Part 2: ALFs for the Less Affluent - Availability, Affordability, and Alternative Options

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An earlier version of the paper "The Ideal Assisted Living: What It Should Be and Why?" discussed the quality-of-life-oriented values that have guided the development of assisted living over the last 20 years. The main focus was to identify and describe the core values of assisted living, which include resident autonomy and choice, social engagement, privacy and dignity, and the capacity of assisted living to allow residents to age in place in an affordable, homelike setting.

A point mentioned in the previous paper is that the growing problem with assisted living is the lack of availability of access for the less affluent aging population who require public support, have limited access to community resources, and want to avoid ending up in a nursing home. For many of these people, assisted living offers the optimal long-term care setting for not only receiving the physical care they need, but also for achieving a quality of life that may not be available in their own homes. Therefore, a primary societal goal for assisted living should be to expand access for publicly supported residents.

Making assisted living more affordable will depend on two major factors: expanding public funding for assisted living, including Medicaid; and ensuring the survival and growth of small, lower cost facilities which now have a higher percentage of low-income residents than larger facilities. This paper illustrates the reasons behind the lack of affordability and availability of ALFs for lower-income individuals and describes alternative options for possible solutions.

Availability

Although historically the demand for long term care came from individuals relying heavily on public assistance, as middle and higher income individuals have shown greater interest in these care communities more options have become available to assist them with their increasing functional dependency (Coe and Boyle 2013). In a study by Stevenson and Grabowski (2010), data was collected on county-level ALF supply throughout the United States. They found that, when compared to areas with fewer choices for ALFs, counties with multiple options tend to have greater educational attainment (19.9% versus 13.8%), higher median household income ($43,034 versus $35,379), and higher median home values ($98,541 versus $69,560). In addition, there are a lower proportion of minorities (12.8% versus 17.1%). On the other hand, the counties with few or no facilities are disproportionately located in rural areas.

The availability of long-term care insurance among people ages 45–65 is greater in states with higher access to ALFs. These states also spend a greater portion of their Medicaid long-term care dollar on home and community-based services (44.4%) than do states with lower saturation (31.2%), which suggests that community-based service capacity matters (Stevenson and Grabowski 2010). Furthermore, accessibility to capital for new construction faced pressures in the context of the financial downturn in 2008, leaving less affluent individuals, including minorities and people living in rural areas, with substantially less access to ALFs.

Assisted living has the potential to serve as a cost-effective substitute for nursing home care for some people. Yet, to date, states have been cautious in expanding Medicaid coverage for services in ALFs. Unlike care delivered in nursing homes,

Medicaid does not pay for residents' room-and-board expenses in ALFs, which potentially creates a further barrier to access.

There are, however, many states with small programs under which Medicaid pays for personal care and medical services in ALFs (Stevenson and Grabowski 2010). Some larger private-pay, for-profit ALFs allocate a small number of their units to low-income older persons, but few residents receive these public supports (Golant 2008).[1] In 2011, the Florida Legislature created the Statewide Medicaid Managed Care (SMMC) LTC program.[2] Medicaid recipients who are enrolled in the SMMC LTC program receive long-term care services from a managed care plan. Assisted living facilities are included in the list of managed care plan services. The plans cover services only and excludes medications, doctor's visits or other healthcare related services.

There are a limited number of ALFs in Florida that are housing and providing care and services to thousands of SMMC recipients. These facilities receive inadequate reimbursement amounts, with a median of $35-$38 per day from the LTC plan providers and somewhere between $700-$900 a month for room and board from residents with restricted incomes (Wilson 2015). Anyone familiar with assisted living costs knows that on average the monthly rate ranges from $2600 to $5800. As you can see, these numbers do not add up to meet the costs of the necessary operations for staffing, compliance requirements, and operational costs that must be met to maintain quality care standards (Wilson 2015). This, along with reimbursement delays, makes it difficult to cover costs for resident care and thus, inhibits the ALFs ability to deliver quality care.

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[1] A recent ruling from the federal court mandated Ohio MCD program to eliminate the coverage gap for low-income ALF residents. The full court order can be accessed on the Justice in Aging website: http://www.justiceinaging.org/wp- content/uploads/2015/09/121-Order-Granting-Summary-Judgment.pdf.

[2] Agency for Health Care Administration http://www.flmedicaidmanagedcare.com/GeneralInfo.aspx

The broken system has caused a large strain on the foundation of the industry. If 50 percent of these ALF providers said that, starting tomorrow, they could no longer accept any SMMC recipients as residents because of the current contracted payment rates, there would be an even bigger crisis regarding placement of these residents and the ever-growing waitlist (Wilson 2015). Therefore, there is an immediate need to reevaluate the funding and reimbursement rates for the ALFs that cater to the less affluent population. Providing the adequate financial resources necessary to cover costs for each SMMC recipient will ensure that thousands under the LTC plan can age in place safely, receiving the care and services they deserve.

Overall, policymakers are concerned about the so-called "woodwork effect" likely associated with offering people an array of long- term care services, especially attractive options such as ALFs (Stevenson and Grabowski 2010). The government's role in ALFs will inevitably evolve if Medicaid and other public payers invest more in this area. Therefore, it is important to evaluate how the changing demands in long-term care use, and the assets available to pay for that care, will have an impact on the future costs for Medicaid and availability of ALFs to lower income individuals (Coe and Boyle 2013).

Affordability

In the ALFA survey of AL residents (2013), the results show that residents are overwhelmingly satisfied (93%) with their community on the whole. More specifically, over 90 percent of the residents say they enjoy a high quality of life, feel safe, and benefit from a high level of care. However, although residents express high levels of satisfaction with many aspects of their community, there are two factors that get the lowest ratings:

the overall value for the dollar of assisted living community services (47% satisfied) and the cost associated with living in your assisted living community (36% satisfied).

According to the 2015 Glenworth cost of care report, the national median monthly rate for an ALF is $3,600 (a 2.86% increase from the previous year). Similarly, the Residents Financial Survey (RFS) found the average monthly bills range from $2,400 to $3,700 (Coe and Wu 2014).[3] A more detailed look at the RFS shows that one quarter to one third of the respondents have a total income of at least $3,500 a month and approximately 26 percent of the self-reported total net worth is less than $50,000 (Coe and Wu 2014). If the residents' total income tends to be equal to or less than the monthly cost for an ALF and they have a low total net worth, the question then becomes, who pays for their housing and what income sources are used to pay the bills? The answers can be useful when it comes to figuring out the best ways to expand access to lower income individuals.

The RFS found that only 21 percent of ALF residents pay *all* expenses with their current income, with an additional 26 percent stating *most* expenses are covered by their current income (Coe and Wu 2012b). Among those residents with *most* expenses covered by their current income, 86 percent spend down their savings and assets to pay for housing and care, and 19 percent receives help from family (Coe and Wu 2012b).

According to the RFS, the top four income sources are Social Security (97%), pension/annuity (59%), interest from bank accounts (44%), and interest from stocks/bonds (33%) (Coe and Wu 2014). In terms of assets, 85 percent have a

[3] The Residents Financial Survey was created to gather a detailed demographic and economic profile of residents living in ALFs and Independent Living. The survey asked specific questions about how residents pay for their care and concerns regarding their ability to pay their bills. The RFS found that the residents in these facilities are, on average, over 80 years old, predominately white, female, and college educated (Coe and Wu 2012a).

checking/savings account, 35 percent have brokerage/stocks/bonds, 24 percent have a house/property/land, and 17 percent have a 410(k)/IRA (Coe and Wu 2012c). Means-tested government programs (Medicaid, SSI, food stamps, HUD rental assistance) have the lowest percentages of use. Of these programs, Medicaid coverage has the highest (8%) reported use from the ALF residents (Coe and Wu 2014).

Overall, the RFS findings illustrate that most ALF residents are mid- to high-income, which explains the relatively high self-reported monthly incomes. Less than 10 percent of the sample is living with incomes below the poverty line (Coe and Wu 2014). Further, higher wealth and education levels are associated with paying more of the community costs out of the resident's own income (Coe and Wu 2012b). Individuals overwhelmingly report that they pay for their own services, with very few relying on family or government programs for assistance.

Similar to the ALFA study, 55 percent of the residents from the RFS agree that their ALF offers good value for the money (Coe and Wu 2012b). However, many report actively spending down their assets to pay for their care and 70 percent have concerns about their ability to afford the cost of the current community in the future (Coe and Wu 2012b).

A study by Fonda and colleagues (2002) examined low-income residents in an affordable ALF, and compared them to similar low-income individuals who resided in the community to find out whether the ALF residents had more or less beneficial outcomes.[4] The results showed that when compared with community-dwelling

[4] The context for this research was a new, affordable ALF in North Carolina. This facility was affordable because people were eligible for residency only if their incomes were 60% or less than the 1993 to 1994 median income for the county, or about $16,000 per year, and rent assistance was available to most residents.

participants, the ALF residents were no different (statistically) in terms of improvement, decline, and death, but they were more likely to have stable high functioning (42.4%). This finding suggests that the affordable ALF model provides opportunities for maintaining high functioning and assists residents with attaining the goal of independent living through the provision of as-needed compensatory care.

The National Assisted Living Workgroup generated several recommendations designed to increase the affordability of assisted living for low-income persons, including expansion of the assisted living Medicaid waiver and HUD-funded programs related to assisted living. The workgroup also recommended an increase in SSI spending to cover assisted living room and board costs and allowing supplemental support by family members for assisting living residents. The following section describes the HUD funded programs that are designed to assist with aging in place.

Alternatives to ALFs: HUD-Assisted Housing

The most commonly cited factor affecting how long aging individuals can remain in their homes is "access to quality support services" (Locke et al. 2011). In fact, having the appropriate resources allows many older adults to avoid or delay leaving their independent housing for a higher-level care facility such as a nursing home. However, services that can assist with aging in place, such as the ones provided in an ALF, are not accessible to the majority of lower-income aging individuals. As a result, special types of affordable assisted housing arrangements have emerged to help low-income older persons cope with their long-term care needs in their communities. These housing options make it possible for their occupants to benefit from both affordable shelter and long-term care

services, and have become an essential part of preventing nursing home placement for many older people (Golant 2008; McFadden and Lucio 2014).

Housing care arrangements share various similarities with private-pay models of seniors housing property types such as ALFs, except they do not cater to high-income older individuals (Golant 2008). The U.S. Department of Housing and Urban Development (HUD) has created affordable housing across the country by funding programs for rent assistance, home ownership, and assistive services for aging individuals in need and the disabled. These multifamily programs include the following: Section 202 Supportive Housing for the Elderly, Section 811 Supportive Housing for Persons with Disabilities, Housing Choice Voucher Program (formerly Section 8), Demonstration Program for Elderly Housing for Intergenerational Families, Emergency Capital Repair Program, and Assisted-Living Conversion Program.[5]

Section 202 Supportive Housing for the Elderly

This program helps expand the supply of affordable housing for low-income aging individuals by offering options that allow them to live independently in an environment with supportive services, such as assistance with ADLs, housekeeping, cooking, transportation, and counseling. Those 62 and older with low household income (50% of area median) are eligible.

HUD provides interest-free capital advances to private, nonprofit sponsors to finance the development of supportive housing. Repayment of the capital advance is not expected as long as the housing serves very low-income aging persons for 40 years. Project rental assistance funds are provided to cover the difference between the HUD-

[5] The following descriptions come from the HUD website http://portal.hud.gov/hudportal/HUD

approved operating cost for the project and the tenants' contribution towards rent. Assistance is approved initially for 3 years and renewed depending on the availability of funds.

Section 811 Supportive Housing for Persons with Disabilities

Similar to Section 202, this program allows persons with disabilities to live as independently as possible in the community. Supportive services may include personal assistance, meals, housekeeping, counseling, training in independent living skills, and transportation. Those low-income households (50% of median income) with at least one adult member who is physically, mentally, emotionally and/or developmentally disabled, are eligible.

HUD provides funding to develop subsidized rental housing opportunities with the availability of supportive services. It operates in two ways: (1) providing interest-free capital advances and operating subsidies to nonprofit developers of affordable housing for persons with disabilities; and (2) providing project rental assistance to state housing agencies. The assistance can be funded through different sources, such as Federal Low-Income Housing Tax Credits, Federal HOME funds, and other state, Federal, and local programs.

Housing Choice Voucher Program

This program provides rent vouchers for housing in the private market to low-income individuals, families, the aging individual, and the disabled. These vouchers are run by local Public Housing Agencies (PHAs) and are associated with specific properties. There are two kinds of vouchers: tenant-based and project-based. Tenant based vouchers are portable and can move with the renter, and project based vouchers are fixed to units

or buildings and are non-transferable. Residents are eligible if their income is at or below 50 percent of the Area Median Income of a community. A family that is issued a voucher is responsible for finding a suitable housing of the family's choice where the owner agrees to rent under the program.

To cover the cost of the program, HUD provides funds to allow PHAs to make housing assistance payments. A housing subsidy is paid to the landlord directly by the PHA on behalf of the family. The family then pays the difference in rent charged by the landlord and the amount subsidized by the program.

Demonstration Program for Elderly Housing for Intergenerational Families

This program was created to expand the supply of intergenerational dwelling units for very low-income grandparent(s) or relative(s) heads of household 62 years of age or older raising a child. Capital advance funding is available to private nonprofit owners of Section 202 Supportive Housing for the Elderly properties, under Notice of Funding Availability (NOFA), to cover the cost of expanding the supply of intergenerational housing. In addition, Project Rental Assistance Contract (PRAC) funds are available for projects that are funded under this program to cover the difference between the HUD approved operating costs of the project and the tenants' contribution toward rent, which is 30 percent of their adjusted monthly income.

Emergency Capital Repair Program

This program provides private nonprofit owners of eligible developments designated for occupancy by aging tenants with grants to provide one-time assistance for emergency items that could not be absorbed within the project's operating budget and other project resources. The grant is only given if there is an immediate threat to the

health, safety, and quality of life of the tenants. The maximum grant amount an individual project owner may apply for is $500,000. Funds may be used to repair or replace systems including, but not limited to: (1) Existing major building and structural components that are in critical condition; and (2) Repairs or replacements to existing mechanical equipment to the extent that they are necessary for health and safety reasons.

Assisted-Living Conversion Program

This program provides private, nonprofit owners of eligible developments with a grant to convert existing units into an ALF or Service-Enriched Housing (SEH) for residents to age in place. The funding typically covers the unit configuration, common and services space, and any necessary remodeling consistent with HUD or the State's statute/regulations (whichever is more stringent). Funding for the supportive services, such as Money Follows the Person funds and State Home Health Care programs, does not come from HUD but must be coordinated by the owners or residents, either directly or through a third party.

While there are a small number of HUD subsidized ALFs already in existence, one being the Village at Oakwood in Oklahoma, HUD recognized that there was a large demand for more due to the rapidly aging population.[6] In 2012, $26 million in grant funding was awarded to the owners of multi-family housing developments in Arizona, California, Colorado, Connecticut, Massachusetts, Minnesota, New York, Ohio, and Texas to convert existing units into ALFs for low-income aging individuals. One of the first grants awarded was $2.4 million to Fowler Christian Apartment in Dallas, Texas.[7]

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[6] http://villageatoakwood.com/

[7] http://housingapartments.org/rental_detail/10917

Another one of the awardees was Delta Volunteers of America Elderly Housing Inc.[8] These grants not only help apartment owners to convert their properties into service-enriched environments, but also allow aging individuals to remain in their homes for longer periods of time.

The HUD assisted housing programs can be welcome news for aging Americans and their caregivers because they have the potential to help fill the disappointing gap in the availability of housing for low-income individuals in need of assisted living care. However, there are some problems with these programs:

1. With the economic downturn in 2008, there had been little investment of the private sector in affordable housing projects (McFadden and Lucio 2014). Since the demand for housing assistance often exceeds the limited resources available to HUD and the local housing agencies, the waiting lists are often long (from two to five years), especially in metro areas.
2. For those in need of high-level assisted care, HUD options are limited. HUD programs are designed primarily for independent aging adults.
3. Funding focuses on developing existing housing units, and excludes supportive services.
4. Many of these new construction buildings are spatially isolated, located in areas that have high concentrations of crime and poverty, and are not near city centers with access to resources (McFadden and Lucio 2014).

Overall, the HUD-Assisted housing programs provide an alternative to ALFs and can allow many older adults to age in place. However, the current state of affordable

[8] http://www.voa.org/housing

housing policy demonstrates that we are not ready to deal with the growth of the frail aging population in need of supportive housing. More than 700,000 additional rent-assisted units would have to be created by 2020 to bring unmet housing needs back down to their 1999 level (McFadden and Lucio 2014). Yet, the funds were recently cut as a part of the congressional sequestration. A renewed legislative focus on promoting community living for the growing population of older adults could lead to improvements on many of these issues for future housing programs, and therefore, funding for these programs should be reevaluated.

The Hearth Model of Care for Older Homeless Adults

While it is commonly known that the general population is aging, only a small percent are aware that the homeless population is aging at an even faster rate (Brown et al. 2013). Over the past decade, permanent supportive housing programs have been created to address this issue. Permanent supportive housing is subsidized housing with on-site or closely linked supportive services (medical, psychiatric, personal care, case management, vocational, and substance use counseling services) for homeless individuals (Brown et al. 2013). Since their development, these programs have demonstrated improved health outcomes and decreased health care costs among chronically homeless persons with a range of disabilities including active substance use, severe mental illness, and HIV/AIDS (Brown et al. 2013).

One example of a successful permanent supportive housing model is the Hearth program, a non-profit outreach in Boston developed specifically for older homeless adults. There are two parts to the Hearth model: outreach and housing. The Hearth outreach program identifies homeless individuals (or those at risk) aged 50 and older and

helps them to find/maintain permanent housing (Brown et al. 2013). Case managers assist these individuals with all aspects of the subsidized housing application process. Once placed in a home the case managers continue with follow-up visits to ensure the person maintains their residence. The case managers also invite the resident to attend a support group called "Back on Our Feet". The program is funded by McKinney-Vento Homeless Assistance Act funds, Emergency Solutions Grant funds, and philanthropy (Brown et al. 2013). Overall, it has placed over 1,000 individuals in permanent housing with 96 percent maintaining their housing for at least a year or longer.[9]

The Hearth permanent supportive housing program provides safe, affordable housing and optional on-site supportive services (Brown et al. 2013). The program currently manages 196 units. All of the Hearth residences include an interdisciplinary team (director, nurse, social worker, personal care workers) that coordinates any care and services needed. Group meals and activities are also provided to alleviate social isolation and encourage a sense of community (Brown et al. 2013). On-site support groups and counseling are available to all residents. Funding sources for Hearth housing includes Section 8 project-based housing subsidies, Medicaid, Department of Mental Health funding of eligible services, and other local and state funding sources (Brown et al. 2013).

Overall, the Hearth program has shown to be a successful model that can not only be a solution to older adult homelessness, but can also be adapted to the issues regarding affordability of ALFs. However, in 2013 HUD housing grants were cut, which resulted in approximately 100,000 individuals being removed from their housing programs. From

[9] This rate exceeds the HUD's benchmark housing retention rate of 71% at 6 months (Brown et al. 2013).

this, the National Leadership Initiative to End Elder Homelessness made three policy recommendations that addresses the lack of affordable housing units: 1) amend the Low-Income Tax Credit Program to provide a 15 percent credit increase for permanent supportive housing; 2) increase funding for publicly assisted housing in need of renovation to create new permanent supportive housing through the Section 8 program, and Public Housing capital account; and 3) improve the HUD Section 202 program by encouraging communities to make housing units more available to older adults who are homeless or at risk of homeless (Brown et al. 2013). In order for decision makers to adopt effective policies and services that meet the multifaceted needs of the increasing aging population, they not only need to consider the social and health attributes, but also the economic situation of this population. This is especially true for the less affluent people (Coe and Wu 2012b).

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