the agreement involves commission of a tort or a wrongful act or a breach of fiduciary duty. Courts have also found that exculpatory clauses in residential leases, *Henriouille v. Marin Ventures*, 573 P.2d 465 (Cal. 1978) (Clearinghouse No. 23,510), as well as standardized releases from liability for negligence imposed as a condition for admission to a charitable hospital, violate public policy, *Tunkl v. Regents of Univ. of Cal.*, 383 P.2d 441 (Cal. 1963); *Emory Univ. v. Porubiansky*, 282 S.E.2d 903 (Ga. 1981). An agreement may also be unenforceable as against public policy if it conflicts with or frustrates the intent of

legislation. These problems are not new and have been considered in the somewhat analogous nursing home admissions context. See, e.g., Eric Carlson, *Illegal Guarantees in Nursing Homes: A Nursing Facility Cannot Force a Resident's Family Members and Friends to Become Financially Responsible for Nursing Facility Expenses*, 30 *Clearinghouse Rev.* 33 (May 1996).

/46/ Buck, *supra* note 41, at 6 -- 7.