SENIOR HOUSING

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1 HOUSING CHOICES AND THE CONTINUUM OF CARE

Housing is of critical concern to older people. Because aging inevitably entails frailty and the corresponding need for care, an industry of housing and related services has arisen to meet this demand. Retirement magazines display a panoply of housing choices that exist under a "continuum of care." The continuum of care may be thought of as a system of appropriate lodging and services that meets clients' needs for care while maintaining maximum independence.[1] The continuum ranges from independent living that includes supportive services to assisted living, nursing care, and finally acute care in a hospital. While the selection of appropriate housing ideally should be based on an assessment of the client's care needs, the high cost of supportive care must also be considered. An upper middle class older person can typically afford facilities that offer supportive housing, while many older persons of more limited means must rely upon a patchwork of government and private services to fashion living arrangements that permit them to maintain their independence.

The attorney must be prepared to explain the concept of continuing care to the client and his or her family. Clients and their families generally do not understand how such housing and services are paid for and how to plan for their eventual needs. This chapter is intended to inform Virginia elder law attorneys about the availability of housing and services and how to advise the client in selecting them.

The elder law attorney first needs to understand where his or her client is within the continuum of care. Some basic definitions are crucial to understanding assessment within the continuum:

> "Activities of daily living (ADLs)" means bathing, dressing, toileting, transferring, bowel control, bladder control, and eating/feeding. A person's degree of independence in performing these activities is a part of determining appropriate level of care and services.[2]
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> "Instrumental activities of daily living (IADLs)" means meal preparation, housekeeping, laundry, and money management. A person's degree of independence in performing theses activities is a part of determining appropriate level of care and services.[3]

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[1] Lawrence A. Frolik & Alison McChrystal Barnes, *Elder Law: Cases and Materials* 388 (4th ed. 2007).

[2] 22 VAC 40-745-10.

[3] *Id.*

Elder law attorneys are not expected to make assessments; indeed, geriatric care managers are much better at matching client needs with particular facilities. But clients do need advice from attorneys about finding the resources to pay for such care and contracting to receive it.

2 INDEPENDENT LIVING

2.01 "Aging in Place."

A. In General. Many older persons seek to "age in place"—to continue living where they are and bring in supportive care to help maintain their independence. Most supportive care in America is provided by family members, but the prevalence of this kind of support has declined as more adults now work outside the home and the mobility of the American population has led to widely dispersed family members. Consequently, older persons who wish to continue living in their homes have had to resort to professional in-home services. The question for many is how to afford these services. The elder law attorney should be able to suggest some solutions.

B. Reverse Mortgage as a Source of Payment for Home Care. Reverse mortgages are a form of home equity conversion that allows the homeowner to borrow against the value of the home but delays payment on the loan. The homeowner uses equity in the home but makes no loan payment until he or she sells the home, permanently moves out, or dies.

Borrowers can receive the loan in a lump sum, in a fixed monthly sum, or as a line of credit to be drawn on when needed. The loan amount is based on the age of the homeowner and the value of the home.[4]

Reverse mortgages may be available either as FHA-insured loans or private lender insured loans. Both types of loan are very much alike except that FHA loans are limited in dollar amount by regulation. To be eligible for an FHA-insured loan, the borrower must be at least 62 years of age and hold title to the property. Borrowers must receive additional counseling about reverse mortgages from third parties approved by HUD.

Monthly payments received from a reverse mortgage are treated as loans rather than income and do not affect public benefits, but funds kept after the month received will be treated as countable assets if they accumulate above minimum resource allowances.[5]

A client who is considering a reverse mortgage should understand that he or she will lose equity in the home in the amount of each payment received under the mortgage. The client should also be aware that interest rates for a reverse mortgage are higher than for regular mortgages. The most important consideration for the client is whether the reverse mortgage will accomplish the client's goal. If the goal is to provide supportive care at home, the question to determine is whether the client's income plus the reverse mortgage payment will meet the client's expenses, including home care.

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[4] Michael Gilfix, Rebecca C. Morgan & David M. English, *Tax, Estate and Financial Planning for the Elderly: Forms and Practice*, Vol. 2, at N-14 (2007).

[5] *Va. Medicaid Manual* §§ M0815.350, M1120.225.

C. Private Caregivers. Most home care is not home health care but rather personal or custodial care. Personal care includes helping with bathing, feeding, cooking meals, cleaning, shopping, and providing transportation. Although professional care-giving agencies exist, most private caregivers are neither licensed nor trained. Because the quality of individual private caregivers varies greatly, the elderly person seeking such care must consider physical safety as well as affordability. When contracting for these services, the following steps should be taken:

1. Identify the services needed. This will also help to determine the available sources of payment for the care. Home health care services may be provided by Medicare, while personal care assistance must be paid for privately.

2. Determine how many hours of assistance are needed, taking into consideration informal or voluntary care services that can be provided by family members.

3. Consider what supplies and equipment need to be provided. To what extent must the home be outfitted to ensure that the home care tasks can be adequately performed? For example, does the bathroom have to be outfitted so bathing can be safely done? Can any of these items be paid for by Medicare or Medicaid?

D. Personal Care Contracts. Another solution for remaining in the home is contracting with relatives to provide specific care services. Such an agreement should be in writing, the services should be expressly stated, and payment for services must be reasonable. To ensure Medicaid recognition of such contracts, a geriatric care manager should be hired to evaluate the person's need and report on the customary rates for such services in the area. The contract should be in place before any payments are made.[6]

E. Long-Term Care Insurance. Some long-term care insurance policies include a home health care rider. Such insurance may cover not only limited attendant care but also some case management. Because LTC policies are not designed to cover 24-hour care, some form of family support or other forms of payment may be required to fully make use of the benefit.

F. ECHO (Elder Cottage Housing Opportunities). "ECHO" is an acronym used to describe a temporary, modular, handicapped-accessible cottage designed to enable older persons to live near family or other caregivers. An ECHO cottage enables adult children to care for elderly parents in a home-like environment that is both close to family and supportive of independence. Such cottages are ideal for persons living in rural areas who wish to install them on family land. But zoning laws often restrict this type of structure and may require its removal when it is no longer in use by the authorized individual.

G. Adult Day Care. To reduce the number of hours of private care needed, adult day care may be used to provide aged or infirm adults with supplementary care and protection during part of the day. Adult day care facilities are licensed by the Department of Social Services.[7]

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[6] Letha M. Sgritta, "Taxation of Care Coordination Agreements," *15th Annual Elder Law Seminar II*, 5-6 (2006).

[7] Va. Code § 63.2-1733.

Licensed facilities require an entrance assessment profiling each applicant's capabilities and needs. Payment for most facilities is on a sliding scale based on income.

2.02 Retirement Housing. Most of us are familiar with upscale senior retirement communities that include recreational services. Such age-restricted communities cater to affluent older persons who remain independent. They may contain single detached houses or townhouses with recreational facilities and various stores for the resident. Such communities should not be confused with assisted living or continuing care retirement communities (CCRCs), which provide increased assistance as the occupant's independence decreases.

Even though the federal Fair Housing Act (FHA)[8] bars discrimination based on family "status," Congress exempted such senior communities by specifically requiring all units to be occupied by residents at or above a specific age.[9]

2.03 Subsidized Housing (Federal or State).

A. In General. Government housing assistance is available to low-income elderly residents through various affordable housing and rental assistance programs. Federal programs include the Section 8 Housing Voucher program, usually administered by local governments or by public housing authorities (PHAs), and congregate housing programs.[10] Some localities in Virginia provide rental assistance to low-income tenants who are elderly or disabled. The attorney should ask the local Social Services Department or the Area Agency on Aging to see if a particular city or county funds such programs.

B. Section 8 Housing.

1. The Voucher Program. Section 8 is a federal subsidy program that assists low-income families with monthly housing costs.[11] Section 8 vouchers are available to low-income families, the elderly, and persons with disabilities.[12] The voucher program subsidizes tenants who find landlords willing to accept vouchers as partial payment for the tenant's rent. Generally people who qualify for the program pay no more than 30% of their income. To be eligible for the Section 8 program, an applicant must not have income that exceeds the applicable income limit,[13] be a citizen or a non-citizen with eligible immigration status, and be in good standing with the PHA. The voucher program has long waiting lists, and even if the applicant is approved for a voucher, it may be difficult to find a landlord willing to accept it.

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[8] 42 U.S.C. § 3601 *et seq.*

[9] 42 U.S.C. § 3607(b); 24 C.F.R. §§ 100.303, 100.304.

[10] For federal statutes that provide for lower income housing, see 42 U.S.C. §§ 1437-1440.

[11] "Section 8" refers to section 8 of the U.S. Housing and Community Development Act of 1974, which authorized the program. The Section 8 program is administered under the provisions of 42 U.S.C. § 1437f.

[12] *See generally* 42 U.S.C. § 1437f; 24 C.F.R. §§ 5.601 *et seq.* and 982.1 *et seq.*

[13] The income limits used to determine eligibility vary by program from 30% of median income for the area to 80%.

2. Income Eligibility. The applicant's income cannot exceed 80% of the median income for the area. Therefore, income eligibility varies from one area to another. Income includes earned income, unearned income, and public benefits.[14]

3. Resources Eligibility. There are no asset limits for subsidized housing. Instead HUD imputes an income amount when family assets are greater than $5,000. If an applicant has transferred an asset for less than its fair market value, for two years after the transfer HUD will treat the asset as if it were still owned by the applicant and will impute an income amount to the transferred assets.[15]

C. Congregate Housing. Other federal housing programs include Section 202, 221, and 236 programs.[16] These programs fund housing provided by private, nonprofit housing and services-oriented organizations. Often the housing is called "congregate housing" because all residents in the complex must be at least 62 years of age or older, or disabled. Congregate housing complexes frequently have their own waiting lists, so applications for residency are made at the complex itself. These complexes provide low-income housing supportive services and may also make available meals, social services, transportation, and other accommodations. Applicants to the facilities must be able to live in an independent setting to be admitted,[17] but seniors who need higher levels of care that do not qualify them for nursing care often remain in congregate settings because of the high cost of assisted living.

The Virginia Housing Development Authority (VHDA) also supports congregate housing for elderly residents.

The same general rules on income and resources that apply to the voucher program apply to congregate housing.

D, Section 8 Housing and Special Need Trusts. A question that occurs often is disbursements from a Special Needs Trust and its effect upon a recipient of Section 8 Housing. The issue is not so common with regard to SSI and Medicaid benefits because federal statutes and regulations pertaining to those benefits are directly addresses by federal statutes, the POMS and the Medicaid Manual. But there are no regulations for recipients of federal housing benefits. *DeCambre v. Brookline Housing Authority (1st Cr., 15-1458-1515, June 14, 2016)* provides new guidance. DeCambre was the beneficiary of a court-established First-Party Special Needs Trust that was funded with the proceeds from a $330,000 personal injury settlement. After receiving distributions of more than $60,000 the Brookline Housing Authority decided she was no longer eligible for the housing voucher. The District Court upheld the Housing Authority's decision but the First Circuit reversed. In looking at housing regulations the Court reasoned that since a lump-sum addition to family assets is excluded from the broad definition of 'annual income' then a lump

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[14] For the definition of "income" as it applies to various recipients and types of accommodations, see *HUD Occupancy Handbook* No. 4350.3.

[15] *Id.*

[16] Section 202 refers to section 202 of the federal Housing Act of 1959, Pub. L. No. 86-372, 73 Stat. 667, codified at 12 U.S.C. § 1701q. Section 221 refers to section 221 of the National Housing Act of 1934, as added by Act of Aug. 2, 1954, 68 Stat. 599, codified at 12 U.S.C. § 1715l(d)(3), (4). Section 236 refers to section 236 of the National Housing Act of 1934, as added by Act of Aug. 1, 1968, Pub. L. No. 90-448, 82 Stat. 498, codified at 12 U.S.C. § 1715z-1.

[17] 24 C.F.R. §§ 700.100 to 700.175 (congregate housing), §§ 891.100 to 891.865 (supportive housing for the elderly).

sum payment into a SNT should be equally excluded from family assets. The Court then made a distinction between investment income earned by trust assets and distributions that are countable as principal. Distributions from principal are not countable income for purposes of the Section 8 housing calculation.

Two issues remain. This is a First Circuit decision and we do not know if other courts will follow the First Circuit lead. Second, the decision applies only to disbursements from First Party Trusts and not disbursements from Third Party Trusts. Generally, Third Party Trusts have never been an issue because the source of the funds were never owned by the recipient. This is also an important case for people with First Party pooled trust accounts.

2.04 Virginia Property Tax Relief. Like many states, Virginia provides for relief from property taxes levied on the homes of elderly residents.[18] These exemptions or deferrals can be crucial in allowing an elderly person to remain in his or her home. The statutes authorize the governing body of any county, city, or town to provide by ordinance for the exemption or deferral, or a combination of exemptions and deferrals, from increases in tax liability that occur after the ordinance takes effect or the resident reaches the age of 65, whichever is later. The real estate must be owned by, and be occupied as the sole dwelling of, a person who is at least 65 years old or permanently and totally disabled. A home owned jointly by a husband and wife can still qualify as long as either spouse is 65 or older or disabled.

Eligibility for an exemption or deferral is based on the applicant's income and resources (excluding the value of the exempted property).[19] Because localities have some flexibility in determining income and resource limits, the local government agency should be contacted to obtain specific eligibility criteria.

3. SUPPORTIVE HOUSING

3.01 "Supportive Housing" and "Assisted Living." "Supportive housing" refers to non-medical facilities that provide some level of assistance to individuals who need help in their normal life activities. Such help is less extensive than the degree of health care provided in a nursing home. A type of supportive housing known as "assisted living" has come to dominate what we mean by supportive housing. In Virginia, assisted living has replaced what formerly was referred to as "board and care homes," which were small boarding homes that appealed to moderate and lower income residents. In recent years, assisted living facilities have increasingly directed their marketing efforts at middle and upper income residents. Virginia has a specific definitional requirement for assisted living facilities that qualify for licensing by the Department of Social Services.[20]

3.02 Assisted Living Facilities (ALFs).

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[18] Va. Code §§ 58.1-3210 to -3218.

[19] Va. Code § 58.1-3211.

[20] Va. Code § 63.2-100; *see also* §§ 63.2-1732, -1800.

A. In General. An assisted living facility (ALF) is "any congregate residential setting (public or private) that provides or coordinates personal and health care services, 24-hour supervision, and assistance for the maintenance of care of *four or more adults* who are aged, infirm or disabled."[21] The licensure of ALFs is further divided between residential living care and assisted living care.

B. Residential Living Care. "Residential living care" means a level of service provided by an ALF for adults who may have physical and mental impairments and require only minimal assistance with activities of daily living. Minimal assistance is defined as dependency for only one activity of daily living or one or more instrumental activities of daily living.[22] A typical individual is one who requires only medication administration.

C. Assisted Living Care. "Assisted living care" means a level of service provided by an ALF for adults who may have physical and mental impairments and require at least moderate assistance with activities of daily living. Moderate assistance is defined as dependency in two or more activities of daily living.[23]

D. Uniform Assessment. Virginia law requires that all residents of and applicants for assisted living facilities be assessed using the "uniform assessment instrument." An assessment must be done before admission, at least annually, and whenever there is a significant change in the resident's condition.[24]

The "uniform assessment instrument" (UAI) means the Virginia Department of Social Services' designated assessment form.[25] An alternative version of the UAI may be used by private-pay residents, but the alternative UAI does not include some social and financial information necessary for assessment of the resident for auxiliary grant eligibility.[26]

Private-pay residents must obtain a UAI prepared by either the staff of the ALF trained in the completion of a UAI or an independent physician. Public-pay residents must obtain a UAI prepared by an employee of a public human services agency also trained in the completion of a UAI.[27]

E. Admission and Retention. Although Virginia law states that DSS may not remove a resident from an assisted living facility unless the resident consents, there are numerous medical conditions and circumstances that disqualify an applicant or resident from being admitted to, or continuing to live in, an assisted living facility. These conditions include:

Ventilator dependency;

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[21] Va. Code § 63.2-100.

[22] 22 VAC 40-72-10.

[23] *Id.*

[24] Va. Code § 63.2-1804; 22 VAC 40-72-430.

[25] See Appendix 3-1 for an example of Virginia's uniform assessment instrument. The Virginia UAI, with Instruction Manual, is available in .pdf format at www.dmas.virginia.gov/downloads/pdfs/ltc-UAI_User_Manual.pdf.

[26] The auxiliary grant program is discussed below in paragraph 3.302(L).

[27] ~~22 VAC 40-745-20~~. 22 VAC 40-72-430

Dermal ulcers III and IV (with exceptions);

Intravenous therapy or injections (with exceptions);

Airborne infectious disease in a communicable state;

Psychotropic medications without appropriate diagnosis and treatment plans;

Nasogastric tubes;

Gastric tubes (with exceptions);

Individuals presenting an imminent physical threat or danger;

Continuous licensed nursing care required;

Physician certification that placement is no longer appropriate;

Maximum physical assistance required, as documented by the UAI;

Facility determines that it cannot meet the individual's physical or health needs; and

Other medical and functional care needs that the Board determines cannot be met properly in an assisted living facility.[28]

F. Hospice Care. Notwithstanding the above limitations, a resident who requests to remain in an assisted living facility and have hospice care provided there may do so, provided the ALF is capable of arranging for the care and the hospice program determines that it is appropriate.[29]

G. Service Plan. A service plan for the resident should be developed based on the uniform assessment. The plan should document the description of need, what services will be provided, who will provide the services, when and where the services will be provided, and the expected outcome.[30]

H. Rights of Residents. Rights of residents in ALFs are governed by state statute and common law. Because federal funding for assisted living is either limited or nonexistent, there are no federal rules with regard to rights of residents in such facilities.

Virginia law provides that residents be fully informed, at or before admission, of their rights and "all rules and expectations governing the resident's conduct, responsibilities, and

[28] Va. Code § 63.2-1805.

[29] Va. Code § 63.2-1806.

[30] 22 VAC 40-72-440.

the terms of the admission agreement. . . ."[31] Section 63.2-1808 of the Virginia Code sets forth numerous specific rights of ALF residents. The most important rights are:

1. Management of their own financial affairs, unless a conservator or committee has been appointed;

2. Freedom to select available health care services and to participate in planning medical treatment for conditions that arise while a resident;

3. Confidentiality of personal affairs and records;

4. Freedom from mental, emotional, physical, sexual, and economic abuse or exploitation;

5. Assurance that their known needs are not to be neglected or ignored by personnel;

6. Freedom of reasonable visitation and voluntary participation in activities;

7. Freedom from transfer or discharge without a statement of reasons and adequate advance notice;

8. Right to voice grievances and recommend changes in policies and services without coercion, discrimination, threats, or reprisal;

9. Freedom from use of physical or mechanical restraints except in response to unmanageable behavior in an emergency situation or as deemed medically necessary by a physician in writing; and

10. Respect for ordinary privacy in aspects of daily living.

Section 63.2-1808(B) states that if a resident is unable to fully understand and exercise the rights and responsibilities provided in the statute, the ALF must require that a responsible individual, of the resident's choice when possible, be made aware of each right enumerated in the statute and the decisions that affect the resident or relate to those specific rights.

The Virginia Code provides no specific right of action for residents of ALFs who have been deprived of particular rights.

I. Transfer and Discharge. The Virginia Code provides almost no guidance as to procedural safeguards when a resident is involuntarily transferred within or discharged from the facility. It states that the resident of an ALF is to be transferred or discharged only when provided with a *statement of reasons*, or *for nonpayment*. The resident must be given *reasonable advance notice*, and the facility is required to *ensure an orderly transfer or discharge*.[32]

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[31] Va. Code § 63.2-1808.

[32] Va. Code § 63.2-1808(A)(5).

The Virginia Administrative Code provides further guidance concerning transfer and discharge procedures:

1. Discharge planning is to begin immediately. The resident must be moved *within 30 days*, and the resident and his or her personal representative must be informed *at least 14 days* before the actual discharge date.[33]

2. The facility must help the resident prepare for relocation and discuss the resident's destination. The facility is not responsible for transporting the resident or the resident's property.[34] The 14-day notice is waived in case of emergency.[35]

3. The facility is required to provide a discharge statement, which is to include the date of notification of the discharge, the discharge date, reason(s) for the discharge, and the actions taken by the facility to assist the resident in the discharge.[36]

It is unclear whether, in an involuntary discharge, Virginia law requires the facility to avail itself of the Virginia Residential Landlord and Tenant Act[37] procedures for evicting tenants. The discharge hearing that DMAS provides to nursing home residents *is not* available to assisted living residents. The question remains whether these agreements are contracts for services or lease agreements. In any event, the admission agreement should be closely reviewed in any discharge situation.

The ALF must have a written policy regarding the notice requirement when a resident wishes to move from the facility. The required notice of intent to move cannot exceed 30 days.[38]

J. Reviewing the Admission Agreement.

1. In General. Elder law attorneys have not included reviewing ALF admission agreements as part of their traditional services to clients. This is a mistake. Admission agreements are significant financial undertakings for clients, and it is extremely important for clients to understand what they are purchasing and the problems that may arise under the contract. Family members as well as the client must be made aware of issues raised by the contract as written.

2. Fees, Charges, and Level of Care. Although the Virginia Administrative Code requires that the admission agreement list specific fees and charges, up-front

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[33] 22 VAC 40-72-420(B).

[34] 22 VAC 40-72-420(D).

[35] 22 VAC 40-72-420(E).

[36] 22 VAC 40-72-420(H).

[37] Va. Code § 55-248.2 *et seq.*

[38] 22 VAC 40-72-420(C).

deposit payments, and the facility's policy regarding increases in charges,[39] ALFs have great discretion in how they present their charges.

Counsel should carefully review with clients how the facility charges for services. Contracts usually have two components, consisting of a basic daily rate and a schedule of fees for additional services. But some contracts, instead of providing a basic daily rate, offer a range of services at fees that differ according to the level of service that is appropriate for the resident's level of need. Within the particular levels there may be additional services for a fee. Because some contracts use a basic daily rate with charges for additional services and others have fees that vary with the level of care, comparisons between them are difficult.

A frequent concern is how the determination of the need for a particular service or increase in level of care is made. Residents may be admitted at a particular level only to have the facility quickly increase the level of service after admission. This makes predicting costs at the outset difficult. The level of care should be determined before admission based on the uniform assessment. The facility should be questioned as to the assessment and the resultant level of care in the facility. Section 63.2-1805(A)(2) requires that the ALF provide a written statement of its policy on "admission, transfer, and discharge criteria, including criteria for transfer to another level of care within the same facility or complex." Another important question to ask is how frequently rates have been raised for both the base level of care and the menu of additional services.

3. Guarantor Agreements. Unlike nursing homes, ALFs are not prohibited by federal or Virginia law from requiring a third-party guarantee of payment. Admission agreements are often ambiguous regarding the obligations of third-party signatories. An agreement may refer to the third party as the "responsible party" without clearly defining what that term means. Only the proposed resident should sign the contract. A third party who does sign the contract should never do so in his or her personal capacity but only as agent under a power of attorney or as guardian. The third party's liability should be limited to the extent of his or her access to the resident's income and assets. Counsel can assist the family in negotiating these clauses.

4. Other Provisions. Other provisions that should be reviewed with the client include the date of occupancy, identification of the unit assigned to the client, furnishings, security deposit, late fees, bed hold policies, refunds, and liability issues.

K. Licensure. Assisted living facilities are regulated in Virginia under the Department of Social Services. They are licensed to provide either residential living only or residential living and assisted living level of care. At one time there were two levels of assisted living care (assisted living and intensive assisted living). The intensive assisted living services were provided through a Medicaid waiver program and served as an alternative to Medicaid placement in a nursing facility, but in 2000 the Centers for Medicare and Medicaid decided not to renew the Virginia intensive assisted living waiver.

[39] 22 VAC 40-72-390(A).

The regulations were revised in 2005 because of publicity about the poor quality of care provided by facilities in Virginia. Changes in the regulations focused on staffing requirements and staff training and education.[40]

Other aspects of the regulations include physical environment, resident funds, health care services, and DNR orders.[41]

L. Auxiliary Grants Program. An auxiliary grant (AG) is a state and locally funded assistance program to supplement income of a Supplemental Security Income (SSI) recipient and certain other aged, blind, and disabled individuals residing in a licensed ALF. The recipient may have income above the SSI level but resources must meet SSI criteria. The program is administered through local departments of social services.[42]

To be eligible one must:

1. Be 65 or older, blind, or disabled;

2. Have non-exempted income of less than the total AG maximum amount as determined and revised periodically by the General Assembly, plus a personal needs allowance;

3. Have non-exempted resources of less than $2,000 for one person or $3,000 for a couple; and

4. Have been assessed by a local social worker, using the uniform assessment instrument, and determined to be in need of either residential or assisted living level of care.[43]

All of the recipient's income, less the personal care allowance, is paid to the facility. The state pays the balance up to the AG amount.

The fundamental drawback of the program is the small amount of the payment that the ALF receives (at this writing $~~1,220~~ $1,388 in Northern VA and $1,207 for the rest of VA). This is the maximum an ALF will be paid for accepting a resident under the auxiliary grant program. Thus, most facilities either refuse to accept auxiliary grants or limit the number they will accept.

3.03 Continuing Care Retirement Communities (CCRCs).

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[40] *See* Va. Code § 63.2-1803.

[41] *See* Standards for Licensed Assisted Living Facilities, 22 VAC 40-72-10 to -1160.

[42] Va. Code § 63.2-800; 22 VAC 40-25-10 to -70. The Department of Social Services has an Auxiliary Grant Manual under Vol. II, Pt. III of the Virginia Department of Social Services Manuals.

[43] An Alzheimer's Assisted Living (AAL) waiver is available to individuals in an assisted living facility. This waiver is for persons who are Auxiliary Grant recipients, have a diagnosis of Alzheimer's disease or a related dementia but no diagnosis of mental illness or mental retardation, and who are age 55 or older. The AAL waiver allows for the provision of services to individuals in approved assisted living facilities who, without the waiver, might require nursing home placement. *Va. Medicaid Manual* § M1410.040 C 7.

A. Definition and Description. As defined by Virginia law,[44] a CCRC is a facility that provides lodging, social activities, assistance with daily living, and a nursing home component based on a fixed entrance fee combined with monthly periodic charges. CCRCs are attractive to middle- and upper-income people because they provide the security of a lifetime guarantee of residence ranging from independent living through nursing home care. Three levels of housing and care are provided:

1. Entry level housing is typically independent living in a unit. Congregate meals along with recreational services are provided.

2. Assisted living is provided where help with activities of daily living is necessary.

3. Nursing home care is provided should medical needs exceed the services that can be provided under assisted living care.

Different licensure requirements apply to the different levels of care. The ALF section of a CCRC is licensed by the Department of Social Services, while the nursing section is licensed by the Virginia Department of Health.

B. The Problem of Solvency. Much of the statutory law on CCRCs was enacted as a response to problems arising from poor financial planning by some facilities when CCRCs first appeared. Many facilities had financial difficulties because they underestimated the outlay that would be required for residents when they began to need skilled nursing care. As a result, certain financial disclosures from the facility to the prospective resident are now required.[45] In theory, this data allows the resident to determine whether the facility is likely to continue operating in the future and be able to provide high quality services for the remainder of the applicant's life.

A continuing care contract also serves as a vehicle for disclosing to the facility whether the applicant has sufficient funds to pay the entrance fee and future monthly fees (which may increase over time) and that the applicant's health is good enough to assure that the need for long-term skilled nursing care is not imminent.

C. Reviewing the CCRC Contract.[46] Counsel should assist prospective applicants to understand the contract. Terms of particular import include:

1. How much is the entrance fee? Will all or some of it be held in escrow and for how long? Is any part of the fee refundable? If so, under what conditions? How much are the monthly fees?

2. What does the monthly fee cover and not cover? What will the monthly fee be if the resident's health care needs or other services increase?

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[44] Va. Code §§ 38.2-4900 to -4908.

[45] *See* Va. Code § 38.2-4902(A)(9)-(12).

[46] David M. English, Rebecca C. Morgan, John J. Regan, *Tax, Estate and Financial Planning for the Elderly*, § 15.06 (2007).

3. Can the resident use Medicare or Medicaid for services offered at the facility?

4. What is the availability of nursing home beds at the facility? Most CCRCs do not guarantee that a bed in the facility will be available when the applicant needs it. If this is the case, does the facility use a specific offsite location for its overflow nursing home care? If it has no designated offsite facility, how does the CCRC determine what facility to use, and is the resident allowed to participate in the decision?

5. What are the criteria for making changes in a resident's level of care, and who decides such changes?

3.04 Adult Foster Care Homes. Generally, adult foster care homes are unregulated "homelike" settings for older persons who need some supervision or assistance with activities of daily living. At one time referred to as "board and care" facilities, they are now commonly called adult care homes or adult foster homes. An adult foster care home can only serve three or fewer individuals, since a house with four or more individuals must be licensed as an assisted living facility.

Because these services are typically used for adults who can't afford expensive assisted living facilities, the local department of social services is best able to locate such providers.

An adult foster care provider is defined as "a provider who gives room and board, supervision and special services in his own home for up to three adults who are unable to remain in their own home because of a physical or mental condition or an emotional or behavioral problem."[47] Although these homes are licensed and inspected by the state,[48] they often provide less than optimal conditions for their residents.

4 NURSING FACILITIES

4.01 In General. Nursing facilities are institutions that house people who need health care but who do not need the level of care provided in hospitals. Unlike assisted living facilities, nursing facilities are heavily regulated under federal and state law. Under the federal Omnibus Budget Reconciliation Act of 1987 (OBRA 87),[49] nursing home residents received significant protections and specific legal rights. Virginia also enacted protections for residents, many of them buttressing provisions under the federal law, but despite OBRA 87 and the Virginia reforms, significant problems of quality of care in nursing facilities persist. Although enforcement provisions are built into federal and state law, no private right of action exists, so enforcement is limited by the funding and initiative of the regulatory agencies.

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[47] 22 VAC 40-771-10.

[48] *See* 22 VAC 40-771-10 to -160.

[49] Pub. L. No. 100-203, 101 Stat. 1330 (1987).

4.02 Sources of Law. Nursing facilities are regulated by the Virginia Department of Health. Chapter 5 of title 32.1 of the Virginia Code provides the statutory basis for the regulation of Virginia nursing homes and services for their residents.[50]

The federal Nursing Home Reform Act of 1987 (NHRA), which was a component of OBRA 87, enacted several sections of the U.S. Code[51] to bring nursing facilities that accept Medicare or Medicaid payments under its regulatory authority. When a facility accepts any Medicare or Medicaid payment, OBRA applies to all residents in that facility, not just those who qualify for Medicare or Medicaid benefits.[52]

4.03 Quality of Care and Resident Rights.

A. Quality of Care. Under OBRA, a nursing facility "must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident."[53] The facility is responsible for preventing a patient's condition and abilities from deteriorating.

Comprehensive assessment of each resident must be completed within 14 days of admission. The assessment is compiled using a standardized form known as the minimum data set (MDS). Based on the MDS, a plan of care is developed for each resident. The plan must be updated at least once annually and any time there is a substantial change in the resident's mental or physical condition.[54]

Because many facilities handle the planning process by rote, an attorney should advise families to take the care planning meetings seriously and attend them. Complaints of the resident should be addressed and resolved, if possible, at the care conferences.

B. Resident Rights.[55] Both Virginia and federal law provide residents with specified rights, including the right to be fully informed of such rights. Resident rights include, among others, the right to:

1. Participate in one's planning care and treatment, unless adjudicated incompetent or incapacitated;

2. Be free from chemical and physical restraints;

3. Have personal and medical records kept confidential;

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[50] For the rights and responsibilities of patients in nursing homes, see sections 32.1-138 to -138.5 of the Virginia Code.

[51] 42 U.S.C. §§ 1395i-3, 1396r.

[52] The NHRA became law with the passage of OBRA in 1987. Consequently, for many years the NHRA was more commonly known as OBRA 87. Medicare requirements for certified facilities are located at 42 U.S.C. § 1395i-3, and Medicaid requirements are located at 42 U.S.C. § 1396r. The implementing regulations for both programs are found at 42 C.F.R. § 483.1 *et seq.*

[53] 42 U.S.C. § 1396r(b)(1)(A).

[54] 42 U.S.C. §§ 1396r(b)(3), 1396r(f)(6)(A).

[55] 42 U.S.C. § 1396r(c)(1), 42 C.F.R. § 483.10, and Va. Code § 32.1-138 generally provide for the rights of residents. In addition, nursing homes have proactive responsibilities to notify residents of their rights under law. *See* 42 U.S.C. § 1396r(c)(1)(B); 42 C.F.R. § 483.10(b); Va. Code § 32.1-138(A)(1).

4. Have privacy;

5. Manage one's own personal and financial affairs;

6. Participate in social, religious, and community groups;

7. Voice grievances; and

8. Choose physicians and be fully informed of one's medical conditions.

4.04 Admission, Transfer, and Discharge Rights.

A. Medicaid Discrimination.[56] A nursing facility is explicitly prohibited from including provisions in its admissions contract that discriminate against Medicaid applicants and recipients. Contracts may not:

1. Contain provisions that restrict or limit the ability of a resident to apply for and receive Medicaid coverage;

2. Require a period of private payment in the nursing facility before applying for Medicaid;

3. Require a deposit or other prepayment from Medicaid recipients; or

4. Refuse to accept retroactive Medicaid benefits.

B. Transfer and Discharge Policies. Federal and state laws provide a number of regulatory requirements for the transfer and discharge of residents.[57] "Transfer" refers to movement to another facility or in some cases to another room within the facility, while "discharge" refers to removal from the facility itself. Virginia law provides a list (reflected also in the federal statute) of the *only* circumstances under which a resident can be transferred or discharged involuntarily. Involuntary transfers or discharges are allowed only:

1. To meet the patient's documented medical needs;

2. To safeguard the patient or one or more other patients from physical or emotional injury; or

3. On account of nonpayment after reasonable and appropriate notice.

Transfers and discharges are also subject to federal and state notice requirements.[58] Notice of transfer or discharge must:

1. Be in writing;

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[56] 42 U.S.C. § 1396r(c)(5); Va. Code § 32.1-138.2.

[57] 42 U.S.C. § 1396r(c)(2); 42 C.F.R. § 483.12; Va. Code § 32.1-138.1.

[58] 42 U.S.C. § 1396r(c)(2)(B); 42 C.F.R. § 483.12(a)(5); Va. Code § 32.1-138.1(C).

2. Provide notice to the resident and if known, a family member or legal representative;

3. State the reason for the transfer or discharge and its effective date;

4. State the location to which the resident is being transferred or discharged;

5. Give 30 days' notice, unless emergency circumstances permit or require a shorter notice;[59] and

6. Notify the resident of any appeal rights.

Unlike discharges from assisted living facilities, an involuntary transfer or discharge from a nursing home triggers a right to a fair hearing appeal through the Department of Medical Assistance Services (DMAS).[60] Any resident is entitled to such a hearing whether on Medicaid or not. The appeal request must be *in writing and signed* by the recipient or a legal or authorized representative.[61] The appeal must be filed before the date of the discharge. When the appeal has been filed, the facility will be told by DMAS that it must permit the resident to remain in the facility until a hearing decision is reached, which allows additional time to make alternative arrangements in anticipation of an adverse hearing decision.

The resident and his representative are entitled to a copy of the facility's required appeal summary and may also review and copy the nursing home's file on the resident. The appeal is held before a department hearing officer either in person or by telephone. An adverse decision can be appealed on the record to the circuit court.

Before filing an appeal, the resident should consider contacting the local long-term care ombudsman to see if the matter can be resolved informally, but the appeal should not be unduly delayed if the issue is not resolved quickly.

Facilities often fail to comply with the requirement under section 32.1-138.1(B) of the Virginia Code that the attending physician or the medical director of the facility make a written notation in the patient's record approving the discharge or transfer "after consideration of the effects of transfer or discharge . . . and the care and kind of service the patient needs upon the transfer or discharge." This oversight may provide a basis for delaying an involuntary discharge and allow more time to make suitable alternative arrangements for the client.

C. Admission Contract Issues.

1. Guarantors and Third-Party Signators. Historically, nursing facilities often attempted to obtain third-party guarantors to satisfy the financial liabilities of

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[59] *Id.* Note that section 32.1-138.1(C) of the Virginia Code provides: "Except in an emergency involving the patient's health or well being, reasonable advance written notice shall be given in the following manner. In the case of a voluntary transfer or discharge, notice shall be reasonable under the circumstances. In the case of an involuntary transfer or discharge, reasonable advance written notice shall be given to the patient at least five days prior to the discharge or transfer."

[60] 12 VAC 30-10-670.

[61] The appeal should be sent to: DMAS, Appeals Division, 600 E. Broad St., Suite 1300, Richmond, VA 23219.

residents. Federal and Virginia law now expressly prohibit nursing facilities from requiring a third-party guarantor as a condition for admission or continued stay in a nursing home.[62]

Facilities continue to surreptitiously obtain guarantors by having family members sign as "responsible parties," making them personally liable if the applicant or resident fails to pay. Counsel should advise that only the applicant or resident sign the contract.

If the resident or applicant has appointed an agent under a power of attorney or has a guardian, any signatures of the agent or guardian should be qualified to disavow personal liability.63

2. Basic Rate Services and Extra Charges. Nursing home contracts should contain an itemized list of services included in the basic daily rate. A clear explanation of extra services should be separately explained if those services are not included in the basic charge.

3. Liability Waivers. There are no regulations specifically controlling the nature of liability waivers contained in admission contracts. Such waivers appear to be left to the arm's length negotiation of the contracting parties. But blanket waivers imposed on the resident by the nursing home are illegal at common law as against the public interest and probably are not enforceable.

4. Arbitration Clauses. Some contracts contain a clause requiring that all disputes be assigned to binding arbitration. Counsel should advise the client that such clauses are intended to protect the facility from exposure to a jury trial in an action for negligence, and the attorney should request the facility to remove the provision from the contract.

4.05 Enforcement.

A. Virginia Long-Term Care Ombudsman Program. The Virginia Long-Term Care Ombudsman Program is mandated under the federal Older Americans Act of 1965[64] to receive, investigate, and resolve complaints made by persons in nursing facilities and assisted living facilities. The ombudsman investigates and mediates complaints and serves as a source of information and referral to government and non-government agencies that can provide assistance to long-term care facility residents. Some localities in Virginia have local ombudsman services, usually with support from local government entities. The program is a division of the Virginia Department for the Aging but is managed under the Virginia Association of Agencies on Aging (V4A) to maintain independence from state agencies.[65]

B. Adult Protective Services (APS). Adult Protective Services (APS), a service of the Virginia Department of Social Services and its local departments, investigates reports of abuse, neglect, and exploitation of adults aged 60 and over and incapacitated adults over

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[62] 42 U.S.C. § 1396r(c)(5)(A)(ii); 42 C.F.R. § 483.12(d)(2); Va. Code § 32.1-138.3.

63 Inova Health Sys. Serv. Inc. T/a Commonwealth Care Ctr. V. Brainbridge (Va Cir. 2010)

[64] Pub. L. No. 89-73, 79 Stat. 218 (1965), codified at 42 U.S.C. § 3001 *et seq.*

[65] More information on the ombudsman program is available at www.vda.virginia.gov/ombudsman.asp.

18 years of age.[66] They are required to investigate any reports of abuse, neglect, and exploitation of any elderly or incapacitated adults, including residents of nursing homes, and provide protective services when a person is found to be in need of them. Investigations are typically triggered by calls to local social services departments or the Virginia DSS's hotline reporting suspected abuse. APS does not require disclosure of the identity of the person reporting the matter to them.

C. Federal and State Enforcement.

1. Annual Inspection of Facilities. The Centers for Medicare and Medicaid Services rely upon state health departments to perform annual surveys of nursing facilities.[67] Inspection teams observe resident care processes, staff and resident interaction, and the facility's environment. Clinical records are reviewed. When an inspection team finds that a facility does not conform to a specific regulation, it issues a deficiency citation.

2. Sanctions. When a state enforcement agency finds that a facility is not in compliance with requirements, it can impose intermediate sanctions (civil monetary penalties), deny payments under state plans, decertify coverage for Medicaid or Medicare, seek appointment of a receiver, or close the facility.[68]

3. "Nursing Home Compare." "Nursing Home Compare" is an interactive database provided by the official U.S. government website that allows users to compare information about all nursing home facilities that are Medicare- or Medicaid-certified.[69] The data on the website specifies the regulatory requirements that any listed facility failed to meet.

D. Quality of Care Litigation in Virginia. When an elder law attorney's client suffers harm or injury from deficiencies or errors in nursing home care, the attorney should be prepared to refer the client to a personal injury attorney who specializes in quality of care litigation. Issues that frequently generate litigation include:

1. Falls and dropping residents, where the facility failed to follow the care plan for residents with risk of falling;

2. Failure to discover and assess pressure sores in a timely manner;

3. Medication errors;

4. Choking deaths, where the facility failed to follow the care plan for residents at risk of choking and aspiration; and

5. Malnutrition and dehydration.

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[66] More information on APS is available at www.dss.virginia.gov/family/as/aps.cgi.

[67] The authority for these inspections is set forth at 12 VAC 30-20-100.

[68] 42 U.S.C. § 1396r(h).

[69] www.medicare.gov/nursing/overview.asp.

Causes of such problems often include (i) shortage of staff (over 50% of cases are directly linked to staff shortage and excessive turnover) and (ii) poorly trained and underpaid certified nursing assistants.