Affordable Assisted Living: New Frontiers for Aging in Place

Our industry is well acquainted with the impact of the Baby Boomer generation reaching the age of retirement and eligibility for Medicaid and Medicare; see the draft of the 2014 white paper *Overview of Senior Housing Options* by Bob Rogers. Our industry also has substantial experience in developing market analyses for assisted living and skilled nursing facilities in the market rate world. However, the marriage of assisted living with tax credit senior properties is relatively new and offers challenges for analysts trying to reconcile both programs.

This white paper is an attempt to sort out some of the issues associated with assisted living programs implemented in senior tax credit multifamily properties.

The assisted living business is dominated by the private pay industry. The majority of low-income seniors cannot afford private pay assisted living, so they have no alternative other than to enter a skilled nursing facility that accepts Medicaid waivers for services. Assisted living is a home model in which residents manage their own apartments and receive assistance as needed. In contrast, skilled nursing facilities follow a medical model in which skilled healthcare professionals are on staff and provide constant care and assistance. The transition for a primarily independent senior from a home to an institution is overwhelmingly difficult, and according to representatives from Mia Senior Living Solutions (MSLS)[1], evidence suggests that seniors in this situation deteriorate faster than those who transition from assisted living.

One of MSLS's hallmark projects involved licensing a public housing facility in Miami, the Helen Sawyer Building, and bringing assisted living services, through Medicaid waivers, to the residents at the facility. The project allowed the residents to stay in their apartments rather than move to a nursing home. The transition occurred in 1998. In the Congressional record in September 2006, Senator Mel Martinez spoke about Conchy Bretos of MSLS noting how the project inspired similar projects in dozens of public housing projects across the country.

Some state allocation agencies are seeing applications from developers intending to build senior tax credit projects and work with service providers to offer assisted living services to seniors needing the next level of care.

Overview of Medicaid Waivers

The Medicaid Waiver program makes the whole concept possible.

Medicaid is the federal program established in 1965 that provides healthcare and related services to some qualified, low-income people.[2] It is jointly funded by states and each state administers their

[1] Mia Senior Living Solutions provides assisted living services to seniors in home models.
[2] SSA.gov, accessed April 29, 2014.

implementation and management of the Medicaid program. Therefore, persons eligible in one state for Medicaid may not be eligible in another state. In 2014, the Affordable Care Act expanded Medicaid eligibility; since it is a joint program with states, some states chose not to participate in the expansion because the matching federal dollars have specific eligibility requirements.

The Medicaid Waiver program was established in 1981 to provide services in home or community-based settings, waiving the previous requirement that a person be admitted to an institution to receive the services. Again, each state implements the program.

A SAMPLE OF STATE PROGRAMS

This paper describes the program as implemented in a handful of states. The challenge for a market analyst working in multiple states is to find the relevant information when states use varying terminology and the program continues to evolve. The following website maintains a list of links to the various state Medicaid Waiver programs:

http://www.aplaceformom.com/senior-care-resources/articles/directory-state-medicaid-websites

In addition, this website gives an overview of how each state handles Medicaid Waivers and paying for assisted living services:

http://www.payingforseniorcare.com/medicaid-waivers/assisted-living.html

Indiana

Indiana's Division of Aging has two Medicaid Waivers: the Aged and Disabled Waiver (A&D) and the Traumatic Brain Injury Waiver (TBI). For home and community-based service waivers, a person must qualify for institutional care in order to be eligible for the waiver. Information on the Indiana Medicaid website indicates that the best way to know if a person is eligible is to apply.[3]

However, the general guideline is that an income-eligible senior may earn up to 300% of the maximum SSI benefit. As of January 2014, the maximum is $2,163 per month and the amount changes annually. There are also asset tests that may impact eligibility.

Indiana uses a standardized Level of Service Assessment/Evaluation for Assisted Living form that rates an individual in 20 areas. The areas include memory, receptive communication, wandering, night needs, and so on. Points are assigned to different levels of ability in each area and the total points indicate if the person is eligible for Level I, II, or III services. Each level also has a corresponding per diem to pay for services.

Michigan

<get input from Kelly>

[3] Member.indianamedicaid.com/am-i-eligible, accessed April 29, 2014.

California

An Assisted Living Waiver (ALW) program was piloted in 2006 in three counties. Since 2009, the waivers are available to expand into more counties.[4] The purpose of the ALW program is to move Medi-Cal eligible seniors from skilled nursing facilities into community home settings and use the ALW program to provide assistance services. It also intends to provide existing seniors in a community home setting with assistance services.

The program provides assisted care services to persons who reside in publicly subsidized housing (PSF) which, in the language of this waiver program, is not necessarily public housing but also includes any affordable housing development financed or regulated through subsidy funding sources and includes LIHTC, HUD 202, and HUD 811 properties. Medi-Cal reimburses service providers for assisted living services provided to seniors with the waivers. Some seniors, depending on their income, are still responsible for paying for their room and board.

Elder Focus Consulting helps organizations integrate services, health care, and housing to allow low-income seniors to stay in their homes and communities; they regularly discuss the ALW program and its integration into housing communities in their ElderFocus publications.

IMPLEMENTING TAX CREDIT PROPERTIES AS ASSISTED LIVING FACILITIES: A SAMPLING OF STATES

Sometimes the best way to grasp new types of housing projects is to use a case study approach. This section offers a brief description of how some states have implemented tax credit assisted living projects.

INDIANA

One project was proposed in a bond round in the summer of 2013 and was given a tax credit award in August. Problems lining up financing for the unusual project caused delays and the developer, Integral Development of Atlanta, GA, was forced to submit another application in early 2014. The project, in Indianapolis, is planned to close in May 2014. It is new construction of 124 one-bedroom units with the units renting at 50% AMI to 60% AMI. Assisted living services will be provided by Mia Senior Living Solutions and reimbursed by Medicaid Waivers.

Alan Rakowski, Rental Housing Tax Credit Manager with the Indiana Housing and Community Development Authority (IHCDA), explained that assisted living tax credit projects are not an explicit priority, but align nicely with the priority to allow seniors to age in place. He said, “We’re excited about it. There is certainly a need and we recognize it.”[5]

He acknowledged that the service provider linked to the project is likely to be a key to the success. Mr. Rakowski said there have been some phone calls from other developers expressing interest in similar projects but no other applications have been submitted yet.

[4] http://www.dhcs.ca.gov/services/ltc/Documents/ALW%20SERVICES.pdf
[5] Interview with Jennifer Atkinson, April 29, 2014.

Another implementation of a senior home community with assisted living services is available in the Villas of Guerin Woods in Georgetown, Indiana. Owned and operated by Guerin Inc., a Community Housing Development Organization, the Villas consist of ten 7,100-SF buildings. Each building has ten private one-bedroom, one-bathroom units with multiple common areas including a common dining area. The community also has Guerin Woods, 22 two-bedroom units for seniors 62 and older and the Meadows of Guerin, which is a HUD 202 property with 24 units.

IOWA

ILLINOIS

DETERMINING DEMAND AT ASSISTED LIVING PROJECTS

In determining demand for assisted living at tax credit projects, we may leverage lessons from the market analysts who specialize in private pay assisted living facilities. However, this section describes some of the challenges specific to a tax credit project.

INTERVIEWS WITH PROPERTY MANAGERS

Before one can assess the demand for any senior project, it is important to have an understanding of both the eligible market and the potential market for the specific proposal. The two groups may be quite different. Quantifying the eligible market based on income, age, and other restrictions is important, but it is equally important to determine how many of these eligible people actually have a reasonable potential to live at the property proposed. For example, while the eligible age may be 62, the typical resident may not move in until they are well over 75. Or, while there are numerous eligible two-person households, how many would truly consider a senior residence – especially one with services that a spouse may be quite capable of performing. Therefore, it is key to gather as much detail as possible about the likely residents from managers at similar properties.

Market or draw areas for assisted living properties may differ from senior housing without services, especially if there are subsidies and/or Medicaid waivers involved. In areas where few such opportunities exist, the market areas could be considerably larger than for projects without them.

Important questions to ask include the following, and knowledgeable managers should be able to give percentages and other details:

- Typical age range at entry?
- Household size and relationships? (If two people – couples, siblings, etc.). The percent of two-person HHs is critical.

- In assisted living – is the resident single or is there a spouse at home or elsewhere?
- Gender?
- Predominant income ranges? (Very low 30%, <50%, etc.)
- Any other notable characteristics?
- Details of former residence:
  - ✦ Location – exact towns, neighborhoods, or ZIP Codes, etc. (and is this impacted by how they market?). Which nearby areas do they never move from?
  - ✦ Type – owned or rented home, or with family.
  - ✦ Age, condition, and layout of former home.
- What made them move from former home and into current residence? Reasons for moving into senior housing without services include affordability, manageability, mobility, loneliness (especially if widowed), to be near adult offspring, to be nearer to local amenities, and more. Which specific assisted living and other services are predominantly needed at this property?
- Why did they choose this particular property?
- Do they have to turn away prospects who don't qualify? If so, why don't they qualify?
- What portion of residents move from beyond the immediate area to be near adult offspring?
- What portion of residents are strongly influenced by adult offspring in their choice of property?
- What portion of residents get financial assistance from adult offspring?
- Any other notable reasons for moving to their property?

If it is possible to gather a reasonable amount of such anecdotal information from a number of similar properties, a profile of the likely resident base can be formed. Based on this, the universe of eligible households/persons can be refined to produce a more accurate assessment of true demand.

Determining Demand for Affordable Assisted Living

After the income and age range eligible for the proposed program and the demographic and other characteristics most likely to be the market for the project have been established (see X and Y Sections above), the number of people who fall into the appropriate categories in the market or draw area(s) needs to be estimated.

However, calculating the number of people or households that are income- and age-qualified plus have a need for affordable assisted living is difficult, if not impossible, to do with any real precision. There are no sources of data that cross tabulate income, age, and need for assistance with activities of daily living (ADL) or other needs that require assistance.[6] The impact of adult children of those with such needs on the market is also difficult to assess.

Although one could calculate the qualified income and age population using existing household data and apply ratios of those needing assistance from other data sources, the result is unlikely to produce reliable results as such needs can be found in all income levels – probably to varying degrees. Such

[6] For more information, see *Addendum: Activities of Daily Living* on page 8.

needs are also more likely to be found among individuals, but income data is only available by households.

Due to this lack of reliable methods for calculating demand with any precision, it is necessary to focus on those individual items that are considered to be Indicators of Demand. High numbers or percentages among these items would indicate sufficient demand, while low figures across the board would indicate less need.

Indicators of Demand (Sources of Data):
To determine income- and age-qualified households, use data from Ribbon Demographics, Nielsen, ESRI and other private vendors for most recent current estimates.

- Tenure? (As above)
- Senior population trends (As above)
- Individuals by Age with independent living disability (ACS Table B18107)
- Individuals by Age with other disabilities (ACS Tables B18101 through 6)
- Individuals by Age by Disability Status by Poverty Status (ACS Table C18130)
- Individuals by Age by Disability Status by Health Insurance Coverage Status (ACS Tables B18135)
- Younger households containing individuals aged over age 65 (Census/ACS Table B11007)
- High occupancies (Anecdotal information from local comparables)
- Waiting lists (Anecdotal information from local comparables)
- Reported need (Anecdotal information from local agencies)

CAPTURE RATES

Is it feasible to try and calculate these with the limited information we have at this point?

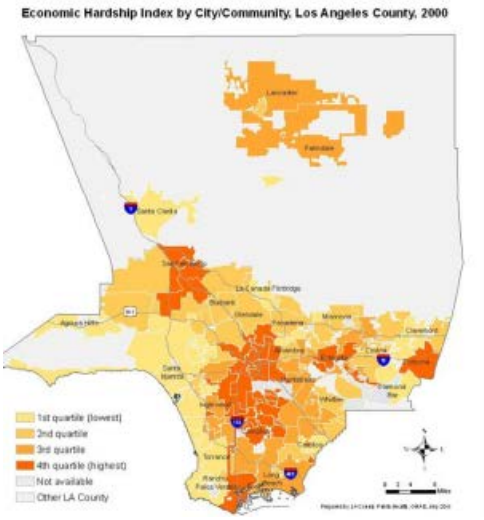
OTHER RESOURCES

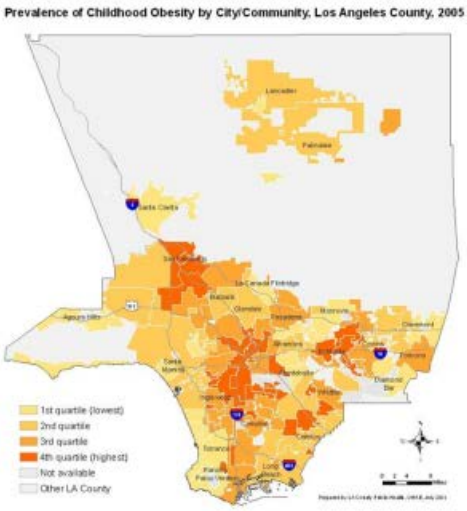
Various articles, papers, and organizations appear to be focusing on the marriage between community development and improving health.

David Erickson, Federal Reserve Bank of San Francisco, prepared testimony for the Robert Wood Johnson Foundation Commission to Build a Healthier America in June 2013.[7] He makes a well-supported argument for the wholesale benefits of integrating the efforts of community development and health organizations. Erickson uses an argument made by UC Berkeley professor and pediatrician Dr. Doug Jutte that public health departments focus on infection outbreaks, air and water quality, and other traditional health threats. Population health groups focus on the health issues common to a population and look to social determinants such as poverty, overcrowding, poor schools, and lack of access to nutritious foods.

[7] You can download the report from http://www.rwjf.org/en/research-publications/find-rwjf-research/2013/06/linking-community-development-and-health.html.

Erickson points to heat maps created by the LA County Department of Public Health that compared areas with higher percentages of poverty and areas with higher percentages of childhood obesity. The maps are startlingly similar leading the Robert Woods Johnson Commission to conclude that your zip code is more important than your genetic code in determining your health.



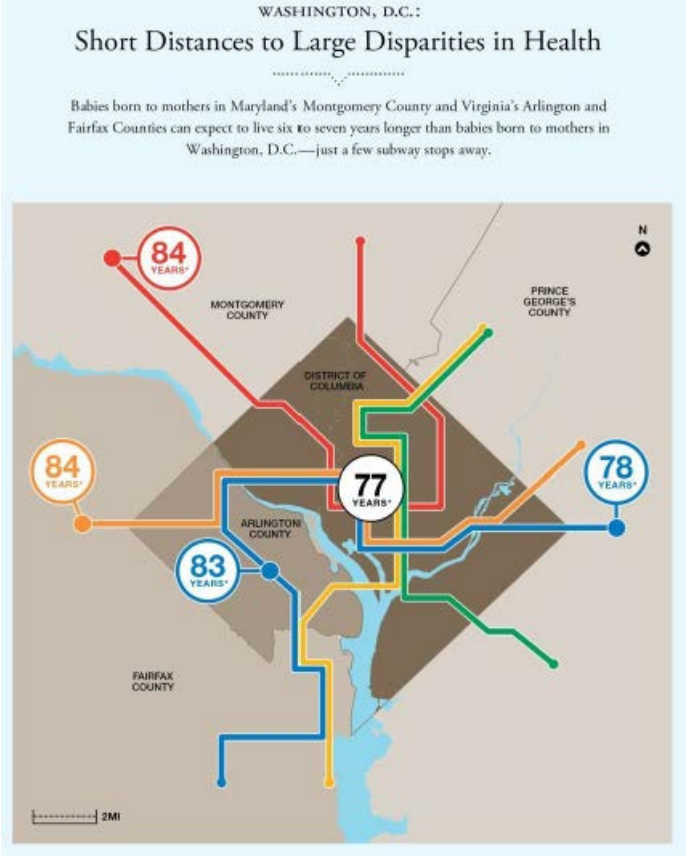


Erickson points out that the community development industry is in the business of improving zip codes. He cites the success of the LIHTC program, building more than 3 million homes for low income families since 1987. This represents more housing than other federal programs combined dating back to 1937. Erickson said it is natural to leverage the resources and infrastructure in place in the community development industry to move towards goals of improving health.

Erickson's paper also discusses the involvement of new finance vehicles such as the Healthy Futures Fund offered by Morgan Stanley, the Kresge Foundation, and the Local Initiatives Support Corporation. Public policy will also contribute with Choice and Promise Neighborhoods programs, as well as a new generation of Federally Qualified Health Centers.

Findings presented by the Robert Wood Johnson Foundation in *Overcoming Obstacles to Health in 2013 and Beyond*[8] showed that despite spending more on health care per person than any other industrialized country, our country has poorer health. By far, the largest determinants are income and education. It also makes the connection to geography, showing maps of the Washington D.C. metropolitan area. Residents in affluent suburbs in Montgomery County have a life expectancy of nearly seven years more than the residents of the District of Columbia. Residents in middle class Prince George County have a life expectancy of six months more than the residents of Washington D.C.

[8] Highlights and the full paper are available from http://www.rwjf.org/en/research-publications/find-rwjf-research/2013/06/overcoming-obstacles-to-health-in-2013-and-beyond.html.



CONCLUSION

As Erickson observed in his paper, this is a time of "wet cement" for our industry and may signal a significant shift in the landscape for low income seniors. Our challenges in fulfilling our obligations to appropriately and clearly define the market analysis techniques necessary for this type of project are daunting. But the resources available to us and our previous experiences will serve us well so we can play our part in this new landscape.

Credits

This draft is presented at the June 2014 conference of NCHMA. The paper represents contributions from Mary Ellen Shay, Al Forsythe, Julia Lavigne, and Jennifer Atkinson.

ADDENDUM: ACTIVITIES OF DAILY LIVING

In understanding the need for assisted living, the term Activities of Daily Living (ADL) is often used. There is not a universally agreed upon understanding of the specific tasks included in this list and it will vary from state to state depending on their Medicaid program. To qualify for a Medicaid Waiver for assisted living services, it is likely a person will go through a functional assessment by a geriatrician that includes a review of the Activities of Daily Living and the Instrumental Activities of Daily Living.

ADL are basic self-care tasks and generally include the following:

- *Bathing:* The objective of this service is to allow the senior to maintain as much of their independence and dignity as possible. The service provider helps the senior adjust the bathwater to a comfortable temperature and, if necessary, will help them into the bath or shower. The aide will then close the curtain and give the senior privacy to bathe and, if necessary, help them out of the bath or shower and help them dry off.
- *Grooming:* This service ensures teeth are brushed, hair is combed, and all clothes are put on properly. It may also include guiding the senior to appropriate clothing.
- *Toileting:* The objective is to help the senior remain as independent as possible while helping them manage the challenges of incontinence and maintaining appropriate hygiene.
- *Walking and transferring:* Such as rising from a chair or bed and using a cane or walker.

INSTRUMENTAL ACTIVITIES OF DAILY LIVING

Instrumental Activities of Daily Living are used by geriatrician to evaluate a person's ability to perform more complex day-to-day tasks. These often include the following:

- *Food service:* Grocery shopping, preparation of nutritionally and texturally appropriate meals, and cleaning up after meals.
- *Housekeeping:* This service provides general apartment up-keep and maintenance.
- *Medication management:* This service does not involve the actual administration of medication, which necessitates a certified nurse or doctor. Instead, the service provider reminds the resident to take the medicine and maintains a record of the medication's use. If a healthcare professional is needed, the service provider calls in a certified nurse or doctor.
- *Managing finances and schedules:* This includes the ability to pay bills and managing the scheduling of appointments. It may also include the ability to determine if a bill is an actual payment due or a request to send money to a charity or lottery.
- *Using communication devices:* The ability to use a telephone or other similar communication device is key to maintaining an independent life.
- *Handling transportation:* This may include maintaining a safe driving record or navigating public transit.