Building Assisted Living for the Elderly into Public Long Term Care Policy: A Technical Guide for States

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FOREWORD

Using the Guide. The Guide was prepared for multiple audiences - policy leaders in housing agencies and service agencies and staff whose knowledge of the issues and resources related to assisted living may vary. To some, the Guide may present too many details and for others, not enough. Sections of the Guide will be more familiar to one group than another. The Guide presents a thorough but not exhaustive look at assisted living, the resources available to make it work and the problems that must be resolved to do so.

The Introduction presents an overview of long term care spending, our reliance on nursing homes to meet long term care needs and the emergence of a new resource for serving elders. Some of the confusion surrounding definitions of assisted living are presented. Since no one definition exists, policy makers are left to decide how the concept will be implemented in their state. The Description and Quality Assurance chapters present conceptual frameworks for developing definitions, standards and examples based on work in several states. Moving from concept to operational detail requires cross-cutting and collaborative work among a range of agencies and interests. Existing state policies and programs that represent varying approaches to assisted living are described in chapter IV. Chapters V and VI present descriptions of the existing programs available to finance housing and services. The advantages and obstacles of each resource also are described. The final chapter highlights the policy conflict and changes that would make it easier for states to develop and expand residential models for meeting long term care needs.

Actually using the Guide to develop policies and programs requires active discussions among leaders in the respective state service (Medicaid, Aging, Social Services, Health) and housing agencies. With hard work and thorough involvement of all parties, the limitations of existing programs can be overcome to produce successful assisted living
models and to expand the "repertoire" of long term care services, as Rosalie Kane, D.S.W., professor at the University of Minnesota, has noted.

The Plan. This Guide represents the initial focus of the Center's effort on assisted living. Policy makers developing assisted living as a resource for elders can learn from the experience of similar programs in mental health and mental retardation fields which have developed smaller, more home-like settings than institutions, but which retained their institutional character. The Center will issue a similar Guide on Assisted Living Programs for people with disabilities that will examine these models.

The Quotes. The comments and quotes highlighted in boxes throughout the document were made at the Public Policy Seminar on Assisted Living sponsored by the National Academy for State Health Policy on April 15, 1992 in Washington, D.C. The agenda for the seminar is included in the appendix and edited video tapes are available. Please contact:

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EXECUTIVE SUMMARY

What is it?

A recent addition to the array of long term care services, assisted living combines the medical aspects of long term care with a model of supported housing and social services. Definitions of assisted living vary and sometimes the services provided overlap with other models: board and care, personal care homes, residential care facilities, rest homes and others. Generally, assisted living emphasizes consumer direction over regulation. Comparing assisted living to nursing homes, Michael Rodgers, Vice President of the American Association of Homes for the Aging, says, "Our role is to assist with, rather than to do for, residents in assisted living."

Key variables are the philosophy of operation, the services provided, the residents who can be served and the design of the units and the building itself. Thus far, state programs are not consistent in their approach to these variables. State definitions should be determined by the primary goal of their program - to replace a portion of the supply of nursing home beds, reduce the future rate of growth in supply, or expand home care services to support aging in place.

Assisted living is an important policy issue because of the cost of long term care; our reliance on expensive institutional models; the demographic trends, especially the growth of people over 85 years of age; and the demands of consumers themselves for services in homelike environments. The Guide examines assisted living policy in five states: Florida, Massachusetts, New York, Oregon and Washington.

Philosophy

The philosophy of this model - as much as the description of the building, the characteristics of people served or the services provided -
separates assisted living from other models that combine housing and varying levels of oversight and care. Assisted living emphasizes "home-like" living units, privacy, resident choice, independence, shared risk, and shared responsibility in which residents actively participate in the accomplishment of regular tasks and activities. Oregon and Washington implement the assisted living philosophy in buildings with single occupancy units (unless shared by resident choice) with baths and cooking capacity. Florida’s program creates a new operating philosophy and broader services within its residential care program. New York requires higher service levels, more training for staff and other important improvements.

States that increase the services provided in board and care facilities will make a real difference in the operation of and services available in these facilities. However, implementing assisted living within the existing stock of board and care facilities may hamper its image and emergence as a distinct option. As states continue to license assisted living, the requirements that apply can differ. Oregon and Washington distinguish assisted living from board and care by including skilled nursing among the services provided, requiring units that are larger than units in their board and care facilities and requiring a bathroom and cooking capacity within each unit.

State programs reflect their own unique environments and circumstances. With a strong legislative mandate to develop assisted living, Florida’s regulations contain an extensive list of services that can and cannot be provided in assisted living. Guidelines in New York and Washington contain similar though not as extensive lists which limit who can be served more so than in Oregon’s program. The Massachusetts draft policy suggests an open-ended policy regarding the target population.

**Who is it for and what services are available?**

All states, except Massachusetts, have based their policy on serving nursing home eligible Medicaid recipients in assisted living programs. Though Massachusetts’ providers will be encouraged to serve nursing home eligible elders, the programs were developed to serve elders who are no longer eligible for placement in a nursing facility due to changes

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in the state’s level of care criteria.

While the target populations are similar - elders with impairments in activities of daily living, cognitive impairments and some skilled nursing needs - state models vary. The current status of publicly subsidized assisted living ranges from mature models (Oregon) which rely on newly constructed or rehabilitated units to incremental models (Florida, New York) which build on the existing supply of housing resources.

Personal care and administration of medications are two core services. The availability and scope of skilled nursing determines the extent to which assisted living serves as nursing home replacement model for many nursing home residents. Housekeeping, shopping, meals, laundry, transportation and social or recreational activities are basic assisted living services.

Facilities in Oregon can provide any service available in a nursing home, however people who require continuous medical or nursing care are not served. Other states have listed services which can and cannot be provided in assisted living. (See page 50 for a comparison of state programs.)

**How much does it cost?**

Private rates for assisted living range from $900 to $3,000 a month and higher for room, board and services. Variables include the building design, development costs, service packages and amenities. Public costs in Oregon, which serve very impaired residents, average 80% of the cost of comparable care in a nursing facility. The Medicaid cost in other state programs are generally 50% of comparable nursing facility care.

**How are they financed?**

States have used existing housing and service financing programs to develop remarkably different programs (See page 73 for a summary of housing resources). Though most were not designed to focus explicitly
on assisted living, policy leaders, providers and developers can combine housing and service resources to support such projects but it requires extensive collaboration between state agencies. While only Oregon has intentionally encouraged new construction, state housing finance agencies and service agencies have the tools to collaborate and set priorities for the use of state tax exempt and taxable bonds and tax credits to attract developers to start new facilities.

Medicaid waiver programs and state community based care programs financed through general revenues are most amenable to assisted living. Modifications to the Medicaid income eligibility guidelines and SSI payment standards offer options for states to increase eligibility and gain access to private, mixed income projects. Most states rely on Medicaid to pay for services. Florida, Oregon and Washington will utilize their home and community based care waivers to pay for services. New York, which does not have a waiver for its elderly recipients, will provide a flat capitation payment for state plan services provided in assisted living facilities. The supportive services, which are required by regulation (housekeeping, limited personal care, laundry, activities), are covered by a higher SSI payment rate. States can develop programs with state general revenues to divert elders with incomes near but above Medicaid levels and avoid the costs for those who would spend down if admitted to a nursing facility.

The U.S. Housing and Urban Development's 202 elderly housing and 232 mortgage insurance programs can be used to develop supportive housing and assisted living resources. Low Income Housing Tax Credits and Industrial Development Bonds can also be used. Because these resources were not developed expressly for assisted living, there are many complications, obstacles and conflicts that, if resolved, would facilitate the construction of new assisted living facilities.

**Future policy changes**

While assisted living concepts will change the operation of existing licensed board and care programs and the operation and design of nursing facilities, the real potential for this model is in new construction or rehabilitation to realize the full scope of the concept (home-like buildings, single occupancy units with baths and cooking
capacity, privacy, shared responsibility and risk sharing, and skilled nursing and support services available to nursing facility eligible residents). To develop effective assisted living policies and programs, officials from the housing finance and service programs need to work together to develop common goals, definitions, priorities, guidelines and packages.

To facilitate the expansion of assisted living, state and federal policy makers might:

- Develop stable long term funding commitments for services in bond financed projects.

- Expand funding for services for non-Medicaid low income elders.

- Address the ability of Medicaid recipients to pay for the shelter (room and board) costs outside an institution.

- Develop subsidies for the shelter costs for elders who are not eligible for Medicaid and cannot afford market rate "rents."

- Differentiate licensed housing and service models from institutions which could be eligible for HUD 202 funding.

- Reconcile cost sharing differences between HUD and Medicaid programs.

- Allow the cost of mandatory service packages outside the rent caps in the Low Income Housing Tax Credit program.

- Modify the HUD 232 guidelines to support single occupancy units with baths and cooking capacity.

- Develop quality assurance measures that focus on consumer satisfaction and outcomes.

- Coordinate funding and RFP cycles for housing and service programs that must be combined to implement successful projects.

- Build policies and programs that reflect consumer preferences.
Don Redfoot, Legislative Representative for the American Association of Retired Persons, offers this advice to policy makers: "Always keep your ears tuned to what consumers are saying and how markets reflect demand from older consumers themselves; not what you think they ought to want, not what you think is tasteful but what consumers themselves are saying."
I. INTRODUCTION

Since the inception of Medicaid in the late 1960s, long term care services have been provided traditionally in medically regulated nursing facilities. At the same time, housing for the elderly has developed without significant attention, until recently, to the relationship between shelter and services. Combining services with housing options to support independent living has become a priority for state policy leaders.

Interest among state policy makers has been fueled by the rising cost of Medicaid expenditures for long term care. Adjusted for inflation, Medicaid spending for all services grew 34% between 1981 and 1988, 23% between 1988 and 1990 and 22% in 1990 alone.\(^1\) The Congressional Budget Office predicts that Medicaid spending will rise almost 120% between 1990 and 1996. The study attributed growth in long term care spending to the increase in the average payment per elderly recipient and increases in both the number of disabled recipients and the average payment per recipient. In 1990 Medicaid payments were made for 1.5 million, primarily elderly recipients (excluding ICF-MR) at a cost of $17.7 billion. Aged recipients comprise 5% of the Medicaid recipients yet they account for 23% of expenditures.\(^2\)

Spending rates vary significantly by states (See Table 1). A Congressional Research Service (CRS) report projects that total Medicaid spending in actual dollars will increase

<table>
<thead>
<tr>
<th>Table 1. Rate of Medicaid Increase over Previous Year</th>
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<tbody>
<tr>
<td>Florida</td>
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<tr>
<td>Massachusetts</td>
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<td>New York</td>
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<tr>
<td>Oregon</td>
</tr>
<tr>
<td>Washington</td>
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<tr>
<td>National Ave.</td>
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Source: Congressional Research Service.
from $92 billion in 1991 to $197 billion in 1996.³ Medicaid expenditures for long term care services grew 60% between 1987 and 1991, from $22 billion to $35.7 billion.⁴ By category, nursing home expenditures for the elderly and disabled grew 53.5%. Home health spending grew 136% and spending for home and community based waiver services grew 256%.⁵ While spending for nursing homes grew more slowly than other Medicaid services, expenditures grew faster in 1991 than the previous year by 16%.⁶

<table>
<thead>
<tr>
<th>Table 2. Medicaid Spending Growth</th>
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<tr>
<td></td>
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<tr>
<td>Nursing Homes</td>
</tr>
<tr>
<td>Home Health</td>
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<tr>
<td>HCBS Waiver Services</td>
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</table>

Increases in nursing home spending rates have been attributed to the effects of the nursing home reform provisions of the Omnibus Budget and Reconciliation Act of 1987 (which requires functional and cognitive assessments of residents, raises the staffing ratios for licensed nurses and requires added training for nurses aides), and the effects of court suits under the Boren Amendment which requires reimbursement methodologies which are "reasonable and adequate." States with stable bed supply and numbers of Medicaid recipients are experiencing increases due to the rising cost of care.

**Population and Functional Impairment Trends**

Population trends and the functional characteristics of an aging population confront policy makers with further challenges. As the cost of care rises, demand and increased supply complicate the situation even further.

Who needs long term care and what are the demands and risks for long term care? Today over 1.5 million people live in nursing homes. Five percent of the people over 65 and 22% of the population over age 85 live in nursing homes. Though most nursing home stays are short, 21% stay between one to five years and six percent stay more than five years (See Table 3).⁷

In 1990, 2.2 million people turned 65. A study by Peter Kemper and Chris Murtaugh at the Agency for Health Care Policy Research projected that 43%, or 946,000, of the people who turned 65 in 1990 will enter a nursing home in their lifetime.⁸ Twenty-six percent of
the people turning 65 in 1990 will spend less than three months in a nursing home (See Table 4). Nineteen percent will stay between three and 12 months. Thirty-four percent, 322,000, will stay one to five years at a cost between $30,000 and $180,000, and 200,000 will spend $150,000 to $180,000 during their stays of five years or longer. The costs are based on current nursing home rates and are not adjusted for inflation. The expansion of assisted living and community care programs may alter the projected nursing home utilization rates by offering more choices to those who need long term care.

<table>
<thead>
<tr>
<th>Table 3. Average Length of Stay in Nursing Facilities</th>
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<tbody>
<tr>
<td>3 months</td>
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<tr>
<td>3-12 months</td>
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<tr>
<td>1-5 years</td>
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<tr>
<td>&gt; 5 years</td>
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</tbody>
</table>

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<tr>
<th>Table 4. Projected Lifetime Nursing Home Use Rates</th>
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<tr>
<td>&lt; 3 months</td>
</tr>
<tr>
<td>3-12 months</td>
</tr>
<tr>
<td>1-5 years</td>
</tr>
<tr>
<td>&gt; 5 years</td>
</tr>
</tbody>
</table>

Measures of Need

Between 5 and 8% of the population over 65 - about 6 million people - living in the community have limitations in activities of daily living (ADL), depending upon the survey and the definitions used in the survey. Age is an important variable in predicting impairment. Impairment rates for people over 85 are often three to six times higher than for the 65-74 age group (see tables 5 and 6).

The number of people needing long term care will rise from just under 7 million in 1988 to 9 million by 2000 and 18 million by 2040. As the rate of impairment increases with age, the population trends among the aging highlight the importance of these rates. In 1990, 1.3%, or 3.2 million, of all Americans were 85 or older. By 2000, the number will rise to
4.6 million and by 2010, 6.1 million will be over 85. Assuming other trends remain constant, the number of people over 85 with bathing impairments will increase from 694,000 in 1990 to 1.3 million in 2010. A 1988 study of long term care financing options by the Brookings Institute projected that the number of elders in nursing homes during the course of a year would increase from 2.3 million between the 1986-1990 based period to 4 million in 2016-2020 and 51% of all people over 85 would spend part of a year in a nursing home during the projection period. While this represents a nine percent increase over the base period, the actual number of people over 65 spending part of the year in a nursing home will more than double (1.0 million to 2.2 million).

<table>
<thead>
<tr>
<th>Table 5. Percentage of Community Residents 65+ by Impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bathing</td>
</tr>
<tr>
<td>Toiletting</td>
</tr>
<tr>
<td>Dressing</td>
</tr>
<tr>
<td>Mobility</td>
</tr>
<tr>
<td>Transferring</td>
</tr>
<tr>
<td>Eating</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 6. Percentage of Elders with ADL Impairments by Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
</tr>
<tr>
<td>65-74</td>
</tr>
<tr>
<td>Dressing</td>
</tr>
<tr>
<td>Mobility</td>
</tr>
<tr>
<td>Toileting</td>
</tr>
<tr>
<td>Transferring</td>
</tr>
<tr>
<td>Eating</td>
</tr>
</tbody>
</table>
While policy makers feel pressure from today's utilization and expenditure rates, a look to the future using these figures highlights the urgency of planning now to shape the system for the next generation of elders. Some policy makers believe that assisted living can serve 35% to as many as 80% of the people who live in nursing homes.

Supply Trends

Projections of future expenditures are predicated on demand, price and supply assumptions. The supply variable receives little attention in most estimates. Projections assume that the mix of resources available to meet demand reflects past supply patterns. Between 1971 and 1988, the supply of nursing home beds grew at an annual rate of 2.3% to a total of 1.6 million beds.\(^4\) However, the population 85 years of age and older, which comprises 40% of the nursing home residents, grew 4.2% annually for a net loss of 1.9 beds per thousand during the period. This trend suggests that new dynamics are affecting the ways in which demand is met. On recent study\(^5\) attributed the slow growth to certificate of need programs, nursing home reimbursement policies and the cost of construction. The study showed that despite the increase in the number of elders, occupancy rates have held fairly stable at around 91%. The expansion of community and residential care options may also have contributed to the relative "loss" of bed supply. While the imbalance between nursing facilities and community care continues, projected demand and cost trends support the need.

<p>| Table 7. Supply of Nursing Home Beds and Percent of Costs Paid by Medicaid, 1989 Data |
|----------------------------------|----------------------|----------------------|----------------------|</p>
<table>
<thead>
<tr>
<th>State</th>
<th>Number of beds(^{(1)})</th>
<th>Beds/1000(^{(1)})</th>
<th>Percent Medicaid(^{(2)})</th>
</tr>
</thead>
<tbody>
<tr>
<td>Florida</td>
<td>34,939</td>
<td>61,127</td>
<td>68,199</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>43,295</td>
<td>49,182</td>
<td>53,288</td>
</tr>
<tr>
<td>New York</td>
<td>90,178</td>
<td>102,595</td>
<td>119,760</td>
</tr>
<tr>
<td>Oregon</td>
<td>14,653</td>
<td>12,381</td>
<td>14,963</td>
</tr>
<tr>
<td>Washington</td>
<td>28,225</td>
<td>28,636</td>
<td>31,912</td>
</tr>
</tbody>
</table>

1. 1978, 1989 supply data: Institute for Health and Aging, University of California, San Francisco.
3. 1992 figures obtained from each state's licensing agency.
for expansion of community and residential programs such as congregate housing and assisted living.

**Assisted Living - A New Resource**

Perhaps the primary force behind assisted living has been elders themselves. The cultural and social preference to reside in one's own home is strong among older Americans and has resulted in the growth of in-home services and a variety of supportive housing arrangements such as retirement centers and congregate living centers. In-home service programs as well as other community-based care programs are generally regulated as social services. The concept of "aging-in-place" has replaced the notion of "the continuum of care" which expects a person to move from place to place as frailty or deterioration occurs. Aging-in-place allows a resident to remain "at home" with the array of services provided in that home changing as needs change.

Assisted living is a recent addition to the repertoire of long term care services. Assisted living combines the medical aspects of long term care with a model of supported housing and social services. Definitions of assisted living vary and sometimes the services provided overlap with other models: board and care, personal care homes, residential care facilities, rest homes and others. However, more than the description of the building, the characteristics of people served or the services provided, it is the philosophy of this new model that separates assisted living from others that combine housing and varying levels of oversight and care. The current status of publicly subsidized assisted living ranges from mature models (Oregon) which replace nursing homes to incremental models (Florida, New York) which build on the existing supply of housing resources. Incremental programs will expand as state funding for services and construction of housing for the elderly permit.

A recent publication by Regnier, Hamilton and Yatabe suggests that assisted living differs from board and care (small scale, family operated models) and personal care (based on a more medical model of care). Assisted living "represents a model of residential long term care. It is a housing alternative based on the concept of outfitting a residential environment with professionally delivered personal care services, in a way that avoids institutionalization and keeps older frail individuals independent for as long as possible. Care consists of supervision with minor medical problems, assistance with bladder or bowel control and/or management of behavioral problems as a result of early stages of dementia. In an assisted living environment, all of these problems are managed within a residential context." 

The Regnier description emphasizes important dimensions that differentiate assisted living from other models. However, there is no commonly accepted definition. Others see similar
care provided in a range of licensed, regulated models. The Assisted Living Facilities Association of America definition has a much broader scope: "[A] special combination of housing and personalized health care designed to respond to the individual needs of those who need help with activities of daily living. Care is provided in a way that promotes maximum independence and dignity for each resident and involves the resident's family, neighbors and friends." This definition encompasses facilities that are licensed as board and care, residential care, adult homes and other names.

In addition to definitional variations, facilities which describe themselves as assisted living provide varied service packages to residents with a wide range of needs. Residents served range from people with impairments in instrumental activities of daily living (housekeeping, shopping, laundry, meal preparation) and limited impairment in activities of daily living (ADLs) (bathing, dressing, eating, toileting, continence) who would not qualify for admission to a nursing facility to residents with extensive ADL impairments and skilled nursing needs who would readily qualify for nursing facility admission.

In some states assisted living is seen as something very close to retirement homes, with perhaps some minimal services for residents with light care needs. In other states, assisted living is seen as a replacement for the nursing home level of care. Indeed, while assisted living is not usually equipped to handle chronic complex medical problems, it is serving many people who would otherwise be in both custodial and skilled nursing facilities.

Several states limit the population eligible for board and care facilities to those who do not require the services provided in a nursing facility. In Massachusetts, rest homes are defined as "a supervised supportive and protective living environment and supportive services incident to old age for residents having difficulty in caring for themselves and who do not require level II or III nursing care (formerly SNF and ICF) or other medically related services on a routine basis." As defined, rest homes could not serve as an assisted living facility and care for someone who required services provided in a nursing facility.

Similarities in services and populations served by assisted living, board and care, residential care facilities, rest homes and nursing homes create confusion for policymakers. The Massachusetts policy is being revised, but it highlights the policy conflicts states are facing as they consider the purpose and place of assisted living in the context of their existing licensing and regulatory framework. The definitions are critical in relation to state licensing.
requirements which often attempt to create mutually exclusive categories of entities which serve impaired populations. State definitions will determine the type of licensing requirements that apply, who can be served in a facility, and what services may be provided which may artificially constrain the scope of assisted living.

Many older persons need services that can be provided in multiple settings: home, assisted living, board and care or a nursing facility. People living in their own homes or apartments can receive any service a licensed professional can deliver. Home and Community Based Medicaid Waivers allow nursing home eligible elders to receive extensive nursing and support services at home. The definition of "home" is critical in determining what and how services can be delivered. Once people move from their private residences, different rules apply. Both the housing and the services are subject to regulation. As the regulatory framework takes over, care becomes more health or medically oriented, institutionalized, less responsive to individual capabilities and more responsive to dependencies. To a considerable degree the source of financing dictates the degree of regulation of the setting in which services are provided. Government income and service programs, including Supplementary Security Income (SSI)\textsuperscript{18} and Medicaid, define and regulate both the services provided and the setting in which services are provided. Housing financing programs almost always separate the housing and service aspects. Modifying the definition of "home" will have a significant effect on where people with functional impairments and skilled nursing needs can be served.

Despite the continuing identity confusion, this increasingly popular model is becoming known to investors, developers, and social and health service providers. Government has also developed an interest in replicating and regulating these facilities. The promising potential of assisted living facility development may be hampered by the lack of a standard definition, an uncertain regulatory environment, disagreement about the appropriate resident population, a lack of financing for construction, start up and operating costs and limited public subsidies for the low income population.

Assisted living attempts to resolve the issues surrounding housing and services and the accompanying regulation. In order to promote the concept of independence and ability with assisted living, government policy will have to clarify the extent to which these environments will be considered a person’s home. While the services provided and the setting in which services are provided are essential

\begin{quote}
"It shouldn't matter which door you live behind, whether it's the door of a single family home on Main Street or at the Sunnyvale nursing home, it's the services that count," Trish Riley, Executive Director, National Academy for State Health Policy.
\end{quote}
components, ultimately, the definition of assisted living will be shaped by the philosophy and values orientation reflected in a state’s policy.

In a sense assisted living may represent a movement, a new vision in the delivery of long term care toward a less regulated, or more appropriately regulated/licensed, housing and service model. In all but a few states, assisted living serves primarily private pay markets. A key test for government policy makers will be to maintain the essential elements of the assisted living environment at a cost that middle income populations can afford and that government will be willing to absorb for the low income population.

**Is There Common Ground for A Definition of Assisted Living?**

Conceptually at least, assisted living can be described from four perspectives: the philosophy of the model, the environment or setting, the services available and the residents who live there. Programs by many other names may represent elements of one or more components or perhaps portions of each. State definitions range from assisted living as a unique combination of the four variables to adding services in existing programs regulated as board and care and its multiple terms. Proponents of the full concept (single units with baths and cooking capacity, privacy, shared responsibility, managed risk, skilled services and other components) support definitions and policies that clearly differentiate assisted living from nursing homes and board and care. Definitions which differentiate assisted living from board care attempt to set higher standards for providing residential long term care and to eliminate consumer confusion caused by programs that offer a range of physical settings, service options and costs.

Others recommend a broad definition that encompasses the full range of residential options. This view contends that a narrow definition will restrict innovation and the continued development of models based on competition and consumer choice. Strict definitions may hinder the development of new programs to finance the housing and service components and limit state flexibility to develop policies based on local needs. What is common among states is their effort to provide additional services to frail elders to encourage and support aging in place.

If a uniform national definition of assisted living existed, states would ask for flexibility to develop policies and models that meet state needs. On the other hand, the absence of a clear definition and considerable overlap among models frustrates people looking for clarity and a path to pursue. States might take advantage of the flexibility to determine the definition and policy that is best suited to their own state. Setting policy, states might first determine the goal and purpose of assisted living in their long term care system. The goals may be: to develop a nursing home replacement model which reduces the need for beds over time and
offers residents a choice to move into assisted living; to contain the growth in the supply of beds over time and divert new admissions; or to expand the home care system to facilitate aging in place. While these goals may overlap, the major emphasis differs among the options.

"The definition of assisted living should include the nursing home level of service," Rosalie A. Kane, D.S.W, University of Minnesota.

II. DESCRIPTION

This section is based on the core components of assisted living as it has emerged thus far in the public and private sectors. Traditionally, community programs, such as adult day care, are described in terms of the services offered and the clients served. For assisted living that description must be broadened to include the setting where service is given in order to establish such settings as home-like environments. Alternatively, institutional programs contain very clear descriptions of the environment which emphasize minimizing risks and create an environment that is regimented and contrary to "home-like." In describing assisted living, perhaps the most subtle but important parameter is its value orientation. Programs may differ in their scope of service, the impairment level of the people served and the characteristics of the physical environment. The principles which guide the development and operation of assisted living uniquely shape the core elements or components inherent in the environment and the services as well as the clients who are served. Assisted living is characterized by its value orientation, setting and services, which are described below. Programs by many other names may share elements of these characteristics.

Values Orientation

Difficult to describe, harder to operationalize and measure, values are always reflected in public policy. Assisted living emphasizes clear values. These values respect client decision making in ways which foster dignity, independence, privacy, individuality and choice. Underlying this respect is an affirmation that vulnerable adults can participate meaningfully in directing their care, even when physically, intellectually or psychologically impaired. This participation occurs in a way which delineates mutually accepted limits, responsibility and risks by the stakeholders.

Thus, assisted living puts new emphasis on the approach or philosophy used to deliver services. Unlike traditional models of long term care (e.g. nursing facilities) which are focused on responding to illness and disability, assisted living is directed toward functioning
and competency based on personal preferences. Ultimately, this values orientation acts to influence the conceptualization, regulation, development and operation of assisted living.

In the past ten years numerous attempts have been made to describe this values orientation. At least three states (Oregon, Washington and Florida) have incorporated explicit values in their standards for assisted living. The common theme in these efforts is the focus on human values which is especially strong in American culture. It is also important to understand that the personalization of these values will vary individually and culturally. Thus, the ultimate goal in policy formulation and implementation for assisted living has to be flexibility to accommodate variability in the expression of commonly accepted values.

This is illustrated by observing how the value of independence is reflected in daily activity. The ability to make decisions, and describe them, regarding one’s own life is central to "independence." Yet, individuals willingly defer to others in many circumstances; in some cultures, group consensus is far more important than individual expression of self. The central criteria for assisted living is the extent to which opportunities and support for individual decision making are readily available.

Ability and willingness to personalize values should characterize assisted living. This can only be accomplished when the balance between control over decision making and responsibility for the results of decisions are shared. This is in contrast to traditional approaches to long term care where historically both control and responsibility lie primarily with the provider. Efforts to "give" more control to residents are hampered by both an unwillingness to create expectations for residents and a reluctance to permit them to exercise the right to assume risk. This is a crucial issue, for only when resident-defined priorities are viewed in conjunction with professional judgements of "best interest" can the meaning of values such as choice be readily realized. Promoting consumer choice means allowing residents to take some risks. Risk can be managed through the care planning process in which preferences are discussed and risks are identified. The outcome may reflect compromise between the resident and the facility staff but the process respects the person’s preferences rather than "facility rules."

In sum, assisted living owes much of its potential as a viable option for long term care to a shift in thinking about how resident empowerment can be achieved for vulnerable adults. While there is little disagreement over expressed values such as dignity, individuality,
privacy, independence or choice, consensus still is being sought on the operationalization of these principles for vulnerable adults.

Setting

The term "setting" or "environment" is more descriptive of assisted living than "facility." The term "facility" has become linked emotionally (for consumers) and operationally (for providers) with undesirable, institutional qualities. Indeed, payors refer to "facility rates," an orientation at odds with assisted living's focus on individualized plans of care. These qualities include over-reliance on bureaucratic decisions which act uniformly to limit personal freedom and designs which ignore features most frequently associated with "home." Assisted living addresses both of these issues. As a consumer-driven option which meshes housing and services, the setting feels more "homelike." One reason assisted living feels more "homelike" is the design of the physical plant. Common design elements include:

- Individual sleeping space, typically studio/efficiency or one bedroom units.
- Full baths accessible without exit to common corridor.
- Kitchen space with food preparation and storage capacity.
- Lockable doors, individual temperature controls, personal furnishings.
- Community space for resident use (e.g. dining rooms, laundry, living rooms, libraries, television lounges).
- Residential approach to construction and commercial furnishings (e.g. dormer windows, carpet, upholstered furniture).

This normalization of the environment includes enhanced ability of the individual to control access to personal space and continue, to the extent possible, lifestyle patterns which help define the functional, social and emotional elements of home.

In addition, the apartment type complexes which range in size from small (20-35 units) to large (more than 100 units) have incorporated many features to facilitate "aging in place." These often include:

*Our role is to assist, not to do for elders in assisted living,* Michael Rodgers, Senior Vice President, American Association of Homes for the Aging.
• Accessible design features in private and public space (e.g. wider doorways, lever handles, special showers, wider hallways).

• Enhanced life safety features to accommodate non- and semi-ambulatory residents (e.g. sprinkler systems, additional fire walls, single story construction).

• Additional support services capacity (e.g. intercom systems, central kitchen and laundry, medication storage and distribution, optional grab bar installation).

While the amenities vary in assisted living, general consensus exists regarding the need for:

• Private space, shared only by personal choice.

• Increased client control over access to private space and lifestyle practices which do not put others at undue risk or inconvenience.

• Non-institutional furnishings and interior design.

• Support space capacity to ensure delivery of a full complement of services.

The size of facilities in the private sector range from 40 to 120 units. Each building includes common areas, service areas and living units. Common areas, which may include dining rooms, lounges, libraries, living rooms, beauty salon, gift shop, activity rooms and laundry areas, account for 30-40% of the building's square footage. Between 10-15% of the area is developed as service areas (kitchen, laundry, administrative offices, housekeeping and maintenance) while individual units range from 300 to 600 square feet.

The standards for assisted living in some states are less prescriptive and more flexible than governmental approaches to either nursing facilities or board and care programs. Yet the standards are developed to promote higher levels of "livability."

**Services**

Great diversity currently exists in the range of services available and the

--- Principles of Assisted living in Sunrise Retirement Homes: personal services; maximizing independence; encourage independence; protect privacy; enable freedom of choice; preserve dignity; nurture the spirit. Paul J. Klaassen, President, Assisted Living Facilities Association of America. ---
mechanisms used to provide the services in assisted living. In what might be called developing models of assisted living, services can be characterized as low intensity. Services typically include housekeeping, structured activities, one or more meals, laundry and transportation. Some states refer to these arrangements as congregate housing. In the middle range, services focus on the provision of personal care, such as bathing, dressing and assistance with medication in addition to the "hotel" type services. At the high end in the most mature model, services generally include nursing care (e.g. injections, skin care, dressing changes, health assessment and monitoring of clinical symptoms) and specialized programs for incontinence, significant memory impairment and less stable medical conditions which require frequent ongoing monitoring (e.g. insulin dependent diabetics, oxygen dependent COPD, history of TIA). Core service capacity in assisted living, at a minimum, includes:

- Twenty four hour response capability to meet unscheduled, unpredictable needs.

- Service coordination capability to arrange access to services not provided directly.

- Service planning capability to create individualized service plans.

- Skills capability to address the most common dementia related problems (e.g. memory loss, depression, sleep disorders).

In some models a full range of services is available directly from project based staff. Other models use third party providers for all or most personal care and nursing related services. Such decisions are often related to existing regulatory or reimbursement policy. For example, generally, the more restrictive existing licensure requirements are, the higher the incentive to use third party providers contracting independently with clients. Such an arrangement may also facilitate more frequent utilization of Medicare dollars, shifting the cost from the client and/or the state. Generally, facilities with project based staff have greater core service capacity.

**Staffing and training**

A unique feature of assisted living is the flexible configuration of services to meet needs incrementally. Variable levels of service delivered to the client facilitate aging in place. This variability serves to improve the availability, acceptability and affordability of assisted living. In part the ability to individualize service packages is tied to the merger of staff functions. Staff typically are cross-trained and respond to varying needs with significantly less focus on departmental segmentation or task restricted job descriptions unlike nursing homes where
regulations determine how many of what type of staff are needed to care for a specified number of residents. Even when staffing ratios are imposed, much more flexibility exists to organize staff more effectively to meet fluctuations in needs.

**Tenant Profiles**

Characteristics of the tenant population in assisted living is a function of admission and retention policies of state regulatory agencies and provider practice. Consumers of services in developing models tend to be younger (low 80s), more mobile (less likely to be wheelchair or transfer dependent), have few critical ADL dependencies (less likely to need toileting or eating assistance), and have more cognitive abilities (less likely to need protective oversight or dementia related care) than those in mature models. Tenants of mature models are likely to be older (high 80s), more ADL impaired, more at risk due to impaired intellectual functioning and more compromised medically.

Generally, assisted living serves a population at some risk of institutionalization. In more mature models (whether the service is provided directly or by contract), tenants are likely to have needs very similar to nursing facility residents who do not receive continuous skilled care.

Typically, residency restrictions are focused upon issues related to ambulation, incontinence, ability to self transfer, need for regular nursing intervention, and degree of deviation from commonly required social skills. State policies differ on each of these variables. Even when guidelines exist, it is common for providers to stretch their own and state policies to meet care needs of tenants on a case by case basis. State guidelines in these areas will determine the extent to which assisted living can substitute for nursing facilities.

In developing models, the frailty of tenants may be more directly related to aging in place. To accommodate the needs of existing tenants, services are added incrementally. Special-purpose-built assisted living appears to attract tenants forced to relocate after a serious health episode resulting in hospitalization, "needs" based eviction from another form of multi-person housing, significantly altered access to a caregiver or insufficient "in-home" services, cost or coordination difficulties. This is often a function of the lack of accessible design in their previous living unit.

"When I go into an assisted living facility, I always have the feeling that I could live there. I could not live in a nursing home." Richard Ladd, Commissioner, Health and Human Resources Commission, Texas.
While assisted living programs vary widely, a survey by the Assisted Living Facilities Association of America indicates that the average resident is 85 years old, female who resides in assisted living for 2.5 years. On entrance, residents have 2.5 ADL impairments. Between 30-40% are incontinent and a similar range have cognitive impairments.

Cost

Charges to residents vary as greatly as the definitions of assisted living. They are a function of the service package, amenities in the setting and payment source. As discussed earlier, rates for shelter, food and services range from $900 to $3,000 per month and higher. The shelter and food portion can range from $150 per month in low income projects utilizing tax credits or other public subsidies to $1,000 per month in upscale projects in higher income communities. In most cases the board and care rate established by states for public pay clients (SSI) covers the property related costs of shelter and food. This ranges from the federal payment of $422 a month to $857 a month in states with supplemental payments. Total service payments for both public and private pay clients ranges from 50% to 80% of comparable rate for care in a nursing facility.

Development costs for market rate units range from $40,000-50,000 per unit in Oregon to as high as $100,000-125,000 per unit in Massachusetts. A typical cost breakdown among development components is land (15%), construction (60%), soft costs (15%) and financing/interest (10%).

At least some of the cost difference between nursing facilities and assisted living is due to regulation. Almost every aspect of nursing facility construction standards and operations are regulated by state and federal agencies which prescribe in detail how to staff and manage the facility. These regulations exist because of poor living conditions and inadequate care provided by some operators. Agencies have tried to ensure quality by adopting a punitive model of regulation, which has met with only partial success.

In many areas of the country, the lack of long term care options has created a monopoly for nursing homes. Services provided through a regulated monopoly and its financing structures often do not support the value base described earlier. The lack of competition has limited the impact consumers can have when there are real choices and it has left government regulators with full responsibility for ensuring quality. Introducing competitive forces may increase quality by offering other options to people in a way that government regulations alone can.

"I regulate nursing homes in Washington. I wish I could tell you that regulation assures quality. It does not," Charles Reed.
are unable to accomplish. By and large, regulatory approaches have improved safety for residents and produced double digit inflation without changing the "institutional" environment or significantly improving less tangible quality of life indicators.

Other housing models, such as congregate care, generally have been able keep cost increases consistent with the general inflation rate for other goods and services. This is assumed to be related, at least in part, to greater managerial flexibility to control costs and increased competition for consumers. Assisted living may offer a model in which these factors can be taken into account. A different regulatory process, in conjunction with a consumer oriented approach to service, may result in higher quality long term care and lower costs.

III. QUALITY ASSURANCE

Assisted living offers an opportunity to alter the approach used to assure quality care in long term care settings. Historically, nursing facilities have been regulated and surveyed to ensure appropriate utilization, adequate capacity based upon fixed standards and outcomes as measured by predetermined results. This posture has generated a defensive operational mode in which the prevailing response is to follow the letter of the regulations. Regulations intended to represent minimum standards often become a ceiling for achievement.

Preventing deficiencies often becomes the primary focus of staff when they count the number of caregivers on duty, record information in the resident's chart, or make decisions related to the provision of care. The survey process assumes that fear and negative reinforcement will motivate operators to a consistently better performance. Unfortunately, while this approach usually has a temporary positive effect on providers, it has also led to impersonal, sterile environments, in which fear of negative outcomes acts to restrict resident autonomy and to increase cost.

State efforts to measure quality in assisted living have been focused on capacity and outcomes. In addition, significant attention has been paid to adherence to the values that underpin a client centered approach to service delivery. Virtually no attention has been paid to utilization (services needed and the setting in which needs are best addressed), except in states with very strict admission and retention standards. Ironically, when such utilization criteria are enforced in assisted living, it is typically to move tenants who utilize higher amounts of service into nursing facilities.

"Problems are not always the fault of regulators; there is very little competition, market forces and choice at work here," Paul J. Klaassen, President, Assisted Living Facilities Association of America.
Adherence to Model Principles

The Setting

Perhaps the most easily evaluated principle of assisted living is the setting. This is the most conventional of the quality assurance measures. Typically, evaluation is focused upon structural features, which include the following:

- Assurance that personal space meets established criteria (e.g. unit size, lifestyle preferences honored, occupancy, privacy, accessibility).

- Assurance that unit features support normalization of environment (e.g. cooking capacity, locking doors, personal furnishings).

- Assurance that community space is appropriate (e.g. accessible, residential furnishings, adequately designated support services space).

- Assurance that tenants are not exposed to undue risk (evidence of working life safety system, adequate sanitation to prevent illness, general precautions to prevent injury).

Absence or presence of these criteria generally are easily confirmed visually. Risk factors such as those above often are evaluated by other regulatory agencies such as local fire departments, building inspectors, sanitation inspectors and workers' compensation safety analysts. Accepting these reports avoids duplication of regulatory efforts.

Criteria related to the principles of consumer empowerment and a client-based approach to service delivery are significantly less developed. These are the most commonly used:

- Assurance that plans reflect individualization of services to reflect needs/preferences/priorities of tenant.

- Assurance that tenant decision making is supported in day to day practice.

- Assurance that values (e.g. dignity, independence, choice, privacy) are understood by staff and upheld in day to day interactions with tenant.

- Resident and/or family satisfaction surveys.
The consumer empowerment criteria are measured through confirmation of policy practices, record review, observation of tenant-staff interaction and tenant (or proxy) perceptions.

Program Capacity

Part of the interest in assisted living stems from its program capacity. While measures of capacity in nursing facilities have focused upon numbers and types of staff, assisted living has targeted other criteria, including:

- Assurance that the defined range/intensity/scope of services is available and that practice illustrates staff ability to implement it when needed.

- Assurance that service linking and monitoring mechanisms (e.g. case management, managed care, service coordination,) are present and working as evidenced by:
  
  □ an assessment of the tenant which identifies service needs, preferences, priorities;
  
  □ a service contract with the tenant which articulates his/her needs, a plan for meeting the needs and the shared responsibility for meeting those needs;
  
  □ a method for amending the service contract in response to the tenant's changing needs, preferences and priorities;
  
  □ a process to formally manage risk (and uphold tenant autonomy) when tenant decision making may result in poor outcomes for him/her or other tenants.

- Assurance that policy and procedures are adequately developed to provide guidance to staff in the day to day operations of the program.

- Assurance that staff respond appropriately to a variety of situations (personal interaction with tenants, emergencies, technical knowledge base).

"Safety is the most important value for regulators. It's the quality of life that should count most, not safety. In pursuing quality of life, I'm willing to take a lot of risk," Richard Ladd
The licensing process may include submission of a written plan to demonstrate program capacity and adherence to model principles. On-site reviews to assess capacity are typically conducted before a license is issued. Periodic "monitoring" via informal program visits plays a more prominent role in assessing program capacity. Generally, licensure is bi-annual and participation in ombudsman programs is common. A consultative model which emphasizes technical assistance, backed by traditional sanctions, may be used to maintain or enhance program capacity.

**Outcomes**

In the past quality assurance programs for nursing facilities were too process oriented. Outcome measures generally focused on the prevention of risk (e.g. falls), the absence of selected conditions (e.g. bedsores), and the success of clinical interventions (e.g. ambulation). Ideally, regulations should address the mutual responsibilities of the provider and the tenant. Recent legislation (the Omnibus Budget and Reconciliation Act of 87, OBRA) addresses the provider side of the equation by focusing on resident plans of care, goals for intervention and the extent to which residents are moving toward goals stated in their plan of care. In assisted living the focus on outcomes is also broadly focused and consumer oriented, including tenant preferences and the tenant’s role and responsibilities for achieving agreed upon outcomes. For examples, measures typically would include:

- Assurance of tenant and/or family satisfaction with services delivered and results achieved.

- Assurance of working systems which result in mutually agreed upon plans of service, process of implementation and outcomes.

- Assurance of appropriate ancillary service use as evidenced by:
  - amount/cost/timing of medical/non-medical service use (e.g. emergency room use, supplemental provider charges, specialized care agreements);
  - move-out experience due to limited provider capacity to address tenant service needs or inadequate knowledge of the appropriate responses to meeting tenant needs;
  - process of initiating, accessing ancillary health services.

Throughout the range of quality measures, the intent is to examine assisted living’s ability to make tenants or their families feel, whatever the outcome, that the process used
was appropriate and the result is the best that could be achieved under the circumstances. While consumer satisfaction may not fully substitute for professional standards, clearly it is given considerable prominence in assisted living as an important indicator of quality.

**IV STATE MODELS**

**OREGON**

**Background**

Oregon initiated its assisted living program in 1986 with a demonstration project in a licensed residential care facility. After successful implementation of the pilot, the state decided to develop a nursing facility replacement model that would not only promote consumer driven long term care, but would also address the increasing fiscal crisis that was developing in long term care. The assisted living program is expressly designed to serve elderly persons who meet the criteria for placement in a nursing facility. Several assisted living projects are designing programs to target younger persons with a disability.

The Oregon Senior and Disabled Services Division (SDSD) has stimulated the construction of nearly 1000 assisted living units in 21 licensed facilities ranging in size from 15 to 105 units. All projects have been funded privately or through the Oregon Housing Finance Agency. Four projects have been submitted for HUD funding and six more are in advanced developmental stages. Projects have opened at the rate of one per month. One nursing facility has converted to assisted living. The owner remodeled the building and reduced capacity from 130 nursing facility beds to 76 assisted living units. The state's residential care facilities operate about 4,000 beds of which 1,000 are subsidized by state programs.

Although assisted living is still an affordable option for the middle class, it is also a service offered to Medicaid eligible persons by both the state's 1915(c) and 1915(d) home and community based care waivers. The 1915(c), or 2176, waiver, allows the state to provide support services and services that are not part of the state plan to nursing home eligible Medicaid recipients. The number of people served is capped in relation to the number of available or vacant nursing home beds, or the capacity of the nursing home system to serve people in the absence of the waiver. The 1915(d) waiver is limited to persons 65 and older and caps the amount of funds spent on long term care for institutional and community services. In exchange for a fixed level of federal reimbursement, the state has the
flexibility to cover services similar to the 1915(c) waiver. The primary difference is the basis for determining spending and federal reimbursement. Oregon is the only state that has applied for and received a 1915(d) waiver. Other states have thus far been reluctant to accept a cap on federal reimbursements, adjusted annually for population growth and inflation, despite the increased flexibility that accompanies such a waiver.

**Principles**

The assisted living model is built on six key principles: individuality, independence, privacy, dignity, choice and a home-like environment. Facilities maintain written policies, approved by the state agency, that incorporate these principles. The policies recognize resident rights, responsibilities and preferences, describe the form of addressing the resident, and assure that residents may select or refuse service. In practice, service delivery is similar to client-directed or client-employed arrangements.

**Access**

All clients applying for Medicaid long term care services are assessed by the local Area Agencies on Aging (AAA) who contract with the state to administer Medicaid's long term care programs. Applicants are assessed by a case manager or a pre-admission screening team using a uniform assessment document that records information on demographics, functional impairments, a medical assessment, income and resources. Clients are provided information about available resources, including nursing facilities, community care and assisted living. Clients interested in assisted living are assessed by the facility to determine their appropriateness for placement.

Residents supported by Medicaid must qualify for placement in a nursing facility; however, assisted living facilities cannot serve residents who require 24 hour skilled nursing care or monitoring. Residents who are permanently bed bound and unable to ask for assistance, or who are medically unstable, require IV treatments, heart monitors and feeding tubes, for example, are not served in this setting. Medically stable means that a resident's clinical and behavioral status is known, does not change rapidly and does not require continuous licensed nursing observation and evaluation.

When a resident moves in, the service coordinator, AAA case manager, resident and family develop a service plan that describes the services to be provided and the manner in which they will be provided. Oregon requires that assisted living staff manage the services for the residents. The facility must develop a service plan with each resident that clarifies the shared responsibility for meeting the service needs. The plan must reflect the choices and preferences of the resident and maximize each resident's capability and independence.
The facility must provide agreed upon services, monitor outcomes and change service plans as needed. The AAA case manager continues to authorize Medicaid payment and to monitor the plan. Each service plan contains written outcome measures that address functional abilities, psycho-social well-being, stability of medical conditions and client/family satisfaction, which are monitored by the AAA case manager.

The assisted living environment allows individuals to live in their own apartments and receive the services they would otherwise receive in a nursing facility. Services are provided in a social model that complements each resident’s capabilities and strengths in day-to-day activities. The model is developed to support independence, respect for dignity and privacy and freedom from restraints. Staff are available 24 hours a day to provide services based on the resident’s needs. The average resident is female, age 87 with dependencies in 3.4 ADLs. Forty percent are incontinent and over half have cognitive impairments.24

Assessment, Costs and Service Rates

Charges for private pay residents are based on market rates. Charges to Medicaid residents include a monthly shelter (room and board) rate and a service rate. The total rate is based on the impairment of the resident and ranges from $517 to $1,483 per month. The shelter portion of the rate is constant across the range and the variable portion is the service component. Rates increased 4% between 1991 and 1992. The five levels for service payments are based on impairments in less critical ADLs (dressing/grooming, bathing/personal hygiene, mobility) and critical ADLs (bowel and bladder control, eating/nutrition, and behavior/cognition). During the assessment process, distinctions are made between total dependency in an ADL and the need for partial assistance to complete an ADL. Separate weighting is given for the presence of impairment in the behavior (cognition) ADL. The shelter portion of the rate is a constant across all five categories. (See Table 8.)

Most assisted living residents are reimbursed at level 3 or 4 rates. Only rarely are residents admitted at level 5 rates. Residents with this level of impairment usually are those who have declined since admission.

The Supplemental Security Income (SSI) standard is $423.70 a month. However, Oregon has elected the Medicaid Special Income Level eligibility option (see page 82) and residents with income below 300% ($1,266) of the federal SSI payment standard ($422 a month) are eligible for Medicaid. The maintenance level, the amount of income a recipient under this option can retain to pay for room and board, is $423.70 a month. Any income above $423.70 and below $1,266 a month is applied to the cost of services.
Table 8. Oregon Impairment Threshold and Medicaid Rate Matrix

<table>
<thead>
<tr>
<th>Primary Eligibility</th>
<th>Alternate Eligibility</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 5</td>
<td>Dependent in 3-6 ADLs</td>
<td></td>
</tr>
<tr>
<td>Level 4</td>
<td>Dependent in 1-2 ADLs</td>
<td></td>
</tr>
<tr>
<td>Level 3</td>
<td>Assistance in 4-6 ADLs</td>
<td></td>
</tr>
<tr>
<td>Level 2</td>
<td>Assistance in 3 critical ADLs</td>
<td></td>
</tr>
<tr>
<td>Level 1</td>
<td>Assistance in 2 critical ADLs or assistance with 3 ADLs</td>
<td></td>
</tr>
</tbody>
</table>

Note: Dependent means a person cannot do an activity without substantial hands-on help.

Assume that both Client A and B are assessed as Level 3, which warrants a service rate of $915 a month. Client A has no income other than SSI. S/he may retain $63 a month for personal needs. The remaining $360.70 is paid to the facility to cover room and board costs. The Medicaid program pays the full service rate of $915, but pays no room and board.

Client B has income of $1,123 a month which is below 300% of the federal SSI payment and client B is therefore eligible for Medicaid. However, since the maintenance level has been set at the state’s SSI payment standard of $423.70 a month, all "excess income" must be applied to the costs of services. Thus, client B retains $63 a month for personal needs, pays $360.70 to the facility for room and board costs and applies the remaining $699.30 toward the service cost. The state pays the balance of $215.70 (See Table 9.)

In Oregon, the average development costs are $40,000 to $55,000 per unit. Staffing accounts for about half of the facility’s costs; food and supplies, 10-15%; and debt service and related physical plant costs, 35-40%.

**Occupancy and Service Package**

Assisted living programs in Oregon operate at 100% occupancy with waiting lists. This compares to an 85% occupancy rate for nursing facilities. The average level of impairment for both private and public residents is only slightly lower than the average impairment of nursing facility residents.
### Table 9. Oregon Income and Cost Examples

<table>
<thead>
<tr>
<th></th>
<th>Client A</th>
<th>Client B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Charge - Level 3</td>
<td>$1,275.70</td>
<td>$1,275.70</td>
</tr>
<tr>
<td>Client Income</td>
<td>$423.70</td>
<td>$1,123.00</td>
</tr>
<tr>
<td>Less R&amp;B Allowance</td>
<td>$360.70</td>
<td>$360.70</td>
</tr>
<tr>
<td>Less Personal Needs</td>
<td>$63.00</td>
<td>$63.00</td>
</tr>
<tr>
<td>Income applied to $915 service rate</td>
<td>$0.00</td>
<td>$699.30</td>
</tr>
<tr>
<td>Net Cost to Medicaid</td>
<td>$915.00</td>
<td>$215.70</td>
</tr>
</tbody>
</table>

The typical service package includes: meals in a common dining room, opportunities for individual and group social interaction, housekeeping, laundry, transportation, support for a broad range of activities of daily living including bathing, dressing, eating, bowel and bladder management, personal hygiene and special approaches for behavior management. Other services include medication management, nursing services such as injections, catheter care, wound care, health status monitoring and assessment, and planning and reviewing the direct and ancillary services for supporting resident independence. Assisted living programs must have the capacity to respond 24 hours a day to unscheduled and unpredictable needs.

### Standards

Licensing for nursing, residential care and assisted living facilities is the responsibility of SDSD. Standards include requirements for services and service delivery, standards for the physical plant including both the living units and the common space, and a demonstration of an understanding of the program’s philosophy. The manager of an assisted living facility, to qualify, must participate in a training program approved by the state licensing agency.

Unlike most state residential care or board and care standards, Oregon’s assisted living model requires that each resident have a locking private apartment that includes a handicapped accessible bath and at least a galley kitchen and a voice-to-voice emergency communication system. Units generally have a kitchen area, dining area, living and sleeping area. Newly constructed units must have a minimum of 220 square feet of barrier-free living space (not including the bathroom). Rehabilitated units must provide a minimum of 160 square feet. All buildings must meet zoning, building and fire safety codes. Facilities must have a rental/service agreement with residents that covers the terms of occupancy, charges, fees, services to be provided and the conditions under which fees may be increased.
Staffing

Defined staffing ratios are not required by the standards. Instead, facilities are required to maintain staffing patterns and ratios that are sufficient based on the resident mix, special needs and the services identified in the resident service plans. Staff in assisted living facilities are expected to provide comprehensive services to residents to enhance quality of life. Staff may provide personal care, administration of medications, assistance with housekeeping, laundry, assistance in the dining room, as well as structured socialization and behavioral interventions. This "cross-training" of staff differs from the role of the nursing assistant in a nursing facility, who usually performs only one set of tasks.

In addition to cross-training, Oregon’s Nurse Delegation Act permits registered nurses to delegate certain tasks formerly restricted to licensed personnel. The Act requires nurses to assess the client, teach the non-licensed person how to perform the task and monitor the outcome. The delegation must be made for each task, each client and each non-licensed person.

Implementing the model required collaboration between providers of long term care, representatives of the assisted living industry and consumers, who were interested in promoting the new model. The state agencies played a leadership role by promoting the concept, defining the parameters for regulation and providing incentives for developers to participate in the process. The program was launched with the understanding and expectation that assisted living contributed to the goal of establishing an affordable, accessible and livable option for both the public and private pay persons in need of long term care.

Housing Finance Agency Role

The SDSD, which provided the leadership, had several advantages as it embarked on the project. The Division regulates all of the long term care residential programs: nursing facilities, adult foster care homes and residential care facilities. The Division also administers the state’s Medicaid nursing home program, the Medicaid waiver programs, the Older Americans Act program, and the state general revenue program - Oregon Project Independence. The Division also has a strong working relationship with the state housing finance agency which issues elderly housing bonds and influences other financing for elderly housing.

At the outset, SDSD, the Office of Health Policy and the Housing Finance Agency (HFA) met to review the policy to ensure that each agency understood and agreed with the goals and substance of the program. The HFA made assisted living a priority for its tax exempt and taxable bond issues. The agency also agreed to use the physical plant and
program standards set by the Office of Health Policy and SDSD as review criteria. This inter-agency coordination explains some of the major differences between Oregon and other state programs.

WASHINGTON

Background

Assisted living is the latest component in Washington's plan to reduce reliance on nursing home beds by expanding community programs. In 1989, the state expanded its personal care program in boarding homes and individual homes. The Medicaid waiver program was expanded. Assisted living and other options are expected to reduce the supply of nursing facility beds to 45 beds per 1,000 people 65 and older. The ratio in August, 1992 is 52 beds/1,000, down from 53/1,000 in January, 1992.

Washington's assisted living program will fund 180 units by the end of 1992 in existing licensed boarding homes which meet program standards to provide assisted living services. The project is designed to "promote the availability of services for elderly and disabled persons in a homelike environment enhancing the dignity, independence, individuality, privacy, choice and decision making ability of the resident." The program stresses an environment that provides individual apartments where people can receive services that support and maximize independence.

The program was based on the results of a 45 unit pilot project in Seattle that began in October 1990. An evaluation\(^2\) compared the pilot project to nursing homes and housing facilities that marketed themselves as assisted living and found that residents had an average of 4.5 ADL impairments. Thirty-eight percent of the residents were relocated from nursing facilities and the remaining residents had lived independently but needed medication management or some other regular nursing intervention, did not have a caregiver, experienced frequent, unscheduled care needs or required protective oversight. More than 35% were periodically incontinent. The highest impairment rates were for bathing (94.4%), dressing (67.9%) and personal hygiene (69.6%).

Residents received an average of 2.3 health services a day. The most common interventions were assistance with insulin injections, assistance with other medications and assessment of health conditions.

While all publicly supported residents were eligible for nursing facility placement, assisted living residents tended to be younger and less likely to have been admitted from a
hospital than from a nursing facility. More nursing facility residents tended to be totally dependent in critical ADLs (transferring, eating and continence) than assisted living residents. On average, nursing facility residents had one more ADL impairment than assisted living residents. Much of the difference was attributed to a higher incidence of residents who were bed bound and had cognitive impairments.

The evaluation gave the project high marks for respecting dignity, providing privacy and choice. Staff knew the residents well. Since the facility was originally built for different purposes, some of the design and furnishing elements of assisted living were lacking (window treatments, auxiliary lighting) although the units were home-like and appropriate. Resident satisfaction was high.

Seventy-one percent of the residents were publicly subsidized. The rate for publicly subsidized residents for the study period was $40 a day compared to $54.51 paid by private residents. Resident payments averaged $13.72 a day and the state costs were $26.28 a day.

The pilot project was compared to 21 assisted living facilities in Washington with a total of 1,478 units. Most facilities offered studio units and about 35% had kitchenettes and another 40% offered limited cooking capacity. Most residents were relatively independent on entry. More than 1,000 units were licensed as boarding homes and 16% of the units were occupied by clients of the state’s community care program. Rates for the programs varied and many offered a la carte service options. Those with flat fees ranged from $806 to $2,035 per month for IADL assistance and $1,500 to $3,270 for minimal ADL assistance (1991 figures).

Newer facilities tended to offer less services as part of their program, due in part to boarding home regulations. Outside service providers frequently provide additional services to residents. Older facilities offer more services but provide double and triple occupancy rooms with few amenities. The pilot site offered private apartments with baths and kitchenettes.

Based on the findings from the evaluation, the state decided to fund an additional 135 units. Contracts for 102 new assisted living units began in July 1992. The balance, 32 units, will be available by September, 1992. The number of units occupied by Medicaid recipients in any given facility is limited to 12 to ensure a public private resident mix and to spread limited resources to as many parts of the state as possible.

The origin of the program in Washington differs from other states. While the legislature approved funding for a specified number of units, the program policies and guidelines are contained in a contract modification for board and care homes.
Units

The primary changes from the state’s board and care standards are the requirements that facilities provide complete apartments that include a minimum of 220 square feet of living, and kitchen space (not including bathroom). Units are private except when couples or persons choose to share a unit. Regular board and care homes must provide 80 square feet of useable space in a single room unit and 70 square feet per person in a double room. Kitchens must be furnished with a refrigerator, two burner stove top or 1.5 cubic foot microwave oven and a sink. If kitchens are not provided, the facility must provide space for residents to prepare food. Each room must be equipped with an emergency response system. Common areas must be smoke free and handicapped accessible. Most boarding homes do not meet these standards. The state agency views the current contracting standards as a test to gain experience for a broader program. Existing boarding homes have indicated an interest in upgrading the facilities to meet assisted living standards when broader implementation occurs.

Program Guidelines

The program policies balance safety, independence, choice and risk through a service plan that defines responsibility and distinguishes between "managed risk" in which a resident is capable of weighing risks and choosing services, "shared responsibility" in which the staff present the consequences of a resident’s choices but the resident is responsible for making the choices and "bounded choice" in which the resident choices are structured. Facilities must have written procedures to document staff efforts to involve residents in their care.

The general service package includes meal (three per day) service, laundry, and housekeeping, as well as personal care (except positioning), behavior management, incontinence care and the following nursing services: assessment, monitoring, medication administration, stage one skin care, and temporary bed care.

Facilities may provide an enhanced level of care as needed by the resident and described in the "negotiated service agreement" (see appendix). These allowable health related services include range of motion exercises, wound care, ostomy care, occupational therapy, psychiatric consultation, podiatrist services, nutritional supplies and medical equipment and supplies. The enhanced services are not included in the daily rate and must be billed to other
payers, e.g. Medicare. Nursing services must be provided by a licensed nurse employed, rather than contracted, by the facility.

Facilities must also have agreements with dieticians and pharmacists for consulting services. The contract modifications also require that facilities establish a resident council "to provide input on all aspects of the facility or care provided to residents."

The continuing discussion of this model among agencies and providers highlights the tensions and conflicts between assisted living, nursing facilities and a consumer focused model. The initial guidelines allowed assisted living facilities to be responsible for ensuring the provision of additional skilled nursing services (catheter care, stage 2-3 skin care and changing sterile dressings.

Health department staff concluded that such care was beyond the scope of a boarding home license. However, residents may still receive such services in assisted living and facility staff may help residents arrange such services with certified home health agencies. The facility is not now responsible for such care. The distinction reflects concerns among regulators and providers over the model. As the pilot program progresses, separate licensure requirements may be developed for assisted living to resolve this issue.

The program was developed to divert or relocate up to 180 current nursing home residents. Residents must be sufficiently impaired to need the level of services available in the assisted living program and they must be eligible to receive services under the state's community options programs.

**Rate**

The rate (1992) for Medicaid recipients is $45.90 per day, which includes the room and board portion paid by the resident from their income (SSI, Social Security). The state SSI payment standard is $450 a month. The resident retains $38.84 as a personal needs allowance and pays the remaining $411.16 to the facility to cover room and board. The facility receives a service payment from Medicaid of $965.70 a month. On average, residents are paying $15.61 a day, compared to $13.72 during 1990. The state's costs average $30.30 a day.

Washington also uses the Medicaid Special Income Level (300% of the federal SSI standard) for its waiver program (COPES). This allows people who qualify for placement in a nursing facility whose income exceeds the normal Medicaid levels to participate in the program. Income above the personal needs allowance is applied to room and board and service costs.
Assisted Living Guide

Staffing

Similar to Oregon, staffing standards are flexible and require the capacity to meet the needs of residents as contained in the service plans. Registered nurses must be available on-site eight hours a day and accessible 24 hours a day.

Housing Finance Commission Role

The Washington Housing Financing Commission offers bond financing for profit and non-profit borrowers to develop nursing homes, Continuing Care Retirement Communities, Assisted Living and independent housing. The Commission completed several bond offerings over the last 2 1/2 years. While no free standing assisted living projects have emerged, several projects have included assisted living as part of a larger proposal. All projects funded thus far have been done by non-profit organizations. The Commission’s tax exempt bonds require a low income set aside of 20% of the units for people below 50% of the area median income or 40% of the units for those below 60% of the median income.

NEW YORK

Background

Based on legislation passed in 1991, the New York Departments of Social Service and Health are implementing an assisted living model that combines adult care facilities and home care services for individuals who are medically eligible for placement in a nursing facility. One goal of the program is "to develop a less restrictive and lower cost residential setting that can serve people who do not need the highly structured, highly medical environment of a nursing facility." Revisions to the state's long term care need methodology showed a need for 4,200 assisted living units across the state.

Adult care facilities (ACFs) provide residential care and services to adults who do not require continual medical or nursing care but are unable, or substantially unable, to live independently. ACF options include adult homes, enriched housing, family type homes (four or fewer residents), shelters and residences for adults. The assisted living program is open to ACFs who operate as adult homes and enriched housing programs. These programs provide long term residential care, room, board, housekeeping, personal care and supervision to five or more unrelated adults.

The program builds upon the existing adult care facilities and enriched housing programs to meet changing resident needs. The state has licensed 455 Adult Homes with a capacity of
30,995 units. There are 119 non-profit facilities with 6,986 units, 329 proprietary facilities with 23,604 units and seven facilities operated by local governments with 407 units.

In May 1992, the supply of nursing home beds totalled 119,760, including 14,291 beds approved but not yet built, for a ratio of 50.7 beds per thousand. The goal to approve 4,200 assisted living units was based on a direct substitution of assisted living units for nursing home beds in the bed need formula. The formula projection is based on estimates of the projected number of people in ICFs who could be served in assisted living. The planning figure assumes that people seeking admissions to a nursing facility will be diverted to assisted living rather. Existing nursing facility residents will not be required to relocate. While a certificate of need is not required for an assisted living facility, approval and contracts with the state agencies are required and no more than 4,200 units will be approved on a competitive basis.

**Adult Homes**

Adult Homes must provide room and board, housekeeping, personal care, supervision, case management and activities. Personal care functions include "direction and some assistance with" grooming, dressing, toileting, walking, eating, taking and recording weights monthly and assistance with self-administration of medications.

Adult homes constructed after 1978 limit bedrooms to two people. Single bedrooms must provide at least 100 square feet of space and double rooms, 165 square feet (excluding foyer, toilet room and closet). Units are not required to include a bathroom. At a minimum buildings must contain one toilet and wash room for every six residents and tub or shower facilities for every 10 residents. The regulations contain minimum standards and most facilities exceed these minimums. Facilities which have expressed an interest in applying for an assisted living approval have either single or double units with an attached bath.

Residents may not be served who are chronically chairfast or bedfast, need continual medical or nursing care provided by a nursing facility, chronically need physical assistance with walking or stairs, have unmanaged incontinence and other chronic personal care needs that cannot be met by facility staff or community agencies.

Residents must have a complete examination from a physician and an interview with the facility staff to determine that the resident’s physical, personal care and dietary (including religious and cultural preferences) needs can be met.
Staffing varies with the number of units. Personal services staffing is based on a minimum of 3.75 hours per resident per week, one hour for housekeeping and two hours for food service. Supervisory staffing is based on one staff for the first 40 units, two up to 80 units and three up to 150 units. Facilities are required to meet the needs of residents and to operate with staffing that is adequate to do so. If the aggregate service needs of residents exceed the capacity of minimum staffing levels, the facility must increase its staffing capacity.

Enriched Housing

Enriched housing programs operate in existing conventional elderly housing buildings. They were developed to address aging-in-place in elderly housing projects. No more than 25% of the total units in a building with individual or shared units can be designated as enriched housing. Buildings in which all space, other than bedrooms, is shared are limited to seven residents at any single site. Units in larger buildings must contain living, dining and sleeping areas and full baths, including a toilet, lavatory and a shower or tub. The minimum size for single bedrooms is at least 85 square feet excluding foyer, bath and closets.

Enriched housing residents must also have a health examination from a physician, an interview by the program sponsor’s coordinator and a functional assessment by a case manager, nurse or program coordinator. A physician must sign a statement that the resident’s needs can be met in an enriched housing environment. Enriched housing programs exclude the same residents with conditions describe for adult homes.

Enriched housing programs provide (or arrange for) supervision, personal care, case management, activities, housekeeping and food service. Personal care includes "some assistance with personal hygiene, including dressing, bathing and grooming; and assisting with the self-administration of medications." If authorized by a physician, the provider can assist by prompting the resident, identifying the medication to be taken, bringing the medication and necessary supplies, opening the container, positioning the resident, disposing of used supplies and storing the medication.

Enriched housing programs must offer a minimum of one meal a day in a congregate setting and provide sufficient food for all meals prepared in the resident’s unit. Operators must employ a full time coordinator per 32 residents. The coordinator may also provide case management services. Minimum staffing standards require six hours of housekeeping,

"We are working with what we have: 30,000 adult home beds and a very extensive community care system," Barry Berberick, Director of Long Term Care, Department of Social Services, New York.
personal care and food service per resident per week. However, these minimum levels must be increased as the service needs of the residents increase.

The regulations allow the state to make development grants to new facilities in order to reduce their initial operating deficit caused by low occupancy rates during the initial rent up phase.

**Assisted Living**

The assisted living program organizes a more extensive in-home service package to support residents who are aging-in-place by adding additional health services. Assisted living providers must be licensed as ACF adult home providers or enriched housing programs. They must also hold a license as a home care services agency, a certified home health agency or a long term home health care program. Licensed home care services agencies provide personal care but not skilled nursing. Adult care facilities and enriched housing programs can expand their programs by obtaining a license to provide personal care as a home care services agency and contracting with a certified home health agency to provide nursing services and therapies.

The program will be jointly administered by two Departments. The Department of Health now licenses home care agencies. Two divisions of the Department of Social Service have key roles. The Division of Medical Assistance reviews and monitors personal care contracts and the Division of Adult Services regulates the adult home and enriched housing programs. The Department of Social Service issues the license.

**Eligibility**

Assisted living residents must have stable medical conditions. The program will not serve people who need continual nursing or medical care; anyone who is chronically bedfast or chairfast and requires lifting equipment or assistance from two persons to transfer; or anyone who is cognitively, physically or mentally impaired to a point where safety is compromised. Residents may be served if they can transfer independently or with assistance from one person.

The assessment and eligibility process begins with physicians who must make a finding that the person requires nursing facility services. Recipients are free to explore assisted living options. An assessment is done for Medicaid recipients by the assisted living facility's staff to determine program eligibility and the appropriate Resource Utilization Group (RUG) category which determines the nursing facility's reimbursement rate. Assessments are
reviewed by the local Department of Social Services office. Once eligible, the assisted living provider develops a plan of care based on the physician’s orders and the assessment.

**Rates**

SSI payments will cover room and board costs as well as the services that are required in Adult Care Facilities. The monthly SSI payment levels for this living arrangement are $857 a month in New York City, Nassau, Suffolk and Westchester Counties and $827 a month in the rest of the state. The state agencies do not set the amount that providers can charge residents for room and board. Rates are negotiated between the provider and the resident, however, and the resident is permitted to retain at least $94 a month as a personal needs allowance.

Services will be covered through a daily prospective payment per resident (capitation payment) for nursing, personal care, home health aide, therapies, medical supplies and equipment (which do not require prior approval), personal emergency response and adult day health care. The service package bundles Medicaid community services covered by the state plan. The primary distinction between personal care services that must be covered by the resident’s SSI payment and the Medicaid capitation payment is the intensity and duration of care. State plan activities cover total assistance with an activity for someone with a chronic impairment. Personal care under the ACF licensure provides partial assistance with an activity for a resident whose impairment is not expected to continue indefinitely. The capitation rate will be 50% the amount that would have been spent in a nursing facility based on the resident’s classification under the RUG prospective payment methodology. There are 16 RUG categories and the payment rate for each category may vary across the state’s 16 regions. Program information indicates that the expected rate will range from $30 to $47 a day depending upon the geographic area of the state.

**Status**

Prior to the final design and implementation of the program, the Department of Social Services issued a notice to potential sponsors/applicants which outlined the program and invited “letters of interest” in order to accelerate implementation. More than 200 letters were received from existing licensed adult care facilities, hospitals, nursing homes and other organizations who were interested in developing programs. The regulations to implement the program have been published for public comment. The regulations will be finalized in the fall. Application forms have been issued and the deadline for proposals is October, 1992. Because one goal is to expand the supply of services, a criteria in selecting sponsors will be whether the proposal adds capacity to the system. The program will save a projected $61.8 million annually based on a supply of 4,200 assisted living units.
Housing Finance Agency Resources

While the program will likely be implemented initially in existing Adult Care Facilities, the New York Housing Finance Agency (HFA) will become a resource for developers and agencies seeking funds to build new facilities. The HFA is using a tax exempt bond to finance a project that will rehabilitate a school building into an enriched housing facility and construct congregate housing apartments in a new, separate building. Both buildings are designed for elders who are still independent but who may need varying levels of assistance. The philosophy of the sponsor is to maximize the independence of residents by providing the supportive assistance necessary to enable the resident to accomplish daily activities.

Based on a market analysis, sponsors concluded the largest unmet need was among moderate income elders. Twenty percent of the units are reserved for elders with incomes below the area median income.

The 50 apartment congregate building will include full apartments (620 to 920 square feet) with kitchens and baths, one meal a day in a common dining room, emergency call system, security, transportation, activities and a washer and dryer on each floor. Monthly charges will range from $1,375 to $1,600 per month per unit and include all utilities and basic cable. Units with a second person will be charged an added fee of $350. Extra services such as meals are available on a fee-for-service basis. Congregate housing does not require licensing by the state.

The "enriched housing" units, which must be licensed, will provide 260 square feet for a sleeping and sitting area with bathroom, including a step-in shower. Units will also include a refrigerator and a cook top stove or microwave oven. The units are designed so that two units may be connected to accommodate couples. Monthly charges of $1,485 include rent and services similar to the congregate facility, as well as all meals and unlimited access to services of a "resident aide" who provides personal care. A case manager is available to conduct assessments and monitor care. Residents from both buildings have access to a convenience store, a beauty parlor and other common spaces but each building has its own lobby, lounges and dining room.

Financing was obtained from several sources. The construction loan, at prime plus .5%, was obtained from a local bank. An 8% percent, 30 year mortgage was obtained from a tax exempt bond issued by the (HFA) and is insured by the State of New York Mortgage Agency (SONYMA). The project also received a $408,000 grant from the HFA's Infrastructure Development Demonstration Program for infrastructure costs and $1.3 million from the New York State Housing Trust Fund for soft costs associated with development, including a
reserve fund required by SONYMA to cover potential operating losses prior to achieving full occupancy.

The project will be ready for occupancy in the fall of 1992 and marketing for the congregate units has been completed. Sponsors expect that over time residents of the congregate building will move into the enriched housing units as they become more frail. Three additional congregate buildings are planned for the site.

While this project was not developed as an assisted living facility, or with the state's new initiative in mind, it provides an excellent example of how a developer could utilize existing housing and service financing sources to build and operate a new, mixed income assisted living facility. Although assisted living residents may be slightly frailest and require more services than projected in the financial plans, the rates planned by the sponsor are comparable to the combined shelter and service rate available for state subsidized assisted living. This is one of several examples of facilities being financed or planned by the HFA. The HFA's interest in financing supportive housing models complements the policies being developed by the Department of Social Service.

FLORIDA

Background

Regulations issued by the Florida Department of Health and Rehabilitative Services to implement the Adult Congregate Living Facilities Act were effective in August, 1992. The Act builds on the Adult Congregate Living Program and creates a new licensure category, extended congregate care. The law codifies the principles of assisted living and describes the intent of the Act:

"... to promote the availability of appropriate services for elderly and disabled persons in the least restrictive and most home-like environment, to encourage the development of facilities which promote the dignity, individuality, privacy and decision-making ability ...."

The law further states that facilities "shall be operated and regulated as residential environments with supportive services and not as medical or nursing facilities."

The Act guides the activities of state agencies responsible for implementing the program. It says, "Regulations shall be flexible to allow facilities to adopt policies which enable residents to age in place when resources are available to meet their needs and accommodate their preferences."
During the license application process, facilities specify how their policies will allow aging in place and maximize independence, dignity, choice and decision making. The policy also describes the staffing pattern (but does not specify staffing ratios) required to achieve these goals and the personal, supportive and nursing services that will be provided to residents, as well as the extent of service, the manner in which services are provided and the type of staff who will provide them. Applications must also describe how the facility will meet unscheduled service needs.

Facilities are allowed to provide care to people who do not need 24 hour nursing care. Facilities can serve people who are terminally ill with additional care provided by a hospice program if the person’s physician agrees that the person’s physical needs can be met.

Administrators and supervisors in the Extended Congregate Care programs (ECC) must receive six hours of training in assisted living. Facilities must have a registered nurse, licensed practical nurse or nurse practitioner on staff or contract and a staffing pattern that is adequate to provide the services outlined in resident plans of care.

Florida has 68,199 licensed nursing home beds and 7,545 beds in the pipeline. The law focuses on the existing supply of licensed Adult Congregate Living Facilities (ACLFs). Florida has about 1,450 licensed ACLFs with a capacity to serve 62,000 residents. Sixty-three percent of the facilities serve fewer than 17 residents. About 11% of the residents are subsidized by the state. Residents must be age 60 and over or disabled adults. ACLFs were initially licensed to serve people who do not need 24 hour skilled nursing care or supervision, except for terminally ill residents. ACLFs must provide an apartment, private room or shared room, one or more meals and assistance with one or more ADLs such as bathing, dressing, ambulation or supervision of medication. Monthly fees range from $500 to $3,000 a month. Eighty of the facilities are part of larger Continuing Care Retirement Communities.

**Licensure Standards**

The ECC or assisted living program allows ACLFs to apply for a special license to provide supportive and nursing services in an environment which promotes dignity and independence, limited nursing services and limited mental health services. All or a portion of the facility’s units may be licensed as Extended Congregate Care. ECC facilities must offer
residents a private room or apartment, or a semi-private room (2 person) shared with a person of their choice. All entry doors shall have a lock unless it jeopardizes the resident's safety and this is noted in the service plan.

The minimum room size for a single unit is 80 square feet. Bathrooms may be shared by a maximum of three other residents. However, the size of units varies widely among licensed facilities. Facilities which serve private markets are more likely to have bathrooms and kitchens facilities included in the unit. Those that serve higher percentages of public residents are more likely to have smaller units, shared by two to four residents, and shared baths.

Rates

In an effort to improve access of low income elders to better facilities, the legislature considered increasing the SSI payment standard from $575 a month to $750 a month. Due to the state's budget crisis, the increase was not adopted. Facilities, especially those which do not yet serve low income residents, are likely to delay applying for an ECC license until payment rates are increased. The Department of Health and Rehabilitative Services plans to develop a service rate for ECC that will be based on 50% of the rate that would have otherwise been paid to a nursing facility. The rate would be paid through the state's home and community based waiver (Section 2176). The new payment methodology has to be approved by the legislature in the next session before it can be implemented. Until a new methodology is approved, services will be reimbursed on a fee-for-service basis.

Waiver eligible recipients can now be served in ACLFs, although the waiver does not allow facilities to be reimbursed as providers of waiver services. ACLFs have to contract with a community agency to deliver services. The state plans to amend its waiver to allow ECCs to be reimbursed as providers of the additional services.

Opposition and Compromise

While the law sets a solid foundation for developing the program, opposition grew from a section of the nursing home industry which complained, according to an article in the Wall Street Journal, that the program did not differentiate between services that could be provided in a nursing home and those provided in assisted living. While other states (Washington, Oregon) specify that residents could receive services similar to those provided in an Intermediate Care Facility, opponents in Florida sought clear distinctions between the two types of care.

After a lengthy series of negotiations, the final regulations identify the characteristics of people who may and may not be served in ECC facilities. People may not be served who:
- Are dependent in four or more ADLs (bathing, dressing, eating, grooming, toileting).
- Require 24 hour nursing supervision.
- Have medically unstable conditions.
- Have complex medical needs (stage 3 or 4 pressure sore or multiple stage 2 pressure sores).
- Have cognitive decline severe enough to prevent simple decisions such as choosing a dessert.
- Are a danger to themselves or others.

The regulations also list a series of services that ECC facilities may not provide: oral suctioning, assistance with gastrostomy or tube feeding, monitoring of blood gases, intermittent positive pressure breathing therapy, intensive rehabilitation due to stroke or fractures, and treatment of a surgical incision unless the causal condition has stabilized. Quadriplegics, paraplegics and residents with muscular dystrophy may be served if they can communicate their needs and do not require assistance with complex medical needs.

Prior to the new regulations, residents who met the criteria for ICF placement but who needed some skilled nursing services generally could not be served in an ACLF. Early versions of the regulations allowed all residents who qualified for an ICF to be served in an ACLF that obtained an extended congregate care license. The final regulations reached a compromise between the two positions.

MASSACHUSETTS

Background

While other states developed their publicly subsidized assisted living models for those who meet the criteria for placement in a nursing facility, Massachusetts has taken a different route. The state tightened its level of care criteria in 1991. Nursing home residents must have a combination of at least three care needs including one nursing need (at least three times a week) and two ADL needs. In July 1992, a further tightening of the eligibility criteria would have required a combination of four care needs including at least one nursing need, e.g., two ADLs, two nursing; three ADLs, one nursing need. However, the policy was
reversed by legislation despite a gubernatorial veto. To meet the needs of people who are no longer eligible for admission to a nursing facility, the state has supplemented the existing community care programs with assisted living; however, there are no maximum criteria and people who are eligible for nursing facility admission may also be served.

In 1991, two programs were created to complement changes in the criteria for admission to a nursing facility. As the criteria became tighter, efforts to address the service needs of people who were no longer eligible for placement were developed. The Medicaid Division developed a "Group Adult Foster Care Program," or assisted living model. In addition, the legislature appropriated $8.3 million for the Executive Office of Elder Affairs to implement a managed care program for frail elders. The agency decided to develop a program as a companion to the Medicaid Group Foster Care program.

**Group Adult Foster Care**

The Medicaid program was implemented, initially, in existing conventional housing developments in which elders were aging in place. New facilities may emerge as state and federal sources of housing financing are used. Medicaid contracts with approved community agencies (Home Care Corporations/Area Agencies on Aging, Certified Home Health Agencies) or housing management companies were signed to operate the program. Eligible residents are likely to require 24 hour supervision and require routine assistance with activities of daily living. Client eligibility must be approved by the pre-admission screening process and a physician must certify that the resident's health needs can be met in the group care setting. The contracting agency conducts resident assessments and a nurse (agency staff or contract) develops and monitors a care plan. Services can be delivered by the agency staff or through subcontracts.

Medicaid makes two payments to the contracting agency. An administrative rate based on actual approved costs, averaging $18 per person per day, covers overhead and staffing costs (except personal care services) and "other services necessary for the maintenance of a helpful environment, (including housekeeping, shopping, arranging for transportation)." A separate rate of $13.60 per person per day is paid to cover personal care services. (See Table 9.)

**Managed Care In Housing**

The Executive Office of Elder Affairs' program is targeted to elders with incomes under $15,540 for single persons who are not financially eligible for Medicaid, and its Group Adult Foster Care program, and who need supervision and assistance with personal care. The program operates through contracts with 27 Home Care Corporations (HCCs) which administer the agency's home care program. The state appropriation of $8.3 million will fund
850 slots statewide. HCCs receive $814 per client per month to cover administration, case management and direct service costs. Eligible residents are assessed by a multi-disciplinary case management process. Unlike the regular home care program which covers a specified list of services, the HCCs have the flexibility to use managed care funds to provide the most appropriate and cost effective services. Contractors must provide access to 24 hour service and operate an emergency response system. A "responsible person" must be available between 10 P.M. and 6 A.M. and personal care services must be available between 6 - 8 A.M. and 6 - 10 P.M.

Since the programs were developed in separate agencies, housing sites and program contractors have to deal with separate reimbursement schemes, targeting criteria and regulations. However, despite the differences, these programs form a bridge between the existing community care system and assisted living. The state has extensive experience operating community care programs and more than half the clients in the state general revenue funded home care program live in publicly subsidized housing. The managed care program has formalized a series of efforts to address aging-in-place to take advantage of economies of scale which included clustering care managers and service providers and restructuring the delivery of personal care and homemaker services. No longer are individual clients approved for specific hours of care; rather, based on individual assessments, discrete tasks are identified for all participating clients and a total "block" of hours is authorized which allows flexibility and individual variations depending on client needs.

As developers submit proposals for new assisted living projects, the two programs will help support the service costs associated with serving a more frail population.

**New Regulatory Approach**

Since these two programs were developed, state agencies have begun working together to create a new regulatory approach to assisted living. Historically, the state has licensed rest homes that "provide or arrange to provide, in addition to basic care, a supervised, supportive and protective living environment and support services incident to old age for residents having difficulty in caring for themselves and who do not require Level II or III (nursing facility) care or other medically related services on a routine basis." The new approach will maintain a register of facilities which seek to operate as assisted living programs. The register will be maintained by the state housing agency, the Executive Office of Communities and Development. Staff will conduct a paper review to ensure that facilities comply with the filing requirements. Facilities will have to meet program standards set by funding agencies (Medicaid and Elder Affairs) to participate in their programs. Certificate of Need and Department of Public Health licensure are not required.
<table>
<thead>
<tr>
<th>ISSUE</th>
<th>MEDICAID</th>
<th>ELDER AFFAIRS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate</td>
<td>$31.60/day ($13.60 personal care, $18 administration &amp; other services).</td>
<td>$314/client/month to cover services and administration.</td>
</tr>
<tr>
<td>Funding</td>
<td>No limits.</td>
<td>Capped at $8.3 million. Allocation for each HCC.</td>
</tr>
<tr>
<td>Target Group</td>
<td>Aged (65+) and disabled.</td>
<td>Aged (60+) who are not Medicaid recipients.</td>
</tr>
<tr>
<td>Eligibility</td>
<td>Likely to require 24 hour supervision, routine assistance with ADLs.</td>
<td>Elder in need of a managed home environment due to the supervision and assistance with personal care tasks required to maintain them safely in a community setting.</td>
</tr>
<tr>
<td>Certification</td>
<td>Approved by screening process. Physician signs plan of care and certifies that the resident's health needs are met in group care setting.</td>
<td>Approved by multi-disciplinary case management process. Plan of care done by Client Management Team.</td>
</tr>
<tr>
<td>Agency Role</td>
<td>Evaluation, health and care plan monitoring done by staff RN.</td>
<td>Assessment and care plan done by Client Management Team which includes HCC case managers, RN (preference for CHHA contract) and housing manager/staff.</td>
</tr>
<tr>
<td>Service Delivery</td>
<td>Delivered by agency staff or contract.</td>
<td>Delivered through provider contract. Requires a &quot;clustering&quot; of Case Managers, providers and service tasks by HCCs.</td>
</tr>
<tr>
<td>Covered Services</td>
<td>Personal care (assistance with medication management and ADLs); and &quot;other services necessary for the maintenance of a helpful environment which includes housekeeping, shopping, arranging transportation.&quot;</td>
<td>&quot;Maximum flexibility to provide the most appropriate and cost effective services.&quot;</td>
</tr>
<tr>
<td>Service Requirements</td>
<td>24 hour supervision. Emergency response system, daily personal care.</td>
<td>24 hour access to emergency response system. Responsible person available 10 PM - 6 AM; on-site not required; beeper ok; Personal care must be available 6-8 AM and 6-10 PM.</td>
</tr>
<tr>
<td>Agency Staffing</td>
<td>Program director, RN, clerical. 1 caregiver per 10 residents.</td>
<td>NA - See Agency role.</td>
</tr>
</tbody>
</table>
The philosophy outlined in the draft guidelines states that assisted living entities should adopt policies which enable residents to age-in-place. Needed services should be added, increased or adjusted to compensate for the physical or mental status of the individual while maximizing the person's dignity and independence.

The guidelines describe a baseline model that all assisted living entities must meet. A responsible person must be on the premises 24 hours a day. Residents must have access to an emergency response system. Facilities shall provide direct assistance with or reminders to perform any activities of daily living that the entity indicates it will cover. The guidelines allow an organization to set admission criteria by limiting the ADLs it will address; however, at a minimum, entities must provide assistance with bathing, dressing and ambulation and they are "strongly encouraged" to assist with feeding, transferring and toileting. Entities must provide 24 hour response availability to meet an unscheduled or emergency need.

Services must be provided that ensure adequate daily nutrition and are appropriate to the resident's needs. Household services provided include "laundry, floor cleaning, dusting, bed-making, dish washing, vacuuming, cleaning kitchens and bathrooms and shopping."

**Resident Agreements**

Assisted living entities serve elderly (no age specified) and disabled adults. Written agreements of at least one year duration must be executed with residents that address the following issues:

- Responsibilities of the resident.
- Responsibilities of the entity.
- Services included in the assisted living package.
- Supportive services that are provided, as well as services that are not provided.
- Frequency of services.
- The cost of standard and optional services.

The guidelines do not specify the characteristics of residents of who may be served but the resident leases or agreements must describe these characteristics and the responsibilities of the parties for finding alternative living arrangements if it becomes necessary.
Service Planning

Service plans must be developed for each resident. The resident or family member must agree in writing with the service plan. The plan "must address the unique physical and psychosocial needs, abilities and personal preferences of each resident" and describe the services to be provided, the modality of delivery, a service schedule and the purpose and benefits of the service. An assessment of personal care needs must be done by a licensed nurse.

Dealing with Medication

The guidelines require the provision of assistance with medication administration.

"Unlicensed personnel may supervise the administration of medication. This supervision includes: reminding residents to take medication, opening bottle caps for residents, opening pre-packaged medication for residents, reading the medication labels, observing residents while they take medication, checking the self-administered dosage against the label, reassuring residents that they have obtained and are taking the dosage as prescribed, and immediately reporting noticeable changes in the condition of a resident to the resident's physician."

Actual administration of medications may be done by any duly licensed personnel. Facilities must provide locked storage cabinets in multi-bedroom units. Single units must have lockable bedroom doors.

The Ombudsman Program administered by the Executive Office of Elder Affairs will be used to provide advocacy and consumer protection. Its role will be conflict resolution and mediation. Consumer protection issues that cannot be resolved will be referred to appropriate oversight agencies (local building inspectors, fire and safety authorities or to the state consumer affairs agency).

The only physical plant guidelines require that "locations where service is delivered must meet local fire, safety and building codes and applicable state and Americans with Disabilities Act requirements."

This policy has significant implications for the existing supply of rest homes and free standing facilities which were formally licensed as ICFs. Both of these groups will have the option of dropping their current license and operating as assisted living programs. Those facilities which do not convert must continue to meet the standards for rest homes or nursing facilities.
The draft policy was developed to deal with pressing realities. The supply of rest homes has declined over the past several years and costs of upgrading free standing ICFs to meet nursing facility criteria suggested other alternatives were needed. Tightening of the nursing home level of care criteria created a need for an increase in the supply of living and service models to serve those who are no longer eligible for placement. A less intrusive, non-regulatory approach to assisted living has emerged to address each of these areas.

Massachusetts has a supply of 53,288 nursing facility beds and 4,794 rest home beds. Of these, 8,745 nursing home beds are in 180 free standing ICFs and nearly all rest home beds, 4,295, are free standing. The supply in 1980 was 48,808 nursing home beds and 6,461 rest home beds. The number of free standing ICFs was 14,730, almost double the current supply and the number of free standing rest home beds was 4,907. The supply of nursing home beds per thousand people over 65 is 65.0 compared to 67.2 in 1980.26

Housing Financing

Massachusetts has two agencies that provide financing for elderly housing and assisted living. The Massachusetts Industrial Finance Agency (MIFA) is an independent public agency created to issue bonds, insure loans and make direct loans to attract private investment in the state. MIFA is able to finance nursing homes, continuing care retirement communities and assisted living projects. MIFA issues tax exempt and taxable bonds for non-profit and for-profit long term care providers in Massachusetts. Since 1980, the agency has financed $335 million for 58 long term care facilities. As the leading issuer of debt for Massachusetts elder care facilities, MIFA is committed to providing funding opportunities for assisted living facilities.

In reviewing assisted living proposals, MIFA assesses the strength and experience of the manager and developer, the strength of the sponsoring organization, the projected project reserves and the feasibility study. Given the various costs associated with a bond issue, the project size should at least $2 million.

Because MIFA is a dominant issuer of debt for the private, non-profit and public sectors, it offers a well-recognized name in the capital markets. Strong relationships with underwriters, feasibility consultants and lawyers in the field of bond finance and health care enable MIFA to provide new financing options for long term care transactions. MIFA has structured a variety of elder care projects including multi-purpose continuing care retirement communities that involve assisted living programs and hospital sponsored start-up nursing homes.
The Massachusetts Housing Finance Agency (MHFA) has been developing plans to finance housing and service packages, including assisted living, for several years. The program originally planned to use operating and rent subsidies but financing for this component was terminated during the state’s budget crisis. MHFA is now developing guidelines using tax exempt and taxable bonds. MHFA will require that a minimum of 20% of the units be set aside for low income residents. The agency’s statutory guidelines also require apartments with baths and kitchens. The definition of a kitchen is being refined to give developers more flexibility to offer models that allow varying balances between use of a meals program and meals prepared in the resident’s unit.

MHFA may become a resource for ICFs and rest homes seeking funds to renovate buildings to convert to assisted living programs. Without rent subsidies, facilities with high public occupancy rates may need a substantial shift to private pay residents to generate sufficient cash flow to repay the MHFA mortgage. Depending upon the size of the mortgage needed to complete the renovations, the current SSI payment standard may not support the public/private occupancy mix in most free standing ICFs and Rest Homes. However, the home care program administered by the Executive Office of Elder Affairs, which serves frail elders with incomes up to $15,540 for a single person, creates an opportunity for elders with incomes above Medicaid to afford a higher room and board rate. The service package for these residents could be covered by the Managed Care in Housing Program, however, the program is capped each year by the appropriation and it may not be accessible to developers when construction is completed.

In addition to these efforts by agencies responsible for housing financing, the state Division of Capital Planning and Operations has contracted for a study of the feasibility and options for converting surplus state property to assisted living. The study is reviewing elderly population trends, and current housing, health and financing options for elders. The study will also review the regulatory, financing and programmatic changes needed to facilitate such a conversion and the costs to the state of such policy changes. The details of the program are being developed in the context of state policy on assisted living and the available financing sources. The value of the land might be used as an incentive to make a portion of the units available to low income residents.
Summary of State Programs

Assisted Living Does Vary from Board and Care

Much of the present confusion stems from the absence of a universal, commonly accepted or mandated definition of assisted living. In addition, regulatory definitions and the nomenclature of board and care programs also vary widely. As a result, states can determine what assisted living will be, how it will operate, who it will serve and who can be served. While it may be difficult to define assisted living as distinct from board and care, the continued use of the terms interchangeably masks some important differences. Key variables are the philosophy of operation, the range and intensity of services provided, the residents who can be served and the design of the units and the building itself. As noted earlier, state policy leaders can choose from incremental steps that add services to existing housing models to definitions that encompass all components of assisted living. At a minimum, broad definitions will include models that add services to existing conventional housing buildings, congregate housing and licensed board and care programs. As a state’s definition covers more components, the more it varies from traditional board and care. Further steps can be taken to change the philosophy and the focus of regulation.

States can follow combined approaches. Policies and programs that add services to existing housing programs can and will be used as developers seek financing for new programs following housing financing guidelines which require full units (living area, bedroom, bath and kitchen capacity). This path will leave states with a wide range of programs that could be called assisted living. However, projects that offer full units may want to differentiate themselves from providers offering added services to double occupancy (and higher) units without kitchenettes and baths.

States adopting a "parallel policy track" would define assisted living as distinct from board and care and include all the components. At the same time, states would also add services to existing board and care and other supportive housing programs without calling them assisted living.

State officials are very practical. They develop pragmatic approaches to solve pressing problems. States often cannot delay policy initiatives or decisions until the results of lengthy research and demonstration programs are known. A series of incremental steps are more likely to emerge than large-scale policy revisions. Imperfect programs that can be improved and modified as experience dictates are preferred over extensive delays until "the perfect solution" can be developed. In this context assisted living has emerged in several states as a practical step to address the increasing frailty of board and care residents who are "aging-in-place." Still, policy makers have to be mindful of the medium and long range implications of
and opportunities created by their efforts to address today's financial and service pressures with the tools available to them now. Programs developed for the existing housing supply will be explored by developers and other providers who see new directions emerging in government policy.

States that develop assisted living in facilities that are unchanged in appearance from their operation as board and care type facilities contribute to the confusion. This is not a criticism of state efforts. Indeed, assisted living emerges in varying environments that are not replicated across state lines. Florida's program creates a new operating philosophy and broader services within its residential care program. New York requires higher service levels, more training for staff and other important improvements. States that increase the services provided in board and care facilities will make a real difference in the operation and services of these facilities. However, implementing assisted living within the existing stock of board and care facilities may hamper its image and emergence as a distinct model. As states continue to license assisted living, the requirements that apply can differ. Oregon and Washington distinguish assisted living from board and care by requiring units that are larger than required in their board and care guidelines and requiring baths and cooking capacity within each unit and higher levels of service. These decisions have been facilitated through coordination with their housing finance agencies to generate new construction.

Four states developed policies to serve nursing home eligible Medicaid recipients in assisted living programs. Though providers will be encouraged to serve nursing home eligible elders in Massachusetts' assisted living programs, the programs were developed to serve elders who are no longer eligible for placement in a nursing facility. States have designed their policies to enhance the current supply of board and care, adult care facilities or equivalent facility. As a result, two states set standards for unit size and configuration which mirror those of existing programs. These are minimum standards and the actual "look" of a facility may depend less on the state standards and more on the adequacy of financing to support the design and furnishing of units that are "home-like." Facilities built and marketed to private pay residents are licensed but exceed the minimum standards in order to attract residents. As the occupancy rate of publicly supported residents increases, the design and amenities of the building will reflect the cash flow generated by public programs. To succeed, state policies must combine and balance building standards, private/public occupancy mix and state/federal subsidies for services, income support and mortgage enhancements.

States have used existing housing and service financing programs to develop remarkably different programs. While only Oregon has intentionally encouraged new construction, state housing finance agencies and service agencies have the tools to collaborate and set priorities for the use of state tax exempt and taxable bonds and tax credits to attract developers to start
| Table 11. Comparison of State Assisted Living Programs and Policies for Public Residents |
|-----------------------------------------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| Status                                        | Oregon          | Washington      | New York        | Florida         | Massachusetts   |
| Operating requirement                        | Operating       | Operating       | Fall start up   | August start up | Operating(1)    |
| Source of service financing                  | Medicaid waiver | Medicaid waiver | Medicaid state plan | Medicaid waiver | Medicaid state plan and Home Care Program(2) |
| Income eligibility                           | Medicaid Special Income Level(3) | Medicaid Special Income Level(3) | Community standard | Medicaid Special Income Level(3) | Medicaid: community standard; HC: program, $15,540 |
| Resident functional standard                | Nursing facility eligible | Nursing facility eligible | Nursing facility eligible | Nursing facility eligible | 24 hour supervision, ADL assistance, need for managed home environment |
| SSI monthly payment                          | $423.70         | $450.00         | $857.00(4)      | $633.00         | $551.00(5)      |
| PNA(6)                                        | $63.00          | $38.84          | $94.00          | $35.00          | $65.00          |
| Service rate                                 | $156 - $1123 a month based on functional evaluation(6) | $965.70 a month | 50% of RUG category; est. $900-$1410 a month(7) | 50% of nursing home rate(8) | Medicaid: $31.60/day; Home Care, $84/month |
| Program authority                            | Agency regulations & financing | Legislative appropriation, agency provider contracts | Legislation and regulations | Legislation and regulations | Agency financing and program guidelines(9) |
| Services allowed                             | Any service provided in a nursing facility | Specific nursing services from regulations | Nursing, home health, personal care, et. al. | Specific skilled services listed in regulation | No specific exclusions |
| Services excluded                            | 24 hour skilled nursing | 24 hour skilled nursing | 24 hours skilled nursing | Specific skilled services listed in regulations | 24 hour skilled nursing. Home health, adult day health are limited under Medicaid |
| CoN                                           | No              | No              | Modified        | No              | No              |

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CVP

50
(1) Financing programs initiated in 1991; assisted living policy statement and registration requirements pending.
(2) Funded from state general revenues.
(3) 300% of the federal SSI payment, in addition to categorical eligibility groups.
(4) Rate for New York City, Nassau, Suffolk & Westchester Counties, $827 in all other counties.
(5) Creation of a new living arrangement and higher payment standard is pending.
(6) Personal Needs Allowance.
(7) There are 16 separate RUG categories and the rates vary among 16 regions throughout the state.
(8) Projected payment rate will range from $30-$47 a day.
(9) Legislation may be filed for the next session.
(10) Total rate of $517 - $1483 includes resident’s share for room and board that is covered by the SSI payment.
(11) Total rate, including SSI share, is calculated at $45.90 a day. The example assumes a 30 day month.

new facilities. In the absence of collaboration, developers, housing management agencies and service agencies may develop proposals for new projects, independent of state direction, utilizing a combination of funding sources.

Policies Reflect State Differences

State programs reflect their own unique environments and circumstances. With a strong legislative mandate to develop assisted living, Florida’s regulations contain an extensive list of services that can and cannot be provided in assisted living. The compromise regulations reflect a change in the political climate, opposition from segments of the nursing home industry that emerged subsequent to the passage of the legislation and the public process through which regulations travel. Policy in New York and Washington contain similar, though not as extensive, lists which limit who can be served more so than in Oregon’s program. The Massachusetts draft policy suggests an open-ended policy regarding the target population.

Administration of medications for impaired populations is a major concern. The borders between nursing facilities and board and care facilities are often drawn by how and by whom medications are administered. Distinctions among administration, assistance and supervision of medications often blur in practice. The spirit of the provisions is often easier to follow than the letter. State policies generally allow extensive assistance with self-administration of medications and appropriately licensed personnel are allowed to administer medications in
accordance with their license. Oregon has benefitted from legislation that allows nurses to delegate procedures to other staff.

Most states rely on Medicaid to pay for services. Florida, Oregon and Washington will utilize their home and community based care waivers to pay for services. New York, which does not have a waiver for its elderly recipients, will provide a flat capitation payment for state plan services provided in assisted living facilities. The supportive services, which are required by regulation (housekeeping, limited personal care, laundry, activities), are covered by a higher SSI payment rate. States could develop programs with state general revenues to divert elders with incomes near but above Medicaid levels and avoid the nursing home costs for those who spend down.

Policy Options

Aggregate Cost

The primary issue facing policy makers is how to meet growing human needs with limited funds. Policy makers face conflicts between cost effectiveness and fulfilling the intent of a particular program. Maximizing revenue, usually from federal sources, is a popular route for budget stressed state officials. Medicaid is frequently used as a vehicle to access federal reimbursements while it is criticized for its increased spending.

Policy makers examine the cost of individual programs and the aggregate cost of programs that cross agency lines in considering their options. Costs are a function of several factors: services covered, supply, reimbursement rates and methodology, eligibility thresholds (income, assets, functional and health) and participation rates. States may be concerned that a new supply of long term care services will increase the total number of people served at state expense. States establish policies to limit these factors to control spending. Spending levels are often acceptable if they can be predicted and managed. Policies which expand assisted living may be combined with steps to curtail the supply of nursing facilities. States have attempted varying strategies to control spending. Oregon has decided to control nursing home spending by creating an adequate supply of the most desirable alternatives. Oregon's policy is premised to some extent on competition and an expectation that occupancy rates in nursing facilities will decline as consumers have other options. The number of Medicaid recipients in nursing homes in Oregon has declined from 8,400 in 1981 to 7,640 in 1992. The supply of beds per thousand in Oregon and Washington has also declined. Given an adequate supply of assisted living projects, recipients will usually select assisted living over a nursing facility. The desired level of supply may take several years and the proper financial incentives and targeting to generate.
Massachusetts took a different approach. Tighter nursing home level of care criteria produced more immediate savings by limiting who is eligible to enter a nursing facility. The state has accompanied this policy change with new assisted living programs that are intended to create additional housing and supportive service options in the community. Over time the supply of assisted living will expand and nursing home occupancy rates, which have dropped 2%, may continue to decline.

States often premise their policy decisions on the basis of cost to a specific program. Medicaid officials, who must create budget and service options in the context of their own budget, are often unable to control resources that serve people who are not eligible for Medicaid. However, serving people who are just above Medicaid eligibility thresholds prevents frail elders from becoming recipients once they enter a nursing home and "spend down." States agencies that are able to work together can develop complementary policies and programs that increase spending in one agency or program in order to save a greater amount in another agency. An increase in general revenue programs for elders just above Medicaid eligibility levels may prevent placement in nursing homes at a higher net state cost to Medicaid. Policy makers would be well advised to consider net state cost as they decide whether or not to expand a program and expand state revenues since new expenditures may create savings elsewhere. Net state cost is a principle that extends beyond individual programs.

The Massachusetts Office of Elder Affairs’ assisted living program uses state general revenues to serve non-Medicaid elders with incomes up to $15,540 for a single person. If it was targeted to elders who are eligible for admission in a nursing facility, it would produce more direct savings to Medicaid. However, until the supply of affordable assisted living expands, units in the existing private, market rate facilities would have to be accessed to achieve direct savings. As supply does expand through MHFA and MIFA financing, the program may offer more impaired elders a lower cost option to nursing home placement through this program.

Assisted living presents numerous conflicts and obstacles. Neither institutional nor strictly housing, it must adapt to the rules and constraints of existing financing programs. Since Medicaid is primarily a health program, financing the shelter component is acceptable in a health related institution even though perhaps the majority of nursing home residents receive functional support which is primarily non-medical care. If assisted living provides a "home-like" environment that clients prefer and is cost effective, as state experience suggests, Medicaid policy leaders have a self-interest in developing assisted living programs that substitute for nursing home use. Yet they must rely on other sources of funding (SSI and the range of housing programs) to develop the supply. Budgetary purists will claim that states will save money in the aggregate only if the expenditures for both assisted living and the
remaining nursing home residents fall below the amount that would otherwise have been spent in nursing homes alone. This approach focuses on real, current supply, not demand or future increases in supply based on rising demand/need. Similar arguments have been applied to the Medicaid Home and Community Based Waiver programs since their inception. The argument assumes that long term care policy is stagnant and the supply of services expands in a linear fashion in the absence of new options, or that state action to expand supply, and its costs, can be predicted based on past experience. Instead, policy should be based on the premise that government will continue to spend resources to address demand fueled by demographic trends and that program and spending decisions should be based on the most cost effective and appropriate resource mix for consumers.

With today’s rules, states can expand Medicaid eligibility for community services such as assisted living by selecting the Special Income Level option (see page 82). This allows states to provide supportive services through 2176 waivers to assisted living residents. States with higher average room and board costs can set higher maintenance amounts that allow a recipient to pay the rate while the service costs are paid by any remaining resident income and Medicaid funds. Since acute care will be covered by Medicare, and eligibility is targeted to nursing home eligible recipients, spending can be controlled. True savings will accrue if actual nursing home occupancy rates decline, supply declines in part through conversion of nursing facilities to assisted living programs or future growth rates in the supply are reduced.

Other steps can be taken to control expenditures. Appropriation limits, regulatory standards and contracting provisions, rather than certificate of need or other measures, can be used to control the supply of assisted living facilities in order to manage total costs.

Shelter costs

Though providers will debate its adequacy, many current SSI state supplementary payment standards provide a reasonable source of funding for shelter costs. States generally use their payment standard for aged recipients living alone. New York uses the higher rate for Congregate Care II living arrangements. However, the rate reflects both the shelter and service costs required by the Adult Care Facility regulations. Massachusetts is considering setting a higher payment standard for assisted living. States might undertake a review of shelter and service costs in assisted living projects to assess the adequacy of SSI payment standards to cover actual room and board costs. On average, room and board costs account for half the total rate. State housing finance agencies or other organizations that provide financing for board and care or assisted living projects may be a source of data for this analysis.
States have several options to use SSI while retaining a favorable "net state cost" at least in states with a 50% Medicaid reimbursement rate. The federal SSI payment is $422 a month for an individual. States may supplement the federal payment at 100% state cost. States with a 50% Medicaid matching rate can set their state supplementary payment standard up to $844 a month and remain cost neutral compared to Medicaid. In other words, Medicaid payments can cover room and board in an institution but not in assisted living or the person's own home. If the room and board portion of the cost in assisted living totalled $844 a month, the state's net cost would be the same for both a nursing facility and an assisted living program. A state with a 60% federal matching rate remains neutral at a state SSI benefit of $704 a month. However, these figures must be adjusted for the personal needs allowance.

SSI based programs can leave a substantial gap between very poor elders receiving SSI and elders with incomes that are sufficient to cover the market rate for assisted living. Without housing subsidies, there are few options for this group.

Conclusion

In short, some states are upgrading building design standards, increasing service financing and developing programs to replace nursing homes for 30-40% of the nursing home population. Some policy leaders believe the replacement potential may be as high as 75-80%. Other states are improving the services provided to board and care residents who are aging-in-place. Still others are developing assisted living to offer new options to elders in the community. While these valuable efforts are implemented, states can also collaborate with housing finance agencies to expand the supply of projects that reflect the design standards of assisted living. Modifying Medicaid eligibility rules under home and community based waivers and adjusting state SSI payment standards are two avenues to increase access to "market rate" facilities. These steps may also increase the financial feasibility of projects financed by housing finance agencies and HUD programs by increasing the amount of income available to cover shelter costs while qualifying residents for Medicaid service packages.

IV. SOURCES OF HOUSING FINANCING

Government financing for rental housing developments, including assisted living, takes a variety of forms. Financing is available for development and operating costs. Development costs include the purchase of land, "soft" costs (designing and legal fees), site development and construction. Financing is available to cover debt service (construction loans) and to supplement tenant payments. Federal and state resources, described in this chapter, offer a
variety of mechanisms to cover some or all of the cost areas, cash grants, donations of land and/or buildings and loans.

**Federal Programs**

**Section 202 Supportive Housing for the Elderly**

Formerly known as Housing for the Elderly and Handicapped, this HUD program has been in operation since the 1960s. The National Affordable Housing Act of 1990, however, made significant changes (effective October 1, 1991), including replacing the combination of mortgage loans and Section 8 rental subsidies with capital advances and "project rental assistance," and creating a separate program for housing for persons with disabilities (Section 811). In addition, provisions that address supportive service needs make it more feasible for 202 funds to be used for certain assisted living facilities. The program is open to private, nonprofit housing developers or consumer cooperatives proposing projects of up to 125 units, with a 40 unit minimum for projects in urban areas.

The capital advances are essentially grants which need not be paid back if the development meets very-low-income occupancy targets for 40 years. Advances are available to cover the costs of construction, rehabilitation and certain acquisitions.

The amount of the capital advance is determined by per-unit development cost limits established by HUD. As an example, a one bedroom unit in a building with an elevator would currently qualify for $33,816 in funds. An efficiency unit qualifies for $29,500. These cost limits will be revised periodically by HUD to reflect changes in construction and rehabilitation costs. In addition, Field Offices have the authority to adjust these limits where necessary by the "high cost factors" used in other HUD programs. The maximum adjustment is 240%.

Example: Worcester, Massachusetts has a high cost factor of 200%. The development cost limit for a one-bedroom unit in an elevator building is, therefore, $67,632. A project of 50 one-bedroom units would be able to apply for a maximum of $3,381,600 in capital advances.

In determining per-unit amounts, certain design elements and amenities (e.g. balconies, decks, dish washers, trash compactors, washers and dryers in the units and common space that exceeds 10% of the gross square footage) are ineligible for HUD funding. The
maximum unit size is 415 square feet for efficiencies and 540 square feet for one-bedroom units. These design restrictions may, however, be waived if the owner can pay for the additional elements from other "non-federal" sources. If funds for these extra elements are borrowed, the sponsor must obtain HUD Field Office approval to ensure that the loan does not provide the lender with control of the property, or increase the need for HUD funds (e.g., the project rental assistance amount must not be used to repay the loan.)

Project rental assistance is based on operating cost standards, determined regionally, which are adjusted periodically by HUD to reflect changes in housing costs (using "appropriate indices such as the Consumer Price Index"). For example, the current standard for the Boston region for fiscal year 1992 is $4,080 per person per unit. No adjustments are made for the size of the unit. Since no projects currently operate under the revised 202 program, it is not clear whether the periodic adjustments will in fact keep pace with increases in operating costs.

Eligible residents for 202 buildings are households with at least one person age 62 or over and with a household income at or below 50% of the area median income, as established by HUD. Residents pay no more than 30% of their income for rent and may contribute up to 20% of their income for services.

Example: In the Worcester, Massachusetts area, 50% of the HUD established median annual income for a one-person household is $15,100. A resident at the maximum eligible income would pay no more than $377 per month for rent and up to an additional $252 for services. Another resident, whose income is $10,000, would pay no more than $250 for rent and $167 for services. An SSI recipient in Massachusetts would pay $165.30 a month.

The HUD project rental assistance provides $340 a month. Rental income for such a unit will range from $505-$717 a month from HUD and SSI.

Services and eligibility

The program requires that services be provided, including but not limited to: meals (which must not be mandatory), housekeeping, personal assistance, transportation and health. No medical personnel are allowed on staff, however, and any health-related services must be

"Assisted living models can be adapted and used in HUD housing," Jerold S. Nachison, HUD.
based in the community rather than the project. The policy allows preventive health screening, wellness clinics, and care for episodic health problems. Residents may access services offered by the certified home health agency, for example, but the project itself cannot offer continuous medical services. Fifteen percent of the service costs, up to a maximum of $15 per unit, per month, is available through the Project Rental Assistance Contract for the service costs of qualifying "frail" elderly tenants.

Frail elders are currently defined in the Program Handbook as persons with limitations in at least three Activities of Daily Living (ADLs) as established by HUD, which include eating, bathing, grooming, dressing and home management. Toileting, which is frequently included as an ADL in other state and federal programs, was specifically omitted. HUD’s position is that incontinence is a health problem and not within the scope of HUD’s housing programs.

The position of service coordinator may be covered through the operating budget if at least 25% of the residents in the development are frail or "at risk" (have limitations with at least one ADL and are in danger of premature institutionalization). Coordinators may serve the entire resident population regardless of their fraility.

Application process and criteria

Each HUD Field Office receives an annual allocation of units. Prospective developers must apply to the appropriate Field Office according to the national timeline and proposals compete with other proposals in the same geographic area (metropolitan with metropolitan and non-metro with non-metro). Each Field Office is responsible for a preliminary review of applications for completeness and for threshold requirements involving the sponsor, the site, the market area, and the proposed project. Applications which pass this technical review are scored by standard rating criteria covering:

1. The Sponsor’s ability to develop and operate the proposed housing on a long-term basis (20 points maximum);

2. The Sponsor’s financial capacity (25 points maximum);

3. Need for supportive housing for the elderly in the area to be served and the desirability of the proposed site (20 points maximum);

4. Project design (15 points maximum); and

5. Provision of supportive services (20 points maximum).
These scores are submitted to the appropriate Regional Office, which ranks projects within each Field Office allocation area (with separate lists for metro and non-metro). A minimum of 50 points is required for selection and funds are allocated to projects as far down the list as there are funds available. During FY 1991, funds for 9,389 units were available nationally and in 1992, 10,500 units.

**Assisted living implications**

The 202 revisions take a significant step in dealing with aging-in-place. Funding is limited and the tradition of funding conventional housing poses obstacles to a building in which all of the units were assisted living. HUD funding for community space is limited to 10% of the total square footage, yet the norm for assisted living is 30-40% of total square footage. These projects cannot be seen as institutions and the presence of residents with nursing needs creates a gray area in HUD policy. While owners and managers cannot employ a nurse to provide the care, nursing services can be provided by outside agencies to 202 residents. In addition the HUD guidelines do not include transferring or continence in its list of ADLs and presume that residents who need care with continence are not appropriate for these facilities.

Despite these limitations, 202 buildings could include a wing or a section of the building designed as assisted living. Designating portions of a building may enable a project to meet the 10% limitation for common space. 202 projects have a tremendous advantage over other financing sources - rent subsidies for low income tenants. The rent cap, 30% of income, leaves residents with additional discretionary income that can be applied to service costs, a particular advantage for residents who are not eligible for SSI. Very frail elders, who meet the criteria for placement in a nursing facility, and who have incomes under $1,266 a month ($15,192 annually) could be served if the state’s Medicaid program elects the Special Income Level eligibility option. Cost sharing for services covered by Medicaid will have to be reconciled with Medicaid cost sharing policies.

**Highlights**

✓ Conducive to organizing assisted living services through provider contracts.

✓ Good targeting to low income residents.

✓ Rent subsidy leaves residents with income to apply to service costs.

✓ May need other financing for extra common space.
Some service eligibility gaps for non-Medicaid residents.

Potential conflicts with Medicaid cost sharing requirements.

Section 232 Mortgage Insurance

This HUD/FHA program was originally designed for nursing homes and intermediate care facilities. In 1985 the program was expanded to include board and care homes, defined as "a type of residential facility that provides room, board and continuous protective oversight" for "individuals who cannot live independently, but who do not require the more extensive care offered by intermediate care facilities or nursing homes." Many assisted living facilities would qualify under this definition. The mortgage to be insured can cover new construction or substantial rehabilitation by a for-profit or a private non-profit mortgagor. Public entities (such as local housing authorities) are not eligible. The official HUD handbook for the 232 program has not yet been revised to include board and care homes, but special requirements and instructions are available in a HUD Notice. It should be noted that some of these requirements are based on past problems HUD experienced with insuring housing with services under the Retirement Service Center (ReSC) portion of the 221(d) insurance program for rental housing, which has been discontinued.

As a mortgage insurance program, Section 232 can assist developers in securing long term mortgage loans which include the construction period, but it does not provide for rental assistance or ongoing operating subsidies. Under the program, a developer/owner locates mortgage financing through a bank, mortgage company, state housing financing agency, or other lender approved by FHA (which makes lists available through Field Offices) and the developer and the lender then pursue the insurance through the appropriate HUD Field Office.

There are three processing stages: site appraisal and market analysis, which requires site control; conditional commitment, after a loan has been approved by a lender; and firm commitment, by which time final architectural designs are required. A relatively new "delegated processing" option allows certain approved lenders to undertake much of the processing themselves and may shorten the total application time. Fees apply at various stages of processing, from both FHA and the lender. The mortgage insurance premium rate is .5%. Mortgages insured under 232 have a maximum 40 year term and a 90% loan-to-value ratio.

Example: One private mortgage company currently financing board and care facilities insured with 232 is offering a 40 year mortgage rate of about 9%. These
facilities have resident payments between $80-90 a day and development costs which vary considerably depending on the physical design of the building.

To be eligible as a board and care, the facility may have shared bedrooms and baths (for up to four people) or individual efficiency or one-bedroom apartments. Even if individual apartments are provided, however, the building must have central dining, kitchen, lounge and recreation areas. A 232 board and care facility must offer "continuous protective oversight" and three meals per day, which are mandatory for residents in units without kitchens. Residents in efficiency or one-bedroom units are required to take at least one meal per day. Meals may be brought in from another location or may be prepared on site, but the facility must have either a full service kitchen or sufficient building space (or adjacent land) to allow for the eventual installation of one if it becomes necessary. Additional services can include, but are not limited to: housekeeping, laundry, supervision of nutrition or medication and assistance with daily living (such as bathing, dressing, shopping or eating).

There are no income limits for residents set by the program, or limits on rents and charges. When reviewing applications, HUD looks at comparable facilities in the area to determine if the charges being suggested are marketable.

Assisted living implications

This financing source is expressly directed toward nursing facilities and board and care programs. It can be adapted to some assisted living programs and it allows, but does not require, a developer to focus the subsidies derived from a lower mortgage rate on low and moderate income residents. Program guidelines limit its application to assisted living programs that provide single occupancy units with kitchens and baths. Per unit cost calculations force developers to design double occupancy rooms without kitchens unless other financing is available for the extra costs. The 10% equity requirement makes it difficult for non-profit organizations to comply.

Highlights

✔ Compatible with some assisted living models.

✔ Does not provide funding for services.

✔ Program has a track record with board and care programs.

✔ No income eligibility requirements.
Congregate Housing Services Program

The HUD Congregate Housing Services Program (CHSP) provides housing and supportive services to low income frail elders. Administered by HUD (and a portion of the funds will be made available through the Farmers' Home Administration), it bridges the housing and service systems by including funding for services. The Act recognizes that 20-30% of residents in federally assisted housing have some form of frailty and that "the effective provision of congregate services may require the redesign of units and buildings to meet the special physical needs of the frail elderly." The 1990 amendments revised the program and may encourage developers/owners of existing projects to apply for the program. The Act lists eight general purposes of the amendments:

- Retrofit existing buildings to meet the special physical needs of residents.
- Create and rehab congregate space to accommodate supportive services.
- Improve the management capacity to assess service needs and coordinate supportive services.
- Provide services that prevent premature and inappropriate institutionalization.
- Provide readily available and efficient supportive services through an on-site coordinator.
- Improve the quality of life for residents.
- Preserve the viability of existing affordable housing for low income residents who are aging-in-place.
- Develop partnerships between the federal and state governments in providing services to frail elders.
- Utilize federal and state funds in a more cost-effective and humane way.

Eligible applicants and projects

States, local government agencies and local non-profit agencies are eligible to apply for five year grants for service coordination and supportive services. The funds may be used in Section 202, 236, 221(d), Section 8 and public housing projects. Approved sponsors may contract with other agencies to implement the service program.
Use of funds

Funds may be used to retrofit an existing building by widening doorways, relocating light switches, outlets, thermostats, and other environmental controls, installing grab bars in bathrooms or reinforcing walls to allow later installation of grab bars, redesign of useable kitchens and bathrooms to permit use by people in wheelchairs and other adaptive designs that meet the needs of frail older people. Retrofit activities also include creating space to accommodate the delivery of supportive services.

Service coordinators

These positions are responsible for chairing a professional assessment committee, working with service providers to meet resident needs, mobilizing public and private resources, and monitoring and evaluating the impact of services.

The professional assessment committee consists of at least three people appointed by housing management and include medical and other health and social service professional competent to appraise the functional abilities of frail elders. The committee determines resident eligibility for services (three or more ADL impairments).

Services and delivery

Grant funds can be used for transportation, personal care, dressing, bathing, toileting, housekeeping, chore, non-medical counseling, group and socialization activities, assistance with medication (in accordance with state law), case management, personal emergency response and other services. Meal service must be offered to residents and coordination with the nutrition program under Title III of the Older Americans Act is encouraged. Title III nutrition providers receive preference for providing meal services in a congregate housing facility.

Services are intended for residents with three or more ADL impairments. However, the law allows other residents to receive services if the housing manager, service coordinator and professional assessment committee determine that their participation will not adversely affect the provision of services to residents with three ADLs.

Resident fees will cover 10% of the service costs. Fees for meals may be set between 10% and 20% of the person's adjusted gross income if they receive one meal a day. Residents receiving less than one meal a day pay 10% of their adjusted income.
Funding

The HUD funds for new projects will cover 50% of the cost of the program. The remaining 50% must come from resident fees (10%), in-kind contributions or state or other sources (40%). Fees may be waived for residents who cannot afford them. These conditions do not apply to existing programs. Housing owners, or states on behalf of owners, may apply for funds.

Status

Regulations and a program handbook to implement the revised program were expected to be issued in the fall. A Notice of Available Funding was expected by early October to fund about 100 projects nationally, the first new round of funding in over a decade.

Assisted living implications

CHSP facilitates aging-in-place though it has many of the characteristics of assisted living - individual units with baths and kitchens, and primarily as a housing program, it does not require licensing. Many residents with three ADL impairments are also likely to have health conditions that require skilled monitoring. HUD’s concerns about delivering medical care are likely to limit the nursing services that can be delivered with project funds. The program mirrors many of the components of assisted living though the percentage of residents who meet the criteria for placement in a nursing facility will be higher in assisted living than in CHSP projects.

Highlights

✔ Designed to assist frail elders to age in place.

✔ Provides funds to retrofit existing buildings to accommodate frail residents.

✔ Provides 40% of the funding for services.

✔ Requires collaboration between housing providers and service programs to obtain full funding for services.

✔ Funding available for program expansion.

✔ Program could be strengthened by adding the ability to provide some skilled nursing services.
Farmers’ Home Administration

The Farmers’ Home Administration (FmHA) provides development loans and rental assistance for congregate housing and group homes for people 62 and older and people with disabilities. Loans may be made to a variety of organizations, state or local public agencies, consumer cooperatives, individuals, trusts and associations. Loans are generally made in towns with populations of less than 10,000. Loans may be made in areas with populations between 10,000 and 20,000 if the area is not part of a standard metropolitan statistical area or adjacent to one. Funds are allocated by state and awarded by local FmHA offices. Loans under $1.5 million for less than 25 units can be approved at local offices. Loans above these limits must be approved by the central office. Loans may be made for up to 50 year terms. Public agencies and non-profit organizations may receive a loan for the entire cost of a project. Other borrowers must provide three percent equity. Applicants must provide initial operating capital equal to two percent of the total project cost which may be included in the loan for non-profit and government organizations. Project cost per unit is considered in relation to area costs. For example, the average cost per unit for New England projects is $55,000 to $60,000.

Projects include private apartments (about 550 square feet) with central dining rooms. Projects must be located as close to service providers and shopping as possible. Units must include bathrooms and a kitchen that includes a cooktop, stove, sink, refrigerator and food preparation surface. Units must be equipped with an emergency call system. The program encourages borrowers to work with architects experienced in adaptive design and congregate housing concepts. Loans may be used to build, purchase or renovate housing.

Tenants must not be totally dependent on others and must be able to vacate a unit in an emergency, and have the legal capacity to enter into a lease. Projects must provide at least one meal a day, seven days a week, transportation, routine housekeeping, personal care, recreation and social activities. Personal services are defined as nonmedical services which can include personal hygiene, nutrition counseling and general health screening. It does not include “recurring medical assistance such as dispensing medication or constant medical supervision.” Projects are encouraged to collaborate with state and area agencies on aging. Borrowers may also contract with home health agencies, hospitals, nursing homes and other organizations to provide services or they may hire staff directly. The service package must be affordable to low and moderate income tenants. Projects may not serve anyone who need continuous medical or institutional care.

All tenants must meet the income eligibility criteria which are related to area median income. Tenants pay 30% of their income for rent in projects participating in the rental assistance program.
Assisted living implications

✓ Requires source of financing for services.
✓ Tenant income may be able to support limited service needs.
✓ Designed for tenants with limited service needs.
✓ Emphasis on specialized design and management requirements.
✓ Requires policy changes to address needs of moderately to severely impaired tenants.
✓ Guidelines allow space for service providers.

Federal Funds Administered by States

Low Income Housing Tax Credits

The Tax Reform Act of 1986 created a new tax incentive program for investment in low-income housing. The Low Income Housing Tax Credit (LIHTC) allows owners/developers of mixed-income rental housing to receive credit against tax liability. This program, administered by the U.S. Treasury Department, is intended to improve on past forms of tax "shelters" (such as accelerated depreciation) by creating a more direct connection between the amount of tax benefit taken and the amount of low-income housing created and by increasing the targeting of the housing. The sale of credits to individual or institutional investors raises upfront cash for a project (equity which can be used to reduce the amount of debt financing required). It provides investors with credit against their own tax liabilities over a 10 year period. State credit allocating agencies (most frequently the state housing finance agency) establish additional restrictions, targeting goals and requirements for developments using tax credits, schedule competitive funding rounds and monitor compliance with both state and federal regulations. Some states have established targeting goals that include a variety of special needs housing.

Example: The Washington State Housing Finance Commission included 10 points in its initial scoring system for projects in which at least 10% of the units were reserved for special needs groups (including elderly) and which included a referral and marketing agreement with a service provider and a monitoring agreement. That year, 47% of projects allocated credits fulfilled this criteria. [The points have since been increased for this item.]
An allocating agency may also set-aside a portion of the total allocation for certain types of housing projects. Ranking systems and set-asides may change from year to year to reflect shifting state priorities, practical experience (e.g., if no applications are received for set-aside allocations, they may be eliminated in ensuing years), or federal requirements.

The maximum amount of credit is calculated as a percentage of the funds spent on the "qualifying basis" - the low-income portion of the housing development, including construction, rehabilitation and/or acquisition costs. The percentage varies according to several factors, including type of development (new construction and substantial rehab receive a 9% credit while acquisition or projects that make use of other federal funds only receive 4%). The applicable percentage applied to the qualifying basis establishes the maximum amount of credit which may be allocated to a proposed development and that amount is then reduced by the allocating agency to the minimum amount required for financial feasibility. In 1991, the average allocation was $4,000 per unit, with investors paying roughly 45 cents to the dollar of credit.

The total volume of tax credits is controlled by Treasury in two ways. There are credits available under an annual state volume cap, administered by state allocating agencies and also credits available for projects financed through tax-exempt bonds, which are themselves subject to state volume caps. Since its creation, the LIHTC program has required frequent reauthorizations by Congress. The latest reauthorization was for a six month period and was due to expire in June of 1992. As of July, the pending House bill would provide the program permanent status and the Senate bill authorizes an 18 month extension.

Minimum occupancy requirements reserve 20% of the units for residents at or below 50% of the area median income, or 40% of the units for residents at or below 60% of the area median income. Rents on these units are capped at 30% of the qualifying income level rather than the resident's income.

Example: A 50-unit building in Worcester, Massachusetts includes 20 units (40%) targeted for elders at or below 60% of median income (approximately $18,120 for one person, $20,760 for two). Rents on units occupied by an income-qualified single person could not exceed $453 and for two people $519, regardless of the actual income level of the resident.

These restrictions are "locked in" for a minimum of 15 years, with the program incentives encouraging even longer periods.

Service charges may come under the rent cap in certain situations. According to an IRS ruling, services which are mandatory are considered a condition of occupancy and therefore
the cost could not be used to increase the resident's rent beyond the established level. The

cost of a mandatory meals program, for example, would need to be covered in the rent (30%
of the qualifying income level of 50% or 60% of median) or would have to be covered by
state programs or other sources.

Assisted living implications

LIHTCs are more difficult to apply in assisted living than 202 or 232 programs. This
program may be more suited to a project for less impaired residents or a mix of independent
and less impaired residents. In this way services may be offered on a voluntary basis and the
costs would not be covered by the rent. Yet rents, though capped, are higher for low income
residents than in 202 buildings. Low income residents are still likely to be able to afford a
reasonably priced service package. On the other hand, an owner may have difficulty
projecting staffing and food costs for a voluntary package.

An IRS "interpretation" complicates combining credits with bonds. According to the
interpretation, if units include kitchens, the bonds cannot be used to finance common kitchens
needed to prepare congregate meals. This requires a higher equity ratio which is difficult for
non-profit organizations to meet. In addition, some states do not allow common space in
projects financed by credits which makes housing with services or congregate housing models
easier to finance than assisted living projects.

Tax credit financing addresses the needs of elders who qualify for SSI and Medicaid and
those with incomes above the thresholds to be charged market rates. Elders between these
levels could not afford to pay for the service package though owners may find them more
attractive than a SSI recipient in a straight rental arrangement since the income base on
which the rent is calculated is higher.

Elders with incomes under $1,266 a month ($15,192 annually) who meet the criteria for
placement in a nursing facility could be served if the state's Medicaid program elects the
Special Income Level eligibility option.

Highlights

✓ States can establish assisted living as a priority for the use of tax credits.

✓ Low income targeting.

✓ Other programs can be combined with credits to finance services to deal with rent
caps.

CVP

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Complex process and financing mechanism.

IRS interpretations and state policies can hinder or preclude assisted living projects.

Limited application for 100% assisted living project because mandatory service costs must be included in the rent caps.

**Tax-Exempt Bonds**

Industrial Development Bonds, or IDBs, secure private investment and serve a public purpose. Under the authorization of the U.S. Treasury Department, states and certain other entities such as state housing finance agencies may issue bonds which fund construction and long term mortgage loans. Since the interest earned by individuals and corporations buying the bonds is exempt from federal taxes, the interest rate is generally lower than that of similar investment instruments. The actual bond rate depends on many factors, including the strength and reputation of the issuing entity, the long term viability of the underlying project and overall bond market conditions. This lower bond rate results in a mortgage rate below prevailing commercial rates.

Example: A bond issued by a state housing finance agency with a good rating and credit enhancements (mortgage or bond insurance) would carry an interest rate of about 7%. The insurer adds a .5% financing charge which results in a 30 year mortgage rate of 7.5%. A taxable bond with the same credit enhancement would carry a 9.5% rate.

The lower rate allows the borrower to access a higher mortgage based on the cash flow generated by project income. A project that generates $500,000 a year to cover debt service could receive a $4.5 million loan without tax exempt bonds or other credit enhancements and $5.6 million using tax exempt bonds.

Under Treasury Regulations, housing developments financed with the proceeds of these bonds must reserve at least 20% of the units for residents at or below 50% of median income, or 40% at 60% of median income, for a minimum of 15 years. The housing must be permanent, rental housing (transition housing or resident ownership is not allowed) and apartments must include their own kitchens and baths. Certain requirements are waived if the bond proceeds are to be used by 501(c)(3) non-profit organizations. For example these bonds would not fall under the state's volume cap and proceeds could be used not only for new construction or substantial rehabilitation, but also for acquisition of properties which do not require substantial rehabilitation. Like tax credits, issuers frequently impose additional
restrictions on bond-financed developments, including greater low-income targeting, or incentives for targeting certain geographic areas or certain special needs groups.

A bond may be issued specifically for one larger project, or several projects may be funded from a single bond. Generally, some level of mortgage loan processing has been completed before a bond will be issued and issuers may provide "bridge loans" to projects which are ready for construction before bond proceeds are available.

Highlights

✓ Targeting for low income residents.

✓ Strong financing source for housing component.

✓ Can be combined with service programs.

Community Development Block Grant (CDBG) Program

HUD's CDBG Program has been used successfully for a number of years by states and cities. While its primary purpose is neighborhood revitalization and economic development, housing activities which benefit low and moderate income people or prevent or eliminate slum conditions are allowed. Approximately 70% of the national funds are allocated directly by HUD to metropolitan cities and urban counties and 30% of the funds are allocated to states for a small cities program. Program priorities are established (with public input) at the state and local levels, within federal guidelines, including targeting 70% of the funds for activities which benefit low and moderate income residents. Units of government receiving funds have the flexibility to provide grants or loans for a variety of purposes including property acquisition and rehabilitation of residential property. In the past, CDBG funds have been used in conjunction with several housing programs to provide the gap financing that projects need to assure affordability.

Highlights

✓ Responsive to local projects.

✓ Flexible source of funding but it competes with multiple community needs.
States and localities can set priorities that include assisted living or housing and services programs.

**HOME**

Title II of the National Affordable Housing Act of 1990 makes funds available to state or local governments which can be used to ensure the availability of affordable housing. The intent is to encourage community-based partnerships, using federal matching funds to leverage funds from other public and private sources. Funds are allocated annually by HUD on a formula basis and are placed in a "HOME Investment Trust Fund" which works as a line of credit, for participating jurisdictions. Monies drawn from the Trust Fund must be matched at rates equal to 25% for funds spent on rental assistance and housing rehabilitation, 33% for substantial rehabilitation and 50% for new construction.

Fifteen percent of the national program funds are set aside for Community Housing Development Organizations - private, nonprofit organizations addressing low-income housing needs. HOME also provides a "model program" option through which HUD encourages state and local development of certain types of programs, including a rental housing production program. Under this option, jurisdictions use Trust Funds to advance up to 50% of the cost of certain housing options, including "projects which provide congregate facilities and supportive services" for frail elders. Advances are repayable and carry an interest rate of no more than 3%. Repayments go back into that jurisdiction’s Trust Fund for continued use.

Program regulations contain multiple tests for low income affordability. In general:

- Ninety percent of funds spent on rental housing must go toward units occupied by residents at or below 60% of median income.

- A minimum of 20% of the units in projects constructed or rehabilitated must be occupied by residents at or below 50% of the median income and rents cannot exceed 30% of income.

- Rents on the remaining units must be the lower of the HUD fair market rent or 30% of 65% of median income.

- Housing must remain affordable for 20 years for newly constructed buildings and 5 to 15 years for rehabilitated structures, depending upon the amount of rehabilitation.
HUD will establish per unit limits for use of program funds, varying by market area and by the different eligible activities, which include: new construction, moderate or substantial rehabilitation, acquisition, site improvements, financing costs, or tenant-based rental assistance. The formula for new construction, for example, is 67% of the high cost limits under the HUD 221(d)(3) mortgage insurance program for multi-family rental housing, which in a high cost New England area would be about $50,000.

When HOME funds are used for rental assistance, the maximum assistance is set at the difference between 30% of income and the local Fair Market Rent, and rents must be between 80% and 100% of the Fair Market Rent. Eligible tenants are those at or below 60% of median income.

Highlights

✓ Very well targeted to low income residents.

✓ Revolving trust fund.

✓ Priority for assisted living type projects.

✓ Requires coordination with service programs.

✓ Suited to local projects.

State/Local Programs

Given limits on federal funds and the matching requirements of several federal programs, state, local and private sources of funds are becoming more and more crucial.

State Programs

Programs established to create affordable housing vary from state to state and like federal programs, many have limited funding. State financing sources may take the form of: appropriations for rental subsidies (either project based or tenant based); donations of surplus buildings or land; zoning incentives; tax or fee deferments; or organizational development or seed loans, particularly for nonprofit organizations. Several states now have housing trust funds or similar arrangements, which use state appropriations or dedicated revenue sources.
<table>
<thead>
<tr>
<th>Component</th>
<th>Industry Average</th>
<th>HUD 202</th>
<th>HUD 232</th>
<th>LIHTC</th>
<th>HOME</th>
<th>IDBs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Unit Size</strong></td>
<td>0 - 2 Bedroom</td>
<td>0-BR 415 sf</td>
<td>&quot;bed&quot; qualifies as a unit; 0-BR; 1-BR</td>
<td>NA(1)</td>
<td>Local decision</td>
<td>NA</td>
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<tr>
<td><strong>Units reserved for low income</strong></td>
<td>100% &lt; 50% of median income</td>
<td>NA</td>
<td>20% &lt; 50% of income; or 40% &lt; 60% of median income</td>
<td>20% &lt; 50% of income</td>
<td>20% &lt; 50% of income</td>
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<td><strong>Development Size</strong></td>
<td>Varies</td>
<td>125 unit maximum</td>
<td>5 bed or unit minimum</td>
<td>NA(2)</td>
<td>Local decision</td>
<td>5 unit minimum</td>
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<td><strong>Development Cost Per Unit</strong></td>
<td>$85,000 - $95,000(3)</td>
<td>$29,500 0-BR(4)</td>
<td>$33,816 1-BR</td>
<td>NA</td>
<td>Tied to 221(d)(3) limits</td>
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<td><strong>Individual Kitchens</strong></td>
<td>Varies</td>
<td>Required</td>
<td>Not Required</td>
<td>Not Required</td>
<td>Not addressed</td>
<td>Required</td>
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<td><strong>Meals</strong></td>
<td>3 per day offered</td>
<td>Must not be mandatory</td>
<td>3 per day offered but not mandatory</td>
<td>NA</td>
<td>Not addressed</td>
<td>NA</td>
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<tr>
<td><strong>Services Allowed</strong></td>
<td></td>
<td>Meals, housekeeping, personal assistance, transportation and health</td>
<td>May provide housekeeping, supervision, personal care, 1 meal a day (minimum)</td>
<td>Not addressed</td>
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<tr>
<td><strong>Rent Limits</strong></td>
<td>$1,300 per month per unit(5)</td>
<td>30% of 50% of median income</td>
<td>Market</td>
<td>30% of 50 or 60% of median income</td>
<td>(1) 30% for low income units; (2) lower of FMR or 30% of 65% of median income</td>
<td>NA(6)</td>
</tr>
<tr>
<td><strong>Service Charges</strong></td>
<td></td>
<td>20% of 50% of median income ($15/unit/month subsidized)</td>
<td>Market</td>
<td>Must come under rent cap if mandatory</td>
<td>Not addressed</td>
<td>NA</td>
</tr>
</tbody>
</table>

1. Not applicable or not regulated by this program.
2. May be restricted by allocating agency due to limited funds.
3. Coopers and Lybrand figure.
4. Adjustments are available for high cost areas.
5. See page 69. Applies to the use of program funds.
6. Not restricted by bond regulations, but frequently required by the issuing agency.
targeted to affordable housing initiatives.

Local Programs

Cities, towns or counties interested in creating affordable housing may provide funds or land, or make zoning or other regulatory concessions to developers. This can significantly lower the cost of a development and increase its affordability. For example, town owned land which is donated or sold at nominal cost can significantly reduce the amount of debt financing required by a project and consequently reduce operating expenses (through decreased loan payments). Similarly, measures which remove or reduce the need for the expensive and time consuming pursuit of variances which keep pre-construction costs lower and zoning for increased density can reduce per unit costs. Cities or towns may also conduct site improvements or construct access roads.

One example of a locally sponsored project is a 52 unit Home for Adults in Fairfax County, Virginia. It is part of a larger complex called the Lincolnia Senior Center and Residences which includes a senior center, adult day health program and 26 units of congregate housing. The Home for Adults serves elders who need some assistance, but who do not need nursing home care. The Home provides all meals, 24 hour on-site staffing, assistance with bathing, medication monitoring and a nurse on-site 40 hours a week who conducts health maintenance and prevention activities. Residents may be in wheel chairs, but must be able to transfer independently. Incontinence must be self-managed.

Residents have a semi-private room (approximately 425 square feet) with bathroom but no cooking facilities. To be eligible, incomes must be below $17,850 (the very low income limit for public housing) with priority given to elders below poverty. About half of the current residents are eligible for the "Auxiliary Grant Program" (incomes below $752 a month), which is a state and county assistance program targeted specifically to Homes for Adults. The state establishes monthly cost standards for each facility that cover shelter, food and non-health services. The auxiliary grant pays the difference between a resident's income, less a personal needs allowance, and the standard. Other residents pay 60% of their income.

A range of county agencies provide operating funds: the Recreation Department (Senior Center); Health Department (Adult Day Health Program); Human Development (on-site social service staff); and the Community Services Board (on-site mental health therapist). The Department of Housing is responsible for the building's operating budget and provides a Director of Senior Housing and Services who coordinates the participation of all agencies and oversees the management contract with Sunrise Retirement Homes which manages the residences.
The County also contributed a surplus school building and land. Funds for the rehabilitation of the school into the senior center and construction of an adjacent three story building, $8 million, were obtained from a capital grants program financed by county revenues. The new building houses the kitchen and the Adult Day Health Program on the ground floor, the Home for Adults on the second floor and the congregate units on the third floor.

Rent Subsidies and SSI Issues - A Key Resource

In every state, the potential to implement the full concept of assisted living lies in newly constructed facilities. A "home-like" environment will be difficult to create in facilities that were not designed on assisted living principles. One barrier to new construction is the source of the subsidy for the "rent." States have looked to Medicaid as the primary source of support for assisted living because of the cost effectiveness of the Federal Financial Participation (FFP) for the full range of assisted living services (except room and board) under their waivers. Except for HUD's 202 program, there is little likelihood that rent subsidies will be available in the near future and SSI will be the primary payment source for room and board for low income people. In some states, SSI covers the room and board costs although providers contend the SSI payments are cross-subsidized by market rate or private pay residents. Adjusting the payment standards and definitions or categories of living arrangements under SSI can substitute for rent subsidies.

States can change the number and definition of living arrangements, and the payment standard for each, under their SSI state supplementary programs. The existing structure of living arrangements in a state need not prevent modifying and targeting payments to support assisted living programs. Federal regulations have been changed to allow states to define up to six living arrangements (including personal needs allowances to recipients in facilities in which Medicaid pays more than 50% of the cost as one arrangement). The regulations list four examples of acceptable arrangements: living alone, living with an ineligible spouse, personal care facilities and domiciliary care or congregate care facilities. There are no definitions in federal regulations or manuals that explain these arrangements and federal Social Security Administration staff indicate that it is up to the states to define the categories. Many states list more than six arrangements (New York has seven, Michigan eight).

"We need to capitalize on SSI to make assisted living affordable for low income people," Rosalie A. Kane.

The process for changing the living arrangements is fairly simple and few states have submitted changes at least during the past five years. States can define the class of recipients that will be included in any
new living arrangement, i.e. aged. A state does not have to apply the living arrangement to all categories of SSI recipients but it must apply the criteria to all members of the defined class. Aged recipients could be covered and blind or disabled recipients could be excluded. The living arrangement can be defined by the needs or functional status of the resident and/or the characteristics of the setting. States can also include conditions that require that eligible residents are determined by a screening or approval process.

In some state board and care programs, a higher SSI payment is made to cover the costs of care. As services are added to existing facilities through Medicaid, the combination of SSI and Medicaid will cover the costs of providing care. Facilities often focus on the Medicaid program for rate increases as costs rise. Yet SSI also plays an important role. Increasing the state SSI payment standard for assisted living may enable a state to target people who are eligible to enter a nursing home and are likely to "spend down" to Medicaid levels anyway. In the absence of other programs, this approach enables the state to serve a person in the community through assisted living rather than in the nursing facility. As an alternative to higher SSI supplements, states may use the Special Income Level approach to broaden Medicaid coverage (see discussion on Medicaid waiver programs, page 78). Each approach offers different ways to limit expanded coverage to residents in assisted living programs only.

**Adjusting SSI to support assisted living - a state example**

In Massachusetts, pending changes in defining and regulating rest homes will affect SSI payments. Currently, rest homes are reimbursed as domiciliary care at $715 a month. Additional supplemental payments are made at state cost based on allowable cost guidelines. The average rest home payment is $32 a day ($960 a month). If current rest home facilities choose to convert to an assisted living facility, it will change their standing as a living arrangement under SSI since they will not be licensed. The current description of living arrangements will reduce the payment that residents will receive in rest homes to $551 a month.²⁷

While the SSI payment will decline, converting facilities will receive two payments - room and board from the resident's SSI check and a service payment from Medicaid. Private sector assisted living rates range from $1,200 to $3,000 and more a month. The existing Group Adult Foster Care rate ($948) plus SSI for an elder living alone ($551) is $1499 a month. Depending upon how much the resident retains, this payment may be adequate in the aggregate.

"We have to be concerned that low income people participate in assisted living programs," Robert Clark, DHHS/ASPE.
However, the distribution of an assisted living facility's expenses between operating and service costs may not match the sources of income.

**Cost Effectiveness**

Assisted living is cost effective from several perspectives. Net state cost is typically measured in Medicaid and state general revenue programs. Massachusetts also operates a rent subsidy program with state general revenues. (A rider to the state budget for FY 93 changed the program from an operating subsidy to a fixed voucher plan). The various financing approaches raise cost effectiveness questions. The net state cost can be compared across three payment sources (Medicaid, SSI and rental assistance) and five settings (ICFs, Rest Homes, Adult Foster Care, Group Adult Foster Care in buildings with rent subsidies and ICFs/Rest Homes which may later convert to assisted living facilities). At an average rate of $80 a day for a free standing ICF (minus $5.60 a day patient paid amount and 50% FFP), the state share is about $37.20 a day. The service rates for assisted living could be increased substantially and still remain cost effective as long as the recipients live in existing subsidized housing. However, the cost effectiveness test extends beyond Medicaid and should include all sources of state funding - SSI state supplements and state rent subsidies (see Table 14).

Including rent subsidy costs, the true state cost of the Group Adult Foster Care program is $908 a month which is still 21% below the Medicaid cost of an ICF. The absence of a rent subsidy could limit construction of new facilities in Massachusetts and the capacity to implement a true assisted living program. Combining SSI and Medicaid will have varied effects depending on the setting: ICFs converting to assisted living; rest homes converting to assisted living; and existing private, market rate assisted living projects. Assuming the state adopts the payment standard for SSI recipients living alone, an ICF facility will see a reduction in its income from $2,400 to $1,499 a month (less the amount retained by the recipient). However, the reduction will be offset by reduced staffing and operating costs resulting from the higher levels of licensure requirements for nursing facilities. Free standing ICFs were required to increase their staffing levels under OBRA while the resident mix may not have matched the higher staffing requirements.

Rest Homes will experience an increase in their payment from $960 a month, on average, to $1,499. Private projects may now be able to serve Medicaid recipients. A key factor in each area will be the ability of the facility to provide room and board for $551 a month (minus the amount retained by the resident). Medicaid service funds may not be used to subsidize room and board. If additional subsidies for room and board were justified and the state policy goal was to quickly expand the supply of assisted living units, supplementary SSI payments could be made by creating a new SSI living arrangement or broadening the
existing definition of domiciliary care. In this situation, the resulting net state costs will still be lower than the cost of care in an ICF.

Table 14. Net State Cost of Massachusetts Programs

<table>
<thead>
<tr>
<th></th>
<th>ICF</th>
<th>Rest Home</th>
<th>Adult Foster Care</th>
<th>Costs in Two Assisted Living Settings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2400</td>
<td>960</td>
<td>948</td>
<td>1894 / ICF/Rest Homes Converting to Assisted Living</td>
</tr>
<tr>
<td>Total Cost</td>
<td>60</td>
<td>960</td>
<td>551</td>
<td>551 / 551</td>
</tr>
<tr>
<td>SSI Share</td>
<td>30</td>
<td>538</td>
<td>129</td>
<td>129 / 129</td>
</tr>
<tr>
<td>State SSI</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>305 / 0</td>
</tr>
<tr>
<td>Rent Subsidy</td>
<td>2230</td>
<td>360</td>
<td>948</td>
<td>948 / 948</td>
</tr>
<tr>
<td>Medicaid</td>
<td>1115</td>
<td>180</td>
<td>474</td>
<td>474 / 474</td>
</tr>
<tr>
<td>Net State Cost</td>
<td>1145</td>
<td>718</td>
<td>603</td>
<td>908 / 603</td>
</tr>
</tbody>
</table>

Total Costs = SSI Share (line 2) + state rent subsidy (707) + Medicaid (line 5) [Italics]
Net state costs = State SSI + 707 + State Medicaid.

1. Average patient amount is $170 a month.
2. Tenants pays a portion of the costs from their SSI payment: $300 a month in Adult Foster Care, $210 on average in 707 buildings.
3. Using current SSI living arrangements. Creation of a new living arrangement and a higher payment level is pending.
4. Average rate minus patient paid amount.
5. Based on the use of adult day care three days a week. Not every resident uses this service.
6. Net state cost for residents who do not use adult day care is $538 a month.
V. SERVICES IN ASSISTED LIVING

The capacity to provide home and community-based services to frail elders has increased steadily through the '80s and '90s. As state systems emerged, they focused on the needs of elders who preferred to live independently and the systems necessary to effectively reach the appropriate market, to evaluate their functional ability and dependencies and to deliver services. Many states have developed extensive networks of case management agencies as the cornerstone of their community systems. During the '70s and '80s, states focused on the organization and delivery of services. In the '90s housing, which did not receive as much attention, has emerged as the central building block of long-term care systems. As a result, traditional concepts of "home" and the regulatory approach to service delivery and quality care have been challenged.

The typical service package in assisted living includes meals, housekeeping, laundry, activities, 24-hour supervision, personal care with activities of daily living and varying levels of health services. Sources of financing for these services include state general revenue programs, Medicaid, the Older Americans Act, the Social Services Block Grant, and to a lesser extent the Community Development Block Grant and the Small Cities programs.

General Revenues

States have used general revenues to establish home and community care programs. The size and scope vary. Some states such as Illinois and Massachusetts, created large programs to provide services that were not covered under Medicaid and to serve frail elders, and often disabled adults, who may or may not have been eligible for Medicaid. Eligibility for state services vary by income level and functional status. Several states limit eligibility to elders who meet the criteria for placement in a nursing facility while others serve those who are defined as "at risk" or who have impairments that make independent living difficult, yet who do not require placement in a more service-intense environment.

While states systems are well known and effective at serving frail elders in their homes, the complexity and limitations of programs for consumers and the housing system are also well known. Separate eligibility guidelines for housing and service programs create confusion and gaps in coverage. Service packages may be available for some elders in subsidized housing and not others. More recently as the supply of various housing and service options has failed to keep pace with the growing need, states have looked more creatively at modernizing their service programs to address the needs of elders as they age and become more frail. For example, states have traditionally limited services to elders in board and care or residential facilities. Residents received meals, housekeeping and limited other services in such licensed facilities. As residents have developed impairments in activities of daily living
(bathing, dressing, eating, mobility, toileting), states have explored ways of providing personal care through community agencies to residents in these facilities. In addition, states are continuing to review their programs to provide the flexibility to adapt to changing models for meeting the housing and service needs of elders as they age.

**Medicaid State Plan**

The largest source of service funding for the poor is Medicaid. There are three sources of funds for community care: state plan services, home and community based waiver services and the relatively new optional community care program.

States are able to provide a range of services to all eligible recipients living in the community. The primary services include skilled nursing, home health aide and personal care with the latter being vital in an assisted living setting. Medicaid cannot reimburse for room and board services except in an institutional setting (hospitals and nursing facilities). Home health aide services can include tasks such as housekeeping, meal preparation and shopping, as long as they remain a subordinate part of the service plan. Personal care services include direct care such as assisting with administration of medications, assisting or supervising with basic personal hygiene, eating, grooming, and toileting. Personal care also includes tasks that maintain a safe and clean environment such as light house cleaning, changing linens and tasks that maintain nutritional needs such as meal preparation or shopping. Personal care services must be approved by a physician and supervised by a registered nurse.

States have recently developed approaches to providing personal care in board and care and adult residential care facilities that are licensed by the state but are not themselves able to provide such service under the state's licensing requirements. Arrangements with home health agencies and home care providers are made to deliver care to frail residents. The practice meets a growing need among residents in these facilities who do not require care in a nursing facility but whose care needs exceed the care allowed by older licensing standards. Concerns about standards of care, monitoring and licensing have been raised. Yet states have been pushed by a combination of consumer demand for nursing home options, a shortage of nursing facility beds, constraints on the growth of beds and budget driven efforts to develop more cost effective long term care resources for frail elders.

**Home and Community Waiver Services Program**

In 1981, Section 2176 of the Omnibus Budget and Reconciliation Act allowed states to receive waivers of plan requirements to provide home and community based services to recipients who met the criteria for admission to a hospital or nursing facility. The waiver
Assisted Living Guide

offers states several advantages. It allows states to pay for services that are not covered under the state plan (e.g., homemaker, personal care, home delivered meals) and to limit the populations eligible for services. It allows states to define services, such as personal care, differently from the state plan. As a state plan service, states must have physicians sign the plan of care and registered nurses must supervise the service delivery. Under a waiver, physician involvement can be changed or eliminated and registered nurses do not have to be as involved in the supervision of the care plan as they do under the state plan.

Finally, states can provide other services such as case management, homemaker, respite care, home delivered meals, chore service, adult day care, transportation, and other services approved by the secretary. In 1986, case management was added as an optional state plan service.

States have used their waivers to serve specified numbers of frail elders, disabled adults and children and other groups. The waiver authority allows a state to limit its fiscal liability by specifying the number of slots that will be funded. The waiver programs must also meet a cost effectiveness test.

In addition to providing a flexible service package, the waiver also allows states to set higher income eligibility levels for people receiving waiver services who would not otherwise be eligible for Medicaid while living in the community. States may receive federal reimbursement for waiver and other Medicaid services to people with incomes up to 300% of the federal SSI payment standard, or $1,266 a month in 1992. States may also determine how much of a person’s income may be kept to maintain a person in the community. Any income above the maintenance level is applied to the cost of waiver services. This would allow nursing home eligible elders to apply more of their income toward the monthly rent or room and board costs in an assisted living facility that does not have rent subsidies.

Assisted living facilities have not been accessible to low income elders because of the high monthly rates required in projects without rent subsidies and the inability of Medicaid to cover room and board costs outside an institution. However, it is possible to establish eligibility under a 2176 waiver to cover nursing home eligible elders who live in an assisted living program that does not have rent subsidies. This approach gives most recipients enough income to cover the monthly fee for room and board charges. It addresses a major gap caused by the absence of rent subsidies and financing for the room and board costs for a segment of the elderly population. This may offer a way to expand the supply of mixed income assisted living developments without rent subsidies.

Eligibility Steps

CVP

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Eligibility for Medicaid may be expanded through the following steps. A state may cover people under several "optionally categorically needy" options. One option, the Special Income Level (SIL), covers people whose income is below 300% of the federal SSI standard [S1902(a)(10)(A)(ii)(5)]. States may select an SIL between their community standard and 300% ($1,266) of the federal SSI payment standard ($422 in 1992). People with incomes above $1,266 a month are not eligible under this category.

The SIL option must be applied in both institutional and community settings, however, states with a Medically Needy program may use both standards in their state plan. States do not have to choose one or the other. The SIL option generally does not expand eligibility for institutional care in states with a medically needy program. However, it may expand eligibility for home and community based services waiver programs. Medicaid may cover people in the community who would be eligible if they were institutionalized and if they would require institutional care in the absence of home and community based services (CFR 435.217). Since people with incomes below the special income level are eligible in an institution, they become eligible in the community.

The SIL option triggers very different procedures for treating income. First the state sets the SIL at any amount between the state's community standard and 300% of the federal SSI payment standard. Second, it must apply the post eligibility treatment of income rules (435.726 & 435.735) rather than the medically needy spend down rules. In so doing, the state must exempt an amount of income that the state determines is necessary to meet the individual's maintenance needs in the community. Until 1986, the maximum maintenance amount was based on the state's SSI standard or its medically needy standard. After 1986, states are free to set an amount for maintenance needs at any level.

Income that exceeds the maintenance level must be applied to the cost of waiver services. There is no other spend down. Excess income is not applied to covered medical services. Here are two examples:

<table>
<thead>
<tr>
<th></th>
<th>Client A</th>
<th>Client B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recipient Income</td>
<td>$1,266</td>
<td>$1,266</td>
</tr>
<tr>
<td>Maintenance Level</td>
<td>$1,266</td>
<td>$ 800</td>
</tr>
<tr>
<td>Excess</td>
<td>0</td>
<td>$ 466</td>
</tr>
</tbody>
</table>

Assuming a state sets the maintenance level for exempt income at the maximum, client A could keep all their income which allows them to pay a reasonable monthly fee for the room.
and board component in an assisted living facility. If the maintenance level were set at $800 a month, a recipient with monthly income of $1,266 would have to apply $466 toward the cost of waiver services. They may be able to pay the monthly fees but they will have very little income available once it is paid and excess income is applied to waiver services.

Assisted Living Implications

This option would allow states to expand eligibility under a 2176 waiver to support assisted living. The maintenance level should be determined based on the expected costs of room and board, the cost of waiver services that would be paid by the recipient, and the amount of discretionary income a recipient will need in a such a setting. A higher maintenance level will increase participation. Depending on the room and board costs and the state’s maintenance income level, recipients with incomes near the $1,266 maximum may be more likely to participate in an assisted living program than someone with income of $700 a month. The closer the room and board component of the facility’s fee is to the recipient’s income, the less discretionary income that is available. If a facility’s negotiated room and board rate were between $500 and $800 a month, someone with $1,200 a month would have $400 and $700 a month for other expenses. A maintenance threshold of $1,000 would leave the resident with $200 a month after the remaining $200 was applied to the service costs. Residents with incomes above $1,266 would not be eligible as Medicaid recipients.

The waiver approach allows the state to control participation through enrollment caps. This will preclude every existing private facility from trying to enroll their eligible residents in the program though some added steps may still be necessary to focus available slots on real nursing home diversions.

While waivers can be used to serve residents in assisted living facilities, they may not convince a lender as to the long term viability of a new project. Initial waivers are approved for a three year period and renewed for a five year period and cannot guarantee continuation during the full term of the financing.

Home and Community Based Services Waivers for the Elderly (1915d waivers)

The Omnibus Budget and Reconciliation Act of 1987 created a new waiver program for home and community based services to elders. The program was developed as an alternative to the 2167 waiver primarily for states that could not demonstrate unused capacity or "cold beds." The waivers apply only to Aged Medicaid recipients who are likely to enter a nursing facility in the absence of community services. States may receive waivers of income and resource limits, comparability and state wideness. In exchange, states must limit expenditures
for long term care (nursing homes, home health, personal care, private duty nursing and community care services).

Rather than compare the amount of spending that would have occurred with and without a 2176 waiver, the 1915(d) waivers simply cap Medicaid spending for all long term care services. The limits are set based on projected increases in spending for institutional, community and in-home services and population growth (65+). FFP for state expenditures is tied to an Aggregate Projected Expenditure Limit (APEL). The APEL uses federal fiscal year 1989 as the base. Expenditures required by federal mandates, such as the OBRA nursing home reform amendments, may be added at state request. Base year expenditures are trended forward using the greater of 7% per year or the sum of adjusted expenditures for nursing facility and home and community based care. The formula steps include:

*Base year nursing facility expenditures*
- plus the market basket increase for such services;
- plus 2% per year;
- plus the percentage increase in the number of people 65 and older.

*Base year home and community based care expenditures*
- plus the market basket annual increase;
- plus 2%;
- plus the percentage increase in the number of people 65 and older.

The market basket increase for nursing home expenditures is based on the Medicare SNF Input Price Index and the inflator for community care is based on the Medicare Home Health Agency Input Price. The population 65+ in a state is based on a count of Medicare beneficiaries.

This waiver approach includes the same services as the 2176 waivers: case management, homemaker, personal care, adult day health care, and "other medical and social services that contribute to the well being of individuals and their ability to remain in the community." The program's interim final regulations, published June 30, 1992, contain some suggested definitions though states are free to propose alternative definitions. The regulation do allow personal care to be provided by a family member, other than a spouse. The waiver must describe the conditions under which this is allowed and states must have a mechanism to ensure that care is provided and it would not be furnished in the absence of payment, e.g. a relative leaves a job or moves to care for a family member.
These waivers also allow states to use the institutional deeming rules (e.g., income of the husband or wife is not counted toward the spouse’s eligibility) and the special income level eligibility category.

Only one state, Oregon, has applied for and received a 1915(d) waiver. In order to successfully use this waiver, states need:

- To control the supply of nursing facility beds;
- A case management system that screens recipients for entry into the long term care system;
- An expanding supply of appropriate community and residential services; and
- An effective nursing home reimbursement methodology.

Frail Elderly Community Care as an Optional Service (Section 4711)²⁸

While the 2176 waiver program brought considerable flexibility, it also brings added requirements and responsibilities. States must document the financial impact of the waiver on their projected and actual Medicaid expenditures. Initial waivers are approved for three years and renewed every five years. Waivers must be evaluated. More importantly, state policy makers contend that home and community based services that allow frail elders to function in the community should be the rule rather than the exception. Some would argue that states should be required to provide home and community based services and seek waivers in the absence of adequate community care to cover care in a nursing home.

States have been seeking opportunities to provide home and community based care without the lengthy processes and procedures that have become part of the Medicaid 2176 waiver program. Over a period of several years, Congress developed proposals that created a permanent program free of the limitations of the waivers. As steps to deal with the federal budget deficit evolved, it became more difficult to pass new legislation carrying the large costs of community care expansions. To respond to the constraints of the budget agreements, sponsors of a new home and community care bill agreed to compromises which, while necessary to secure passage, have made it difficult for states to implement the new authority.

Section 4711 of the 1990 Omnibus Budget and Reconciliation Act (sometimes called the Rockefeller Bill) offers states an optional state plan approach to providing home and community based services.
Eligibility

Eligibility is limited to elders who need substantial assistance with two of three ADLs (toileting, transferring and eating); or to elders with Alzheimer's Disease who cannot perform two of five ADLs (bathing, dressing, toileting, transferring or eating), or who are so cognitively impaired that they require substantial supervision. These tight criteria may be more restrictive than a state’s criteria under the waiver program. States may further limit eligibility using reasonable classifications based on age, degree of functional disability and need for services. This provision allows states to test approaches to serving high risk, vulnerable elders. For example, states could develop a separate program for elders over 85 who live alone, do not have a caregiver and who require full assistance with two or more ADLs.

Funding

Funds are capped at $40 million nationally for FY 91, $70 million for FY 92; $130 million in FY 93; $160 million in FY 94 and $180 million in FY 95. The law caps a state’s maximum reimbursement based on its relative share of "elderly individuals 65 and over." The law also says that "elderly individuals, to the extent practicable, shall be low income elderly individuals." Since there is no standard measure of low income elders across states, HCFA has concluded that this formula element is not practical.

Language allows the Secretary of HHS some flexibility in setting state caps based on the number of people 65+ in relation to the rest of the country. HCFA will use the flexibility to base each state’s maximum reimbursement on its relative share of elders 65+ among states participating in the program. For example, HCFA would determine the number of elders 65+ in each of the participating states and cap each state’s share proportionally. A state with 35% of the 65+ population would receive a maximum of $14 million in FY 92. If the relative share were 5%, the maximum reimbursement would be $3.5 million.

In order to facilitate budget planning pending regulations would begin state participation at the October 1st start of a federal fiscal year. Otherwise a state may begin the year with 10% of the available funds and see its cap reduced if additional states enter the program during the year. Each year on September 30th, once the number of participating states is known, state caps based on the authorization will be allocated among the states with approved amendments. While this reduces mid year reductions in the cap, it leaves some measure of uncertainty at the beginning of the state’s fiscal year since states will not know until October 1st what their cap will be for the remainder of their fiscal year.
As more states participate each year, the relative shares drop. The annual increases in the appropriation may be enough to prevent a state from receiving less in a subsequent year if additional states choose to submit amendments. Yet, there are no guarantees that caps will not decline for early participants.

Capped Entitlement

Once a state elects to participate, it must serve all eligible elders regardless of cost. FFP will be limited and states are required to provide care at 100% state cost if additional eligible applicants apply. States must guarantee services to all eligible recipients for the duration of the state's "election period." In developing its plan, a state must determine the length of time it will operate the program. The "election period" may be four or more calendar quarters selected by the state. Once selected, states cannot withdraw the amendment for the duration of the election period. The regulations will clarify whether state action will be necessary to extend the program after the expiration of the initial election period.

Maintenance of Effort

The statute includes a maintenance of effort provision that is cumbersome and probably cannot be implemented as drafted. Section 4711 requires that states report their expenditures for community care beginning in fiscal year 1990. If expenditures fall below FY 89 levels, federal reimbursements are reduced by an equal amount yet there is no requirement that states submit a report for FY 89 expenditures.

Though the Secretary probably has the authority to require a report for FY 89, other provisions create more extensive problems. While the Congress intended to establish a maintenance of effort provision, the language cannot be easily applied to state general revenue programs. In addition, the maintenance of effort is to be applied to functionally disabled elders, as defined by the Act, who are assessed by an instrument approved by the secretary. No state used such a definition of eligibility during the base year and therefore there is no way to determine how many eligible elders received home and community based services under state programs or Medicaid. In addition, the Secretary has not approved any assessment tool. As a practical matter the maintenance of effort requirement will most likely be applied only to Medicaid home and community based care expenditures for elderly recipients.

Assessment and Case Management

The Act requires that eligible clients be assessed by an interdisciplinary case management process. Applicants cannot be charged a fee for the assessment. Based on the assessment,
care managers must develop an Individual Community Care Plan which identifies the services needed, the services to be provided and the amount, duration and scope of any limitations accompanying the care plan. The care plan must also indicate the individual's service and provider preferences.

Case management can be performed under contract by a public agency or a non-profit agency that does not provide direct services. The language allows states to contract with Area Agencies on Aging or other non-profit organizations which do not provide home and community care or nursing facility services and which have no financial interest in any agency that provides such services.

The assessment and care planning process is consistent with the case management systems in many states. HCFA is developing a standard assessment form, however, states may use their own form as long it contains the minimum data that must be collected. At a minimum, quarterly visits will be required.

Standards for Community Care Settings

The law sets new standards for providers of home care services and facilities in which services are received. Facilities can be day care centers, rest homes, board and care homes, even CCRCs. These complex provisions grew from concern about unregulated board and care programs in many states. Elders who reside in rest homes, board and care facilities and conceivably some CCRCs seem to be eligible to receive community services. The law applies survey and certification standards to any setting or facility in which elders receive services. For example, an elder who receives personal care in a day care center (or social day care center) under the program, or someone living in a rest home receiving services forces the setting in which services are received to comply with new requirements. The standards will apply life safety code and other requirements that are appropriate to the setting.

States must establish an annual survey and certification process for all facilities (residential settings, community care settings) and providers of in-home services. HCFA will conduct on-site surveys of a sample of settings to validate state survey procedures. HCFA's regulations will be based on comparable procedures for nursing facilities, modified as appropriate for community care settings.

The law also requires that HCFA establish guidelines for minimum compensation to individuals providing care. HCFA will allow states to use current rates for similar services or their existing rate setting process to comply with this provision.
Status

Section 4711 was covered by the President's moratorium on issuing new regulations. The law required that final regulations must be issued by October 1, 1992. Because of the moratorium, there is no date planned for issuing the regulations. However, the absence of regulations does not preclude implementation of the program, nor does it reduce a state's responsibility for complying with all requirements.

So far, few states have actively considered this approach. Only Texas and Rhode Island have sought and received approval to implement the program to replace an expiring demonstration program. Language in the law exempts Texas from the functional eligibility criteria in order to grandfather all participants in their demonstration program.

Pennsylvania explored the program and has decided to submit a 2176 waiver application. Florida's interest in submitting a plan amendment has been delayed by budget constraints that affect the state match.

State Impact

There are several variables to consider in determining the impact of the new authority on states with existing 2176 waivers. First, what are the similarities and differences in the populations that can be served? Second, will states be able to predict participation rates? Third, what are the revenue implications? And fourth, what are the incremental financial and management costs of meeting the survey and certification requirements of the new program?

Population. States with existing waivers that are considering the program should analyze how the new eligibility criteria will apply to their current 2176 waiver participants. The major differences in the 2176 and 4711 eligibility criteria are the ADLs considered and skilled care needs of elders. Most states include from five to seven ADLs in assessing functional impairment: bathing, dressing, eating, toileting, transferring, continence and mobility. Bathing and dressing, the two most frequent ADL impairment, are not included in the definition of "functionally disabled" in the new program unless the person is also cognitively impaired. Elders could have three ADL impairments (dressing, bathing, eating) and problems with continence and not be eligible under the state plan option.

States whose current waiver participants exceed the new criteria must operate two similar programs or eliminate services to elders who will no longer qualify under the tighter criteria.
However, states may devise programmatic reasons for testing and developing new models to serve an impaired population in a controlled manner without undertaking the process of developing a new and separate waiver request. The law allows states to waive state-wideness under the state plan approach.

States may consider the optional program if they are near their maximum number of people who can be served through their waiver. States that have reached their maximum number of approved waiver slots may consider a section 4711 plan amendment and transfer eligible clients to the new program to free up slots for new eligible waiver participants. In this circumstance, states may also consider submitting an amendment to their waiver to increase the number of approved slots.

Florida's interest in the law can be attributed to several factors. Enrollment in their waiver is approaching its maximum of 11,000 slots and the dynamics of the cost effectiveness formula make it difficult to increase the number of slots. High nursing home occupancy rates, new and tighter COs bed need guidelines and the relatively low nursing home rates make it difficult to serve increased numbers of high cost elders and still meet the waiver's cost effectiveness test. The section 4711 approach was explored to provide more intensive, higher cost service plans to severely impaired elders and avoid potential conflicts with the waiver formula.

Starting March of 1992, Rhode Island covers elders with a primary or secondary diagnosis of Alzheimer's Disease who need personal care and would be a danger to themselves if left unattended. Officials felt many in this group would not meet the criteria for admission to a nursing home. The program extends an existing state funded program to a new group and covers personal care, homemaker, personal emergency response and adult day health care. The program was developed to provide support for caregivers. In three months, the program has built a caseload of 300 people including some who were transferred from the state's Social Services Block Grant program.

The new law recognizes the importance of care in residential settings and supports the expansion of assisted living models. While the eligibility criteria may fit the profiles of functionally impaired elders in subsidized housing, the 2176 waiver allows greater flexibility for those in unsubsidized facilities. Spend down requirements apply to the 4711 program, while states have greater leeway under 2176 to set higher levels for the maintenance needs of individuals in the community who are eligible under the "special income category." Higher disregards are necessary to allow a nursing home eligible elder enough income to pay for room and board in a facility without rent subsidies.
Participation. Services provided under an amendment will have to be made available to eligible recipients in their homes and in community care settings that meet the requirements. State participation and expenditure projections based on the current provider supply may under-estimate actual costs if provider supply expands in reaction to new financing sources. The most likely source of new supply is from providers of care in residential settings since financing sources for in-home care are reasonably well established through Medicaid and state general revenue programs. However, more restrictive eligibility criteria can be used to limit the eligible population and service definitions can be developed that lend themselves toward environments in either in-home, community or residential care settings and thereby indirectly limit potential supply and participation rates.

Revenues. With limited participation among states in the early years of implementation, states may be eligible for fairly sizeable reimbursements. The revenue implications should be examined carefully. From a financial standpoint, operating dual programs may not increase revenues, especially for states that are below their waiver enrollment caps or that are able to increase the number of slots, since elders served under the state plan option may also be served under the waiver. Revenues earned by the 4711 participants are, in effect, transferred from the 2176 program.

States that are not able to enroll additional waiver clients may gain from this optional plan approach.

Administrative Costs. The optional program will increase administrative costs to the state. If the 4711 authority does not replace the waiver, states would have to manage, administer and track two programs instead of one. In addition new survey and certification requirements will apply to case management agencies, in-home care providers, community care and residential settings that may be serving elders through both programs.

In summary, the law provides support for states interested in developing assisted living programs and expanding supportive housing and services models, yet section 4711 does not have the flexibility found in section 2176 to set higher income eligibility levels that would be necessary to serve frail elders in unsubsidized projects. Section 4711 carries additional constraints and limitations. The programmatic and financial advantages of this new authority seem limited for most states with existing 2176 waivers that can be used to achieve similar goals and, in fact, the law may create financial risk if enrollment levels exceed federal reimbursement caps. The management and financial consequences of developing new sets of standards, survey and certification requirements cannot be fully measured until regulations are issued.
The legislative history of the program over several years suggests that extensive compromises were necessary to control eligibility and to hold spending within ever tightening budgetary guidelines. Though many observers concluded that the program has been so hampered by compromises that, although necessary to win passage, severely limited its utility to states. However, efforts to develop its potential may launch legislative initiatives to modify the law or spawn state experiments with new combinations of care in residential and community settings.

<table>
<thead>
<tr>
<th>Official name</th>
<th>Home and community based services waiver program</th>
<th>Home and community based services waivers for the elderly</th>
<th>Community care for the elderly as a state plan option</th>
<th>State Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Common name</td>
<td>Section 2176; 1915 (c)</td>
<td>Section 1915 (d)</td>
<td>Section 4711; Rockefeller bill</td>
<td>Same</td>
</tr>
<tr>
<td>Functional eligibility requirements</td>
<td>Nursing facility criteria</td>
<td>Nursing facility criteria</td>
<td>Impaired in 2 of 3 ADLs (eating, toileting, transferring) or 2 of 5 with Cognitive impairments</td>
<td>Medical necessity</td>
</tr>
<tr>
<td>FFP limits</td>
<td>Based on approved number of people to be served</td>
<td>Long term care expenditure cap</td>
<td>Maximum based on relative share of the funds appropriated</td>
<td>Federal matching rate for all expenditures</td>
</tr>
<tr>
<td>Formula</td>
<td>Cost effectiveness test based on nursing home capacity, and costs with/out the waiver</td>
<td>Aggregate projected expenditure limit (FY89 adjusted)(^1)</td>
<td>Based on relative share of recipients in each participating state</td>
<td>Relative per capita income</td>
</tr>
<tr>
<td>State liability</td>
<td>100% of costs for people served above approved limit</td>
<td>100% of expenditures above APEL</td>
<td>100% of expenditures above maximum allocation</td>
<td>NA</td>
</tr>
<tr>
<td>Special rules</td>
<td>Deeming waiver; special income level; post eligibility treatment of income</td>
<td>Deeming waiver, special income level; post eligibility treatment of income</td>
<td>Regular rules apply</td>
<td>Regular rules apply</td>
</tr>
</tbody>
</table>

1. Adjusted each year based on the inflation rate for nursing facility and home health spending (Medicare indices), plus 2% per year, plus the percentage increase in the number of Medicare beneficiaries in the state. Oregon's base year is 1987.
Older Americans Act

The Older Americans Act (OAA) provides relatively small grants to assist State Units on Aging and Area Agencies on Aging (AAAs) to develop and implement comprehensive and coordinated systems to serve elders. However, its flexibility readily supplements funds available from other sources, to states to support services that promote independence. The Act's broad mandate and limited funding hinders its ability to serve as a funding source for extensive programs. Services are targeted to those in greatest social and economic need with particular attention to low income minority elders. Funding for three broad areas receive priority: access, in-home and legal services. State Units on Aging administer the program through regional AAAs. Local AAAs have discretion to fund services that respond to local needs based on a needs assessment and an area plan. The most common services include health, transportation, housing assistance, community long term care (meals, homemaker, personal care, day care and others), legal assistance, health promotion and information and referral. Separate funding is allocated to states for congregate and home delivered meals. OAA funds are used to supplement services in states with large general revenue programs. In many states, the OAA and Medicaid waiver services, are the primary sources of funds for home and community based care.

Robert Wood Johnson Foundation Supportive Services in Senior Housing Demonstration Program

This demonstration project was designed to add consumer driven service packages to state HFA-financed housing developments for the elderly and make creative use of the unique funding sources available to those developments and to Housing Finance Agencies (HFAs). It is unique in that grants were administered through the housing provider network rather than the service network.

HFAs in Colorado, Illinois, Maine, Massachusetts, New Hampshire, New Jersey, Pennsylvania, Rhode Island and Vermont and Virginia received $4 million in grants from the Foundation in 1988. These grants have been combined with $1 million in housing finance agency funds, development funds ($2.5 million), tenant contributions ($300,000) and other resources. The states spent three years designing and implementing mechanisms to provide services to elders who were aging-in-place. By the third year, 240 sites were participating in the demonstration program.

The profiles of residents were similar in some respects to assisted living residents. First year surveys conducted by the sites showed that resident profiles varied slightly by state. Between 23-26% of residents were over 80 years old, 70-88% were female and 78-94% lived alone. Data collected on participants between May 1990 and April 1991 by Brandeis
University, the National Program Office for the project, found that 37.9% of the residents used meals, 19.6% received housekeeping, 14.1%, transportation and 10.1% received personal care.

Service coordination was a key factor in the program. Service coordinators were developed to "broker" services for residents and to access existing local service programs. Coordinators arranged for traditional services to be provided in non-traditional ways (such as contracting for a block of service time which was then allocated among residents according to their preferences). Coordinators also worked with local businesses to arrange discounts, deliveries and other special treatment. One goal of coordination was to reduce the cost of services to the consumers.

Another key principle was the consumer focus of the project. Sites did extensive resident surveys to determine which services were most important to residents. Service use was based on resident choice rather than screening, assessment and authorization based on frailty or income. This aspect of the demonstration parallels the trend in assisted living toward a social, residential service model that maximizes independence.

In part because of the consumer orientation, resident contributions to service costs totalled $300,000 in the first three years. Although most service users (80.6%) had incomes below $10,000, 57% of service units included resident fees for all or part of their cost.

<table>
<thead>
<tr>
<th>Service</th>
<th>Percent of Costs paid by residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chore</td>
<td>96.8%</td>
</tr>
<tr>
<td>Shopping</td>
<td>83.7%</td>
</tr>
<tr>
<td>Health Services</td>
<td>78.4%</td>
</tr>
<tr>
<td>Transportation</td>
<td>62.7%</td>
</tr>
<tr>
<td>Meals</td>
<td>57.8%</td>
</tr>
<tr>
<td>Personal care</td>
<td>50.0%</td>
</tr>
<tr>
<td>Light housekeeping</td>
<td>40.0%</td>
</tr>
<tr>
<td>Coordination</td>
<td>4.4%</td>
</tr>
</tbody>
</table>
Services most likely to include a fee were meals (90%) and chore services (80%). The least likely was service coordination (10%). Service usage and fee payments varied by state. After two years, one state reported that in 23 participating developments, a high percentage of residents paid fees for all or part of services (see table 16).

Health services included screening, wellness clinics, education events such as nutrition classes and exercise programs. The remaining service costs were covered by contributions from the developer - $2.5 million by September, 1991 - including capital improvements (adding or enlarging kitchens in common space, improving accessibility for frail elders), staff (particularly the service coordinator) and equipment (van and others).

While the residents were not as impaired as the population served in assisted living, the demonstration program effectively involved HFAs in meeting the needs of residents who are aging-in-place and sets the stage for HFA involvement in assisted living. Participating states are continuing the program and expanding the number of sites.

Lessons for assisted living and government policy

Most of the participating projects were subsidized under the HUD Section 8 New Construction/Substantial Rehabilitation program, which means that the developments’ operating and reserve funds are controlled by HUD and the state HFA. Decisions by housing management staff to develop service capacity and renovate space may need to be reviewed by the state HFA and HUD. The use of the funds for service related activities highlights the need for more flexible regulations governing the use of funds as projects respond to the changing needs of their residents. The experience also highlights the need to modify the design standards for new buildings to reduce costly retrofitting as the building and its tenants age.

The presence of Section 8 rental subsidies limited tenants’ rents to 30% of their income. Because of the rent subsidies, low income tenants had funds available to share in the cost of the services. Residents with an income of $5,000 in a section 8 unit might pay $125 a month for rent which left $291 a month in disposable income. Another resident with an income of $10,000 might pay $559 a month, the average rent for a one bedroom unit in a high cost area, leaving $274 a month for other expenses.

Lessons from the demonstration support the experience of private assisted living models. Others reinforce the potential to successfully manage assisted living using multiple funding sources for low income residents who could not afford the private rates. The project results stressed the benefits of a consumer oriented program, cost efficiencies available through
packaging of services, the ability to administer a program of "unbundled" services with a variety of funding sources, and the ability to separate but coordinate "housing" functions and "service" functions.

Putting It All Together

Despite the seemingly lengthy list of problems and conflicts, existing programs can be tapped to develop successful assisted living programs.

✓ At a minimum states can use the flexibility in Medicaid to develop service packages for elders in conventional housing that simulate the service component of assisted living programs and allow elders to age in place in conventional housing.

✓ Service programs can be fashioned to support delivery of personal care, skilled nursing and support services to residents in existing board and care and similar facilities for residents who are aging in place.

✓ While HUD policy generally limits frailty of residents (incontinence), and prohibits the direct provision of "medical care" (space for on-site nursing staff, use of HUD funds to hire a nurse, residents may receive skilled nursing care and personal care provided by community agencies.

✓ States can use the flexibility in SSI to increase resident income to cover room and board costs in the low to moderate end of market rate assisted living projects.

✓ States can use Medicaid waivers to serve nursing home eligible elders.

✓ States can use the Medicaid Special Income Level option to increase income eligibility and to cover room and board costs.

✓ States can coordinate priorities, guidelines and funding between Medicaid agencies and Housing Finance Agencies to expand the supply of affordable assisted living units.

✓ Housing financing sources can be successfully used to create a new supply of assisted living.

✓ Each housing program has its advantages and limitations but each can be used to finance assisted living.
VII. POLICY IMPLICATIONS FOR FEDERAL AND STATE GOVERNMENT

Existing programs do allow states to move forward. The previous chapters have described some of the opportunities and problems associated with attempts to re-shape older programs to new uses. The conflicts and obstacles are many though not insurmountable. The final chapter describes the issues that state and federal policy makers could address to make it easier to develop assisted living programs.

General Climate for Setting Long Term Care Policy

State experience with assisted living has implications for both state and federal policy makers in three areas: consumer protection through regulation, offering consumer driven social long term care models over traditional medical models and containing the fiscal crisis fueled by population growth and the increasing cost of nursing home care.

Issues related to regulation are extensive. Currently the level of laws and regulations governing assisted living are limited compared to nursing facilities, which may be one of the most regulated industries in the country after passage of the Nursing Home Reform Act of 1987. Our national approach to nursing facilities emerged from the Medicaid and Medicare regulation of acute care hospitals. Policy developed in the 1970s and 1980s for long term care attempted to solve care problems by making nursing facilities look more like hospitals even though residents in nursing facilities primarily require assistance with activities of daily living rather than treatment of acute conditions. Lengths of stay are much longer in nursing homes than in hospitals. Instances of abuse and accidents generated regulations governing staffing, health and safety, inspection and enforcement to increase resident safety and protection. This approach forces the industry to operate like hospitals while diminishing resident privacy, dignity and control over one's life. Regulations that focus on safety, treatment and documentation run counter to much of the philosophy of assisted living which emphasizes shared responsibility for care and the ensuing risks, individual client differences, and a "home-like" environment that emphasizes liveability rather than safety.

If assisted living develops as a nursing facility replacement model, regulators must alter their approach. The challenge to policy makers will be to develop regulations which allow and encourage maximum resident choice. Decision making by vulnerable adults brings risks. Balancing resident protection against adverse risk while maximizing choice carries policy makers into uncharted waters.

State and federal policy makers are interested in making assisted living responsive to the desires and needs of elders. The notion of shifting long term care from the medical model to
a more social model has both enchanted policy makers who are interested in the client empowerment movement and threatened those who are highly invested in the current system.

One of the most potent forces driving policy is the projected increase in spending for nursing homes in the next 10 to 20 years. State and federal Medicaid dollars currently pay for about forty two percent of the total nursing home bill. The state share varies from 50% in the most affluent states to less than 25% in states with lower per capita income levels. The higher the cost of care in relation to average elderly income, the higher the percentage of residents on Medicaid. In New York, for example, close to 90% of nursing facility residents are Medicaid recipients.

State spending on nursing home care will double by the year 2000. At 10% inflation, states spending 4 percent of their revenue on nursing facility care today, assuming present policies do not change, will spend over 8 percent of revenues on nursing home care in seven years. States are aware of this phenomenon and have been looking for ways to limit this liability. Over the last 15 years most states have moved heavily into providing home care for the elderly. Providing this alternative care, along with moratoriums on nursing facility construction in many states, has limited nursing facility bed growth in the last 10 years to modest amounts. Continued expansion has been slowed by declining state revenues and reductions needed to balance budgets. Several states, under growing pressure, have lifted their moratoria on construction and are currently building new nursing facilities.

The Nursing Home Reform Act of 1987 set the stage for double digit inflation for nursing facilities during the next 10 years. Since inflation rates for nursing facilities exceed the annual increases in the income of elders, the percentage of nursing facility residents funded by Medicaid is likely to increase substantially. The elderly population most likely to use long term care (85+) will increase 44% by 2000. High inflation, higher percentages of nursing facility residents on Medicaid and higher at risk populations translates into increased pressure on state and federal resources.

Equity - Conflicts between Medicaid and Housing Policy

Tenant Discretionary Income

Straddling the line between a housing model and more traditional long term care model, assisted living raises questions of equity between Medicaid recipients in state licensed facilities and those financed from other sources. Residents in state licensed facilities retain a

"For now, we need, within the current limits of law, to give states the ability to blend funding streams for services." William Benson.
personal needs allowance while tenants in subsidized housing pay 30% of their income for rent and retain the remaining portion of their income (Social Security, SSI). As developers submit assisted living type models for 202 funding, residents of assisted living are treated differentially depending upon the sources of financing for the housing component.

An SSI recipient whose benefit is $551 a month pays $165.30 for rent in a 202 facility, leaving $385.70 available. HUD 202 guidelines also allow projects to charge residents up to 20% of their income, in addition to the rent, for services, which leaves more income for the tenant. The same person in a licensed facility retains only the personal needs allowance of $30-$94 a month, depending on the state and all other income is applied to the service costs.

This additional source of service funding may conflict with state Medicaid policies concerning cost sharing for state plan services. Waiver programs use the post eligibility treatment of income rules which generally require more than 20% cost sharing. Waiver programs also serve nursing home eligible recipients. Many states do not require cost sharing for state plan services. States that do require copayments are unlikely to require payments as high as could be set in a HUD setting with assisted living units. In addition, cost sharing rules apply to all recipients rather than those in a particular setting. A capitated service rate might be developed and the Medicaid share would be based on the costs remaining after applying funding from HUD and the resident. Fee for service payment methodologies may be more difficult to devise unless the 20% cost sharing is not applied or is waived for Medicaid recipients. Waiving the fee creates further inequities with other tenants. In order to maximize opportunities to develop assisted living options for low income elders, Medicaid cost sharing rules and HUD tenant service caps will have to be reconciled.

**Service Policy Issues**

Outside of Medicaid, the greatest single need on the service side is simply a source of financing for low income elders who do not meet the Medicaid income guidelines. However, service programs can be readily tailored to assisted living models though they were not originally designed to support such a setting. A building with nursing home eligible Medicaid recipients who qualify for a waiver, frail but not nursing home eligible Medicaid recipients and nursing home eligible non-Medicaid recipients are treated differently. In states with a home care program financed from general revenues, a housing management company may have to follow three separate billing and documentation guidelines for the same package of services.

Medicaid programs could be revised to be more "user friendly." In addition to new survey and certification requirements, the Section 4711 or Frail Elderly Community Care Act leaves states at risk if participation exceeds the amount of federal reimbursement under the
appropriations cap. States should be able to limit enrollment in accordance with their allocation of federal funds.

**Housing Policy Issues**

In order for assisted living to become a more widely available option for elders, financing mechanisms need to: specifically address assisted living requirements; establish monthly resident charges (for both shelter and services) that are affordable by low and moderate income elders, either by themselves or in combination with other funding sources; and offer sufficient funding streams to create an incentive to leverage non-federal sources.

**Affordable Assisted Living**

Financing sources are increasingly focusing on the need for services in housing for the elderly. None of the public sources described, however, are specifically or solely targeted toward affordable assisted living options. Despite their limitations, they do provide tools that states and developers need to produce assisted living.

The 232 Mortgage Insurance Program is compatible with the assisted living design and service packages through its board and care regulations, but it does not by itself assure affordability for low and moderate income elders. Guidelines that increase allowable per unit costs would encourage developers to add kitchens and baths which would broaden the program’s application to assisted living. Insuring 100% mortgages would enable non-profit organizations to participate in the program.

Section 202 housing is exclusively for low income elders yet the requirement that 85% of service costs come from non-202 sources forces the housing and service sides to work together to complete the funding package. A 202 service cap of $15 per month, per unit is insufficient to sustain an assisted living package. HUD does not provide direct funding for health services in 202 housing. Legislative changes must be developed that make it easier to dedicate service funding for assisted living programs that reflect the unique characteristics of the program.

The new HOME program, which includes housing with supportive services in its model programs and targets elders at a lower income level, is not a major funding source and the CDBG program must cover a broad range of programs in addition to housing. In both
HOME and CDBG programs, targeting of funds for assisted living options depends on state and local priorities. They can, however, be a valuable resource for specific projects in some areas.

Low income housing tax credits and tax-exempt bonds are partially targeted to low income residents, but a focus on elders or supportive services must come from the state or local level and the funds themselves are not sufficient to ensure long term affordability of either rents or service packages. Tax credits were initially not allowed for housing that provided significant services. That has since been changed, but now mandatory services are considered a "condition of occupancy" and their cost to the tenant must fall within the 30% of income rent cap. This is a disadvantage to models which include a "basic" service package purchased by all residents and it is not compatible with design models that do not include individual kitchens, which therefore make meal programs mandatory. It is not even consistent with the provisions of the HUD 202 program that tenants can be expected to pay up to an additional 20% of their income, beyond the 30% for rent, for a service package.

Assisted living developers need to make maximum use of existing targeting and set-asides within current programs to develop viable programs. Over the long term, continued efforts are needed at the federal and state levels to increase policy sensitivity to assisted living models.

Compatibility of Housing Financing Programs

Many current federal programs cannot be combined to finance an assisted living facility. For example, 202 building design costs excluded under the capital advance can be met only by non-federal funds. HOME matching funds (as much as 50% of the cost of new construction) must also come from non-federal sources.

When combined, the value of federal programs is sometimes reduced. For example, the value of the low income housing tax credit is reduced from 9% to 4% if other federal funds are used on the project. Also, if tax credits are combined with the 232 program, the project's normal market-based system of rents and incomes changes to the tax credit income limits (50% or 60% of area median) and rent caps apply (30% of qualifying income) for all units designated as low income. This increases access for low income tenants. However, other provisions compromise a project's viability. Tenant contributions for meals (which are mandatory in a 232 board and care) and services must fall within that 30% rent cap. The tax credits by themselves may not provide sufficient funds to the project to cover those long term costs. Despite the limitations for "middle income" populations, these conditions will work well if state funds are available for the service components.
Income limits themselves are not consistent among the federal programs. While this may not be a problem as long as most programs cannot be combined, it does have implications for other sources of funds to be used with federal programs. Non-federal programs would benefit from compatible income and rent eligibility thresholds. Varying income and eligibility standards for Medicaid and state funded community based service programs mean that frail residents who qualify for assisted living and low income housing may not be eligible for service programs needed to complete the package.

One of the most serious areas of incompatibility is between the underwriting requirements for long term mortgage financing and short term contracts for services or rental assistance. Investors in tax-exempt bonds or Low Income Housing Tax Credits and lenders about to issue 20-40 year mortgage notes are very concerned about the long term viability of the development and its ongoing compliance with governmental regulations. Bonds also achieve the lowest mortgage rates when purchasers of the bond are assured of the long term financial stability of the underlying project. Long term financial stability, in turn, relies on mechanisms that allow a sufficient cash flow through tenant payments and/or long term subsidies.

In contrast, sources of service subsidies, rental subsidies, or other operating funds are subject to annual legislative authorization or appropriation. This includes contracts which are dependent on annual adjustments determined by HUD, such as the 202 Project Rental Assistance Contract. An additional problem is the increasing trend toward tenant-based, rather than project-based, rental subsidies. Subsidies that leave when a tenant leaves and may or may not accompany an incoming tenant, such as Section 8 vouchers or the rental subsidies allowed with HOME monies, do not provide long term cash flow assurances. Market rate projects are able to project their cash flow based on the income and resources of tenants. Some facilities may ask residents to leave when their resources are exhausted. Programs that are dependent upon public programs for low income residents are reluctant to or cannot "evict" tenants when government funding declines or terminates.

Program Funding Limits

Most programs limit their funding levels through annual program caps (such as 202, tax-exempt bonds, Low Income Housing Tax credits, CDBG and HOME), or development or per-unit limits (202, tax credits, HOME). These limits may create practical problems in program implementation. For example, the authorization or appropriation levels for the 202 program may affect the maximum unit size. It is usually set at 125 units, but in fact many HUD Field Offices do not receive sufficient allocations of funds, resulting in lower limits for most non-metropolitan areas and some metropolitan areas. In the first round of funding for
202, in fact, the appropriation for rental assistance funds only covered approximately 5 to 6,000 units, while the capital advances would have covered 9,400. The decreased size of the funding pool forced HUD to move the competition from the Field Office level to the Regional Office level.

Heavy competition for small pools of federal funds means that state or local agencies need to provide timely and helpful assistance to individual applicants, including providing necessary certifications (such as the certification by the appropriate state agency that the service plan for a 202 building is well designed), or allocating state and local funds on convenient timetables. Having a financing "pipeline", for example, where projects are submitted for processing as they are ready, rather than annual funding competitions that occur long before or after annual federal 202 competitions, or state competitions for tax credits, would be most helpful to projects that combine multiple funding sources.

The clear intent of many federal programs is to leverage state, local and private funds with limited federal funds. This means that in states that do not have sufficient funds to create their own programs, or where housing with services for the elderly is a relatively low priority, creating affordable assisted living options is very difficult.

States and localities that do have existing programs and funding sources need to be careful to match them with federal programs, in terms of income limits, rent restrictions and timetables for applications.

Uncertainty of Programs

Financing sources that are new, in transition or need reauthorization complicate long term planning. For example, the effectiveness of operating cost standards in the new 202 program is untested. It is unclear how well they will reflect actual market conditions and whether HUD will find suitable comparable projects in order to determine these levels. The 232 program handbook has not been revised to include complete board and care provisions, although that portion of the program was created in 1985. The Low Income Housing Tax Credit program has required re-authorizations every two years or less since its creation in 1986. Unless it is made permanent by pending House legislation, the program will periodically halt when re-authorization is delayed.

"We need to promote market diversity, choices, price and quality competition."
Don Redfoot, AARP.

In order to succeed, future funding mechanisms must acknowledge the major differences between assisted living and both housing and health care.
Differences from Conventional Housing

Assisted living can be very staff intensive with unusual staffing patterns (e.g., heavier in evenings when personal care needs are highest) that affect operating costs. Assisted living also works best with architectural designs that foster greatest self sufficiency for residents, such as short distances from units to dining room, a small "footprint" or foundation area, elevators in two story buildings, etc. These design factors may not fit design and/or cost standards or limits, but they may in fact help reduce the cost of service delivery and therefore operating costs.

Differences from Health Facilities

Successful marketing of this option depends greatly on a residential appearance and in fact on looking as little like a nursing home as possible. Regulatory or licensing standards based on health facility standards will not work with assisted living. The provision of skilled nursing service does not make a home into an institution and housing policies which equate the two are probably more concerned with perception than the ability of a resident to age in place. The prevailing philosophy of maximum resident involvement and a minimal amount of hands on service to promote independence makes it hard to "bundle" service packages and plan long term. This may also affect operating costs.

Operating Conflicts

HUD guidelines allow 202 projects to provide services, including personal care, yet 202 funds cannot be used to hire nurses. Most state rules require a role for nurses in assessing, supervising and monitoring the need for and provision of personal care. If implemented literally, HUD projects could receive contracts from Medicaid to provide services to Medicaid recipients, yet they would have to contract with a community agency for the nursing component. While HUD appropriately wants to avoid funding institutions, the provision of personal care and nursing services do not make an apartment or assisted living unit into an institution.

Further conflicts may exist in states that require the licensing of assisted living. HUD’s 202 program does not fund sites that require a license since licensure is equated with institutional care. While HUD guidelines are consistent with the configuration and service packages in assisted living, licensure requirements may force owners to adopt terms that do not fit the licensure requirements or, more likely, to develop service packages and resident guidelines that are not considered assisted living. There are two approaches. First, state licensure guidelines could focus on the services delivered in assisted living rather than the
facility in which services are provided. This approach could be applied to all facilities or an exception could be developed for those that are funded by the HUD 202 program. Second, HUD could consider modifying its policy against funding all facilities that require a license. As a housing and service option, assisted living could be considered a residential program which, despite licensure, does not classify assisted living units as institutions.

Summary

Despite the multiple limitations and conflicts between programs, states do have options for developing assisted living programs in existing and new buildings. The task is more challenging because policy has not caught up with state of the art practice and knowledge about this new model. Creative use of SSI and Medicaid eligibility options can provide enough support to interest private sector facilities in serving publicly supported residents. Service agency staff and HFA staff should talk about their mutual interests in developing supportive housing and service arrangements before assisted living policies are finalized. Collaboration between Medicaid, Aging and Housing Finance Agencies can create incentives for developers and owners to build facilities that set aside units for low income residents. Standards for assisted living units can be upgraded more easily when sources of financing for construction and rehabilitation can be accessed through HFAs and HUD.

Each of the resources described in Chapters V and VI includes opportunities and limitations. Some are more amenable to assisted living than others. HUD’s mortgage insurance (232) and construction programs (202) are easier to use than the LIHTC approach. The state programs describe in Chapter IV demonstrate that workable models can be designed to fit a range of priorities.
<table>
<thead>
<tr>
<th>Program</th>
<th>Benefits</th>
<th>Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>HUD 202</td>
<td>Serves low income.</td>
<td>HUD &amp; Medicaid income levels differ.</td>
</tr>
<tr>
<td></td>
<td>Addresses aging in place.</td>
<td>Impairment guidelines target less frail residents than Medicaid waivers.</td>
</tr>
<tr>
<td></td>
<td>Provides funding for services and coordinator staff.</td>
<td>Requires matching funds for 65-85% of service costs and outside contract</td>
</tr>
<tr>
<td></td>
<td></td>
<td>for nursing services.</td>
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<tr>
<td></td>
<td>Can use other non-federal sources of funding to enhance project design</td>
<td></td>
</tr>
<tr>
<td></td>
<td>and amenities.</td>
<td></td>
</tr>
<tr>
<td>HUD 232</td>
<td>Provides financing enhancements. Directed toward assisted living and</td>
<td>Needs rent and service subsidy for low income residents.</td>
</tr>
<tr>
<td></td>
<td>board and care.</td>
<td></td>
</tr>
<tr>
<td>LIHTC</td>
<td>Amount of credit tied to number of low income units.</td>
<td>Income levels vary with Medicaid.</td>
</tr>
<tr>
<td></td>
<td>Includes services: cost of optional services allowed above rent caps,</td>
<td>Limited ability to include mandatory service package.</td>
</tr>
<tr>
<td></td>
<td>(mandatory services within rent caps).</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reduced credit when combined with other federal housing programs.</td>
</tr>
<tr>
<td>Tax Exempt bonds</td>
<td>Favorable financing rates, mixed income (may discourage some developers).</td>
<td>Underwriting standards require stable financing for service funding.</td>
</tr>
<tr>
<td>HOME</td>
<td>Multiple uses, low income focus.</td>
<td>Requires non-federal matching sources; availability varies by state and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>local priorities.</td>
</tr>
</tbody>
</table>
Recommendations

Housing Policy

For a national program to be responsive, it needs to be flexible in design, cost, service packaging and "frailty" guidelines. Different states need to be able to develop programs that work in that state and can't be hamstrung by one national model. Conversely, for a state program to be responsive, it needs to access the growing pool of expertise of developers/sponsors, other states and localities. The existing, workable models around the country should be allowed to create umbrella programs, rather than trying to fit future developments into a narrowly defined national program. Accomplishing this will require that each state seek out input from the appropriate agencies, including the state unit on aging, the housing finance agency and the Medicaid agency.

Successful state programs can pave the way for legislative and regulatory changes which will facilitate the expansion of publicly subsidized assisted living. The steps that will support such an expansion are:

✓ Allow HUD 202 projects to support assisted living projects or units within a project even if they require state licensing as long as they remain residential and "home-like." Licensure alone does not equal institution.

✓ Establish broad criteria that allow flexibility in the physical design, resident profile and service package. There are a range of opinions (and practices) regarding the most appropriate resident population and the best way to serve this population. Industry experience is developing basic parameters and standards which will evolve over time. Today's practices should not be "frozen" or standardized with rigid program guidelines that may limit later improvements and innovations.

✓ Cost and/or design standards should accommodate a variety of models (e.g., with and without individual kitchens) and not rely on other types of housing for comparables.

✓ Regulatory oversight should be limited to basic safety concerns (e.g., fire codes) and avoid attempts to create quality through over regulation.

"We need to bring housing finance people to the table when talking about the future of long term care," Don Redfoot, AARP.
Assisted Living Guide

✓ The 232 mortgage insurance per unit cost guidelines should be increased to cover single occupancy units with kitchenettes and baths.

✓ Equity requirements for 232 mortgage insurance should be waived for non-profit organizations with track records for developing and managing elderly housing.

✓ Service subsidies and shelter subsidies should have the same contract terms and eligibility guidelines.

✓ Originating agencies need housing and services expertise. This is crucial in the initial design of a financing program (i.e., service delivery patterns have implications for architectural design) and for operating the program (developer should not have to go to several places to get funding for different pieces.) Traditional housing philosophies and medical care approaches must be modified to implement successful projects.

✓ Reconcile income eligibility differences between housing and Medicaid programs or develop service programs for non-Medicaid residents.

✓ Upgrade standards for living units in board and care and assisted living.

Service Policy

✓ Expand funding for services in assisted living sites.

✓ Expand financing for services for residents who are not eligible for Medicaid but are eligible for subsidized housing.

✓ Reconcile cost sharing requirements and restrictions between housing and Medicaid programs.

✓ Review state nurse practice acts to determine the potential for delegation of more functions to assisted living staff.

✓ Implement payments for personal care, skilled nursing and other services in board and care programs.

General Recommendations

✓ Policy makers in both state and federal housing and service agencies should coordinate their policies to complement mutual goals to support aging in place.
Time frames for funding, issuing RFPs and awarding contracts for housing and service agencies should be consistent to facilitate maximum use of resources developers, service agencies and providers.

The descriptions in this Guide and the resources available cannot always be applied easily in a state. Successful policy and program development requires careful deliberation and collaboration between service agencies, housing agencies, service providers and housing providers. Many of the obstacles cited in the descriptions of housing and service resources can and have been overcome. The results may be a program that is different from what would have developed in another environment. The limitations were drawn from the experiences of those who have "done" assisted living. Despite the problems, assisted living and housing and supportive models operate today. The limitations teach us what must be done to make government resources more "user friendly."

In many respects it is difficult to present exactly how specific projects worked around the limitations since program guidelines and agency policies are often shrouded in shades of gray. There is no substitute for local brain-storming, creative programming and communication with agency field and regional offices to resolve questions and chart a course.

Assisted living represents an entirely new approach to meeting the long term care needs of elders. The Fair Housing Act and the Americans with Disabilities Act adds even further impetus to the trend toward offering consumers choices based on their preferences. The seeds of a consumer driven model were planted years ago in independent living models for adults with disabilities and more recently in elderly housing models through the Robert Wood Johnson Supportive Services Housing Demonstration project.

Closing Comment

Participants at the Academy's assisted living seminar in April heard several key criteria that explain how assisted living differs from past models and how policy makers, program administrators, developers and providers should view assisted living. Michael Rodgers, Senior Vice President of the American Association of Homes for the Aging said, "Our role is to assist with, not to do for elders in assisted living."

And co-author Dick Ladd raised a more personal variable. "When I go into an assisted living facility, I always have the feeling that I could live there. I could not live in a nursing home." Policy makers might heed that thought as they design long term care policies and models for the future.
Finally, Don Redfoot, Legislative Representative for the American Association of Retired Persons, concluded the April seminar with this advice: "Always keep your ears to what consumer are saying and what markets reflect as far as demand from older consumers themselves; not what you think they ought to want, not what you think is tasteful but what consumers themselves are saying."
Endnotes


3. Ibid.


5. Ibid.

6. Ibid.


8. Ibid.


12. Ibid.


17. Ibid.

18. Throughout the Guide, SSI refers to both the federal payment and the state supplementary payment.


20. Unfortunately, a more appropriate term has not yet emerged. Despite its limitations, the Guide uses the term "facility" top describe assisted living environments in the absence of a better term.


22. Ibid.

23. Ibid.


--- **CVP** ---
26. Free standing ICFs are generally wood framed, 2 story dwellings without elevators. To meet nursing facility standards, these facilities must have an isolation room(s) with private bath close to the nursing stations, emergency generators, elevators if non-ambulatory residents live above the first floor and accessible toilets and bathing facilities. Susan McDonough, Lanzikos, McDonough and Associates. Boston, Massachusetts.

27. The Massachusetts Department of Public Welfare is considering creating a higher payment standard for programs which meet the draft guidelines for assisted living.

28. Since this program is relatively new, it is presented in more detail than the other programs.
APPENDIX
AGENDA

BUILDING ASSISTED LIVING INTO PUBLIC LONG TERM CARE PROGRAMS: A SEMINAR ON PUBLIC POLICY

Wednesday, April 15, 1992

8:30 - 9:00 a.m. Welcome and Introduction: This segment will review purpose of the meeting, format and agenda, defining assisted living and outline what states can do now to implement assisted living.

Charles Reed, Chair NASHP Long Term Care Steering Committee and Assistant Secretary, Aging and Adult Services, State of Washington.

Robert L. Mollica, Professional Staff, National Academy for State Health Policy.

9:00 - 10:00 a.m. The Assisted Living Approach: Private Sector Approaches

Paul J. Klaassen, President of the Assisted Living Facilities Association of America will describe the design, service package, frailty and health status of residents and costs of the private sector models. He will also address how assisted living avoids the institutional syndrome, builds a residential environment and balances social and health services to avoid the medical model.

10:00 - 12:00 a.m. Adapting Private Models for Public Programs - State Models of Innovative Programming and Financing

State models are targeting nursing home eligible populations. This session will present how states have developed assisted living despite multiple obstacles in current law and program regulations. The state experiences will highlight both the innovations and the lessons for policy considerations.

Richard Ladd, Administrator, Senior And Disabled Services Division, State of Oregon.

Charles Reed, Assistant Secretary, Aging and Adult Services, State of Washington.

Barry Berberich, Director of Long Term Care, Department of Social Services, State of New York.

Larry Polivka, Assistant Secretary for Aging and Adult Services, Department of Health and Rehabilitative Services, State of Florida.

Luncheon 12:00 - 1:55 p.m. Assisted Living and Long Term Care: What Is Its Place Along the Continuum?

Rosalie A. Kane, D.S.W., Professor, School of Public Health University of Minnesota, will discuss the potential of this approach to maintain independence as a necessary part of an effective long term care system. She will also explore the services, and the need to restore the essential components of residential living to support and promote independence.
Focus. This interactive working session will explore the policy conflicts between assisted living and existing programs, the need to implement a sound public assisted living model and the public policy changes that are necessary to advance this approach. Respondents and seminar participants will react to short statements on key issues.


Issues

Models: Where does assisted living fit with other models (Board and Care, Adult Homes, Congregate Housing, Conventional Housing with Services Arrangement, Nursing Facilities)? Is assisted living new packaging of old models or a new approach?

Resident profile: Who is it for, how do you target them, how much health care can be delivered in assisted living, how does assisted living fit in relation to long term care priorities?

Impact on state expenditures: What are the goals: cost savings or new services options. Is assisted living a cost effective alternative that will limit aggregate expenditures or new supply that will boost marginal long term care program costs?

Financing: What are the sources of financing for the services and housing (construction and operating costs). Can you balance design, size, amenities and costs.

Eligibility: What are the eligibility conflicts and limitations among programs: housing subsidies, Medicaid eligibility, National Affordable Housing Act and state general revenue programs.

Safeguarding Quality: Do we need licensing and/or standards? Can you safeguard quality without the high cost of extensive regulation? How do we avoid excessive bureaucracy and its added costs? How do you reconcile the roles of multiple state agencies? Which agency should administer the program?

4:30 - 5:00 p.m. The Next Steps - Creating an Agenda For Policy Reform

Don Redfoot, Legislative Representative, American Association of Retired Persons. The wrap up session will synthesize the issues explored during the seminar, highlighting areas of consensus and recognizing issues that require further development to develop a working agenda to pursue steps that will advance assisted living as an affordable state supported option for frail elders and disabled adults.
1. What is it?

Assisted living emphasizes a home environment and the provision of health and support services in a residential atmosphere. In a sense it represents a new approach that emphasizes the housing environment and home care services. Assisted living represents a new enthusiasm for serving elderly and disabled individuals. Some contend that assisted living facilities operate as unlicensed nursing homes. Others compare it to other housing and service models. Do today's models differ from nursing homes, board and care, personal care homes, adult homes? And is there a difference between congregate housing, retirement housing and assisted living or is assisted living a generic term that covers multiple models?

2. Profile

Assisted living interests public policy makers and program managers as an alternative to nursing homes. Private models may sometimes require independence in most ADLs upon entrance. Others do not. The resident mix of most facilities includes a sizeable percentage who are eligible for placement in a nursing facility.

Public models have thus far been developed for people who would otherwise be placed in a nursing home. Who is best served in assisted living? How much medical care can be delivered? Should skilled care be provided? Can everyone in a nursing home be cared for in this model? Is there still a place for nursing homes?

3. Aggregate Long Term Care Costs

Governments at all levels are desperate for effective steps to control long term care expenditures. Community care promised savings that never materialized. Maybe the expectations were faulty and community care is now valued in its own right.

Still states search for alternatives. Is cost savings the driving or even primary force in assisted living? Will new assisted living models mean an increased supply of long term care? What are we looking for in this model?

4. Financing

There are several ways to finance housing and services. The first approach selects a single program for both services, housing construction and operating costs. On the service side, a Medicaid approach creates a struggle to avoid the heavy regulatory tendencies that brought us institutions. Using HUD or a Government Sponsored Enterprise would ask housing agencies to care for, and manage services to, a frail population. In addition it would encroach upon the jurisdictions of multiple congressional committees.
The second approach builds on the expertise of both the housing and service systems. But this requires that existing policies be reviewed and revised from a totally new perspective. On the housing side, HUD or a government sponsored entity such as Fannie Mae could be used. Funds from service programs would have to meet underwriting requirements to ensure the viability of the housing financing. Which is the preferred approach? What is the best vehicle to finance services? Can it be done?

Funding streams affect the product. Should we separate funding streams for housing and services or keep them together like Medicaid nursing home reimbursements?

5. Eligibility

Public programs labor under conflicting eligibility guidelines governing income, assets, functional and health criteria. Guidelines have two basic purposes: to control costs by limiting participation and expressing the goal of the program by identifying the target population. The resulting criteria leave gaps.

How do you bridge the housing and service systems criteria? If HUD provides the housing financing, can only Medicaid recipients receive services? Must HUD cover services for non-Medicaid recipients? Should we preserve the traditional lines between housing development and management and the service systems? Does the new housing bill blur those lines and is the most effective approach.

6. Quality

In a private home or apartment, nearly any long term care service can be provided. When the locus of care moves out of the home, it becomes highly regulated, more institutional and it encourages dependence. A medically and functionally frail adult can often receive very extensive care in their own home and no one worries about the stairs, the corridor a locked medicine cabinet or the distance from the resident to the caregiver. Once the care setting moves outside the home, regulatory steps to protect the resident's safety take over and gradually the home like environment turns institutional.

As this industry comes under public scrutiny, do we accept too much of the regulatory approach? How can the goals of safety be converted into practice without making facilities and staffing requirements too rigid? Can we develop regulation on outcomes and avoid rigid standards for buildings and staffing?
NEGOTIATED SERVICE AGREEMENT

Resident: ___________________________Unit Number: ___________________________

Date of Arrival: __________/________/________ Date Agreement Initiated: __________/________/________

The following Negotiated Service Agreement is a joint effort between the resident, family members (when appropriate), Aging and Adult Services Case Manager and facility staff. Its purpose is to define the services that will be provided to the resident, with consideration for preferences of the resident as to how services are to be delivered.

For each service item, develop a statement which includes service delivered, who provides the service, when the service is provided, how the service is provided, and the frequency of the service provided.

NURSING SERVICE NEEDS AND PREFERENCES

- Health Monitoring
- Nursing Intervention
- Special requests
- Supplies/Services Coordination
- Medication

PERSONAL SERVICE NEEDS AND PREFERENCES

- Toileting
- Bathing
- PM Preparation
- Dressing
- Hygiene
- Ambulation
FOOD SERVICE NEEDS AND PREFERENCES

____ Dietary  ____ Eating

ENVIRONMENTAL SERVICE NEEDS AND PREFERENCES

____ Safety  ____ Housekeeping/Laundry

SOCIAL/EMOTIONAL SERVICE NEEDS AND PREFERENCES

____ Family Intervention  ____ Information/Assistance  ____ Counseling

____ Orientations  ____ Behavior Management  ____ Socialization

ADMINISTRATION NEEDS AND PREFERENCES

____ Business Management  ____ Transportation
LEVEL OF ASSISTANCE NEEDED: ____________________________

For this Service Agreement to be effective, signatures of participating are requested. Signing below indicates that the services that are provided to the resident shall be provided as outlined in this Service Agreement. Amendments shall be added as necessary, when services and/or needs and preferences change.

<table>
<thead>
<tr>
<th>RESIDENT SIGNATURE:</th>
<th>DATE:</th>
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<tbody>
<tr>
<td>FAMILY MEMBER:</td>
<td>DATE:</td>
</tr>
<tr>
<td>FACILITY STAFF:</td>
<td>DATE:</td>
</tr>
<tr>
<td>AAFS SOCIAL WORKER OR COMMUNITY NURSE:</td>
<td>DATE:</td>
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</tbody>
</table>
# RESIDENT DIRECTED GOALS

<table>
<thead>
<tr>
<th>NAME:</th>
<th>APARTMENT #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREFERENCES TO BE CALLED:</td>
<td>PHONE #:</td>
</tr>
<tr>
<td>PHYSICIAN:</td>
<td>PHONE #:</td>
</tr>
<tr>
<td>FAMILY/CONTACT PERSON:</td>
<td>PHONE #:</td>
</tr>
<tr>
<td>AAFS CASEMANAGER:</td>
<td>PHONE #:</td>
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</tbody>
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## FORMER OCCUPATION/CURRENT INTERESTS

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## BRIEF HEALTH HISTORY

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The following statements are written in an effort to assure that the services provided are carried out in a manner consistent with the principles of Assisted Living, supporting choice, independence, individuality, dignity, privacy, and a sense of home. To the extent possible, they should reflect the resident’s own values and goals.

Date new entries.

## GOALS AND APPROPRIATE STAFF PROCEDURES

- [ ]
- [ ]
- [ ]
- [ ]
- [ ]
AN EXAMPLE OF ASSISTED LIVING UNITS

UNIT A 14 ft. x 22 ft. module
State Contacts

Florida
Vicki Flynn
Vicky Campos
Aging and Community Services
Aging and Adult Services
1317 Winewood Boulevard
Tallahassee, Florida 32399
904-488-2881

Massachusetts
Diane Flanders
Medical Assistance Division
600 Washington Street
Boston, Mass. 02111
617-348-5570

Jan Levinson
Jean Moltenbrey
Executive Office of Elder Affairs
1 Ashburton Place
Boston, Mass. 02108
617-727-7750

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Department of Social Services
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Albany, New York 12243
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Frank Rose
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503-378-3751

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Charles Reed
Harry Sedies
Aging and Adult Services
MS OB-44A
Olympia, Washington 98504
206-586-3768