

Working Session: Expanding Senior Housing with Supportive Services

1:15 p.m.-2:45 p.m.

Room 306, Level 3

Creative new policy strategies for senior housing tap into multiple streams of housing, medical, and transportation funding.

Moderator: Michelle Norris, National Church Residences

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Senior Supportive Housing

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Authored by:

A Committee

Stewards of Affordable Housing for the Future (SAHF) and American Association of Homes and Services for the Aging (AAHSA) with special thanks to Helen Dunlap and Nancy Eldridge



IDEA: Increase resident stability, choice, and health while reducing medical and related care expenses by merging community based long term care and supportive services with affordable senior housing

The Challenge and Opportunity

The U.S. is experiencing unprecedented changes in its elderly population. The senior population is expected to double by 2030, when one in five citizens will be over the age of 65. While those ages 85 and older made up 12 percent of the senior population in 2000, they are projected to account for almost 25 percent by 2050. Research shows a strong correlation between old age, chronic conditions, disability and the use of long-term care services. This convergence of trends places an enormous strain on the United States' long-term care system while exponentially increasing costs to Medicaid and Medicare.¹

Affordable senior housing properties, such as Section 202, low income housing tax credit or public housing communities, provide a cost-effective answer by providing affordable housing with supportive services. Over two million lower-income seniors currently live in these settings across the country. Many residents have aged in

¹ In 2005, national spending for long-term care amounted to \$206.6 billion. Medicaid paid nearly half (49%) of this amount, while Medicare paid 20%. The primary source of long-term care services, Medicare and Medicaid, are already stressed under the current demands placed on them. Although the elderly and persons with disabilities comprise only one-fourth of Medicaid enrollees, they account for two-thirds of Medicaid spending, largely due to the high cost of nursing home services.

place—the average age of residents in Section 202 properties is 84—and are experiencing declining health and increasing frailty and disability levels. It is not unusual to find residents who are eligible for nursing home level of care. Many proactive housing providers are cobbling together various public and private resources to provide needed supports for their elderly residents.

Despite their efforts many needs still go unmet. Often the result is seniors cycling in and out of the emergency rooms and hospitals, resulting in costly expenses to Medicare. Some may transfer unnecessarily or prematurely to a nursing home, costs paid by Medicaid, because they need more care or oversight than is available at their housing site.

Although many states are redirecting their Medicaid systems to provide more home and community based services, Medicaid funding retains an institutional bias. In 2006, 75% of Medicaid long-term care spending for older persons and adults with physical disabilities went towards institutional care. Medicaid spending in 2004 for home and community based services provided through a waiver program for the aged and disabled averaged \$8,440 per beneficiary compared to \$25,585 for nursing home services. On average, Medicaid can support three persons with home and community based services for every person in a nursing home.

The economy of scale created by affordable congregate settings provides an efficient platform for the delivery of home and community based services to help residents meet their needs as they age and avoid recurring hospitalizations and unnecessary transfers to nursing homes. The potential also exists for these congregate properties to become a hub for service delivery, extending their reach into the surrounding neighborhoods to help even more seniors. This document outlines a new framework that offers a normative, sustainable system for providing affordable housing with services and encourages housing providers, service providers, states and local communities to develop these creative strategies.

Guiding Principles

This proposed framework would enable current and future housing providers, States and localities to replicate successful models at scale seamlessly to meet local needs cost-effectively. The goal is to create an environment where providers can meet the evolving needs of most seniors in residential settings. Based on the learning from the existing successful State and practitioner developed approaches, the following principles must guide the development and implementation of any new framework:

- Support residents so that they safely age in place as their health and functional needs change, thus preventing unnecessary or premature transfers to higher levels of care at higher costs to Medicare and Medicaid,
- Enable the tools and approaches for housing finance, including both operating and capital support, to work effectively with the tools provided for supportive services,
- Dedicate services funding to the housing property and/or housing residents,
- Allow for the provision of health related and other supportive services on site, increasing resident access,
- Permit delivery by the housing property and/or through partnerships with community service providers,
- Capitalize on the economy of scale created by congregate settings to provide for the efficient and cost-effective delivery of services.

Recommendations

The framework would have two essential components: (1) a housing platform with supportive services provided by participating housing providers and/or through partnerships or contracts with community service organizations, and (2) reliable, coordinated revenue streams to provide health and related supportive services for those who choose to receive them in a housing setting.

To be sustainable, this framework must make the funding streams, both housing and services capital, predictable, available and integrated from the outset.

As the goal of this model would be to support a resident's ability to safely age in place, a range of services would be provided to meet a resident's evolving needs. A resident may initially be independent and benefit from wellness and prevention programs. As their health or frailty level begins to change, however, they benefit from congregate meals or help with keeping up their home to ultimately needing assistance with managing their personal care. The model would require a minimum level or package of supports, and available services might include:

- Care/case management
- Transportation
- Meals
- Wellness and prevention programs (fitness, education, wellness nurse, etc.)
- Homemaker services (shopping, running errands, housekeeping, laundry, etc.)
- Personal care (assistance with dressing, bathing, grooming, etc.)
- Medication management
- Nursing

- 24/7 protective oversight

The service delivery mechanism might vary—the housing provider might deliver services directly, it might contract for services from a community provider, or services might be made available through a combination of direct delivery and contracting. The key to the service model is flexibility. The objective would be to complement the array of services currently available in the community by improving resident access to existing services, facilitating a more efficient delivery of services to residents, and filling in gaps where resident needs may be going unmet.

The coordination and integration of housing and services and the creation of a sustainable funding source for the services would be accomplished through the following strategies executed in tandem to insure predictable and adequate resources for development and operation of the housing coupled with supportive service monies for the services appropriate for the resident community over time:

Housing Platform with Supportive Services

- **Expand the Low Income Housing Tax Credit (LIHTC) Program.**
Low income housing tax credits currently account for the lion's share of newly constructed and rehabilitated affordable housing projects for low- and moderate-income persons. Competition for tax credits is stiff, and only a few states have elected to prioritize supportive senior housing projects in their allocation plans. A new supply of tax credits for service enriched senior housing would be created that would not force states to reallocate tax credits from other important uses. Housing sponsors would agree to use a portion of the equity raised by the new credits for the provision of support services. In addition, States would agree to provide a basis boost for senior service enriched supportive housing.
- **Expand the Section 202 Senior Housing Grant and Rental Assistance Contract.**
To build additional housing with support services for very low income seniors, the Section 202 senior housing grant and rental assistance program would be expanded to require and pay for supportive services within the current 202 program. The Capital Advance would include funding for the capital costs associated with the delivery of services. The Project Rental Assistance Contract would include funding for a portion of the ongoing costs of the supportive services. Project selection would be delegated to the State Housing Finance Agencies and would allow mixed financing with tax credits. The program would authorize providers to set selection criteria for residents to achieve a

particular mix of service needs that could be accommodated by supportive services funding.

Revenue Streams for Supportive Services

- **Establish a dedicated and predictable funding stream for the delivery of services in affordable congregate senior housing settings.**

Currently, supportive and health-related services delivered in the community are funded through multiple mechanisms such as Older American's Act (OAA) programs, various State and local programs, and Medicaid waivers.

Opportunities would be examined to retool or expand any of these current funding mechanisms in a way that could provide a predictable revenue stream for the provision of supportive services in senior housing properties. This could include a program that directs Medicaid home and community based services funding to senior housing settings or combines Medicaid funds with OAA funds to create a congregate services package. Food stamp funding on behalf of eligible seniors could be assigned to the housing provider to cover certain costs of a meals program.

A mechanism combining Medicaid and Medicare funding streams might also be considered to provide a more integrated and extensive package of health and medical related services and supports. Although most housing providers would not choose this option, a housing provider could provide the medical care itself or through an affiliate, assuming it was properly licensed, or it could contract with one or more other care providers. The goal of the funding mechanism would be to allow senior housing providers to respond to the range of resident needs in their properties and support residents' ability to remain safely in their own home as their needs change.

Existing, successful State models provide guidance and insight into how to craft a larger federal initiative. Attachment A includes examples of existing programs that fund services in affordable senior housing settings and incorporate many of the principles described in this proposed framework.

Strategic Value

This approach offers a new framework for long term care service delivery that is more efficient and cost-effective and may help to preserve the financial viability of Medicaid and Medicare. At the same time, it honors seniors' choices and desires to remain in

their own homes for as long as possible. This approach offers a model that can be implemented widely and in a way that is commensurate with the dramatic growth in the senior population and with the varying needs of the senior housing population. It builds on existing programs rather than reinventing the wheel or creating something totally new. Finally, this new approach breaks down the existing silos and overturns a stale assumption – that housing and supportive services cannot be treated as one – as we address the demands of the future in long term care for seniors.

Illustrations of Successful Current Programs

The following are descriptions of four services models that have been successfully combined with either existing housing or newly built affordable housing. None of them, however, is perfect; nor does any one of them make the funding streams, both housing and services capital, predictable, available and integrated from the outset. Each, however, has aspects that can be adapted for the new framework and has elements that are a part of the new framework.

Illinois Supportive Living Model

Illinois' Supportive Living Program combines housing and supportive services offering the same care as traditional assisted living facilities, but in affordable settings. The Illinois supportive living model is administered through the Illinois Department of Healthcare and Family Service and the services are paid for under a federal Medicaid 1915c waiver specifically targeted to residents of Supportive Living Facilities (SLFs). SLFs offer apartment homes ranging from studios to two-bedroom apartments that residents can furnish themselves financed by a variety of housing finance tools, including low income housing tax credits, state financing programs, conventional financing or Section 202. Residents have access to services including three meals a day, housekeeping, social, education and wellness activities, help with bathing, dressing and medication management and scheduled transportation. In some cases, meal programs are paid for by the federal food stamp program. Food stamp eligible residents assign their food stamps to the provider in return for providing all meals, snacks, and beverages. Residents who are not food stamp eligible have other optional meal plans. All Supportive Living residents must be able to take care of themselves and do not have health needs that require skilled, 24-hour nursing care.

The 1915c waiver designated the number of Medicaid-supported individuals that can be served under the model each year. Funding for the SLF services comes from the Medicaid waiver, food stamps, if available, and from a portion of the residents' SSI checks (on average, \$537.00 covers room and board and leaves each resident approximately \$100.00 for monthly pocket expenses).

Currently there are 101 operating buildings with 8,000 apartments. The 1915c waiver allows up to 12,000 units, and 47 additional buildings are currently under development to achieve that level. The properties are developed by both for- and non-profit entities. There are two Sections 202, one Section 232 and several LIHTC properties.

Congregate Housing Services Program (CHSP)—The New Jersey Model

The CHSP is a program within the State Department of Aging that provides services, including one meal per day (which can be self-prepared or provided by an outside provider), housekeeping, laundry, linen change, shopping, assistance with bathing, dressing and personal care, assistance with food preparation and medication management to low-income, to frail elderly residents residing in subsidized affordable housing developments.² Housing providers can either deliver the services directly or contract with outside providers.

Eligible residents are those who are at least 62 years of age and in need of assistance in one or more activities of daily living as determined by the property who establishes criteria for eligibility (participants must be frail or at risk). There is no minimum level of care required nor is there an asset limitation. This is not a prescriptive model, nor is it a medical model.

Each property has a CHSP Coordinator who advertises, promotes and administers the program in the building. The CHSP Coordinator assesses participants' needs while arranging for service delivery as requested. The CHSP traditionally covers 25% of the residents in the building—though a waiver can override this.

On average, the cost to New Jersey per CHSP participant is approximately \$1,000 per person, per year. The State gives the housing property a lump sum of money on behalf of eligible residents which the property allocates as needed. New Jersey provides funding for the CHSP program through casino revenue. Seniors in subsidized housing in New Jersey who participate in the CHSP program pay a co-pay based on a sliding scale according to income.

In New Jersey, CHSP serves approximately 2,700 residents in approximately 60 subsidized independent senior housing buildings, each with unique programs.
<http://www.nj.gov/health/senior/conghouse.shtml>

² The types of subsidized housing include public housing, Section 8, HMFA restricted income apartments, balanced housing, HOME developments, tax credits for the 20% and 40% affordable units, Sections 221, 202, 236, 207, 213, 223 and 231.

Maryland Congregate Housing Services Program (CHSP)

Maryland's CSHP provides support services and State subsidies to eligible residents of affordable, subsidized housing in need of assistance with activities of daily living such as meals, housekeeping, and personal services. The Maryland Department of Aging contracts with housing and senior service provider organizations, such as local housing authorities, non-profit organizations, or housing management companies, to operate the program in designated buildings. Eligible residents are those who are at least 62 years of age and in need of assistance in one or more activities of daily living. The program provides meals, weekly housekeeping, and limited personal assistance with activities such as bathing, dressing, and laundry.

The cost of the Maryland CSHP varies by site, depending on the services provided. Individual program participants contribute to the cost based on a sliding scale. For residents who require financial assistance, State subsidies are available to seniors with incomes less than 60% of the State's median and with assets that are less than \$27,375 for an individual, or \$35,587 for a couple.

Currently more than 800 housing units in 35 apartment communities across the State receive CSHP funding and services.

<http://www.mdoa.state.md.us/housing.html#Congregate>

Massachusetts Supportive Housing Program

This program is a partnership between local housing authorities, the Aging Services Access Point (ASAP) (the single point of entry to state and federal funded service programs) and a service provider. The ASAP assigns a case manager to a building and they select one service provider to provide services in the building 24/7. Services include service coordination and case management, 24-hour personal care, on-call response, homemaker services, laundry, medication reminders, social activities and at least one meal a day. Services are paid for by a range of funding sources based on the individual's eligibility: state funded home care services; Medicaid HCBS services; Medicaid state plan services; Older Americans Act Title III-C nutrition services; and, Title III-B social services. The program also serves private pay residents who may not be eligible for the above subsidy programs.

Mission Creek Senior Community Services Plan-Mercy Housing California

Mercy Housing California (MHC) is the owner, developer and manager of Mission Creek Senior Community (MCSC), an affordable housing community for seniors (elders 62 years and older), located in the Mission Bay Neighborhood of San Francisco (SF). This affordable senior housing development offers 139 apartments which includes 51

apartments for very low-income disabled elderly households who are homeless or at risk of homelessness, 88 apartments for very low income elderly households, and one manager's apartment. All residents have incomes that fall below 50 percent of area median income (AMI) and are subsidized by Section 8 rent subsidies from either HUD through the SF Housing Authority or the San Francisco Department of Public Health.

A unique and critical component to MCSC is the existence of a 7,820 square foot adult day health center in the complex, operated by North and South of Market Adult Day Health, where a variety of health and social services are available for frail senior residents as well as other frail elders in the community at-large. Other non-residential uses in the complex include a branch of the San Francisco Public Library (7,535 sq ft.), community-serving retail (3,660 sq ft of a neighborhood coffee shop and "green" laundry); and a multi-purpose community space with warming kitchen and dining room (6,000 sq ft). Various lounges, laundry facilities, outdoor gardens and other appropriate residential amenities are built into the facility.

The program at Mission Creek Senior Community integrates on-site service staff and programs with linkages to community-based providers who have the capacity to provide a spectrum of services for independent to frail seniors thereby offering a level of service not unlike assisted living. What follows is a brief summary of the services plan as implemented:

Mercy Services Corporation through an enriched staffing which includes 2 full-time on-site Resident Services Coordinators (RSC's) and a full time Activity Coordinator, with 24-hour front reception desk coverage provide a supportive environment that assures residents access to an array of community based services on a 24 hour basis if needed. In addition, MSC property management staff includes a full time Community Operations Manager, Assistant Manager, Maintenance Worker, and two full-time janitors. Services for residents in the housing include in home care givers, delivered meals, individual and group counseling, regular socialization and visiting nurse services to mention the basics.

In addition, the location of the North and South of Market Adult Day Health Center (NSM-ADHC) in the complex offers health services to frail residents of the housing and other elders in the neighborhood through their attendance in the adult day health center a minimum of four hours per day from two to seven days per week. The on-site program can serve a total of 80 to 100 individuals, with an average daily attendance of up to 50 reflecting a mix of building and community residents. The Health Center services include skilled nursing, occupational and physical therapy, and personal care.

Chronic conditions and illnesses that NSM-ADHC commonly manage include stroke, dementia of all kinds, incontinence, lung and heart diseases, cancer, diabetes, crippling arthritis, neurological disorders, et cetera. Every ADHC client has a personal plan of care developed by a multi-disciplinary team and authorized by a physician. NSM-ADHC is regulated by the State of California Department of Health Services and Department of Aging, and Medi-Cal pays much of the cost for eligible participants. NSM-ADHC also has extensive experience providing services to individuals with mental health, substance abuse, and other behavioral issues, and is prepared to offer services to challenging clients as long as they are not disruptive in group settings. In addition to daily health monitoring and socialization participants receive 2 meals each day.

OVERVIEW OF RESIDENT SERVICES community-based agencies and services provided.

SERVICES	PROVIDER	FUNDING SOURCE
Property Management	Mercy Services Corp.	Property Budget/HUD subsidies
Resident Services Coordinator (RSC)	Mercy Services Corp.	Property Budget/HUD subsidies
Resident Services Coordinator (RSC)	Mercy Services/ ADHC	DPH subsidies
Resident Services Activity Director	Mercy Services	Property Budget/HUD subsidies
Adult Day Health Services	NSM-ADHC	Medi-Cal, DPH; VA, Private Funding
IHSS	DHS/DAAS	Primarily Medi-Cal
Case Management	Multiple Providers	Multiple sources, incl. DAAS – AoA funds, general fund and IHSS.
Meals – ADHC Clients	Project Open Hand	Medi-Cal, DAAS, Dept. of Education
Groceries	Food Bank	Private funding
Home-Delivered Meals	Multiple Providers, Coordinated by Clearinghouse	DAAS – AoA and General fund Private funding
Third-Party Rent Payment and Money Management	Lutheran Social Service currently providers for DAH clients	DPH

Transportation - Other	Para-transit Services, MUNI Accessible Srvs.	Transportation Authority
LGBTQ groups	MSC and Open House	
Health Services	Multiple Providers	DPH
Other specialized services, like Hospice, Home Health, DME, etc.	Multiple Providers	Medicare, Insurance, Medi-Cal, DPH
Substance Abuse Support Groups	AA, NA, DPH	Self-funded, volunteer run organizations
Social and Recreational Activities	Mercy Services Corp.	HUD
Wellness Promotion and Preventive Services	IOA and other well elder programs	Multiple

Notes

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