Aging in Place

Promises to Keep

An Investigation into Assisted Living Concepts, Inc. and Lessons for Protecting Seniors in Assisted Living Facilities

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To Members of the Public and Policymakers:

A recent study conducted by AARP found that 84% of those surveyed hope to "age in place," remaining in the same home or community-based setting as their health deteriorates. This demand for "aging in place" has created a ready market for assisted living facilities, which provide seniors with congregate living situations and the ability to add on services and assistance as needs develop.

However, assisted living facilities are expensive. Even those with significant resources are likely to deplete them if they live long lives after entering an assisted living facility. For many, going on Medicaid may be the only way to continue paying for assisted living care after resources are depleted. As our national economy takes a toll on home values and stock market portfolios, it is even more likely that many middle class seniors will exhaust their savings sooner and need to rely on Medicaid for their long-term care. Thus, for seniors who are shopping for an assisted living facility, a promise by a facility to allow the prospective resident to eventually convert to Medicaid is a major selling point.

For the past eighteen months, the New Jersey Department of the Public Advocate has been investigating Assisted Living Concepts, Inc., after receiving reports that its New Jersey-based assisted living facilities were throwing out seniors who sought to convert to Medicaid, despite having previously promised that they would be permitted to convert to Medicaid. Unfortunately, our investigation confirmed that Assisted Living Concepts, Inc.'s facilities have indeed made and broken these promises and that residents and their families have suffered financial, physical, and emotional harm as a result.

Throughout the course of this investigation, the Public Advocate sought not only to chronicle Assisted Living Concepts, Inc.'s actions and their consequences, but also to assist residents and their families in a time of great stress. This included advocating on behalf of residents who wished to remain in their facilities. It also included helping residents, and their families, make difficult decisions about whether remaining in their Assisted Living Concepts, Inc. facility was in their long-term best interest. Throughout this investigation, we have worked closely with our partners in the Department of Health and Senior Services (DHSS) to respond to individual cases, and DHSS has been an aggressive and effective ally.

This report details and explores the findings we reached over the course of our eighteen-month investigation and provides recommendations that we have developed, based on these findings and on policy research and analysis. While we recognize that Assisted Living Concepts, Inc. is only one assisted living provider among many more who honor their promises, we believe that the lessons learned can teach us a lot about the weaknesses in our system of regulating the assisted living industry at large.

The Department of the Public Advocate continues to assist residents of Assisted Living Concepts, Inc. and their families, and looks forward to working with policymakers to create meaningful protections for New Jersey seniors seeking to "age in place" in assisted living facilities.

Sincerely,

Ronald K. Chen

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Introduction and Summary

When Sandy Cates helped her then 86-year-old aunt, Lillie Hitchner, leave her home of 83 years to move to the Lindsay House assisted living facility in Pennsville, NJ, in April 2005, she assumed that her aunt would never have to move again. While Ms. Cates knew that her aunt's resources would not last forever, she understood that Lindsay House residents could convert to Medicaid when they ran out of money.*

Leaving the only home she could remember was not easy for Mrs. Hitchner, but health problems and the need for help in her day-to-day life made it too difficult for her to live on her own. With time, Mrs. Hitchner came to consider the Lindsay House her home. By August 2008, Mrs. Hitchner had spent nearly $200,000 at Lindsay House and Ms. Cates realized that her aunt's remaining funds would run out by December. Although Ms. Cates, who is her aunt's agent under a power of attorney, repeatedly sought confirmation from the Lindsay House that Mrs. Hitchner could convert to Medicaid when she had spent down her resources, none came.

Lillie Hitchner in her twenties with her husband Malc

By form letter dated November 10, 2008, Sandy Cates finally got her answer: Lindsay House would no longer allow residents to convert to Medicaid. After Mrs. Hitchner became Medicaid-eligible in December 2008 and stopped paying her private pay rate of more than $6000 per month to the facility, Lindsay House sent her an involuntary discharge notice, telling Mrs. Hitchner she had to leave her home by January 28, 2009. It wasn't until the Department of the Public Advocate (the Public Advocate or Department) and the Department of Health and Senior Services (DHSS) intervened on her behalf that Mrs. Hitchner was allowed to convert to Medicaid and remain at the Lindsay House.[1]

* * * *

Unfortunately, Mrs. Hitchner's situation is not unique. It reflects a broader strategy employed by Assisted Living Concepts, Inc. – Lindsay House's parent company – to reduce the number of Medicaid-eligible residents living in its assisted living facilities throughout the country.[2] Assisted Living Concepts, Inc., a company founded with the express purpose of serving low- and moderate-income residents including Medicaid-eligible residents, historically converted residents to Medicaid when they had depleted their resources in accordance with resident contracts and the company's business model.[3] But in November 2006, after the company was purchased by Extendicare, Inc., it announced a plan to "actively reduc[e] the number of units available to Medicaid programs."[4] In some states, like Texas and Washington, the company strategy included discharging residents already on Medicaid.[5]

Roughly two years ago, the policy change began to impact New Jersey's elderly residents. Assisted Living Concepts, Inc. started involuntarily discharging residents from its eight New Jersey facilities after they had depleted their resources and become eligible for Medicaid. The Public Advocate's Office of the Ombudsman for the Institutionalized Elderly (the Ombudsman),

*Throughout this report for the sake of simplicity, we use the terms "Medicaid" or "Medicaid-eligible" when we refer to assisted living residents who are or may be eligible for the 1915(c) Medicaid waiver called Global Options for Long term Care. As discussed herein, Medicaid waiver eligibility for assisted living residents is different from other long-term care Medicaid eligibility criteria as well as community Medicaid for people who are aged, blind or disabled.

ALC captures attention of Washington State lawmakers

New Jersey is not the only place where Assisted Living Concepts, Inc. has battled authorities over the discharge of elderly residents. The company has also captured the attention of officials and lawmakers in Washington State.

"They're not honorable," says Louise Ryan, Washington State's Long-term Care Ombudsman. "When the financial collapse happened, and they were sold to Extendicare, then we saw the corporate push to get rid of their Medicaid contracts. So it's kind of a giant bait and switch."

When she tried to convert to Medicaid... the company served her with a Superior Court eviction notice – two days after her 99th birthday.

She said clients were lured into the company's facilities with the promise that Medicaid funds could be used when private resources were exhausted. But under new ownership, the company is trying to change the deal with its residents.

"The company sold itself to many state lawmakers and policymakers as the nursing home alternative that could be done on Medicaid. When the new company came in, they were ruthless in getting rid of the Medicaid contracts. There's no conscience," Ryan said.

She told the story of Cordelia Robertson, who had already spent more than $300,000 of her private funds to live in an Assisted Living Concepts facility. When she tried to convert to Medicaid to pay her monthly bills, the company served her with a Superior Court eviction notice – two days after her 99th birthday, Ryan said.

The state legislature tried to act to protect the senior citizens remaining in the care of the company. The state passed a law that would require the company to accept Medicaid payments for the people who had moved in before the policy change and thought they would be able to convert. But in January 2009, a federal court overturned the law to the extent it applied retroactively to Medicaid contracts. The court held that the statute violated the contracts clause of the U.S. Constitution, because it conflicted with a preexisting contract regarding Medicaid participation between Assisted Living Concepts, Inc. and the state. Ryan said she thought that the law will apply to renewed Medicaid contracts going forward. (*Telephone interview with Louise Ryan, Washington State Ombudsman for the Institutionalized Elderly, January 21, 2009*); *Washing-*

soon noticed the phenomenon and quickly took action. Consistent with our mandate to provide "consumer protection and advocacy on behalf of…the elderly," the Public Advocate launched a campaign to

(1) prevent spend-down related discharges in the eight New Jersey facilities operated by Assisted Living Concepts, Inc.;

(2) help residents and their families make informed decisions about their future care;

(3) mitigate the impact of any actual discharges on the state's elderly; and

(4) determine the scope of reform policy necessary to prevent this situation from occurring again.[6] We concurrently launched an investigation to aid us in these efforts.

The Public Advocate and the Ombudsman's joint efforts led to a partnership with the DHSS, the state agency responsible for licensing and regulating assisted living facilities.[7] After reviewing the eight applications filed by Assisted Living Concepts, Inc. to obtain its certificates of need (one for each facility), DHSS determined that the company's new strategy – of involuntarily discharging residents after they spend down and become Medicaid-eligible – would violate an enforceable agreement made at the time of licensure.[8] In particular, DHSS found that Assisted Living Concepts, Inc. had pledged that it was "committed to serving a moderate to low-income population which would include Medicaid-eligible clients…Residents will not be asked to move from the Residence because of spend-down situations."[9] While DHSS offered Assisted Living Concepts, Inc. the opportunity to formally apply for relief from this agreement, it never did, choosing instead to simply retain its new policy of involuntarily discharging residents when they spend down and become Medicaid-eligible.[10]

The report that follows chronicles the history of this investigation and our inter-agency collaborations, explains our investigative methodology, and details our on-going advocacy efforts, findings, and recommendations. We used various mechanisms, including in-depth interviews with residents or family members, review of resident admission agreements, and extensive legal and policy research, in the course of this investigation. Among our notable findings regarding the effect on residents of Assisted Living Concepts, Inc.'s new involuntary discharge policy, are the following:

- Assisted Living Concepts, Inc. made oral and written promises to residents that they would be able to convert to Medicaid if they spent down their resources at the facility, and residents relied on those promises;
- Assisted Living Concepts, Inc. facility administrators continued to make oral promises that residents would be able to convert to Medicaid upon spend-down well after November 2006, and as recently as early November 2008, even to residents who were ultimately told they could not convert to Medicaid;
- Assisted Living Concepts, Inc. told Medicaid-eligible residents that they had to move out of their homes after spending down, despite having previously made promises to some of those residents that they could convert to Medicaid;
- Some residents who were not eligible for Medicaid at the time of spend-down and who were forced to move out of their homes, nevertheless believe that Assisted Living Concepts, Inc. knowingly misrepresented that they could convert to Medicaid upon spend-down;
- Residents who were forced to leave suffered harm, including economic harm, limitation on future care options, and transfer trauma;
- Many residents who left did not understand their legal rights, including their right to have a 30-day written notice of involuntary discharge, and most residents who left were not provided with that notice;
- Existing legal mechanisms designed to give assisted living residents some limited measure of protection in the event of involuntary discharge did little to prevent involuntary discharges of residents who had spent down their private funds; and
- Assisted Living Concepts, Inc. used at least two forms of resident admission agreements which contained significant anti-consumer provisions.

We hope that this report will serve as a guide to policymakers considering the issue of the involuntary discharge of Medicaid-eligible residents after they have spent down their private resources, as well as issues pertaining to the regulation of the assisted living industry more generally. Prospective assisted living residents and their loved ones may also find this report helpful as they make decisions about long-term care options.

A Brief History of Long-Term Care, the Advent of the Assisted Living Model, and a History of Assisted Living Concepts, Inc.

Baker House, located in Vineland, NJ, is one of the eight assisted living facilities ALC operated in New Jersey.

Historically, seniors who could no longer safely care for themselves had few options if they did not have the money to pay for a long-term caregiver or a family member to voluntarily care for them.[11] If care needs were minimal, seniors could choose to live in boarding homes, which provided a place to stay, "three hot meals," and occasional assistance with cleaning, laundering, or other chores. If care needs were more extensive,

seniors could choose to move into "homes for the aged," which were operated by philanthropic or religious organizations, and provided varying levels of care.[12] However, these options were largely unregulated, leaving care quality questionable and access unpredictable.

With the creation of Medicaid in 1965, however, the nursing home emerged as the dominant model of long-term care for low-income seniors. The Medicaid program heavily favored nursing homes, which provides seniors with a place to live and assistance with activities of daily living, such as bathing, dressing, toileting, and eating. Under the Medicaid law, the federal government matches state funds paid to nursing homes to care for low-income seniors who need a nursing home level of care.[13] Since they take significant federal dollars, the federal government subjected nursing homes to considerable regulation for quality and access.[14] In particular, Medicaid-participating nursing homes must allow residents to convert to Medicaid when residents spend down resources and are Medicaid-eligible.[15] Although nursing homes provided residents with the advantage of Medicaid-conversion in most facilities, they traditionally offered shared rooms, un-lockable doors, minimal privacy, and little independence.

While nursing homes were an important advancement, policymakers and seniors alike began to clamor for an alternative by the early 1980s. At the time, a larger movement had emerged in the United States to "de-institutionalize" individuals with care needs, and treat them in their own homes or in community-based settings, instead of "hospital-like" institutions including nursing homes.[16] In addition, federal and state governments had found financing nursing home care through Medicaid expensive.

In 1981, Congress passed the Omnibus Reconciliation Act of 1981 (Act), which recognized the efficacy and cost savings of allowing people to obtain long-term care services in home and community settings.[17] This federal policy change echoed the sentiments of seniors: in a recent AARP study, 84% of seniors reported that they would prefer to "age in place," if possible.[18] Among other things, this Act amended portions of the Social Security Act relevant to Medicaid reimbursement for long-term care services. Prior to the amendments, states could only draw down federal Medicaid dollars to pay for long-term care services that were provided in an institutional setting, such as a nursing home. The amendments allowed states to apply for a "waiver" from these standard Medicaid requirements, by submitting plans to provide care through home and community-based alternatives to nursing homes. Medicaid waivers that allowed eligible residents to live in assisted living facilities, known as Section 1915(c) waivers, were one such community-based option which developed under the Act.

* * * *

It was in this environment of innovation that an Oregonian named Keren Brown Wilson, PhD began to develop her own care model that she would ultimately name "assisted living." Dr. Wilson was motivated to create the model after her elderly mother, a Medicaid recipient, complained about having to live in a nursing home that felt restrictive and institutional. Based on her previous study of gerontology, Dr. Wilson believed that nursing homes denied elderly individuals privacy, dignity, and control – all crucial ingredients to longevity and prolonged quality of life. Dr. Wilson's alternative model offered seniors the opportunity to "age in place," by allowing them to start out enjoying an independent, albeit congregate, living situation and then add on additional care services and assistance as it became necessary. Dr. Wilson envisioned that her facilities would be open to low- and moderate-income individuals, by utilizing the Medicaid waiver program and by keeping costs low.[19]

Park Place Living Center, Dr. Wilson's "assisted living" facility, opened in 1982. Although Oregon had by then received a home and community-based care "waiver," she was initially unable to convince the state to use the waiver to fund her project. Instead, Dr. Wilson had to utilize low-income housing dollars from the state housing

Company founder puzzled by ALC's policy change

Dr. Keren Brown Wilson started company to help low-income seniors like her mother, and puzzled by ALC's trajectory since she left

Dr. Keren Brown Wilson says she founded Assisted Living Concepts, Inc. in response to a request from her mother who had suffered a stroke that confined her to a nursing home.

There was an implicit promise, and while it may be true that they felt they needed to stop participating in the Medicaid program, they should have worked out a transition.

"Why don't you do something to help people like me?'' asked her mother, who was a Medicaid recipient.

Dr. Wilson wanted low-income people like her mother to be able to live in a friendlier, less institutional environment than a nursing home.

That was the whole idea of "assisted living,'' she said – to treat the elderly with dignity, allowing them to live in the most comfortable, home-like environment.

For nearly 30 years, Dr. Wilson, who is currently president of the Jessie F. Richardson Foundation in Oregon, has been helping low-income people gain access to the same kind of long-term care that wealthier people take for granted, she said.

She designed Assisted Living Concepts to specifically include and serve low-income people. Dr. Wilson also pledged in writing, when she applied for a license to do business in this state, that her company would never require people to leave if they had run out of money and had only Medicaid to pay the bills.

That's why she is so concerned and disappointed that the company she founded – ''it's like my child,'' she said – is discharging the very people Dr. Wilson promised her mother she would help.

"It's not good business. It's not ethical, either,'' Dr. Wilson said in an interview. "I don't know about legal, but from an ethical point of view, one has to do one's best to meet one's obligations,'' she said. "If you took a client in, and you want to change your program, you say, 'As of this date, we're no longer accepting new participants in the Medicaid program.' You don't kick people out.''

Asked if she would have stopped accepting Medicaid if she were still running the company, she said: "I would like to think that anything I was involved in wouldn't take away things that had already been promised. There was an implicit promise, and while it may be true that they felt they needed to stop participating in the Medicaid program, they should have worked out a transition.''

In addition to criticizing the propriety of the company's current policies, Dr. Wilson questioned their judgment and common sense. "I am puzzled by why they chose the route they did,'' Wilson said. "I don't understand why you wouldn't want to find a way to avoid all this legal activity and bad publicity. As a business person, I just can't figure it out.'' (*Telephone Interview with Keren Brown Wilson, PhD, founder of Concepts in Community Living, Inc. and Assisted Living Concepts, Inc., February 25, 2009*).

agency. As a result, she was forced to meet certain housing standards in developing her facility, including private apartments, lockable doors, and individual kitchens. Ultimately, it was these housing requirements that would define the assisted living model throughout the country, with others quickly adopting her ideas and her terminology. [20] Within four years of starting the company, Dr. Wilson convinced Oregon's Senior Citizens Division to conduct a Medicaid demonstration project and amend its rules to allow Medicaid patients to receive care in her assisted living facilities. In 1988, Dr. Wilson incorporated her company as Concepts in Community Living, Inc.[21]

By the early 1990s, Concepts in Community Living, Inc. was thriving and the assisted living model was spreading throughout the country.[22] Despite its increasing popularity, the federal government declined to subject assisted living to the kind of intense federal regulation and requirements to which nursing homes had long been subject. In particular, they declined to impose any requirement that residents be allowed to convert to Medicaid upon spend-down or provide

significant standardized resident protections.[23] As a result, the definition of assisted living and the regulation of the industry would be left to the states to figure out on an ad hoc basis.[24] As it turned out, some states promulgated regulations primarily in consultation with assisted living providers, to the exclusion of resident or consumer advocacy groups.

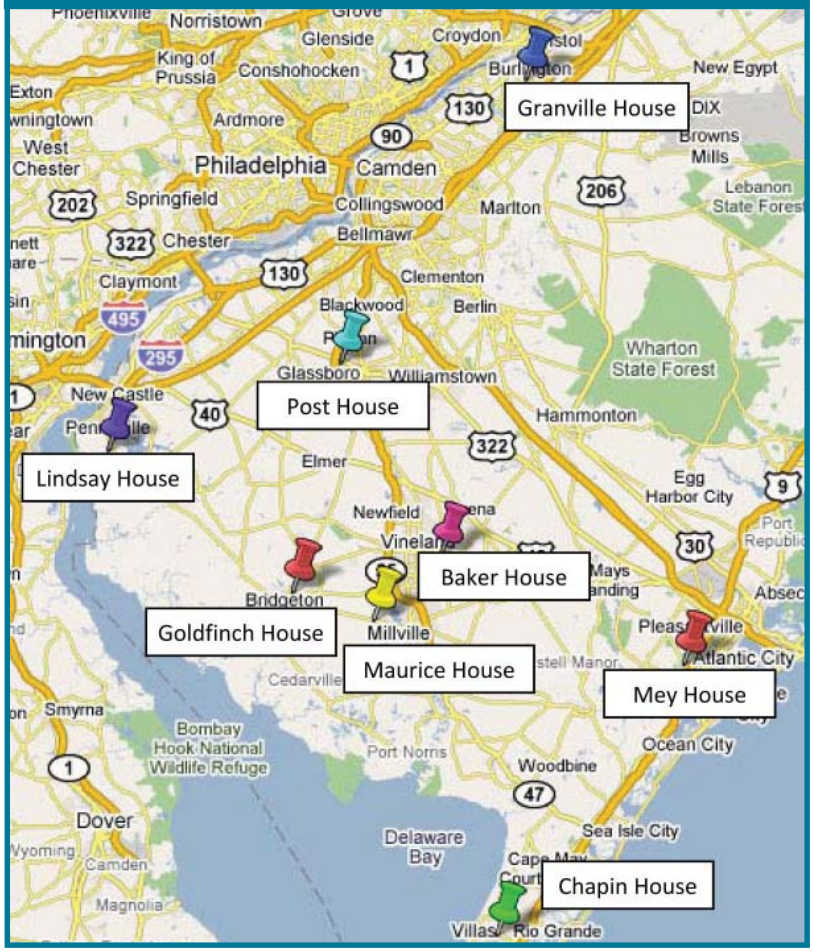
During this same period, DHSS began its planning to apply for a Section 1915(c) Medicaid waiver to be used to allow residents to receive long-term care in assisted living facilities. As part of this planning process, DHSS staff took a trip to Oregon to visit the facilities operated there by Concepts in Community Living, Inc., where Dr. Wilson hosted department staff on a personal tour of her facilities. She also explained how assisted living could be used as an affordable housing model for seniors with care needs. According to the Director of the Office of Certificate of Need and Healthcare Facility Licensure, John Calabria, DHSS staff returned to New Jersey "very enthusiastic" and quickly returned to work on the Medicaid waiver application.[25]

Eventually, the success of Concepts in Community Living, Inc. caught the eye of Wall Street investors. In November 1994, Concepts in Community Living, Inc. became Assisted Living Concepts, Inc., the first publicly traded assisted living company in the United States. Assisted Living Concepts, Inc. took over operation of the Oregon facilities originally owned and operated by Concepts in Community Living, Inc. Within a year of its public offering, Assisted Living Concepts, Inc. had acquired six more facilities in Oregon, ten in Texas, and three in Washington. Throughout the transition, Dr. Wilson remained at the helm.[26]

With Dr. Wilson in charge, Assisted Living Concepts, Inc. retained the guiding philosophies of Concepts in Community Living, Inc. Even as the company continued to grow, Assisted Living Concepts, Inc. continued to seek out and serve the low-end of the private pay assisted living market, as had its predecessor, Concepts in Community Living, Inc. The company deliberately kept costs low so that residences could operate profitably even if all revenues came from Medicaid reimbursements. In determining where to concentrate expansion efforts, Assisted Living Concepts, Inc. focused on states where Medicaid paid for assisted living or waivers were pending so that once residents had spent down to Medicaid eligibility they could remain at assisted living facilities and "age in place," according to Assisted Living Concepts' former public policy director.[27]

By January of 1996, Assisted Living Concepts, Inc. implemented this strategy in New Jersey when it applied to DHSS to own and/or operate eight assisted living facilities in the state: Baker House in Vineland, Goldfinch House in Bridgeton and Maurice House in Millville, all in Cumberland County; Lindsay House in Pennsville, Salem County; Mey House in Egg Harbor Township,

Locations of ALC's New Jersey Assisted Living Facilities



Regulating the New Jersey assisted living industry

When New Jersey first grappled with regulating assisted living in the early 1990s, assisted living occupied the range of care between independent living and nursing home care. This presented a dilemma for regulators. Clearly, the state had an interest in ensuring that residents could age in place in a safe and healthy environment. But how should the state go about regulating this healthcare-residential hybrid? Should the state treat this industry as private housing and provide residents with landlord-tenant protections? Or should the state treat assisted living facilities like nursing homes, subject to extensive patient protections, strict requirements as to who qualifies for the facility, and obligations to care for low -income patients?

After consulting with industry representatives and state health licensing experts, the Department of Health and Senior Services (DHSS) decided in 1993 on a "certificate of need" or "CN" prerequisite to licensure. (*Telephone interview with John Calabria and Barbara Goldman, DHSS, February 29, 2009*). The CN process requires prospective assisted living providers to submit a proposal, thoroughly outlining their planned facilities, to DHSS.

Among other things, prospective assisted living providers must provide sufficient information so that DHSS can determine:

(1) whether the proposal is economically feasible;

(2) whether medically underserved populations will be served; and

(3) whether the proposed facility positively contributes to the existing healthcare landscape.

Essentially, the CN process is a planning tool for DHSS. In particular, it helps DHSS ensure that the facilities built in New Jersey are not inherently at risk of closing down, leaving residents without a home. (*N.J.A.C. 8:33-3.1 et seq.*). Once a proposal is approved and a license granted, assisted living providers must comply with the terms of their approved proposal unless they apply for, and are granted, relief from DHSS. (*N.J.A.C. 8:33-3.9(f)*).

Because New Jersey had not yet been approved for a Medicaid waiver at the time these rules were made, DHSS did not include any requirements, similar to those already found in the nursing home context, that facilities allow residents to convert to Medicaid upon spend-down or to otherwise protect low-income residents. Instead, regulations simply provide that residents may only be discharged in accordance with the terms of their contracts. (*N.J.A.C. 8:36-4.1(a)(36)*). Thus, absent protective CN language - like Assisted Living Concepts, Inc.'s spend-down promise - discharge is governed solely by the resident agreement. In addition, regulations provide that a facility must give residents a 30-day notice of an involuntary discharge. (*N.J.A.C. 8:36-4.1(a)(37)*). The notice must include contact information for the Ombudsman and notice of a resident's right to appeal a discharge (but only to the administrator of the facility). (*N.J.A.C. 8:36-4.1(a)(37)*), (*N.J.A.C. 8:36-5.14*).

DHSS placed few regulatory limitations on the actual contents of assisted living contracts, but did require that facilities be able to provide a nursing facility level of care. *(N.J.A.C. 8:36-5.1, N.J.A.C. 8:33H-1.7*). When these regulations were first adopted in 1993, residents of assisted living facilities tended to have care needs which were best met through the independent living or residential end of the spectrum of care. Even so, the regulations provide none of the pre-removal protections that are available to tenants under New Jersey's landlord-tenant laws. (*N.J.S.A. 2A:18-61.1 et seq.*) Under the Medicaid waiver, approved in 1995, Medicaid would be available to pay for community alternatives (including assisted living) to nursing homes only if the resident met the level of care requirements for a nursing home. (*Omnibus Reconciliation Act, P.L. 97-35 (1981) 42 U.S.C. 1936n*). As a result, more residents of assisted living facilities had greater care needs, and the character of facilities tilted away from the residential model toward the healthcare model. Yet, the regulations were not amended to provide assisted living residents facing involuntary transfer fair hearing rights akin to those afforded to Medicaid-eligible nursing home residents. (*N.J.A.C. 8:85-1.10(g)(2)*).

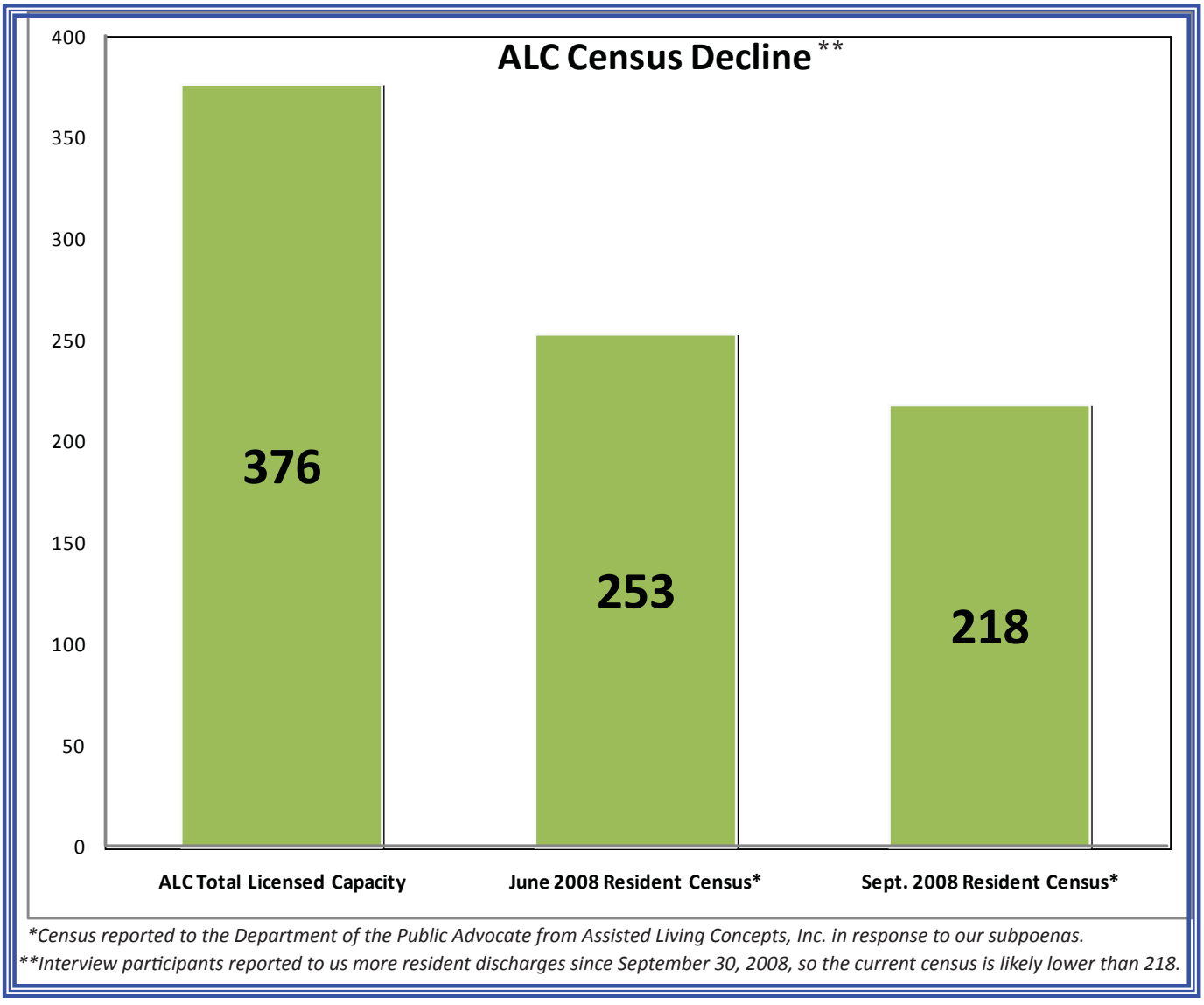
In 2001, the New Jersey Legislature passed a law requiring that the responsibility of caring for low-income elderly be shared among facilities, similar to Medicaid conversion requirements in the nursing home context. (*N.J.S.A. 26:2H—12.16*). The law requires that all assisted living facilities licensed after September 1, 2001 maintain a population of Medicaid-eligible residents equal to 10% of the facility's total population. Facilities are free to achieve the 10% level by directly admitting Medicaid-eligible residents or by allowing private-pay residents to remain after spending down their resources and becoming Medicaid-eligible. Notably, as long as facilities maintain their Medicaid eligible census, the law does not provide protections to any particular resident who is seeking to remain when they become Medicaid-eligible.

Atlantic County; Chapin House in Rio Grande, Cape May County; Granville House in Burlington, Burlington County; and Post House in Glassboro, Gloucester County.[28] At the time, New Jersey's own Medicaid waiver application had recently been approved by the federal government on December 18, 1985.[29] All eight of the facilities submitted "certificate of need" proposals because the state required such facilities to be approved before it would grant the required license.[30] The certificates of need proposals contain the following identical language:

> The Applicant is committed to serving a moderate to low-income population which would include Medicaid eligible clients. The Applicant will apply to become a contracted Medicaid provider to serve low-income eligible clients. Approximately 20 percent of all residents will be Medicaid clients at the opening of the building. As private-pay residents spend-down this percentage may increase to as high as thirty percent. ***Residents will not be asked to move from the Residence because of spend-down situations***. [emphasis added][31]

On May 3, 1996, the eight facilities proposed by Assisted Living Concepts, Inc. were approved as written and licenses were issued.[32]

During the ten years that followed the company's entry into New Jersey, Assisted Living Concepts, Inc. retained the same expansion goals and business model that Concepts in Community



*Census reported to the Department of the Public Advocate from Assisted Living Concepts, Inc. in response to our subpoenas.
**Interview participants reported to us more resident discharges since September 30, 2008, so the current census is likely lower than 218.

Living, Inc. had established. By the end of 1996, the company had more than 50 licensed assisted living facilities in six states – Washington, Oregon, Idaho, Ohio, Texas, and New Jersey. Even as expansion slowed in response to a glut in the assisted living market, the company added facilities in Georgia, Indiana, and South Carolina, and had brought its nationwide facility count to 65 by the end of 1996. Throughout this period, Assisted Living Concepts, Inc.'s New Jersey facilities continued to serve low-income and Medicaid-eligible seniors, consistent with their long-standing business model and promises it had made to the state.[33]

* * * *

Assisted Living Concepts, Inc.'s business model changed after it was purchased by Extendicare, Inc., a Canadian company, in late 2004.[34] In June 2006, Extendicare "spun out" a new iteration of Assisted Living Concepts, Inc.[35] By August 2006, the newly owned company had implemented a revised resident admission agreement, which included provisions limiting the ability of residents to convert to Medicaid after they had spent down their savings.[36] On November 10, 2006, the newly owned Assisted Living Concepts, Inc. was offered for public trading.[37] In its 2006 annual report to shareholders, CEO Laurie Bebo could not have been clearer about the company's change in direction, noting "[d]ue to inherent challenges synonymous with Medicaid participation and because private pay rates generally exceed those offered through Medicaid programs by 25% to 35%, we are actively reducing the number of units available to Medicaid programs."[38]

Consistent with its goal of reducing its Medicaid population, the new Assisted Living Concepts, Inc. subsequently began denying residents the opportunity to convert to Medicaid upon spend-down, including many who had entered under a previous version of the contract. As of the release of this report, Assisted Living Concepts, Inc. continues to adhere to its strategy to minimize the number of residents in its facilities who rely upon Medicaid. The company recently announced that its "long-term business model remains unchanged and we believe we will significantly benefit from both an eventual economic recovery and the continuation of favorable demographic trends."[39]

History of the Public Advocate's Involvement

During the spring and summer of 2007, the Office of the Ombudsman, which investigates abuse, neglect and exploitation in long-term health care institutions, received a notable increase in the number of complaints regarding facilities owned and operated by Assisted Living Concepts, Inc.[40] Most of these complaints related to Assisted Living Concepts, Inc.'s policies about Medicaid acceptance, including the type of room Medicaid beneficiaries could occupy (studio, deluxe studio, one bedroom), whether a Medicaid beneficiary could be required to share a room with another Medicaid resident, and whether private pay residents would be permitted to convert to Medicaid once their resources had been spent down.

Initially, the Ombudsman had success resolving resident complaints on a case-by-case basis. For example, after investigating Assisted Living Concepts, Inc.'s attempt to double-up Medicaid residents in deluxe studio rooms, the Ombudsman substantiated a violation of the New Jersey regulations governing assisted living facilities and referred the matter to the DHSS. DHSS found that the deluxe studio rooms did not have sufficient square footage for two unrelated residents to reside in the apartment together, and those attempts by Assisted Living Concepts, Inc. were halted.

During this same period, a number of residents reported receiving a May 2007 letter from Assisted Living Concepts, Inc. regarding the company's participation in Medicaid. In this letter, residents were informed that while the particular facility they reside in has a limited number of apartments "available for residents who are eligible to participate in the Medicaid program," the quota for the facility has been reached and a unit might

Betty Merklinger, the woman who started it all and the daughter who spoke up

[My mother] asked me, 'Am I going to have to move?' I said, 'You might.' And she said, 'Well, I'm not going to.'

When Marilou Rochford helped her mother, Betty Merklinger, select an assisted living facility in 2002, one thing they liked about Chapin House in Cape May County was the promise that "[Mrs. Merklinger] could age in place and that this would be her last home.'' Staying in one apartment was important because Mrs. Merklinger suffered from dementia and confusion. Having a consistent place to stay was important to her mental health and emotional well-being, Mrs. Rochford said.

For years, Mrs. Merklinger enjoyed the consistency she bargained for. Even after Mrs. Merklinger ran out of funds in September 2004, she was permitted to stay in the facility on Medicaid. From September 2004 until April 2005, the company accepted the Medicaid payments, and the family paid an extra $575 each month so that their mother could remain in a larger, one-bedroom apartment. After Mrs. Merklinger sold her home in 2005, she became ineligible for Medicaid and began to pay for her care from the proceeds of the home sale.

After paying at least $3,400 per month to Assisted Living Concepts, Inc. and a total of $300,000 of her private funds, Mrs. Merklinger again became eligible for Medicaid. Mrs. Rochford offered to resume paying a supplement as she had before so that Mrs. Merklinger could remain in her own apartment. But the company refused to accept the Medicaid. In September 2007, Assisted Living Concepts, Inc. gave Mrs. Merklinger written notice that Medicaid payments would not be accepted and that she would have to leave.

That's when her mother revealed her true spirit, Mrs. Rochford said.

"She could be feisty, and so could I,'' said Mrs. Rochford. "She asked me, 'Am I going to have to move?' I said, 'You might.' And she said, 'Well, I'm not going to.'''

Mrs. Rochford contacted the Public Advocate's office through our Ombudsman's office. Under pressure from the Public Advocate's Division of Elder Advocacy and the Ombudsman, the company agreed to let Mrs. Merklinger use Medicaid and remain at Chapin House.

But when company officials said Mrs. Merklinger would have to move to a smaller studio apartment, Mrs. Rochford opposed the move again and continued to pay the supplementation each month. Mrs. Merklinger remained in her apartment until she passed away this past December.

In a recent interview, Mrs. Rochford reflected on the ordeal. "A part of me did not want my mother's name, or my name, in the public eye,'' Mrs. Rochford said. "Yet somewhere I thought if I don't speak up, no one would speak up for some of these people. My mom had a little bit of a voice through me.'' *(Telephone Interview with Marilou Rochford, March 9, 2009).*

not be available for the residents if and when they become Medicaid-eligible.[41]

* * * *

In early September 2007, the Ombudsman received a complaint on behalf of Betty Merklinger, a then 83-year-old resident of Chapin House, an assisted living facility operated by Assisted Living Concepts, Inc. Mrs. Merklinger had recently spent down her resources and become eligible for Medicaid, but Chapin House refused to allow her to convert from private pay to Medicaid. Instead, the facility issued an involuntary discharge notice telling Mrs. Merklinger that she would be discharged on October 17, 2007.[42] At this point, the Ombudsman determined that a more systemic response was needed. Medicaid problems were too widespread and could potentially harm many elderly residents of Assisted Living Concepts, Inc.'s New Jersey facilities. On September 6, 2007, the Ombudsman referred the matter to the Public Advocate and its Division of Elder Advocacy.

Private Pay versus Medicaid

Part of the reason that some assisted living facilities try to limit their Medicaid populations is that they believe that Medicaid residents are less profitable than residents who can "private pay" with their own resources because facilities can charge a higher rate for the "rent" or "room and board" portion of their bill. However, the Public Advocate found that it's a lot more complicated than that.

The cost of assisted living can be broken down into two distinct parts: (1) the basic rate, which includes the cost of room and board; and (2) the cost of care or services.

When residents are "private pay," they pay both portions of the bill and the amount is dictated by the contract, which presumably reflects rates dictated by the market. The room and board rate will vary at a given facility based on the size of the apartment or room, and whether or not the resident has a roommate. The cost of services will vary depending on the resident's "level of care," which reflects how much care the facility must provide to the resident.

While rates frequently change, presented here are the rates for Assisted Living Concepts, Inc.'s Goldfinch House as of January 22, 2007. For example, a resident living in a studio apartment receiving care services at Level 1 would pay $96/day for the studio and $17/day for the services, and so would pay approximately $3390/month at the 2007 rates.

When a resident utilizes Medicaid in an assisted living facility, the bill gets paid somewhat differently. Medicaid pays the cost of services only, at a rate of $70, regardless of level of care. Residents contribute to the Medicaid payment through a "cost-share." The resident must pay the room and board rate themselves out of their own income. However, facilities are only allowed to charge their Medicaid residents a room and board rate pre-set by the state. While this rate increases slightly every year, the rate was $680.55/month, or roughly $21/ day in 2007. For example, in 2007, a Medicaid resident would pay $680.55 for room and board, and Medicaid would reimburse ALC $70/day for services regardless of private-pay service level need, and so ALC would receive $2780.55/month.

It is important to note that while the Medicaid room and board rate is lower than the private pay rate for a studio, Medicaid reimburses at a much higher daily rate for services, $70/ day, than does a private pay resident at the five lowest service levels under 2007 rates.

2007 Private Pay Rate v. Medicaid Reimbursement Rate

2007 Rates at Goldfinch House*		**2007 Medicaid Reimbursement Rate for a 30-day month** (Studio w/ $70/day Medicaid services)
Room and Board	Services	• Room and Board: $680.55/mth • Service Reimbursement: $2100/mth ($70/day flat reimbursement rate) • **Total: $2780.55**
Studio: $96/day Studio Deluxe: $106/day One Bedroom: $118/day	Level 0: $0/ day Level 1: $17/day Level 2: $31/day Level 3: $45/day Level 4: $59/day Level 5: $73/day Level 6: $87/day	**2007 ALC Private Pay Rate for a 30-day Month** (Studio w/ Level 1 services) • Room and Board: $2880/mth • Service: $510 • **Total: $3390**

2007
$2780.55 Medicaid Rate v. $3390 ALC Private Pay Rate

**2007 Goldfinch House Private Pay Rates on file with Public Advocate*

The Ombudsman also notified DHSS of the growing problem. The Ombudsman and the Public Advocate reviewed Chapin House's 1996 certificate of need application and found that Assisted Living Concepts, Inc. had promised DHSS that, "[r]esidents will not be asked to move from the Residence because of spend-down situations."[43] The Public Advocate also determined that Mrs. Merklinger's contract was consistent with this promise and that the Chapin House administrators repeatedly made oral promises that she could remain in the facility on Medicaid after she had used her private pay resources.[44]

After learning of the results of our collective investigations, DHSS advised Chapin House that its refusal to allow Mrs. Merklinger to convert to Medicaid, and any attempt to involuntarily discharge her, would violate its certificate of need agreement not to discharge residents who have spent-down and are Medicaid-eligible.[45] On October 31, 2007, Assisted Living Concepts, Inc. agreed to allow Mrs. Merklinger to convert to Medicaid. However, Assisted Living Concepts, Inc. refused to commit to converting all Medicaid-eligible spend-down residents of its eight facilities in the future. Instead, the company asserted that its original statement not to discharge any resident for spend-down reasons was not meant to be binding by the company at the time of licensure and DHSS could not legally enforce that provision of the certificates of need. [46]

Concerned that elderly residents of Assisted Living Concepts, Inc.'s New Jersey facilities would continue to be improperly discharged, the Public Advocate launched its broader investigation pursuant to its statutory authority to conduct investigations to protect the health, safety, welfare and consumer interests of the elderly.[47] The Public Advocate sent Assisted Living Concepts, Inc. a letter on December 10, 2007, requesting specific information regarding current and former residents in order to determine if Medicaid-eligible individuals were facing or had faced involuntary discharge after spending-down.[48] The Public Advocate planned to use this information to determine the scope of the harm caused by Assisted Living Concepts, Inc.'s unilateral decision to ignore the commitment in its certificates of need and to reach out to residents, former residents and their family members and caregivers who needed and wanted the Department's assistance.

During this time, the Public Advocate was communicating regularly with DHSS, and learned that Assisted Living Concepts, Inc. had informally asked for relief from the agreement it had made in its eight certificates of need applications to not discharge residents because they had exhausted their savings and needed to convert to Medicaid.[49] Assisted Living Concepts, Inc. appeared to believe that the provisions were not only unenforceable, but also imposed an unsustainable financial burden on the company.

When Assisted Living Concepts, Inc. failed to provide the Public Advocate with the information requested by letter, the Public Advocate issued a subpoena for the information dated January 4, 2008.[50] In early February 2008 letter, Assisted Living Concepts, Inc. "rejected the subpoena in its entirety," claiming that the Public Advocate lacked authority to investigate the company. However, the company promised that it would "not evict any current resident on account of conversion from private pay to Medicaid status at any of its New Jersey facilities," pending completion of its relief discussions with DHSS.[51] In order to avoid disrupting these discussions, the Public Advocate chose to defer enforcing the subpoena, but remained in regular contact with DHSS over the progress of the discussions.

By April 2008, however, the Public Advocate had grown increasingly concerned that Assisted Living Concepts, Inc. was not abiding by its promise to convert residents, pending completion of its discussions with DHSS. The Public Advocate had received reports that at least two Medicaid-eligible Chapin House residents were denied the opportunity to convert to Medicaid upon spend-down. One family member reported that the administrator told him that Assisted Living Concepts, Inc. was no longer accepting Medicaid. We also received information that several residents had already been forced to leave Chapin House.

On May 27, 2008, the Public Advocate filed a court action to enforce its subpoena. On June 12, 2008, the Honorable Maria Marinari Sypek, JSC, ordered Assisted Living Concepts, Inc. to provide

the documents demanded in the subpoena. In her opinion, Judge Sypek wrote that the Public Advocate "would be doing a great disservice to the public and would be turning its back on the Legislature by electing not to conduct any investigations here." [52]

The Division of Elder Advocacy filed a court action against ALC to provide documents demanded in the subpeona.

Assisted Living Concepts, Inc. provided most of the requested information by July 3, 2008, and the Public Advocate was able to begin contacting residents, former residents, and identified family representatives.[53] These individuals were contacted by letter and invited to return a brief survey and also to participate in a more in-depth interview. We received back 275 surveys on behalf of 247 residents and former residents, with nearly 50% of the people who returned surveys requesting in-depth interviews. Ultimately, the Public Advocate conducted extensive interviews with more than 110 people.

As interviews began with residents, former residents, and their family members, it became clear that many residents needed immediate assistance and advocacy. The people we interviewed expressed frustration over their inability to get a straight answer from facility administrators on the issue of Medicaid conversions. Sometimes they were told that conversion wouldn't be a problem. Other times, administrators said they couldn't answer the question until the resident was actually ready to convert. Still other times, administrators told people that Medicaid was no longer accepted - even during the period between February 2008 and September 2008 when the company promised to convert all Medicaid-eligible residents. This uncertainty left many residents unsure whether they should stay at their facility and continue to deplete their private pay resources with the hopes that conversion would be permitted, or make the difficult decision to move out of their home and into another facility while they still had private pay resources. This uncertainty prevented residents from being able to make prudent plans. It is typical for assisted living facilities to require a prospective resident to show proof of the ability to pay privately for some period of time prior to Medicaid conversion. If a resident has spent all of their private funds and is already Medicaid eligible when seeking to enter a new assisted living facility, their options will be severely limited.

The people interviewed expressed frustration over their inability to get a straight answer from facility administrators on the issue of Medicaid conversions.

Recognizing the real harm that this uncertainty was creating, the Public Advocate asked Assisted Living Concepts, Inc. in July 2008, to provide residents with a written copy of its policy on conversion pending completion of its ongoing relief discussions with DHSS. Assisted Living Concepts, Inc. refused, stating that DHSS might, at any moment, relieve it of any obligation to convert residents to Medicaid upon spend-down. In response to this statement, DHSS informed Assisted Living Concepts, Inc. that it was suspending the ongoing discussions to await the results of the Public Advocate's investigation.[54]

Up until this point, both the Public Advocate and DHSS understood that the company intended to make a formal application under the regulations for relief from the conversion provision of the certificates of need proposals. DHSS suspended the informal discussion because it believed that the findings of our investigation would be relevant to Assisted Living Concepts, Inc.'s request for relief.[55] But Assisted Living Concepts, Inc. chose not to submit a formal request for relief.[56] Instead, on October 3, 2008, the company filed an appeal to the New Jersey Appellate Division, seeking a declaration that Chapin House – and, by extension, all of its New Jersey facilities – are not bound by the spend-down provision of the certificates of need proposals and need not convert residents to Medicaid when they have exhausted

their savings.[57] The Public Advocate entered the action as *amicus curiae* or "friend of the court."[58] The Appellate Division recently set a briefing schedule but has yet to schedule a date to hear oral argument on the appeal.[59]

A month after filing in the Appellate Division and well before the court had a chance to review the issue, Assisted Living Concepts, Inc. sent out a letter to private-pay residents and family members informing them, "effective immediately, ALC will discontinue the voluntary practice of accepting conversion of any residents from private pay to Medicaid status." The November 10, 2008 letter went on to inform residents that if they planned to convert to Medicaid within the next six months, they needed to contact the administrator of their facility to begin discharge planning.[60] Within weeks, the company sent out second notices to family members, instructing them to sign a "guarantor agreement," which would make the family member personally liable to the company in the event that the resident did not pay the full private pay rate.[61] Such guarantor agreements created a significant risk that family members would not challenge a Medicaid conversion discharge because of the risk of personal liability should the challenge fail.

As a result of these two letters, the Public Advocate began receiving more calls from residents and their families, a number of whom had previously declined to be interviewed or had simply not returned the July survey. The Public Advocate assisted the residents and families who called in response to these letters, and, in most cases, also conducted full interviews of these residents. In consultation with DHSS and the Ombudsman, the Public Advocate also sent a letter to current residents and their families on December 26, 2008, which updated them on the status of the investigation and appeal, and also advised family members to seek legal advice before signing a guarantor agreement.

Throughout the investigation, the Public Advocate worked closely and collaboratively with DHSS to assist residents who wanted to apply for Medicaid and remain at their facility. In several cases, where it was unclear if a resident would meet state clinical eligibility requirements for Medicaid, the Public Advocate worked with DHSS to ensure that the resident received a clinical evaluation months before financial eligibility. This allowed a resident who did not meet the clinical eligibility criteria to use their last months of private pay resources to move to a different housing situation. In other cases, the Public Advocate successfully advocated for residents to convert to Medicaid and remain at their Assisted Living Concepts, Inc. facility. Some residents, after being fully informed of the situation and their available remedies, decided to move to other facilities.

* * * *

Lillie Hitchner spending time with a younger family member

After the November 10, 2008 letter, it was clear to us that Assisted Living Concepts, Inc. would no longer negotiate over conversion on a resident-by-resident basis. When Lillie Hitchner was deemed Medicaid eligible in December 2008, we worked closely with DHSS and her niece, Sandy Cates.[62] We encouraged Ms. Cates to demand a written involuntary discharge notice which is a necessary legal trigger in the eyes of DHSS in order for it to act. We also worked closely with South Jersey Legal Services, which had agreed to review Mrs. Hitcher's case and possibly file for an order to prevent Lindsay House from evicting her should that step be needed. We spoke weekly with DHSS so that all parties had all pertinent information.

When Sandy Cates received the 30-day notice stating her aunt would be discharged on January 28, 2009, DHSS and the Public Advocate were ready to take the steps necessary to keep Mrs. Hitcher in her home.[63] DHSS exercised its authority to issue "deficiencies" to facilities not in compliance with the assisted living regulations. DHSS fined Assisted

Living Concepts, Inc. $1000 per day, beginning November 10, 2008, for failing to convert Lillie Hitchner to Medicaid in contravention of the 1996 certificate of need. The fine – imposed as of January 14, 2009 – totaled $66,000.[64] During a January 27, 2009 meeting with the facility administrators, Assisted Living Concepts, Inc.'s attorney, and the Public Advocate's Director of Elder Advocacy, Lindsay House informed Ms. Cates that a Medicaid apartment had become available and her aunt could remain at Lindsay House.[65]

DHSS fined Assisted Living Concepts, Inc. $1000 per day, beginning November 10, 2008, for failing to convert Lillie Hitchner to Medicaid in contravention of the 1996 certificate of need.

Lillie Hitchner celebrating her 90th birthday

Since that time, and up until the publishing of this report, the Public Advocate has continued to monitor residents who are close to spending down their savings and who have informed us that they want to remain at their facility or that they want to move, but need time to move somewhere else. We continue to meet with DHSS to discuss these cases and advocate for the wishes of the residents. We will continue to do so until the Appellate Division reaches its conclusion in the pending litigation.

Purpose and Methodology

The Public Advocate is charged by statute to provide "consumer protection and advocacy on behalf of the indigent, the elderly, children, and other persons unable to protect themselves as individuals or a class," and the Division of Elder Advocacy is specifically empowered to investigate issues related to the institutionalized elderly and the expenditure of public funds.[66] Pursuant to this authority, the Public Advocate instituted this investigation in 2007 in order to determine:

- whether Assisted Living Concepts, Inc. was actually carrying out its 2006 policy to refuse Medicaid conversion upon spend-down, resulting in the involuntary discharge of residents who wanted to stay in their homes;
- to whom the spend-down involuntary discharge policy had been, was being, or might be applied;
- whether enforcement of the spend-down involuntary discharge policy violates or jeopardizes a resident's health, safety, or welfare;
- whether Assisted Living Concepts, Inc. was violating laws regulating the assisted living industry when it unilaterally disregarded the provision of its facilities' certificates of need proposal that no resident would be asked to leave a facility because of a spend-down situation; and
- whether enforcement of the spend-down involuntary discharge policy was an unlawful breach of resident admission agreements, oral promises made to residents, or other consumer-protection law, such as the New Jersey Consumer Fraud Act.

From the inception of the investigation, the Public Advocate's plan was to respond thoughtfully to the information discovered to prevent harmful discharges, and to gather information that would assist us in developing and executing a more general and universal advocacy strategy. With those goals in mind, our plan from the beginning was to engage in the following direct advocacy and systemic advocacy strategies:

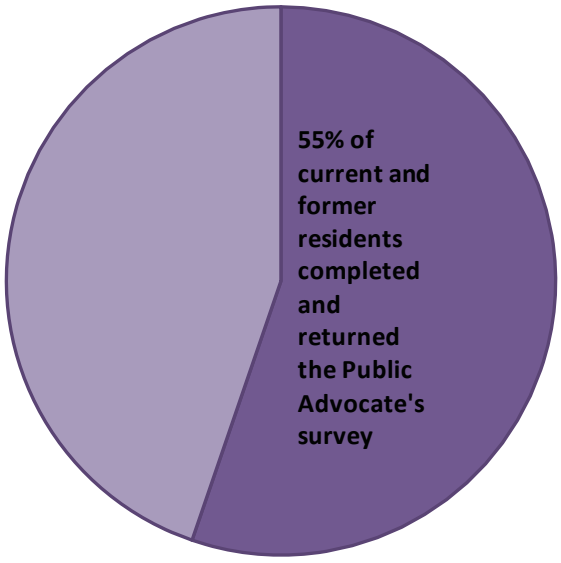
- Conduct in-depth interviews and follow up as needed to provide information to current residents and their families regarding Medicaid eligibility, including information about financial eligibility limits and clinical eligibility criteria;
- Utilize in-depth interviews and continue follow-up to ensure that residents have the most accurate and current information about the position of Assisted Living Concepts, Inc. regarding Medicaid conversion, so that residents could make informed and empowered decisions regarding their future care;
- Refer residents and former residents with possible legal claims to free legal representation;
- Advocate, primarily with DHSS, on behalf of current residents in the six month spend-down window to prevent involuntary discharge and/or to find alternative placement consistent with the wishes of the resident and the resident's legal representative;
- Advocate for legislation and regulations which would allow assisted living residents, in any facility in the state, to convert to Medicaid under specified circumstances, and would give all assisted living residents meaningful procedural protections before independent decision-makers when faced with involuntary discharge; and
- Assess the applicability of the New Jersey Consumer Fraud Act to the potential claims of Assisted Living Concepts, Inc. residents, and the potential for including specific protections for assisted living residents in the Consumer Fraud Act or its regulations.

The Public Advocate's January 2008 administrative subpoena provided the foundation for these efforts. That subpoena demanded, for the period from August 1, 2006, through the production date:

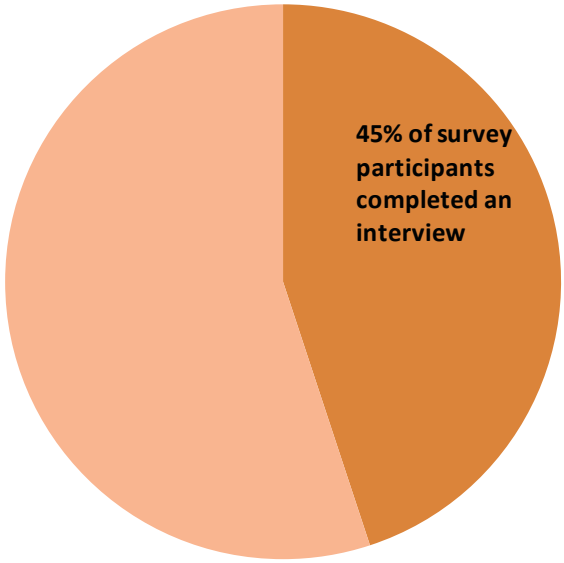
1. The admission/discharge summary (the "face sheet") for each resident, including an explanation of any coding used to identify payment type or other factors;

2. The name and facility address, including room number, for every resident who is or was a beneficiary of the New Jersey Medicaid assisted living residence waiver;

Number of Current and Former Residents who returned surveys: 247 out of 447



Number of Current and Former Residents for Whom The Public Advocate Completed Interviews: 111 out of 247



3. The name and facility address, including room number, of every resident who is presently applying for the New Jersey Medicaid assisted living residence waiver program, to the extent that a facility has knowledge of an application;

4. The date of discharge and reason for discharge for each resident who lived at one of the company's New Jersey facilities during the time period at issue, but who had since left; and

5. All correspondence pertaining to the discharged residents, and the address to which the resident was discharged. [67]

These documents were subpoenaed to allow the Public Advocate to compile a list of all residents who are or were in an Assisted Living Concepts, Inc. facility since 2006, when the company officially unveiled its policy of discharging spend-down residents, including contact information and the names of any family representatives. In addition, the Public Advocate sought the information in order to develop a picture of the resident census so that Assisted Living Concepts, Inc.'s claims of economic hardship could be assessed.

When the company produced most of the information demanded in the subpoena in July 2008, the Public Advocate sent out letters and surveys to current and former residents of Assisted Living Concepts, Inc.'s New Jersey facilities. Where the information showed that a resident had signed a power of attorney, the letter was sent to the resident's agent or "attorney-in-fact." Surveys for participants representing former residents asked, among other things: (1) when the resident left; (2) whether the resident ever tried to convert to Medicaid; (3) why they left; and (4) where the resident was currently residing. Surveys for participants representing current residents asked, among other things: (1) how they currently pay for services; (2) if they are paying privately, whether the resident plans to convert to Medicaid if and when they spend down their resources; and (3) whether the resident is within six months of "spending-down" resources. Both surveys asked participants whether they would like to be contacted for a more extensive interview.

In total, the Public Advocate sent nearly 690 letters and surveys to individuals or their representatives which accounted for 447 current and former residents. Completed surveys were returned on behalf of 247 current and former residents, a far greater response rate than anticipated. Nearly 50% of the people who returned surveys requested in-depth interviews.

While the Public Advocate was awaiting responses and beginning to schedule interviews, the Department finalized tools and protocols for the forthcoming interviews. The Director of the Division of Elder Advocacy trained staff in interviewing technique and on substantive issues, such as Medicaid eligibility. The Public Advocate also created a uniform interview tool, comprised of 36 questions, which focused mainly on care needs, finances, Medicaid history, and history of dealings with the resident's facility. Interviews typically lasted between 45 and 75 minutes, although longer interviews were not atypical since many participants asked complicated questions about financial issues, quality of care expectations, and other concerns. Participants were asked to sign releases authorizing use of the information by the Public Advocate, and were also asked to provide copies of contracts, involuntary discharge notices, and other relevant documents. While conducting the interviews, interviewers also assessed whether we might need to take immediate action to assist the resident – especially those residents within six months of spend-down and those residents who would clearly not qualify for Medicaid in an assisted living even after spend-down.

During the period between August 18, 2008, and January 31, 2009, Public Advocate staff conducted 111 interviews of residents, former residents, and their representatives.

When the interview process was completed in January 2009, the Public Advocate collected and tabulated the participants' answers. The data that resulted was combined with information provided in the surveys returned by people who did not wish to participate in the extended interview. This information was, in turn, combined with the census information provided by Assisted Living Concepts, Inc. in response to the Public Advocate's subpoena and a follow-up subpoena that sought the same

information for the period immediately after the production date through September 30, 2008. This allowed the Public Advocate to develop a more complete understanding of what was actually happening at Assisted Living Concepts, Inc.'s eight New Jersey facilities since it officially unveiled its new spend-down involuntary discharge policy in November 2006.

The Public Advocate's Advocacy to Date

Beginning with our initial efforts to help Betty Merklinger remain at Chapin House, the Public Advocate knew that our investigative work could not focus exclusively on making policy recommendations about what regulatory standards Assisted Living Concepts, Inc. should be held to, or even advocating more broadly for general consumer-oriented reform of the assisted living industry. No doubt, these objectives are important, but it was equally important to provide immediate and individualized advocacy and assistance to the elderly consumers we are charged with protecting. To those ends, our advocacy took the following forms.

* * * *

(1) We empowered residents and their families as consumers, educating them to make meaningful, informed choices.

When William Trimmer's daughter, and agent under his power of attorney, contacted the Ombudsman in early January 2008, it was to inquire about her father's ability to convert to Medicaid at Mey House. Mr. Trimmer was 85-years-old at the time and had been living at Mey House for more than two years. His daughter, Connie Kruegl, was concerned because she had received the May 2007 letter from Assisted Living Concepts, Inc. informing her that Mey House's Medicaid rooms were full. She was wondering if she had to worry about what would come next. The Ombudsman referred Ms. Kruegl to the Public Advocate.

"When Dad got a letter from corporate informing him of the change in policy, they assured both Dad and me that he would have no problem – they told us to ignore the letter," Ms. Kruegl recalled in a letter to the Public Advocate. Ms. Kruegl was looking for our assurances that her father would be allowed to remain at Mey House because, she told us, "He was down to his last $19,000 and when I talked to the administrator right after the New Year that he would need to start the Medicaid process, the color drained from her face." Ms. Kruegl told the Public Advocate that she knew at that moment that Mey House might not allow her father to convert to Medicaid.

When Dad got a letter from corporate informing him of the change in policy, they assured both Dad and me that he would have no problem – they told us to ignore the letter.

What Ms. Kruegl told the Public Advocate next helped us give her the critical information she needed to make the best decision for her father: Mr. Trimmer was teaching an exercise class and running a bible study group at the facility. Based on a quick phone analysis of Mr. Trimmer's need for assistance with his activities of daily living, the Public Advocate was concerned that he would not meet the clinical level of care requirements for Medicaid. Ms. Kruegl was referred to the Supervisor of the Program Operations Unit, the office within DHSS that oversees New Jersey's assisted living Medicaid program. The office quickly helped set up a clinical evaluation, which found that Mr. Trimmer did not qualify for Medicaid.

Ms. Kruegl said Mey House had never told Mr. Trimmer that he would need to require a nursing home level of care to remain there on Medicaid. Because she knew to get the evaluation done, and with the help of DHSS, was able to get it done quickly, Mr. Trimmer still had most of that $19,000 when he left Mey House. Mr. Trimmer now lives with his daughter. Ms. Kruegl is making sure the money is saved, should he need to go to another facility in the future. [68]

* * * *

One of the most important functions that the Public Advocate served throughout the past 18 months was to provide accurate, complete, up-to-

date information to residents or family members, which allowed them to make more informed decisions about future care. Large numbers of residents and family members lacked basic information about assisted living, Medicaid, and the other housing or healthcare options available to them should they have to leave or want to leave. Most significantly, until they spoke with us, many residents and family members mistakenly believed that the resident would be able to convert to Medicaid without difficulty. This misimpression took two forms.

First, many people didn't understand that the Medicaid eligibility rules for assisted living might prevent the resident from converting upon spend-down. The people we spoke with usually had a vague sense that they needed to "spend down" their assets, but generally had no understanding that the program is not an option for those who exceed income limits.[69] Similarly, like Mr. Trimmer's daughter, people did not know that the resident must need a "nursing facility level of care" in order to be eligible for the program.[70] We also encountered residents who had transferred assets, unwittingly in many cases, and perhaps disqualified themselves for five years from receiving Medicaid through any of New Jersey's waiver options, including assisted living.[71]

Second, many people didn't understand that even if they were found eligible for Medicaid,

Am I eligible for Medicaid in an assisted living facility?

If you want to use Medicaid to pay for the cost of your care in an assisted living facility, you must meet certain eligibility requirements. Medicaid is complicated and there are many different rules for different programs. It is important to note that the Medicaid program only pays for assisted living care through a 1915(c) Medicaid waiver called Global Options for Long Term Care. The rules for becoming eligible are different than the rules that may apply to individuals seeking to use Medicaid in the community or in a nursing home. You can find more information about Global Options at http://www.nj.gov/health/senior/go_htt.shtml.

In order to have Medicaid as the primary payor source in an assisted living facility, you must meet Medicaid's eligibility criteria.

- First, applicants must be either 65 years old or older or between the ages of 21 and 64 with a physical disability.
- Second, an applicant must be determined to be clinically eligible. This means that the individual needs a nursing home level of care. *(N.J.A.C. 8:85-2.1).* The Department of Health and Senior Services defines "nursing facility level of care" to mean that the individual needs "hands-on" assistance with at least three activities of daily living. The seven activities of daily living DHSS considers are: bathing, dressing, toileting, eating, being able to move in bed, transfer, and ambulation. Even if an applicant cannot show they need "hands-on" help with at least three of these activities, they may still be deemed to qualify for "nursing facility level of care" if they have a cognitive impairment, and need "cueing" or supervision to self-perform three activities of daily living.
- Third, Medicaid has strict financial eligibility requirements.

* For 2009, an individual applicant cannot have a monthly gross income that is more than $2022. The income limits increase slightly each year. Applicants or residents with income above this number may still be eligible for long term care Medicaid under the Medically Needy Program, but this program applies only in nursing homes, not in assisted living facilities. (Residents whose income is below the threshold for the Medicaid assisted living program, $824.05 in 2009, must apply for an SSI supplement at their local Social Security office). *(42 USC 1382(a)(3)(B); Medicaid Communication 95-11).*

* In addition, the resource limit for an individual is $2000. Certain resources are excluded, such as your home, your car, and your wedding rings. Other resources, such as a life insurance policy with a face value of more than $1500, are included and can unexpectedly put an applicant over the resource limit. *(N.J.C.A. 10:71-4.4).* You might also be denied Medicaid if you transfer assets, so you should review the rules before making any gifts or transferring assets for less than their actual value. Financial eligibility can be complicated. You should talk to an elder law attorney if you have any questions or problems. *(42 USC 1382(a)(3)(B)).*

Assisted Living Concepts, Inc. might not voluntarily allow the resident to convert. Once armed with this information, residents and their families were forced to make a very difficult decision. Should the resident wait to see how the Appellate Division rules? Should the resident seek legal representation and fight it out in court? Should the resident seek out low-income senior housing and apply for home health aide services through other home and community-based Medicaid programs offered by the state? Have the resident's care needs increased to a point where a nursing home can best meet those needs? Should the resident move on to another assisted living facility where conversion will be guaranteed?

These decisions were time-sensitive because many assisted living facilities require prospective residents to demonstrate the capacity to pay privately for at least 12 months before being permitted to convert to Medicaid. Indeed, as residents remained in their facilities, they continued to spend down the very funds that they may later need to acquire a place in another facility.

These consumer education efforts by the Public Advocate were complex, and required on-going research and training of staff, but those who availed themselves of our services were well-equipped to make informed decisions about their own or their loved one's future care. While challenging, it was our belief that these crucial long-term care decisions should rest not with Assisted Living Concepts, Inc. – after it had allowed the resident to spend all their private resources – but with the resident supported by caring family members, who are armed with the knowledge they need to make their best choices.

(2) We worked with our sister state agencies to help Medicaid-eligible residents remain at their facilities or smoothly transfer to another placement if they so chose.

* * * *

When Joan H. first called the Public Advocate in late August 2008, she was on her way to vacation in North Carolina. She had received our survey on behalf of her father, W.S., an 82-year-old resident

How do I apply for Medicaid to cover the cost of my assisted living care?

The application process for Medicaid under the Global Options for Long Term Care waiver (including assisted living care) is in a period of transition. The state is moving toward a one-door entry system called Aging and Disability Resource Centers (ADRCs) which should be statewide by the end of 2010.

Until that transition is complete, you or your representative can apply for Medicaid at your county welfare agency, also known as the Board of Social Services. They are there to walk you through the process. In general, you will need to fill out an application, provide requested financial documentation, and get your physician to fill out a form called at PA-4 form, which substantiates your diagnosis and describes your care needs. The county welfare agency, working on behalf of the state Department of Human Services, will determine whether you meet financial eligibility criteria. Once financial eligibility is determined, the county welfare agency will notify DHSS to begin the clinical eligibility process. Caution: this sometimes takes too long and your Medicaid eligibility isn't approved until after you no longer have private pay funds.

The Department of Health and Senior Services (DHSSS) will determine if you are clinically eligible, and so you may begin the process to be clinically evaluated through DHSS – even before you apply for financial eligibility through the county welfare agency. Currently, the process for determining clinical eligibility is in flux. In some counties, a nurse from the regional Office of Community Choice Options (OCCO) will visit you to conduct an evaluation. In other counties (presently Atlantic and Warren counties), the state is opening up Aging and Disability Resource Centers (ADRC), which will send out nurses to conduct the evaluation.

If you are already living in an assisted living facility and wish to apply and schedule a clinical evaluation, you may either ask your resident director or administrator to have the facility complete a DHSS form called the Assisted Living/Adult Family Care referral form, or if the facility is unwilling to assist, you may submit this form to DHSS yourself. This form can be found at http://web.doh.state.nj.us/apps2/forms/. You can begin the clinical evaluation process with DHSS this up to 180 days in advance of becoming financially eligible. (N.J.A.C. 8:85-1.8). This is very important because the Medicaid Global Options waiver will not pay the facility retroactively and the delay may create a period of non-payment to the facility.

of Granville House. Joan H. wanted to touch base, but was unconcerned: the administrator had always assured her that her father would be able to remain Granville House on Medicaid.[72]

But by mid-October, Joan H.'s casual inquiry took on urgency. Her father had been found financially eligible for Medicaid on October 1 and clinically eligible on October 14. He had less than $2000 in the bank, but his monthly private pay rate at Lindsay House was more than $4000. He could not afford to stay into November without Medicaid. Despite speaking with that same administrator day after day, Joan H. could not get an answer as to whether or not her father would be allowed to remain at Granville House on Medicaid. Because this conversion arose after discussions had broken down between Assisted Living Concepts, Inc. and DHSS, and after the company had filed its appeal, the Public Advocate was uncertain if the company would honor its February promise to convert Medicaid-eligible eligible residents.

We turned again to the Supervisor of the Program Operations Unit, a DHSS office that repeatedly came through for at-risk residents throughout this trying time. The Program Director reviewed W.S.'s file, and found that the Assisted Living slot request form had been signed by the administrator on October 14, 2008, stating that the facility agreed to convert Joan H.'s father to Medicaid.[73] Understanding the stress that Joan H. was experiencing, the Program Director hand-delivered the form to the Public Advocate the very same afternoon. The form was faxed to the company's attorney, and Joan H. soon had her answer: her father would be allowed to remain at Granville House on Medicaid.

This is just one example of the close and collaborative work in which the Public Advocate, the Ombudsman, and DHSS engaged to assist residents who were approaching eligibility to convert to Medicaid. Throughout this period, DHSS and the Public Advocate's staff held weekly conference calls to monitor the status of each resident we knew about who was nearing conversion and wanted our help. When a resident faced a complicated financial eligibility issue, we sought the advice and participation of the Department of Human Services (DHS), which administers the financial aspects of the Medicaid program, as well. Together, the agencies jointly assisted the residents, helping them to convert to Medicaid and remain at their Assisted Living Concepts, Inc. facility. The agencies also worked together to aid residents who decided to move on to nursing homes (where different Medicaid eligibility rules apply), by coordinating agency activity to enable a smoother transition.

(3) In collaboration with DHSS and the Ombudsman, we sent out a second direct mailing to all current residents and family members in December 2008.

The Public Advocate received many calls from residents and family members both in response to Assisted Living Concepts, Inc.'s November 10 letter regarding participation in the Medicaid program and its letter sent shortly thereafter to family members instructing them to sign and return "guarantor agreements" no later than January 1, 2009.[74] The Public Advocate determined that we needed to reach out once again to all people potentially affected by these letters, and do the best we could to explain a very complicated situation. We consulted with the Ombudsman and DHSS regarding the content of the letters, and how to best direct those who had more questions, without panicking residents and their families. On December 26, 2008, the Public Advocate sent a second letter to current residents and their families.

Our first letter addressed Assisted Living Concepts, Inc.'s request that family members sign guarantor agreements. After explaining that by signing a guarantor agreement the family member may become personally liable for amounts due under the resident's agreement, we cautioned that this agreement, or any new agreement Assisted Living Concepts, Inc. asked them to sign, should be reviewed by an attorney before signing. We provided the telephone number for New Jersey Lawyer Referral Services by county, and invited people to call us directly if they had further concern.

Several family members did call us to discuss the guarantor agreement after receiving our letter. Susan Albright, whose mother is a resident of Mey House, met with an attorney, who instructed her not to sign the guarantor agreement. Ms. Albright also met with the administrator of Mey House and a corporate representative to discuss the agreement. When she asked what would happen if she didn't sign, the corporate representative told her that nothing would happen, except that the bills would be delivered to her mother rather than directly to her as her mother's agent under a power of attorney.

Our letter next addressed Assisted Living Concepts, Inc.'s November 10 letter in which the company stated it would no longer voluntarily accept Medicaid conversion and advised that residents who were within six months of exhausting their private savings would need to begin discharge planning. Specifically, our December 26 letter let residents know the following:

- That the issue of whether or not their facility could discontinue accepting Medicaid conversion was the very issue before the Appellate Division, and that we had no way of knowing when the court would make its decision.

- That residents within the six month spend-down window have a right to receive a written involuntary discharge notice 30 days before discharge; that upon receiving written notice, they could call the DHSS Complaint Hotline; and that if the facility began discharge planning and refused to give them written notice, they could call us at the Public Advocate for assistance.

(4) After finding out that Medicaid applicants were getting wrong information at their County Welfare Agency, we informed DHSS and DHS so that they could rectify the problem.

* * * *

Karen Berry took her responsibility to care for her aunt, Kathryn "Kitty" Wright, very seriously. When her aunt moved into Goldfinch House in May 2005, she reviewed the residency agreement and understood that the contract allowed Mrs. Wright to convert to Medicaid after spend-down. She also read the Medicaid Policy disclosure, and knew she needed to notify Granville House and apply for Medicaid when her aunt's funds were below $15,000.

So Mrs. Berry was surprised when she went to the Cumberland County Board of Social Services in August 2007, after her aunt was under this $15,000 threshold, to begin the process and was told that it was too early to apply. The caseworker told her to come back when Mrs. Wright resources were less than $2000.[75] The caseworker even had Mrs. Berry sign a form stating that she "was satisfied that no application" was taken because her aunt was over resources. Mrs. Berry left, taking with her hand-written notes where she made a list of the items to bring back when the time came. On that list was a note to bring in copies of any insurance policies.

Mrs. Wright applied for Medicaid, through her niece, on December 21, 2007. She was already in her last month of private pay, and did not have enough money to pay for January. The caseworker told Mrs. Berry she needed to provide the Board with three additional pieces of information: a PA-4 health form completed by Mrs. Wrights' doctor, a death certificate for Mrs. Wrights' husband, and a copy of the face value and cash value for Mrs. Wrights' life insurance policy. Mrs. Berry hand-delivered these documents to the Cumberland County Board of Social Services on January 18, 2008, and assumed that Mrs. Wright would be found eligible for Medicaid at Granville House within the month, since she no longer had the funds to private pay.

During her visits to and conversations with the Board... Mrs. Berry was never told that her aunt's life insurance policy would likely need to be cashed in and spent down if the face value was over $1500.

During her visits to and conversations with the Board between August 2007 and January 2008, Mrs. Berry was never told that her aunt's life insurance policy would likely need to be cashed in and spent down if the face value was over $1500.[76] She was never told that her aunt would need to be screened for clinical eligibility for Medicaid, and that this

process could happen while the financial eligibility application was pending. She was never told that Medicaid would not pay for the costs of assisted living back to the beginning of January, but only from the date Mrs. Wright was determined both financially and clinically eligible for Medicaid.[77]

Mrs. Berry waited and waited for an answer from the Board of Social Services. By March, after being told by the caseworker that she was still working on the file, she hired an attorney to help. As it turned out, Mrs. Wright did have a life insurance policy that needed to be spent down, and as a result, she was not financially eligible until April 1, 2008. Because of the delay in financial eligibility, a clinical eligibility determination was delayed as well. Mrs. Berry was finally found eligible for Medicaid in an assisted living on April 14, 2008.

Her niece told us that her aunt would sit in her wheel chair by the nursing home door everyday waiting for someone to bring her back home to Goldfinch House.

By then it was too late. By notice dated March 12, 2008, Assisted Living Concepts, Inc. informed Mrs. Wright that she was being involuntarily discharged for non-payment on April 12th. Goldfinch House refused to consider allowing Mrs. Wright to convert to Medicaid unless she repaid the amount outstanding since she had last paid privately. Of course, she could not do that because her resources were below $2000.

In addition, Mrs. Wright had been hospitalized in April, so it was more difficult to convince Goldfinch House to take her back into the facility, rather than keep an existing resident. Mrs. Wright was transferred from the hospital to a nursing home. Her niece told us that her aunt would sit in her wheel chair by the nursing home door everyday waiting for someone to bring her back home to Goldfinch House. Mrs. Wright was sitting by the door in early August when she fell getting up from her chair; Mrs. Berry believes her aunt was trying to go back to Goldfinch House. On August 14, 2008, Mrs. Wright died as a result of the injuries she suffered in the fall.

On some level, despite doing everything in her power to care for her aunt, Mrs. Berry still wishes that something different could have been done. "I feel that if my Aunt had been allowed to return to the Goldfinch House that she would be here today," she told us recently.[78]

Kathryn "Kitty" Wright

Unfortunately, the Public Advocate did not learn of the problems Mrs. Berry was experiencing with the financial application process until well after the problem could be rectified. However, in other cases, we learned through the interviews that applicants or their representatives were being told by a County Welfare Agency (CWA) (also known as a county Board of Social Services) that the Medicaid applicant could not apply until resources were below $2000. This was particularly a problem for residents who applied through the Burlington County Board of Social Services.

By regulation, residents may apply before, and are encouraged by DHSS to begin the clinical eligibility process up to 180 days before they are financially eligible.[79] Early application is preferable for assisted living residents because Medicaid will not pay retroactively, for unpaid bills incurred before both financial and clinical eligibility are determined.[80] Where residents wait to apply, even if they are converted to Medicaid later, there may be a period of non-payment which could be a basis for a discharge if family cannot help pay the bill temporarily.

We also spoke with family members who were helping married parents who both lived

in an Assisted Living Concepts, Inc. facility and needed to convert to Medicaid. There, too, we frequently heard that the CWA gave the applicants the incorrect financial eligibility information. In particular, married applicants were treated as separate individuals, rather than as a married couple, in the income eligibility assessment by the CWA. This sometimes resulted in one spouse being found income eligible and other being found income ineligible. Spouses should have their incomes added together and compared to twice the individual income eligibility limit.[81]

Throughout the investigation, we regularly spoke about these eligibility issues with both DHSS and the Division of Medical Assistance and Health Services (DMAHS), the division responsible for the Medicaid program in the Department of Human Services (DHS). Where we discovered that applicants were receiving this misinformation from the CWA, DMAHS clarified Medicaid

The Giordanos feared separation after 80 years of marriage

When Assisted Living Concepts, Inc., decided to stop allowing residents to convert to Medicaid, the news was especially bitter for Dominic and Jennie Giordano – 96 and 95 years old, respectively.

The pair had had recently exhausted all of their life savings on monthly payments of roughly $6700 to Assisted Living Concepts, Inc.'s Lindsay House in Pennsville, Salem County. Just two months before, the facility's administrator had assured them that they would be able to convert to Medicaid when their money was gone, and even helped them move into a smaller Medicaid apartment. Now they were being told they'd have to move out of the facility.


Dominic and Jennie Giordano

To make matters worse, the County Welfare Office which handles Medicaid applications informed their son, Mike Giordano, that his parents couldn't stay anyway: while Dominic's income was within Medicaid limits, Jennie's income - $2215 per month - was too high to receive Medicaid in an assisted living facility.

Both had incomes low enough to qualify for Medicaid in a nursing home, but Mike worried that his father – whose care needs were always much lower than his mother's – would not qualify for care in a nursing home. After 80 years of marriage, they might have to find separate places to stay. He was afraid his father, who had suffered a stroke, and his mother, who has symptoms of dementia, would be forced to split up for the first time since they were married – at the age of 15.

"That was like a slap in the face. My stomach just dropped,'' said their son, Mike Giordano, of Pennsville. "I said, 'How do you expect me to separate people who've been married for 80 years?' I was sure that one of them would be dead within a week.''

Concerned, Mike contacted the Public Advocate, and learned that the county Medicaid office was miscalculating his parents' income eligibility. In fact, their incomes should have been added together, and divided, rendering them both income-eligible for Medicaid in an assisted living facility. The Public Advocate also helped to arrange for a clinical evaluation for Mr. Giordano, which revealed that he would be found in need of a nursing facility level of care, the eligibility threshold for both nursing homes and assisted living facilities. Thus, it was up to his parents, with Mike's help, to decide whether the couple should move on to a nursing home or fight to stay at Lindsay House.

After consulting with the Public Advocate, Mike decided to move his parents to a nursing home where they could share a private room and bath. Since Mrs. Giordano's income – when not combined with her husband's and divided – was too high for Medicaid in an assisted living facility, Mike decided to move his mother now so that she wouldn't face another discharge situation should she outlive Mr. Giordano.

Mike helped his parents move to a nursing home in December, and recently told the Public Advocate that the move was a "blessing in disguise" because he parents were receiving more attentive care at the nursing home.

While confident that he made the right decision, Mike says he's still angry that Assisted Living Concepts , Inc. announced its policy change with almost no notice. The company didn't help him find a new place for his parents to live or help him figure out the Medicaid rules, Giordano said.

He added, "We should have been treated better than that." (*Telephone Interview with Michael Giordano, January 15, 2009*).

financial eligibility policy and intervened where necessary.

(5) We have participated, and will continue to participate, as *amicus curiae* in the appeal filed by Assisted Living Concepts, Inc. regarding the enforceability the provision of their certificates of need proposal to retain Medicaid-eligible residents.

On December 5, 2008, the Appellate Division granted the Public Advocate's motion, filed on October 29, 2008, to participate as *amicus curiae* in the matter of Assisted Living Concepts, Inc. v. the New Jersey Department of Health and Senior Services.[82] Assisted Living Concepts, Inc. filed this appeal challenging both the authority of DHSS to defer a decision on the company's informal request to be relieved from the enforceable agreement made in its certificates of need applications to permit Medicaid conversion, and the October 2007 letter from DHSS advising the company that the involuntary discharge of Betty Merklinger would violate Chapin House's certificate of need.

Assisted Living Concepts, Inc. is seeking a declaration from the Appellate Division that the provision in its certificates of need, which stated that "residents will not be asked to move … beacuse of spend-down situations" is not binding.[83] The Public Advocate sought to enter the litigation because we are uniquely situated to advise the court on the information we gathered through our investigation into Assisted Living Concepts, Inc. and impact the company's 2006 decision to reduce the number of residents relying on Medicaid has had on residents.[84] The Public Advocate, and its Division of Elder Advocacy, also has the substantive expertise to advise the court in this matter.

The Appellate Division set a briefing schedule by Order dated February 18, 2009. All briefs are due to the court no later than May 11, 2009.[85] We expect the matter to be scheduled for argument in the early summer. The Public Advocate will submit an extended brief and participate in oral argument if permitted by the court.

Investigation's Key Findings

The Public Advocate concluded our active investigation on January 31, 2009, having conducted 111 comprehensive interviews , as well as extensive policy research. We found that Assisted Living Concepts, Inc. changed its corporate Medicaid policy, from one that promised low- and moderate-income residents would be able to convert to Medicaid and remain in their homes, to one which sought to increase shareholder profits by reducing the number of residents who rely on Medicaid. For many former residents, this policy led to their involuntary discharge. For many current and former residents, this policy has been detrimental to their physical health, mental and emotional health, and financial well being. In particular, we conclude that, consistent with the company's national strategy, announced in November 2006, to reduce the number Medicaid residents at its facilities, Assisted Living Concepts, Inc.:

- reneged on the enforceable agreement contained in its original certificates of need applications to allow Medicaid-eligible residents of its New Jersey facilities to remain at their facilities after spending all of their private savings, and it did so without seeking approval from DHSS prior to implementing that change in policy, as is required under the regulations;
- implemented a new version of the resident admission agreement, which limited a resident's ability to convert to Medicaid compared to versions of the contract; residents who moved in after June 2006 were asked to sign this contract, as were existing residents and family members who had signed more beneficial contracts when they first moved into the facility;
- as early as 2005, began using marketing techniques with new residents, including special pricing incentives and oral promises regarding a resident's ability to convert to Medicaid upon spend-down;
- gave residents unclear, inconsistent, and sometimes contradictory, information

about their ability to convert to Medicaid, which resulted in residents and family members being uncertain about the resident's rights and options to remain at their facilities after spend-down;

- discharged Medicaid-eligible or soon to be Medicaid-eligible residents involuntarily upon spend-down, many of whom did not want to move; in most cases, they were discharged without being provided with the 30-day involuntary discharge notice mandated under the assisted living regulations;
- allowed residents to drain their life savings with the promise of Medicaid conversion when the facility should have known the resident was unlikely to be found Medicaid-eligible; and
- implemented this Medicaid-adverse policy to the detriment of residents and former residents, inflicting financial, social and emotional harm, although several former residents and family members report that the former residents received better care at their new facility after leaving the Assisted Living Concepts, Inc. facility.

Our conclusions are based on the following findings:

(1.) Many residents and their families report being promised conversion.

Many interview participants told us that at the time the resident was choosing and entering the facility, and even after moving in, the resident and/or family members believed that Assisted Living Concepts, Inc. promised that the resident could convert to Medicaid when eligible. People attributed this belief to the written terms of the resident admission agreements, marketing materials utilized, and the oral promises made by facility staff.

Of the 111 participants interviewed, 28 were able to produce resident admission agreements or contracts. We reviewed these contracts and determined that half were entered into before August 2006 and half were entered into after that date. In addition, we discovered that at least two different versions of the contract were used before 2006: a 2002 "Rental Agreement" and a 2003 "Residency Agreement." In keeping with Assisted Living Concepts, Inc.'s business model at the time, both pre-2006 vesions contain language consistent with a resident's right to convert to Medicaid upon spend-down. In fact, both versions of the pre-2006 contracts specify that in the event the resident converts to Medicaid, the resident could be required to move to a smaller room or share a room. Neither pre-2006 contract contains language indicating that conversion is conditional.[86]

From our review of various contract addenda utilized before 2006, it appears that prior to 2006, some but not all Assisted Living Concepts, Inc. residents received a 2004 Medicaid policy addenda in addition to the resident admission agreement.[87] Based upon our research, we believe that Assisted Living Concepts, Inc. began providing residents with these 2004 Medicaid addenda in order to comply with two DHSS' Division of Aging and Community Services memoranda, requiring such a notice.[88] In contrast to the 2002 and 2003 versions of the resident admission agreements entered into during this period, the 2004 Medicaid policy addendum does limit the number of Medicaid units at each facility to eight.

Throughout our interviews, some participants recalled that Assisted Living Concepts, Inc.'s marketing tactics promised they could convert to Medicaid when eligible. Several participants remember receiving marketing materials regarding seasonal specials that offered new resident discounts on base rates for a limited period of time, but noted that the resident could not convert to Medicaid during the first 12 months. At the time of contracting, some residents were also asked to sign an addendum, promising not to convert to Medicaid for 12 months. Some participants told us that they drew a logical inference from the

Promised the 'Winter Wonderland' special


Julia Elkins with her son Jeff

When the Residence Director of Chapin House in Rio Grande, NJ, told Daniel Elkins his mother would have to move out because she was running out of money, Elkins made his position clear.

"I said, 'How do you think you're going to get her out? I've got a signed contract here, and I'm not going to physically move her. And if you guys try to move her, you're going to have every TV camera in the area in your front parking lot,' '' he remembered in an interview with the Public Advocate.

To Mr. Elkins, the agreement with Chapin House could not have been more clear when his mother moved in, back in January 2007. The company had called it a "Winter Wonderland" special, and it worked like this: His 87-year-old mother, Julia Elkins, would get a month's free rent at the company's Chapin House residence, and she would not be able to apply for Medicaid for one year.

Mr. Elkins says he lived up to the terms of the "Winter Wonderland" special offer. His mother faithfully paid up to $4,000 a month to Chapin House so that she could stay in what he describes as "a nice little apartment. She had a bed and a bureau, with pictures of everybody and a TV. She was comfortable.''

By July 2007, Mr. Elkins realized that his mother would likely deplete her resources in the next six months and told the facility's then-Residency Director. Elkins said he was told, "not to worry about it."

In March 2008, after having private paid for more than the 12 month "Winter Wonderland" special, Dan Elkins applied for Medicaid on behalf of his mother and informed Chapin House that she would be converting. After some confusion, the new Chapin House administrator told him that his mother was going to have to leave because, the company was no longer taking new Medicaid residents.

Mrs. Elkins was already suffering from dementia, Mr. Elkins said, and he didn't want his mother to be forced to adjust to a new environment. "It was 10 minutes from our house. We could see her every day. She was comfortable, and we liked the people who worked there. All the staff liked her,'' he said.

After speaking to an attorney at South Jersey Legal Services, Mr. Elkins contacted the Public Advocate's Division of Elder Advocacy, which was surprised to learn that Lindsay House was forcing Mrs. Elkins to leave, given that Assisted Living Concepts, Inc. had recently promised to convert Medicaid-eligible residents who spend down.

Mr. Elkins worked with the Public Advocate and ultimately got Chapin House to let his mother convert to Medicaid and remain in the facility.

For nearly another nine months, Julia Elkins lived in Chapin House until, on January 2, 2009, deteriorating health forced her to move to a nursing home.

Today, Dan Elkins says he doesn't regret standing up to the company. He didn't think that was the right way to treat his mother, who was never a wealthy person. "She lived for 50-some years in the home I was born and raised in, a typical World War II row home in Darby, (Pennsylvania),'' Mr. Elkins says.

Mr. Elkins said he witnessed other residents in the Chapin House move out when the company asked them to leave, but that never seemed like the right option to him. His mother had rights, he figured. "We had a signed contract.'' (*Telephone Interview with Daniel Elkins, February 26, 2009*).

addendum: If they were agreeing not to convert to Medicaid for one year, they assumed that they could convert when that year was over. Other family members reported that the administrator or other marketing staff actually told them they could convert to Medicaid at the end of that year, but not before.

Many participants in our interviews also reported to us that one or more Assisted Living Concept, Inc. employees – usually the facility administrator - unequivocally promised that the resident could convert to Medicaid upon spend-down. Most often, participants reported that these oral representations were made at the time of entry. A number of residents recalled that the promise was repeated throughout a person's residency. Significantly, of the 111 participants interviewed, 53 reported to us that the facility administrator promised, without condition, that the resident would be able to convert to Medicaid upon spend-down.

As we reviewed results, we noticed that there was variation in the rate participants reported oral promises, depending on their particular Assisted Living Concepts, Inc. facility. For example, 81% of the participants who spoke to us about Lindsay House reported that the administrator unconditionally promised that the resident could convert to Medicaid, while only 25% of the participants who spoke to us about Baker House reported the same. We also found some variation between current and former residents in the rate participants reported administrators made oral promises. While 55% of the former residents

Facility didn't tell him he'd be ineligible until he spent $250K

More than anything, 87-year-old Robert Jenkins just wanted to keep his cat, Jack, who sits on his lap almost 24 hours a day. Suffering from Alzheimer's, Mr. Jenkins doesn't know all the financial details that recently caused turmoil in his life. He doesn't know that Assisted Living Concepts, Inc. forced him to leave his residence because his money ran out and he did not qualify for Medicaid.

But he knows about Jack, his shy, long-haired orange and white feline friend. "The cat is his whole tie to reality,'' says Mr. Jenkin's son, Adam. "It's something he knows, every single day.''

World War II veteran Robert Jenkins and his cat Jack

After his father lived at Assisted Living Concept's Lindsay House in Pennsville for more than five years, Adam Jenkins learned that his father would soon run out of money to pay Lindsay House's $5000 monthly bill. After contacting the county welfare office to apply for Medicaid in 2008, Adam was shocked to learn that his father's $2090 a monthly income, from pension and social security, meant that his father was ineligible for Medicaid.

"When my father moved to Lindsay House, we were told that after his funds were exhausted, he could convert to Medicaid to cover his stay and would not have to leave," Adam wrote in a letter to the Department of the Public Advocate. Adam said he believes that Lindsay House knew how much his father made from his retirement pension and Social Security income, and knew that his father exceeded Medicaid's 2008 income limits by almost $200 a month.

"There is no question the director of Lindsay House knew this five years ago and yet lied to us to get our business,'' Adam Jenkins wrote. "So five years, and a quarter of a million dollars later, my father's funds are exhausted.''

In an interview, Adam Jenkins said his father is a World War II veteran with four children. "My dad did all the things you were supposed to do,'' he said. "He served his country, he worked at DuPont forever, and now everything he worked for is gone. To put him there under a lie … From the very beginning, they knew what his income was, and he wasn't going to qualify for Medicaid. Instead, they liquidated his home, and everything he had, and then they kicked my father to the curb."

"I understand he's not the only one,'' said Adam Jenkins. "Something needs to be done.''

Robert Jenkins is now at a nursing home in Salem County. And though he was sad to leave Lindsay House, Mr. Jenkins did get good news from his new caretakers: He can keep his cat, Jack. (*Telephone Interview with Adam Jenkins, January 23, 2009*).

or their representatives reported receiving oral promises that the resident could convert to Medicaid, only 42% of the current residents or their representatives so reported.

Our interview results also showed that conversion promises were made to a number of residents who would never be eligible for Medicaid because their monthly income exceeded Medicaid eligibility limits. We found that in 12 of the 53 cases where participants report oral conversion promises, the resident was ineligible for Medicaid because the resident had permanent income (such as social security or a pension), which exceeded the income limits for individuals living in assisted living facilities. Some family members believed that the facility administrator knew the resident's income and that it exceeded allowable Medicaid thresholds. We also found that some residents who were orally promised that they could convert to Medicaid upon spend-down had very low care needs that most likely would not meet the Medicaid clinical eligibility test. Again, participants told us that facility administrators never explained that the resident would require a "nursing facility level of care" in order to be eligible for Medicaid.

Our interview results also showed that a significant number of participants reported that they received additional assurances that the resident could convert to Medicaid upon spend-down, even after Assisted Living Concepts, Inc. publicly announced its national strategy in November 2006 to limit Medicaid participation. Participants reported receiving these additional assurances at different points in time after the resident moved in, frequently when the resident was approaching the six month spend-down window. Some residents and family members continued to receive oral promises that the resident could convert, even after they received the May 2007 letter announcing that only a limited number of Medicaid apartments would be available in each facility. We heard from more than one participant that the facility administrator told residents or families to "ignore the letter."

The Public Advocate also reviewed participant answers about on-going oral conversion promises made during the period between February 2008, when Assisted Living Concepts, Inc. promised that it would allow Medicaid conversion pending completion of discussions with DHSS, and the breakdown of these discussions in the fall of 2008. We found that during this period, residents and family members were sometimes told the ability to convert was still an option, and at other times, they were told that the company was not accepting any new Medicaid residents.

We found that the frequency of oral promises regarding Medicaid conversion after February 2008 was somewhat dependent upon the particular house and administrator, as well as the specific case. Several participants reported that facility administrators at Granville House and Chapin House refused to provide oral conversion promises in the spring of 2008, telling residents and families instead that the resident had to wait until they were deemed Medicaid eligible before the facility could make any decision as to whether it would accept conversion. In contrast, residents of Lindsay House reported that the administrator continued to tell residents and family members that the resident could convert to Medicaid, generally throughout this entire period.

Significantly, of 111 participants surveyed, 53 reported to us that the facility promised, without condition, that the resident would be able to convert to Medicaid upon spend-down.

In fact, one participant, Ruthann Moore, reported that the administrator of Lindsay House very clearly promised in early November 2008 that her aunt would be able to convert to Medicaid. That participant recalled the administrator's exact words: "there will always be a place for [the resident]."[89] This promise was made well after Assisted Living Concepts, Inc. had filed its appeal with the Appellate Division and just days before the company sent out its November 10, 2008 letter asserting that it would no longer allow residents to convert to Medicaid.

Residents and family members reported to us that after the November 10, 2008 letter, administrators stopped promising Medicaid conversion. Recently we learned that residents

who are in the six month conversion window are having difficulty getting administrators to complete and submit paperwork necessary for the resident to have their Medicaid application processed, regardless of where the resident wants to live once he or she becomes a Medicaid-beneficiary.

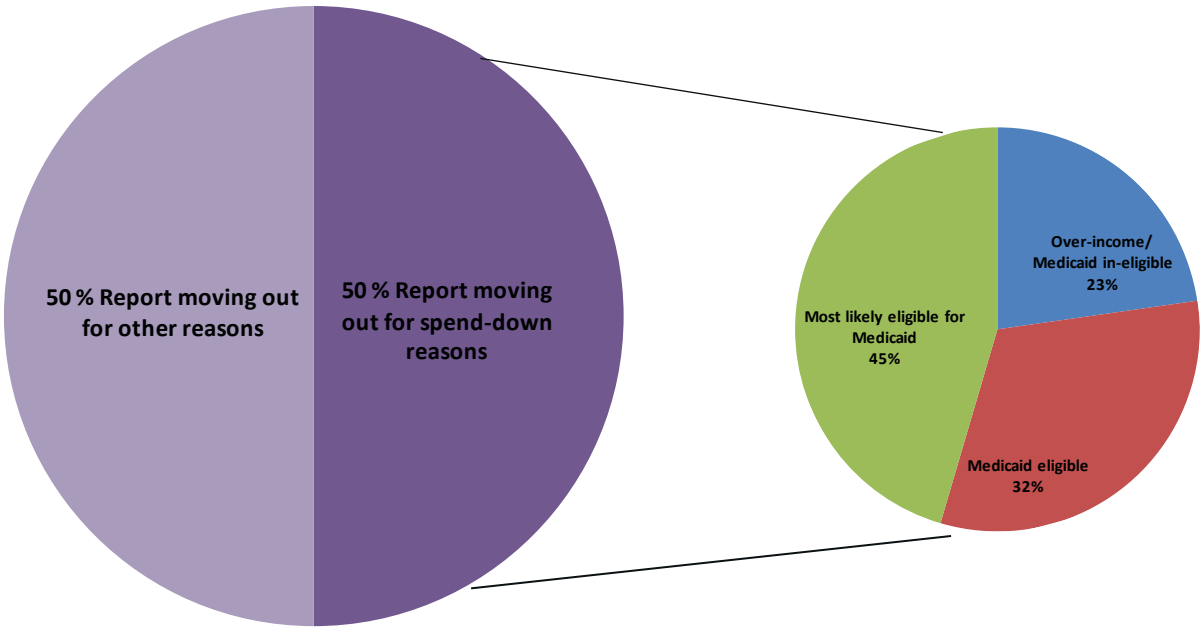
(2.) Many residents have left their Assisted Living Concepts, Inc. facility for spend-down reasons since the company changed its Medicaid conversion policy.

Interviews revealed that a significant number of residents moved out of their Assisted Living Concepts, Inc. facility between June 2006 and December 31, 2008 because they spent down their resources and were either not permitted by Assisted Living Concepts, Inc. to remain at the facility on Medicaid or were not Medicaid-eligible.[90] During the interviews, 22 out of the 44 participants reporting on behalf of former residents self-described spend-down as the reason for the resident's departure. While not all of these residents would have been eligible to convert to Medicaid, a number of them were or would have been Medicaid-eligible. The Public Advocate analyzed the residents' self-reported Medicaid eligibility criteria, including income, care needs, and history of gifting, and determined the following:

- Seven residents were definitely eligible for Medicaid because they applied and were approved for Medicaid concurrent with their discharge from the facilities. In at least two of these cases, the facility was offered and affirmatively refused to sign the form that would allow the resident to convert;
- Five of these residents were not Medicaid eligible because they self-reported permanent income exceeding the income limits for Medicaid in an assisted living facility;
- The remaining 10 residents self-reported information that is consistent with Medicaid eligibility, including appropriate income and care needs consistent with clinical eligibility.

(3.) Residents and their families suffered real

Former ALC residents who told the Public Advocate that they moved out for spend-down reasons



harm from Assisted Living Concepts, Inc.'s new policy and lack of clarity.

Many residents, former residents and their families reported suffering financial harm, social and emotional harm, and transfer trauma, as a result of Assisted Living Concepts, Inc.'s application of the company's new involuntary discharge policy for those who had exhausted their private savings.[91] Participants reported to us that they relied on Assisted Living Concepts, Inc.'s conversion promises and reassurances when they selected their facility and in choosing to remain at the facility.

Unaware that the company might not allow them to convert, residents and their families frequently reported having spent down tens or hundreds of thousands of dollars, believing that they would be able to "age in place" in facilities that had become their homes. In many cases, residents

Troubled economy hits ALC residents

Amidst the familiar headlines about the stock market crash, the credit crunch, the collapse in the housing market, and the rise of unemployment, the New York Times recently reported a troubling phenomenon sweeping the assisted living industry: elderly individuals, unable to sell their homes and finding their investments decimated by the stock market crash, have been forced to forgo much-needed assisted living services. (*Jack Healy, Unable to Sell Homes Elderly Must Forgo Move to Assisted Living, New York Times, November 21, 2008*). Not only has this phenomenon placed seniors at risk for health decline and injuries, it has also created increased vacancy rates at assisted living facilities throughout the country. The Public Advocate's investigation revealed that this phenomenon has already forced some residents to leave their Assisted Living Concept's facilities and that it is likely to persist.

The Myers with their grandson and first great-grandaughter

Pam Paulin, whose parents lived together at Granville House in Burlington, knows this phenomenon all too well. Until recently, Pam thought her parents had plenty of money to pay for their continued care at the Granville House. Pam's father, John Myers, a veteran and former accountant, had invested the couple's savings in the stock market and had always carefully monitored their stocks' values until he became ill in the summer of 2008. When Mr. Myers worsening health problems forced Pam to take over the couple's finances in October 2008, she was shocked to learn that her parents had very little money left. September's stock market crash had decimated their once bountiful stock portfolio and the couple essentially "spent-down" their resources overnight. Without sufficient funds to pay the next month's charges unless Granville House agreed to take Medicaid, and because her parent's health was declining, Pam helped her parents move to a nursing home on January 17, 2009. They were subsequently approved for Medicaid, but sadly Mr. Myer's died in February. (*Telephone Interview with Pam Paulin, August 7, 2008 through January 30, 2009*).

Even residents who never put a dime in the stock market are finding that the weakened economy is jeopardizing their ability to stay at their Assisted Living Concepts, Inc. facility.

Michael Altman moved into the Goldfinch House in Bridgeton last March, after health problems made it difficult for him to take care of himself. Mr. Altman knew he only had enough savings to cover about a year's worth of care, so he asked his neighbor and agent under his power of attorney, Sherrie, to sell his house. By June 2008, the house was on the market, but local layoffs, foreclosures, and the credit crunch meant that nobody was buying houses for sale in his Bridgeton neighborhood. Nine months after the house went on the market, and without a single offer made, Mr. Altman was forced to leave the Goldfinch House and move back to his home on January 13, 2009. (*Telephone Interview with Sherrie Morris, August 1, 2008 through March 2, 2009*).

While it is hard to measure, the accounts we heard in the course of our investigation may represent just the tip of the iceberg. Most of current residents interviewed did not have sufficient permanent income (i.e. pensions, social security) to cover the cost of their stay at their facility after they exhausted their cash savings, leaving them precariously reliant on their ever-shrinking investments and potentially unsellable homes to cover the cost of their care. Vacancy rates have already increased at many of the Assisted Living Concept, Inc. facilities during the past year.

have spent their entire life savings, often generated by the sale of their home or family business, on their care at the facilities. After spending down all of their private pay resources, these residents have limited choices about where to live if they are not permitted to convert to Medicaid and remain at their Assisted Living Concepts, Inc. facility.

After our Mother was accepted in the Medicaid program, we were forced to find another facility for her. At that time she was 93 years old and had to move on her 94th BIRTHDAY!

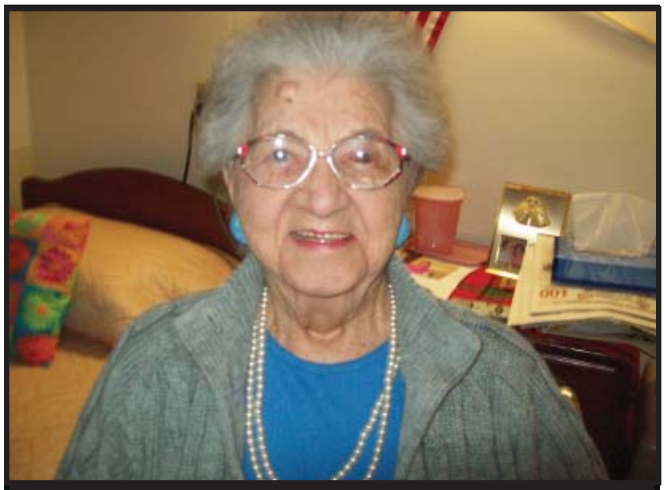
In addition to the financial harm caused to residents and family members, participants reported that being forced to move out of their homes was detrimental to the social and emotional well being of their aging loved ones. Some participants reported that the involuntary discharge of the resident resulted in transfer trauma. Families of residents who either moved out of the Assisted Living Concepts facility or were threatened with involuntary discharge reported that the discharge was traumatic for the resident, especially those who have dementia or Alzheimer's disease. Some family members reported that the resident became depressed or lost the will to live. The Public Advocate also found that family members themselves reported that the experience was stressful, guilt-inducing, and in some cases, exacerbated intra-family strife where families had to make decisions quickly in response to actual or threatened discharges.

* * * *

Julia Tyler was 92-years-old when she moved into Goldfinch House in June 2006, after a brief stay at a skilled nursing facility. The family planned to use the limited proceeds from the sale of Mrs. Tyler's home to private pay for her care, which cost about $4000 per month. At the time her mother moved in, her daughter and agent under a power of attorney, Mary Reed, recounted that she specifically asked the administrator what would happen when her mother's money ran out. She was told not to worry because Goldfinch House accepts Medicaid. When Ms. Tyler was down to two months of private pay, Ms. Reed notified the new facility administrator. The new administrator delivered bad news – the Medicaid policy had changed and her mother would need to leave.

Ms. Reed wrote in a letter to the Public Advocate:

> After our Mother was accepted in the Medicaid program, we were forced to find another facility for her. At that time she was 93 years old and had to move on her 94th BIRTHDAY! Fortunately we were able to find another place for her over in Millville, but needless to say, it really took a toll on her health. She is now approaching 95 years old and is in a nursing facility. . .My brother, sister and I can't even begin to explain how horrible that experience was. . .She never really did get used to the new place and it was very hard on her. . .We realize that at this point, there is nothing that can be done regarding our Mother's situation, but we do hope that something can be done so that no other family has to go through this.[92]



92- year-old Julia Tyler

Our interviews revealed that former residents who were unable to convert to Medicaid, and who left the facility between 2006 and 2008, moved into their own apartments or houses, in with family members, into other assisted living facilities, into nursing homes or into veteran's homes. Not all residents who were discharged involuntarily or threatened with an involuntary discharge reported

trauma or harm. Some told us that their family member made the transition well. In several cases where the resident went to a nursing home or veteran's home, the family member reported that the former resident was receiving a higher level of care than she had received at their Assisted Living Concepts, Inc. home. In one case, Madeline Roe, the daughter of a former resident who is now living in a veteran's home reported that the social worker at the new facility quickly identified what her father, Tony D'Emilio, who now has early dementia, liked to do when he was younger; Mr. D'Emilio now happily tends to a tomato garden.[93]

(4.) The 2003 and 2006 forms of the resident admission agreements contain provisions which are not consumer-friendly.

After reviewing the 2003 version and the 2006 version of the resident admission agreement, the Public Advocate found that the contracts include a significant number of anti-consumer provisions which may be detrimental to a resident's rights, including the right to convert to Medicaid or enforce rights under the contract. In addition, interviews revealed that facility administrators engaged in practices, involving contracts and other legal documents, which potentially undermined the rights and interests of residents, especially when they spent down and wished to convert to Medicaid. We discuss these anti-consumer terms and practices below:

- Fee Increases: Neither the 2003 version nor the 2006 version of the resident admission agreement place any limitations on Assisted Living Concepts, Inc.'s right to increase resident charges, including basic service fees

Todd Buirch's grandmother never recovered from the trauma of leaving her home

Todd Buirch's 84-year-old grandmother loved her cozy little home at the Maurice House in Millville. His grandmother was suffering from the early onset of dementia, Mr. Buirch said. Details were important to her. Doing the same things each day and knowing where she was helped her remain oriented in the world.

After Mr. Buirch's grandmother applied for Medicaid in March 2007, the Residence Director of the Maurice House told her she had to switch rooms. They told her "she would have to move in with another person. We looked at the room, and you couldn't fit two people in it,'' he said.

By May, with her Medicaid application still pending, the Residence Director told her she would have to leave the facility altogether. Mr. Buirch recalls his grandmother cried the day she was told she would have to move. "She told me she had no home and didn't want to live anymore,'' he said.

His grandmother had lived in the same house on Charles Street in Bridgeton for 40 years before she needed to move into an assisted living facility. Having a home was important to her.

Soon after she learned that she would have to leave, Mr. Buirch's grandmother grew depressed and was given mood enhancers that she never needed before. Her health rapidly deteriorated. Mr. Buirch reports that care deteriorated as well. In May 2007, his grandmother fell in the shower and was hospitalized. After she was hospitalized because of her fall, "she never made it back to the Maurice House,'' Mr. Buirch said. On June 12, 2007, Maurice House issued an involuntary discharge notice for non-payment. Todd Buirch's grandmother died four days later.

Todd Buirch remains angry about what happened to his grandmother. "They had told us [Medicaid] would be no problem. They said she would remain in the same room…But after we spent all our money, the company didn't want her anymore,'' he said. Mr. Buirch recalls that the whole ordeal "was just a terrible experience.'' *(Interview with Todd Buirch, January 15, 2009).*

or level of service daily fees. The contract language does not require that price increases be reasonable, nor does the language prohibit unconscionable increases. In addition, neither contract includes any restrictions on the frequency of rate increases. Participants in our investigation reported being charged price increases by Assisted Living Concepts, Inc. even as the quality of care declined.

In addition, at least one resident reported negotiating a basic service rate with Assisted Living Concepts, Inc. in early 2006, after the resident had exhausted her savings and discovered that her monthly income exceeded Medicaid eligibility limits. The family reports that the rate was agreed to in a written contract, but that Assisted Living Concepts, Inc. subsequently and unilaterally raised the resident's basic service rate at least twice.[94]

- Limitation on Liability: The 2003 version of the resident admission agreement contains language limiting the liability of the parties. In particular, this section purports to limit non-economic damages for pain and suffering and prohibits the award of punitive damages, enhanced statutory damages (such as treble damages under New Jersey's Consumer Fraud Statute) and attorney's fees, including those that are specifically permitted by law.

- Arbitration Agreement: The 2003 and 2006 versions of the resident admission agreement contain arbitration agreements. In the 2003 version, the arbitration clause is contained in the body of the agreement, while in the 2006 version it is included in Appendix A. Arbitration clauses or agreements are generally enforceable under federal law. By entering into an arbitration agreement, residents may have forfeited their right to bring an action in state or federal court, may have foregone the ability to have their dispute decided by a jury, may incur significantly higher legal costs, may limit their ability to engage in discovery, and may find it more difficult to obtain legal representation as attorney's fee awards may be limited. Arbitration is generally disfavored among consumer advocates. The arbitration system assumes that the parties to the arbitration have equal bargaining positions and equal access to information and resources, but this is not usually true in the consumer contract arena. For that reason, Congress is considering the Fairness in Nursing Home Arbitration Act of 2009, HR 1237/S 512, a bill which if enacted would invalidate binding mandatory arbitration clauses in admission agreements for all long-term care facilities, including nursing homes, assisted living facilities, and boarding and care homes.

- Guarantor Agreement: The 2003 version of the resident admission agreement contains a guarantor agreement in the body of the contract. The 2006 version does not include one, but some participants reported signing a guarantor agreement as an addendum to that contract. In addition, on December 1, 2008, Assisted Living Concepts, Inc. asked family members to sign a guarantor agreement no later than January 1, 2009. Under the various forms of the guarantor agreements, family members may be held personally liable for any expenses left unpaid by the resident or governmental benefit, such as Medicaid.

These agreements can create ethical dilemmas for family members when the family member also has the fiduciary responsibility under a power of attorney or court-ordered guardianship to act solely on behalf of the principal or ward.[95] A fiduciary has a duty to protect the person's rights and property. However, a fiduciary's efforts to protect the resident's rights – for example by refusing to move Medicaid-eligible residents from a facility after spend-down – could result in the fiduciary's own personal financial harm because she has agreed to pay if the resident does not move. For these reasons, guarantor agreements are disallowed in the context of nursing homes, at least to the extent that they are conditions of admission; in addition, private pay contracts are void once a nursing home resident becomes Medicaid-eligible.[96]

- Revised Contracts: Participants reported to the Public Advocate that after July 2006, Assisted Living Concepts, Inc. sent the new 2006 version of the resident admission agreement to current residents or responsible family members for them to sign. This version arguably limits the right of a resident to convert to Medicaid upon spend-down. Participants told us that they did not understand that by signing the new version of the contract, the resident might be giving up the valuable contractual right to convert to Medicaid, and was not receiving anything in exchange for giving up that right. In addition, some participants told us that the facility administrator would ask residents with known cognitive impairment to sign the new contracts.

(5.) The law provides insufficient procedural protections from involuntary discharge, which Assisted Living Concepts, Inc. was able to use to its advantage.

Essentially, assisted living facilities are a hybrid of health care facilities and residential settings. There are two models available to regulators to protect residents from being involuntarily discharged for non-medical reasons, including spend-down: the nursing home model and the landlord tenant model. Under the nursing home model, a facility may only discharge or transfer a resident after notifying the state and complying with all the procedural requirements. Federal law and the state regulations provide that a discharge must be safe, and must be for one of the reasons permitted under the regulations and federal law.[97] Protections are even greater where Medicaid-eligible residents (including Medicaid applicants) are being involuntarily transferred.[98] Nursing homes are prohibited from transferring a resident who converts from private pay to Medicaid status, regardless of the terms of the resident's contract with the facility, without the involvement of DHSS. Under the landlord-tenant model, tenants can only be evicted upon a showing of good cause and after being afforded all of the procedural protections the law provides. Tenants have the right to a hearing before a judge prior to eviction, and can only be removed by court order.[99]

In the assisted living context, however, New Jersey has adopted neither model. Residents are left to rely on resident admission agreements and limited, ambiguous regulatory protections.[100] Because the current legal framework governing assisted living in New Jersey is primarily a contract-based system, residents usually must enforce their rights in the forum indicated in the contract. For example, the 2003 and 2006 Assisted Living Concepts, Inc. contracts direct that disputes must be arbitrated. Both arbitration actions and court actions are expensive and complicated, and are unlikely to be pursued by residents who - by definition - have less than $2000 in resources. Our investigation revealed that not one resident or former resident who faced involuntary discharge filed an arbitration action to challenge the discharge. Nor did any resident or former resident who participated in our investigation file an action in court to prevent or challenge the involuntary discharge, although some did retain private attorneys to negotiate their conversion to Medicaid.

Participants told us that they did not understand that by signing the new version of the contract, the resident might be giving up the valuable contractual right to convert to Medicaid.

The current regulatory scheme governing assisted living in New Jersey does provide some limited protections for residents faced with involuntary discharge for non-medical reasons, including non-payment, after the resident has exhausted their savings. The protections include:

1. the right to receive a 30-day involuntary discharge notice before discharge which includes the Ombudsman's contact information;[101]

2. the right to appeal discharge decisions to the facility;[102] and

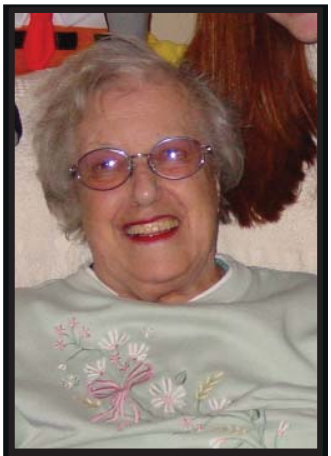
3. the right to be discharged only in accordance with the terms of their residency agreement.[103]

However, our investigation revealed that after November 2006, these regulatory requirements did little to actually protect the right of residents to convert to Medicaid after they had spent down their private funds at Assisted Living Concepts, Inc. facilities. We found that the overwhelming majority of former residents who believe they were forced to leave for spend-down reasons reported that they did not receive an involuntary discharge notice at all. We found that out of the 22 former residents who left for "spend-down" reasons, only four report having received the 30-day involuntary discharge notice before departure.

Assisted Living Concepts, Inc.'s systematic failure to give residents involuntary discharge notices in spend-down situations limited the ability of residents to prevent their own discharge by seeking the help of the Ombudsman. For many residents and their families, the involuntary discharge notice, which should include the Ombudsman's contact information, is their introduction to the office, which serves as a vital resource in the fight to remain at their facility. Certainly, Marilou Rochford was able to successfully advocate on behalf of her mother, Mrs. Merklinger, because she contacted the Ombudsman right away. In several instances where an Assisted Living Concepts, Inc. facility actually did provide an involuntary discharge notice, including the notice received by Mrs. Wright of Goldfinch House, the notice gave contact information for Area Agencies on Aging, but did not give the Ombudsman's contact information.

Interview participants also report being told that if they signed this notice, the resident could leave without incurring additional charges past the end of their discharge month, sometimes characterizing it as a "favor."

Instead of receiving involuntary discharge notices, many participants recounted that after notifying the facility that the resident was had less than $15,000 in resources in accordance with the contract, the administrator simply asserted that the facility was no longer accepting Medicaid and that the resident would need to begin discharge planning. In a number of these cases, residents and family members report being told that it was in the resident's best interest to sign a "Resident Voluntary Move-Out Notice."


Concetta Hafer

* * * *

Michelle Hafer's mother-in-law, Concetta Hafer moved into Granville House with the promise from the then-administrator that she could convert to Medicaid when she spent down all of her savings. Because Mrs. Hafer has dementia, this was particularly important for her daughter-in-law, who is also her agent under a power of attorney. But when the corporate policy changed and Mrs. Hafer was running out of private funds in early January 2008, Granville House wanted Mrs. Hafer to move. Michelle Hafer believes that the facility knew she would never agree to voluntarily move her mother-in-law, and so the new administrator of Granville House had Concetta Hafer sign the Voluntary Move-Out Notice, despite her dementia, to make it look like she was leaving of her own free will. Ironically, Mrs. Hafer left Granville House in early February, right when Assisted Living Concepts, Inc. was promising the Public Advocate that it would convert Medicaid-eligible residents.[104]

Mrs. Hafer is not the only resident with cognitive impairment who was reported to have signed the notice. Interview participants also report being told that if they signed this notice, the resident could leave without incurring additional charges past the end of their discharge month, sometimes characterizing it as a "favor."

For those residents who do receive the written notice, the right to appeal the involuntary discharge decision to the facility administrator is of limited value. It is the facility administrator herself who issued the involuntary discharge notice in the first place, presumably pursuant to corporate policy that she has no authority to change. While requesting an appeal meeting might slow down the discharge, we found that it rarely changed the discharge outcome, except where the resident had legal representation or the assistance of a governmental agency.

Public Advocate's Recommendations for Reform

Many of the problems outlined in this report are specific to Assisted Living Concepts, Inc. and

The not-so-voluntary "voluntary move-out forms"

In the event that she turns to Medicaid, they told me, she may have to share a room. But they never told me she would have to leave.

When her mother could no longer live by herself, Ella May Vanderslice looked at assisted living centers throughout South Jersey, trying to find a suitable facility. Finally, in June 2007, she chose Chapin House in Rio Grande, in part because it advertised that it would accept Medicaid, Ms. Vanderslice said.

Her mother, 85-year-old Ella May Probst, made friends easily at Chapin House. She was happy there, Ms. Vanderslice said. But then, when Mrs. Probst's private funds began to run out, and Ms. Vanderslice began the paperwork to convert her mother to Medicaid, she was notified that the company had changed its policy.

In her mother's admission agreement, Vanderslice said, the company had said there were a limited number of Medicaid apartments available, and that people living in a Medicaid apartment might have to share the space with someone else.

But that's not the story she heard when she spoke with a Chapin House administrator on April 4, 2008. She said the administrator told her: "Whoever told you that (it was in her contract) was wrong.'' Ms. Vanderslice said the administrator advised her: "We are not going to take Medicaid any longer. We are going to be all private pay.''

During a meeting on April 7, 2008, the administrator offered Ms. Vanderslice a "voluntary" move-out form to sign on her mother's behalf, noting that it was the only way to avoid being charged an extra month's charges. While Ms. Vanderslice acquiesced and signed the document, she added a notation to the form in protest which said: "Notified on 4-4-08 that Medicaid not acceptable."

"When I went home, I was crying,'' she said. She was also in tears when her mother had to leave Chapin House three weeks later. Within two months, her mother was in the hospital, suffering from a serious illness. By July 5, she was dead.

Ms. Vanderslice is still bitter, she said, about the way she was treated by Assisted Living Concepts, Inc.

"They gave me all the papers when my mother moved in to Chapin House,'' Ms. Vanderslice said, "In the event that she turns to Medicaid, they told me, she may have to share a room. But they never told me she would have to leave.'' *(Interview with Ella Mae Vanderslice, February 15, 2009*).

its policies concerning involuntary discharges of residents who exhausted their private savings. The Public Advocate also found, however, that the current statutory and regulatory scheme governing the assisted living industry helped Assisted Living Concepts, Inc. to engage in practices which ultimately harmed residents. We offer the following recommendations based upon our findings and analysis.

1. **The Public Advocate supports the enactment of a statewide law that would require assisted living facilities to make 10% of their licensed beds available for Medicaid-eligible residents and would prohibit the discharge of Medicaid-eligible assisted living residents solely because of their Medicaid payor status.**

The Public Advocate urges the New Jersey legislature and the Governor to enact S2066/A3066, a bill introduced on June 22, 2008 by Senator Jeffrey Van Drew. Senator Van Drew's bill includes three significant policy reforms. The bill requires:

(1) all assisted living facilities in the state to provide 10% of their licensed beds to Medicaid-eligible residents (not just those licensed after September 1, 2001);

(2) all assisted living facilities allow residents to remain in their facility after they spend down their savings and become Medicaid-eligible; and

(3) all assisted living facilities to reserve 5% of their licensed beds for individuals who are Medicaid-eligible at the time of admission.

The Public Advocate supports Senator Van Drew's bill because it would expand the current 10% law which only pertains to facilities licensed after September 1, 2001, to all assisted living facilities. This bill would also stop the industry-wide practice of allowing facilities to decide when to retain and when to discharge Medicaid-eligible residents, usually consistent with the facility's "waiting list" policy. Facilities must be disclose their Medicaid policies to residents, in accordance with a July 2004 DHSS memorandum. Under current law and Medicaid policy, residents have little real bargaining power to enforce facility promises to allow them to convert to Medicaid after they have privately paid for an agreed upon period of time. While not limiting a facility's ability to require prospective residents to show the ability to private pay for a specified period of time at the time of entry, S2066/A3066 would require assisted living facilities to allow all Medicaid-eligible residents to remain after they have exhausted their private savings.

The current statutory and regulatory scheme governing the assisted living industry helped Assisted Living Concepts, Inc. to engage in practices which ultimately harmed residents.

The Public Advocate also supports this legislation because it assures that our most needy seniors, those who qualify for Medicaid without having the ability to private-pay for any substantial period of time, are not closed out of the assisted living option. Senator Van Drew's legislation requires that 5% of a facility's beds be reserved for residents who are Medicaid-eligible at the time of admission.

2. **The Public Advocate supports giving consumers meaningful, complete and timely disclosures of information pertaining to assisted living facility services as well as Medicaid eligibility requirements and waiting lists.**

Prospective residents and their families should be given accurate and dependable information when they are shopping for assisted living services and when they are entering into contracts with facilities, so that they can make informed choices about their future care. The Public Advocate supports a number of current legislative and regulatory efforts to expand disclosure requirements.

The Public Advocate supports S221/A2334, a bill introduced by Senator Robert Singer, which requires assisted living facilities to provide informational sheets, developed by DHSS and DHS, concerning Medicaid eligibility to applicants and residents. In addition, the bill requires assisted living facilities to give applicants information regarding the facility's Medicaid conversion policy as well as internal "waiting list" information. The bill, which initially included nursing homes as well as assisted living facilities, originally passed both houses in late 2008. However, the Governor conditionally vetoed the bill because it was inconsistent with federal Medicaid law as it pertained to nursing homes. The bill passed the Senate again on March 16, 2009, and awaits passage in the Assembly.

We also support the adoption of regulations by DHSS that would require assisted living facilities to provide consumers with a uniform disclosure form when they are shopping for a facility. Since August 2007, we have partnered with DHSS on this initiative, as well as with industry, state agencies, and the elder bar. DHSS is drafting regulations requiring facilities to provide prospective residents with a uniform disclosure form. The form is modeled after other states, like Texas and New Hampshire, where uniform disclosure forms have been used successfully. While the uniform disclosure form will arm consumers with important information needed to compare facilities, the form is not meant to be contractually binding and the residents will still need to ensure that the terms they want included, particularly those pertaining to Medicaid conversion, are written into whatever contract they sign. We advise that residents have an attorney review their admission agreements wherever they have questions or concerns.

Prospective residents and their families should be given accurate and dependable information when they are shopping for assisted living services.

3. **The Public Advocate calls for an assisted living working group to be convened to design meaningful procedural protections for residents facing involuntary discharge, and to make recommendations to the Legislature and DHSS to enact better protections.**

The Public Advocate found that the current regulatory scheme provides few effective procedural protections for residents facing involuntary discharge for non-medical reasons, such as spend-down. In the case of nursing home residents, discharge and transfers are governed by laws which provide significant protections for these residents to ensure a safe discharge, but assisted living residents have much more limited protections. Residential tenants have the protections of the New Jersey Eviction with Good Cause law, which arguably may not apply to residents of assisted living facilities.[105] While a resident who is 60 or older may always call the Ombudsman for help, a resident's only real recourse to stop an involuntary discharge that the resident believes violates his contract may be to file in state or federal court. This is an expensive and complicated step that usually requires the assistance of legal counsel. Our investigation also showed that in some cases, assisted living residents may have to submit to arbitration, a difficult and expensive process that typically requires legal counsel.

The Public Advocate recommends that policymakers consider a comprehensive solution that protects individuals facing discharge for a broad range of non-medical reasons, including the need to convert to Medicaid. We applaud DHSS' efforts to bring together stakeholders around the issue of the uniform disclosure form, and stand ready to participate in an assisted living working group, should one be convened. We recommend that consumer and elder advocates form an integral part of that working group.

While a specific solution is beyond the scope of this report, the Public Advocate suggests that policymakers explore mechanisms employed in the landlord-tenant context, as well those employed in the administrative law fair hearing context. Ultimately, meaningful protections would include:

- a mandatory written discharge notice explaining the resident's rights and

the facility's obligations, regardless of whether the facility views the discharge as voluntary or involuntary;

- a requirement that facilities report all resident discharges to DHSS and the Ombudsman, and consider extra transfer protections for Medicaid-eligible assisted living residents akin to those in the nursing home context;

- a pre-removal hearing which provides the resident an opportunity to appear before a neutral decision-maker, such as an Administrative Law Judge or Superior Court Judge;

- a standard which places the burden on the facility to prove that the discharge is consistent with any oral or written contracts;

- a right to appeal a discharge order to the appropriate division of the New Jersey Superior Court; and

- consequences for facilities who engage in "self-help" eviction, removing the resident from the facility without a court order.

4. **The Public Advocate supports the adoption of reforms that would make guarantor agreements in the context of assisted living facilities unenforceable as a matter of law.**

Family members and friends, who serve as agents under powers of attorney or guardians pursuant to court order, should not be placed in a position where they must choose between their legal duty to protect the resident and their own financial interests. While it may be true that families sometimes want to pay for the resident's care, this choice should be strictly voluntary. Guarantor agreements, which can be used to coerce family members to move the resident out of the facility upon spend-down, should be unenforceable as a matter of law. In the alternative, policymakers should consider enacting a law or regulation which voids the contractual guarantee where it is a condition of admission, as well as when the resident becomes Medicaid-eligible. These solutions would allow representatives to fulfill their legal duty to the resident, including fighting to get the facility to accept Medicaid payments if appropriate, without having to worry that they will incur significant expense, ruin their credit, or otherwise face unpleasant financial consequences. This, in turn, will help to ensure that more vulnerable residents, who must rely upon relatives or friends to represent their interests, will have their rights adequately protected.

5. **The Public Advocate recommends that the state encourage voluntary participation in the Medicaid waiver program by assisted living facilities.**

The Public Advocate recommends that policymakers consider ways in which the state can make voluntary retention of Medicaid-eligible residents more attractive to assisted living facilities. As specific recommendations in this area are beyond the scope of this report, we simply note that other states have employed the following strategies to encourage assisted living facilities to serve Medicaid-eligible residents, which New Jersey may want to consider:

- modifying the Medicaid reimbursement formula, which currently provides for a room and board monthly rate paid by the resident and a Medicaid services daily rate paid by Medicaid (minus the resident cost share), to take into consideration resident acuity.

- helping assisted living facilities navigate the complicated and time-consuming process of applying for various public benefits and obtaining financing and exemptions available through HUD, the IRS, and other sources;

- rewarding facilities that maintain higher rates of Medicaid-eligible residents, through tax incentives, housing credits, or other methods; and

We recommend that community organizations, state actors, and the industry convene to consider these and other way to make significant acceptance and retention of Medicaid-eligible individuals attractive.

6. **The Public Advocate recommends that while DHSS is rolling out ADRCs, a one-door entry system for long term care services, it finds ways to help applicants navigate a system in transition.**

The Public Advocate welcomes DHSS' initiative to implement Aging and Disability Resource Centers (ADRCs) throughout the state. ADRCs provide a one-point entry for people 65 and older, or physically disabled people between the ages of 18 and 64, who need to access available services, especially home and community-based services (including the assisted living benefit) under the Global Options waiver.[107] We understand from DHSS that it's Division of Aging and Community Services is rolling out the ADRC, and it is expected they will be operating statewide by the end of 2010. When fully implemented, the center piece of the ADRC's new client pathway will be a care manager who is the point person for coordinating clinical and financial eligibility.

Nevertheless, during this time of transition, our investigation demonstrated that consumers find the current system confusing: while applicants file for financial eligibility on the county level at county welfare agencies or Boards of Social Services, the clinical eligibility is processed by DHSS, either through the ADRC in those counties where the ADRC is operational or through the Regional Office of Community Choice Options (OCCO). Inevitably, consumers receive misinformation – frequently from the county worker who is far removed organizationally from the administration of the DHSS Global Options waiver.

We understand that DHSS is transitioning to the ADRC system and also working with DHS to report to the Legislature about the advisability of having only one state agency responsible for all Medicaid programs. In the system as it presently works, the Public Advocate recommends that the DHSS continue its efforts to educate CWA staff on the Global Options program, and make information regarding each county's Global Options Coordinator – the person responsible for answering applicant's questions -- more accessible to consumers.[108]

7. **The Public Advocate recommends that policymakers collaborate to consider ways of utilizing the Consumer Fraud Act to protect assisted living consumers.**

The Public Advocate believes that New Jersey's existing Consumer Fraud Act (CFA) could be utilized to better protect assisted living residents from the situations described throughout this report.[109] Although there had historically been some question as to whether the CFA is applicable to heavily regulated healthcare facilities, which is heavily regulated by DHSS, the New Jersey Supreme Court's decision in *Lemelledo v. Beneficial Management Corp.* made clear that the CFA will generally apply to already regulated industries unless there is a direct and unavoidable conflict between existing regulation and application of the act.[110] As described throughout this report, the assisted living industry is not heavily regulated. Moreover, application of the CFA to assisted living residents would not conflict with DHSS' regulatory scheme, but rather would bolster efforts by DHSS to provide consumer protections to assisted living residents.

We recommend that policymakers consider ways in which the CFA could be used more effectively to protect residents of assisted living facilities. This may include legislation that would amend the CFA to specifically address assisted living facilities and their representations or omissions regarding consumer issues, including Medicaid conversion. In the alternative, it may include regulations, promulgated by either the Department of Law and Public Safety's Division of Consumer Affairs or the DHSS, which address these issues. While specifics are beyond the scope of this report, an example of a consumer protection might be to create per se violations of the CFA where assisted living facilities make misrepresentations or omissions regarding their Medicaid conversion policies to prospective residents. If such behavior were a per se violation, it would make it easier for residents to bring claims against assisted living facilities that promise Medicaid conversion and later deny it at spend-down. It would also deter facilities from keeping this crucial information from their residents.

Tips for Selecting an Assisted Living Facility Where You Can Truly "Age in Place"

1. Read the entire resident admission agreement or contract. Do not sign it or initial in specified places if you do not understand what you are signing. Do not sign any provision you are not comfortable with, such as arbitration clauses. When in doubt, have the agreement reviewed by an attorney.

2. If the facility makes an oral promise that you will be able to convert to Medicaid after private paying for a specific period of time or upon spend-down – make sure that the promise is drafted into the written and signed resident agreement. Do not rely on oral promises alone.

3. Carefully read any Medicaid disclosure statement given while you are shopping or at the time of the contract is signed. Make sure that the disclosure is consistent with the terms of the contract and oral representations made.

4. Ask if the facility was licensed on or after August 31, 2001. If so, confirm that the facility must make 10% of its resident census available for Medicaid-eligible residents.

5. Make sure you have a copy of the entire, signed resident admission agreement or contract, and any addendum to the contract at the time you sign. Do not rely on promises that you will get a copy of the signed contract later. At the very least, if the facility can not sign the same day you sign, get a copy with all of your signatures.

6. Make sure that you fully understand the Medicaid eligibility requirements for the Global Options for Long Term Care program: the resource criteria (≤ $2000), the income eligibility limits (≤ $2022 for 2009; and the requirement that you need a "nursing facility level of care" which means you need assistance with at least three activities of daily living (such as bathing, dressing and eating).

Conclusion

Assisted Living Concepts, Inc.'s abrupt and unauthorized application of its new policy – of discharging residents who spend down their resources and become eligible for Medicaid - has caused the company's New Jersey residents to suffer significant harm. Residents and their families relied on the company's marketing materials, contracts, and oral promises, which overtly stated or strongly implied that residents would be able to "age in place" and convert to Medicaid if and when they spent down their resources and became Medicaid eligible. Residents have spent significant sums of money, have grown attached to their new homes, and have foregone other long-term care options in reliance on these promises. As a result of the company's policy change, many residents have been forced to leave the facilities, causing them social, emotional, and financial harm. In addition, since the policy was officially adopted in 2006, facility administrators inexplicably continued to reassure residents and their families over the next two years that conversion would occur – causing them to spend even more of their dwindling resources - only to find that the facility will not allow conversion.

New Jersey cannot allow its state's assisted living facilities – vested as they are with the responsibility of caring for our valued senior citizens – to behave this way. In addition to the plethora of promises made to residents and their families, Assisted Living Concepts, Inc. made a commitment that residents would not be asked to move because of "spend-down situations." While we recognize that changing economic realities may sometimes require assisted living facilities to alter their policies to remain viable, Assisted Living Concepts, Inc. has failed to use the already existing mechanism for changing an approved certificate of need: formal application to DHSS. Were Assisted Living Concepts, Inc. to apply for a change according to the rules, it could work with the DHSS to lessen its obligations, while incorporating protections that would mitigate the impact of the alteration on our state's seniors and protect any legal rights they may have.

While the Public Advocate condemns Assisted Living Concepts, Inc.'s practices, it is important to note that this situation did not arise in a vacuum. Assisted Living Concepts, Inc.'s practices were difficult to prevent and to respond to because New Jersey's current system of regulating assisted living facilities – which employs neither nursing home protections or landlord-tenant safeguards - provides little meaningful protection to residents facing involuntary discharge for non-medical reasons. As a state, we must re-imagine a system for protecting seniors who call assisted living facilities their homes. The Public Advocate strongly believes that adopting the recommendations discussed herein would go a long way toward ultimately ensuring that New Jersey's seniors can "age in place."

Protecting People in Long-Term Care

The Office of the Ombudsman for the Institutionalized Elderly investigates allegations of abuse and neglect of people, age 60 and older, living in nursing homes and other long-term healthcare facilities.

If you or someone you know may be abused or neglected, please contact the Elder Ombudsman Office. We investigate, resolve and/or refer complaints to the appropriate agency. By law, callers may remain anonymous and our case files are closed to the public.

To file a complaint:

Call 24-Hour Toll Free Hotline:

1-877-582-6995

Email:

PublicAdvocate@advocate.state.nj.us

Endnotes

1 Telephone Interviews with Sandy Cates, agent for Lillie Hitchner (September 18, 2008 through March 27, 2009).

2 Assisted Living Concepts, Inc., 2006 Annual Report (2006).

3 Telephone Interview with Keren Brown Wilson, PhD, founder of Concepts in Community Living, Inc. and Assisted Living Concepts, Inc. (February 25, 2009); Minutes of Telephone Conversation with Jeff Fischer, Regional Director, Assisted Living Concepts, Inc. (October 11, 2007).

4 Assisted Living Concepts, Inc., 2006 Annual Report (2006).

5 Telephone Interview with Louise Ryan, Washington State Ombudsman for the Institutionalized elderly (January 21, 2009); Assisted Living Company Begins Purge of Residents on Medicaid, Elder Law Answers, available at https:www.elderlawanswers.com/resources/article.asp?id=6312&section=4; See Center for Medicare Advocacy, Lessons from Nursing Home Advocacy: Helpful Strategies for Assisted Living Evictions (July 5, 2007), available at http://www.ltcombudsman.org/uploads/CMA_Weekly_07_07_05_Asst_Living.pdf.

6 N.J.S.A. 52:27EE-2(a).

7 N.J.S.A. 26:2H-1 et seq.

8 Letter from John Calabria, Director of the Office of Certificate of Need and Healthcare Facility Licensure, New Jersey Department of Health and Senior Services to Chapin House Assisted Living Facility (Oct. 29, 2007) (on file with author).

9 Id.; Certificate of Need Application for the Chapin House assisted living facility, Assisted Living Concepts, Inc., (January 1, 1996)(on file with author).

10 Letter from John Calabria, Director of the Office of Certificate of Need and Healthcare Facility Licensure, New Jersey Department of Health and Senior Services to Lindsay House assisted living facility (January 9, 2009) (on file with author); Letter from Brian Rath, Esq.,

attorney for Assisted Living Concepts, Inc., (January 20, 2009)(on file with author).

11 For a discussion of the history of long-term care in the United States, see Patrick A. Bruce, The Ascendancy of Assisted Living: The Case for Federal Regulation, 14 Elder L.J. 61 (2006).

12 For a history of the assisted living industry, See Keren Brown Wilson, PhD, Historical Evolution of Assisted Living in the United States 1979 to the Present, 47 the Gerontologist 8-11 (2007).

13 See 42 U.S.C. 1396 ("Payment to States"). See also Kaiser Commission, Medicaid and the Uninsured: Medicaid Facts, available at http://www.kff.org/medicaid/upload/7235_03-2.pdf It should be noted that, under the federal stimulus bill passed in February, all states are now receiving (retroactive to October 2008) an increase in their federal match of at least 6.2%, and states with higher unemployment rates will receive an even higher increase. So, for example, NJ's federal match for the two quarters since October 1, 2008, is 58.78% (rather than 50%).

14 42 U.S.C. 1819 et seq.; 42 C.F.R. 430 et seq.

15 42 C.F.R. 483.12; N.J.A.C. 8:85-1.10 ("Involuntary Transfer). The vast majority of New Jersey's nursing homes have 100% Medicaid certified facilities.

16 Olmstead v. L.C., 527 U.S. 581 (1999).

17 Omnibus Reconciliation Act P.L. 97-35 (1981); 42 U.S.C. § 1396n.

18 AARP Public Policy Institute, A Balancing Act: State Long-term Care Reform, (July 2008), available at http://www.globalaging.org/health/us/2008/longtermcare.pdf.

19 Keren Brown Wilson, PhD, Historical Evolution of Assisted Living in the United States 1979 to the Present, 47 the Gerontologist 8-11 (2007); *Assisted Living Concepts, Inc.*, Hoover's Business Reports, (on file with author).

20 Keren Brown Wilson, PhD, Historical Evolution of Assisted Living in the United States 1979 to the Present, 47 the Gerontologist 8-11 (2007); *Assisted Living Concepts, Inc.*, Hoover's Business Reports, (on file with author).

21 *Assisted Living Concepts, Inc.*, Hoover's Business Reports, (on file with author). Concepts in Community Living, Inc. website, http://ccliving.com/about/history.html.

22 Id.

23 See Patrick A. Bruce, The Ascendancy of Assisted Living: The Case for Federal Regulation, 14 Elder L.J. 61 (2006).

24 Id.

25 Telephone Interview with Barbara Goldman, R.N., J.D., Assistant Director of the Office of Certificate of Need and Healthcare Facility Licensure, New Jersey Department of Health and Senior Services; and John Calabria, Director of the Office of Certificate of Need and Healthcare Facility Licensure New Jersey Department of Health and Senior Services (February 25, 2009).

26 *Assisted Living Concepts, Inc.*, Hoover's Business Reports, (on file with author).

27 Id; Telephone interview with Mauro Hernandez, CEO, Concepts in Community Living, Inc. (April 13, 2009).

28 Certificate of Need Application for the Baker House assisted living facility, Assisted Living Concepts, Inc., (January 1, 1996)(on file with author); Certificate of Need Application for the Chapin House assisted living facility, Assisted Living Concepts, Inc., (January 1, 1996)(on file with author); Certificate of Need Application for the Goldfinch House assisted living facility, Assisted Living Concepts, Inc., (January 1, 1996)(on file with author); Certificate of Need Application for the Granville House assisted living facility, Assisted Living Concepts, Inc., (January 1, 1996)(on file with author); Certificate of Need Application for the Lindsay House assisted living facility, Assisted Living Concepts, Inc., (January 1, 1996)(on file with author); Certificate of Need Application for the Maurice House assisted living facility, Assisted Living Concepts, Inc., (January 1, 1996)(on file with author); Certificate of Need Application for the Mey House assisted living facility, Assisted Living Concepts, Inc., (January 1, 1996)(on file with author); Certificate of Need Application for the Post House assisted living facility, Assisted Living Concepts, Inc., (January 1, 1996)(on file with author).

29 Telephone Interview with Barbara Goldman, R.N., J.D., Assistant Director of the Office of Certificate of Need and Healthcare Facility Licensure, New Jersey Department of Health and Senior Services; and John Calabria, Director of the Office of Certificate of Need and Healthcare Facility Licensure, New Jersey Department of Health and Senior Services (February 25, 2009). Approval was granted to begin on January 1, 1996. See New Jersey Department of Human Services, New Jersey Medicaid: Guide to 1915(c) Waiver Programs (September 2007).

30 Telephone interview with Mauro Hernandez, CEO, Concepts in Community Living, Inc. (April 13, 2009). Mauro Hernandez was public policy director for Assisted Living Concepts, Inc. in the 1990s and was responsible for preparing certificate of need proposals and licensure applications.

31 Certificate of Need Applications, supra note 28.

32 See Letters from Len Fishman, Commissioner New Jersey Department of Health and Senior Services to Chapin House assisted living facility (May 3, 1996) (on file with author).

33 *Assisted Living Concepts, Inc.*, Hoover's Business Reports, (on file with author). During the late 1990s, Assisted Living Concepts, Inc. ran into legal and financial troubles and temporarily had to halt trading. In 2000, Keren Brown Wilson stepped down from her post with the company.

34 Company News: Assisted Living Concepts Sold to Canadian Company, N.Y. Times, November 5, 2004, available at http://query.nytimes.com/gst/fullpage.html?res=9C0CE6DF153CF936A35752C1A9629C8B63.

35 Press Release, Extendicare, Inc., Extendicare Announces Filing of a Registration Statement by Assisted Living Concepts, Inc. for its Spin-Off from Extendicare (June 7, 2006), available at http://www.extendicare.com/uploads/private/6.7.06_532.pdf; Press Release, Assisted Living Concepts, Inc. Releases 2006 Third Quarter Results (November 16, 2006), available at http://www.alcco.com/News/docs/ALCQT3_PressRelease.pdf

36 Assisted Living Concepts, Inc., State of New Jersey Residence Agreement (Private Pay-Medicaid)(June 2006).

37 Press Release, Assisted Living Concepts, Inc. Commences Trading on the NYSE and Schedules Conference Call on Financial Results (November 10, 2006), available at http://www.alcco.com/News/docs/ALC_Commences_Trading_PressRelease.pdf

38 Assisted Living Concepts, Inc., 2006 Annual Report (2006).

39 Assisted Living Concepts, Inc. Announces One for Five Reverse Stock Split, Reuters, (March 10, 2009), available at http://www.reuters.com/article/pressRelease/idUS224687+10-Mar-2009+MW20090310. While Assisted Living Concepts, Inc. claims its Medicaid-reduction strategy to be a successful one, others disagree. See Guy Boulton, Private Pay not Paying Off Yet, Milwaukee Journal Sentinel (February 4, 2008).

40 N.J.S.A. 52:27G-1 et seq.

41 See e.g. Form Letter from Residence Director of Maurice House, to Residents & Families (May 22, 2007) (on file with author).

42 Letter from Residency Director of Chapin House assisted living facility, to Marilou Rochford, agent for Betty Merklinger (September 17, 2007) (on file with author).

43 Certificate of Need Application for Chapin House assisted living facility, Assisted Living Concepts, Inc., (January 1, 1996)(on file with author).

44 Rental Agreement between Betty Merklinger and Chapin House (November 12, 2002)(on file with author).

45 Letter from John Calabria, Director of the Office of Certificate of Need and Healthcare Facility Licensure, New Jersey Department of Health and Senior Services to Chapin House (October 29, 2007)(on file with author).

46 Letter from Brian Rath, Esq., attorney for Assisted Living Concepts, Inc. to John Calabria, Department of Health and Senior Services, (October 31, 2007)(on file with author).

47 N.J.S.A. 52:27EE-2(a); N.J.S.A. 52:27EE-64(c).

48 Letter from Public Advocate to Brian

Rath, counsel for Assisted Living Concepts, Inc. (Dec. 10 2007) (on file with author).

49 Letter from Brian Rath, Esq., attorney for Assisted Living Concepts, Inc. to John Calabria, Director of the Office of Certificate of Need and Healthcare Facility Licensure, New Jersey Department of Health and Senior Services (January 20, 2008)(on file with author).

50 Subpoena from Public Advocate to Assisted Living Concepts, Inc. (January 4, 2008) (on file with author).

51 Letter from Brian Rath, Esq., attorney for Assisted Living Concepts, Inc. to Public Advocate (February 1, 2008)(on file with author).

52 New Jersey Dept. of the Public Advocate v. Assisted Living Concepts, Inc., No. C-73-08 (Ch. June 12, 2008), available at http://www.state.nj.us/publicadvocate/seniors/pdf/ALC_opinion_061708.pdf

53 Letter from Brian Rath, Esq., attorney for Assisted Living Concepts, Inc. to Gwen Orlowski, Esq., Director of the Division of Elder Advocacy, New Jersey Department of the Public Advocate (June 27, 2008); Letter from Brian Rath, Esq., attorney for Assisted Living Concepts, Inc.; to Gwen Orlowski, Esq., Director of the Division of Elder Advocacy, New Jersey Department of the Public Advocate (July 25, 2008).

54 Telephone conference call including, Brian Rath Esq., attorney for Assisted Living Concepts, Inc.; Laurie Bebo, CEO, Assisted Living Concepts, Inc.; Gwen Orlowski, Esq., Director of the Division of Elder Advocacy, New Jersey Department of the Public Advocate; Rebecca Estelle, Esq., Assistant Deputy Public Advocate, New Jersey Department of the Public Advocate; John Calabria, Director of the Office of Certificate of Need and Healthcare Facility Licensure, New Jersey Department of Health and Senior Services; Barbara Goldman, R.N., J.D., Assistant Director of the Office of Certificate of Need and Healthcare Facility Licensure, New Jersey Department of Health and Senior Services; Bill Conroy, Assistant Commissioner, New Jersey Department of Health and Senior Services (July 29, 2007).

55 Letter from John Calabria, Director of the Office of Certificate of Need and Healthcare Facility Licensure, New Jersey Department of Health and Senior Services, to Assisted Living Concepts, Inc. (Sept. 3, 2008)(on file with author).

56 Letter from Brian Rath, Esq., attorney for Assisted Living Concepts, Inc., to John Calabria, Director of the Office of Certificate of Need and Healthcare Facility Licensure, New Jersey Department of Health and Senior Services (January 20, 2009)(on file with author).

57 Assisted Living Concepts, Inc. v. N.J. Dept. of Health and Senior Services, No. A-000654-08T2 (October 3, 2008).

58 Order Denying Motion for Summary Disposition, Denying Motion for Dismissal, and Granting Motion to Appear as Amicus, December 5, 2008.

59 Id.

60 See e.g. Letter from Residence Director, Lindsay House assisted living facility to Lillie Hitchner (November 10, 2008) (on file with author).

61 Letter from Residence Director, Granville House assisted living facility to Residents & Families (December 1, 2008).

62 Medicaid slot form issued for Lillie Hitchner by the Department of Human Services to Lindsay House assisted living facility (November 21, 2008)(on file with author).

63 Letter from Lindsay House assisted living facility to Lillie Hitchner (December 23, 2008)(on file with author).

64 Letter from John Calabria, Director of the Office of Certificate of Need and Healthcare Facility Licensure, New Jersey Department of Health and Senior Services to Lindsay House assisted living facility (January 14, 2009)(on file with author).

65 Telephone conference call including, Brian Rath, Esq., attorney for Assisted Living Concepts, Inc.; Gwen Orlowski, Director of the Division of Elder Advocacy, New Jersey Department of the Public Advocate; Rebecca Estelle, Assistant Deputy Public Advocate, New Jersey Department of the Public Advocate; Residence Director of Lindsay House, Sandy Cates, agent for Lillie Hitchner (January 27, 2009).

66 N.J.S.A. 52:27EE-2; N.J.S.A. 52:27EE-64(c).

67 Subpoena from Public Advocate to Assisted Living Concepts, Inc. (January 4, 2008) (on file with author).

68 Telephone Interviews with Connie Kruegl, agent for William Trimmer (January 10, 2008 through March 12, 2009).

69 42 U.S.C. 1382 (a)(3)(B); N.J.A.C. 10:71-1 et seq.

70 N.J.A.C. 8:85-2.1(a)(1); See also Patricia Polansky, Information Memo, August 6, 2007; Patricia Polansky, Information Memo, September 10, 2007.

71 Deficit Reduction Act of 2005, 42 USC 1396p(c); N.J.A.C. 10:71-4.7. See also Final Agency Decision In re O.B., OAL No. HMA 6519-07N (July 15, 2008).

72 Telephone interview with Joan H., agent for W.S. (August 7, 2008 through October 31, 2008).

73 Medicaid slot form issued for W.S. by the Department of Human Services to Granville House assisted living facility (October 15, 2008) (on file with author).

74 See e.g. Letter from Lindsay House assisted living facility to Lillie Hitchner (November 10, 2008) (on file with author). Letter from Residence Director, supra note 61.

75 42 U.S.C. 1382(a)(3)(B); N.J.A.C. 10:71-1 et seq.

76 N.J.A.C. 10:71-4.4.

77 Approved New Jersey Global Options for Long Term Care Waiver, Effective January 1, 2009.

78 Interview with Karen Berry, agent for Kathryn Wright (March 27, 2009).

79 N.J.A.C. 8:85: 1.8.

80 Global Options Waiver, supra note 77.

81 Telephone Calls with Elena Josephik and Suzanne Watson (December 11, 2008 through December 31, 2008).

82 Assisted Living Concepts, Inc., supra note 57.

83 Appellant's Br. Summ. D., Assisted Living Concepts, Inc. v. N.J. Dept. of Health and Senior Services, No. A-000654-08T2 (October 3, 2008).

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85 Order Setting Briefing Schedule, February 18, 2009.

86 Assisted Living Concepts, Inc., Rental Agreement (2002)(on file with author); Assisted Living Concepts, Inc., Residence Agreement, (April 2003)(on file with author); Assisted Living Concepts, Inc., State of New Jersey Residency Agreement: Private Pay-Medicaid (June 2006)(on file with author).

87 Assisted Living Concepts, Inc., Disclosure of Assisted Living Facility's Medicaid Policy: Effective 10/1/2004 (2004).

88 Patricia Polansky, Disclosure of Medicaid Policies (July 31, 2004).

89 Telephone Interview with Ruthann Moore, agent for her aunt (November 2008).

90 A number of residents that reported moving out for "spend-down" reasons, left between 2006 and 2008. One left in 2006, eleven in 2007, and eleven in 2008.

91 In the Matter of Review of N.J.A.C. 8:30-14.1 through 8:30-14.6, 83 N.J. 67, 80 (1980).

92 Telephone Interview with Mary Reed, agent for Julia Tyler (July 30, 2008 through October 23, 2008). Letter from Mary Reed to the Department of the Public Advocate (June 5, 2008).

93 Telephone interview with Madeline Roe, agent for Tony D'Emelio (April 9, 2009).

94 Telephone Interview with R.H., agent for I.F. (October 29, 2008 through February 15, 2009).

95 N.J.S.A. 46:2B-8.1; N.J.S.A. 3B:12-1 et seq. .

96 N.J.S.A. 30:13-3.1; N.J.A.C. 8:85-1.4(a). Under New Jersey regulation, nursing homes may not condition admission on a prospective resident's family members' willingness to sign a guarantor agreement. In addition, under N.J.A.C.

8:85-1.4(c), all existing contracts become void when formerly private pay a resident becomes eligible for Medicaid. Thus, if a guarantor agreement is included in the contract, it would likely be void. Guarantor agreements may also be void or voidable under various contract principles, including lack of consideration, adhesion, consumer fraud, etc.

97 Discharges must be safe and adequate: 42 U.S.C. 1395I-3(c)(2)(C); 42 U.S.C. 1396r(c)(2)(C); 42 C.F.R. 483.12; N.J.A.C. 10:63-1.10(e). There must be a discharge plan: 42 C.F.R. 483.12; N.J.A.C. 10:63-1.10(e). There is a right to appeal discharge to the agency: N.J.A.C. 10:63-1.1(g)(2). Contrast N.J.A.C. 8:36-4.1.

98 N.J.A.C. 8:85-1.10.

99 N.J.S.A. 2A:18-61.1 et seq. N.J. Ct. R. 6.2-1 et seq.

100 For those residents facing involuntary discharge who contact the Ombudsman's office, the Ombudsman works with the facilities to ensure a safe discharge.

101 N.J.A.C. 8:36-4.1(a)(37).

102 N.J.A.C. 8:36-4.1(a)(10); N.J.A.C. 8:36-5.14(b).

103 N.J.A.C. 8:36-4.1(a)(36).

104 Telephone interview with Michelle Hafer, agent for Concetta Hafer (July 3, 2008 through February 11, 2009).

105 Starns v. American Baptist Estates, Docket No. A-2412-01T3 (June 27, 2002)(In this unpublished opinion, the Appellate Division holds that the landlord tenant law does not apply to continuing care retirement communities).

106 The New Jersey Department of Health and Senior Services, Division of Aging and Community Services, has hired Myers & Stauffer Consulting to review all reimbursement for long term care services, including assisted living. In addition, they have hired Mercer Consulting to review rebalancing long-term care expenditures

107 New Jersey Global Options Waiver website, http://www.nj.gov/health/senior/go_nft.shtml.

108 There is a statewide Fast Track Eligibility Determination process through which consumers who are clinically eligible for nursing home care and meet the Medicaid financial requirements, receive home and community-based services for up to 90 days while they complete the full Medicaid. Assisted living waiver applicants may not use the Fast Track process.

109 N.J.S.A. 56:8-1 et seq.

110 Lemelledo v. Beneficial Management Corp. of America, 150 N.J. 255 (1997).