SENIOR HOUSING IN NEW YORK STATE

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Prepared by

LeadingAge™ New York

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TABLE OF CONTENTS

EXECUTIVE SUMMARY

Senior housing is the least restrictive and most flexible congregate living arrangement in the senior living continuum, providing a supportive environment for aging-in-place. It also offers an ideal platform for efficiently and effectively delivering home care, other health services and social and environmental supports.

There are a wide variety of housing options available to New York's seniors. Various terms are used to describe these facilities, but there is no universal terminology to describe senior housing. Adding to the confusion are multiple assisted living definitions and models in New York State and the sometimes vague distinctions between assisted living and senior housing with supports.

This paper provides information on the demographics of New York's aging population; the types, features and benefits of senior housing; supportive services and care coordination; health care services available to residents; and state/federal policy initiatives affecting senior housing. The paper also reviews New York's assisted living regulations and how they compare and contrast with senior housing regulations, and describes innovative state and national models of housing development and service integration.

Following a comprehensive review of literature and demographic data and a series of site visits to innovative housing models in New York State and neighboring states, we found that:

1. New Yorkers are aging and there will be an increased future demand for senior housing, support services and home and community-based health care services.
2. There is already an unmet need in many areas of New York for subsidized senior housing with support services and upgraded building features.
3. Federal funding for new subsidized housing development is waning, and other funding programs leave gaps and add complexity.
4. Aging-in-place programs and partnerships can help to address shortages of subsidized senior housing.
5. State assisted living regulations that define independent senior housing are unclear and confound the development of innovative housing with services models.
6. New York's Medicaid redesign initiatives will fundamentally change how services are delivered and paid for in New York, and that in turn will affect senior housing residents.
7. There are important gaps in the availability of service coordination and support services.
8. The state's proposed investment in supportive housing is focused on costly Medicaid recipients, rather than on an aging-in-place model for seniors.
9. Federal regulations, funding and programs are promoting senior housing as a platform for delivering supportive and health care services.
10. Senior housing operators in New York State and around the country have developed creative housing with services models that should be studied and possibly replicated.

Further analysis is suggested to explore the inter-relationships between these conclusions, their broader system implications and the associated public policy ramifications. As these conclusions suggest, housing operators have an historic opportunity to meaningfully participate in the development of living arrangements that blend social supports, wellness programs and health care services in a way that enhances resident quality of life and promotes independence.

INTRODUCTION

Senior housing is the least restrictive and most flexible congregate living arrangement in the senior living continuum, often providing a variety of benefits including socialization, resident assistance and a supportive environment for aging-in-place. Meals, transportation, laundry, housekeeping, security, emergency response, and resident assistance are all examples of services that may be offered as part of senior housing. Senior housing also offers an ideal platform for efficiently and effectively delivering home care, other health services and social and environmental supports. These services enable seniors to remain independent and enjoy a high quality of life as they age.

A wide variety of senior housing options exist in New York State, but their availability to individual seniors is dependent on various factors including financial circumstances and geography. Some models are government regulated (and offer subsidized rent for income qualified residents) while others are not. Some are part of a campus offering multiple long term care and support services, while others are age-restricted buildings that provide no services. Various terms are used to describe or market these facilities, but there is no universal terminology to describe senior housing. Adding to the complexity are multiple assisted living definitions and models in New York State and the sometimes vague distinctions between assisted living and senior housing with supports.

Seniors face a daunting array of potential choices in NYS when they make the decision to move to senior housing. Oftentimes the decision is made at a time of a major life change such as the death of a spouse, general physical decline or following a medical emergency or illness. Even for seniors that are deliberately planning a move, the information needed to make the correct choice can be overwhelming.

The complexity and confusion also extends to senior housing operators and other service providers. The NYS Assisted Living Reform Act of 2004 (the "ALRA") exempted multi-family and independent senior housing from assisted living licensure, but the ensuing regulations failed to draw a clear line between senior housing with supports and assisted living arrangements.

This paper describes in detail the demographics of the aging population in New York State; various types, features and benefits of senior housing; supportive services and care coordination in senior housing; health care services available to seniors; and policy issues affecting senior housing including Medicaid reform and federal initiatives. The paper also reviews New York's assisted living models and regulations and delineates the differences between assisted living and senior housing. Lastly, several innovative and successful state and national models of housing development and service integration are presented based on site visits and interviews with key stakeholders.

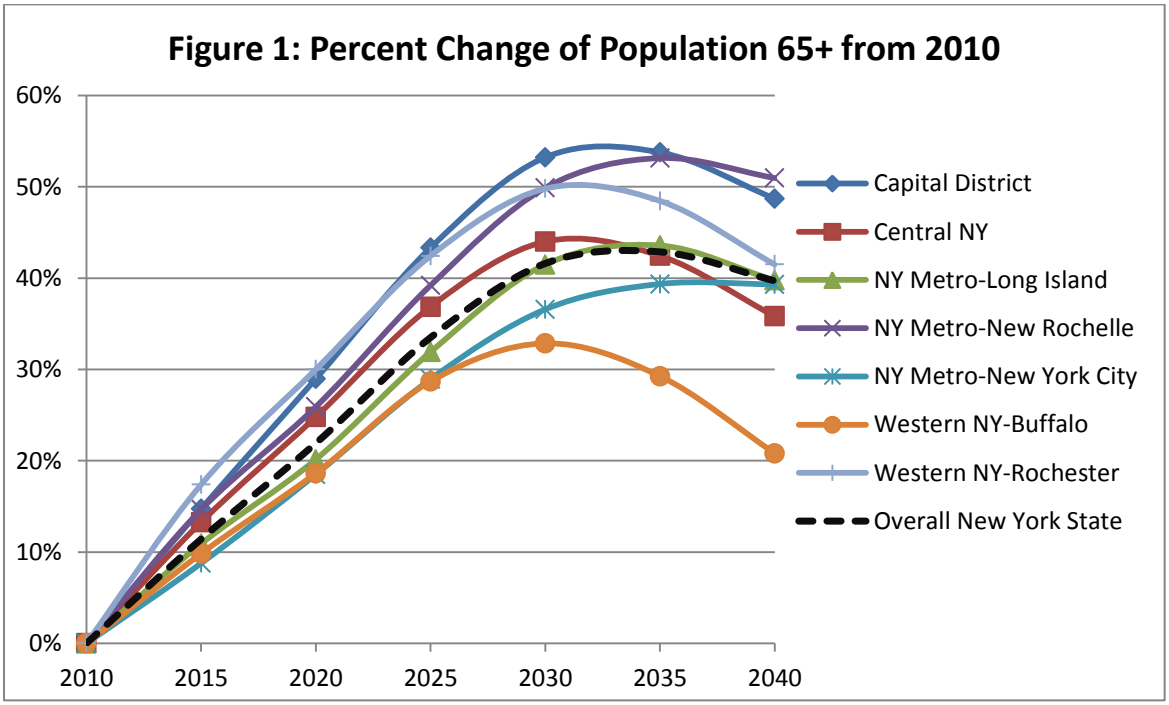
CHAPTER 1: DEMOGRAPHICS AND THE DEMAND FOR SENIOR LIVING AND SUPPORTS

The number of individuals aged 65 and older, as a percentage of the total US population, has steadily increased from 8.1% in 1950 to 12.1% in 2010 and will continue to rise; in 2050 it is projected that over 20% of the population will be 65 years or older [1]. The fastest growing age group is the "oldest old" (defined as those aged 85 and older), with their numbers expected to swell from 5.7 million in 2010 to over 19 million in 2050 [2]. This changing demographic has enormous social and public policy implications, not the least of which is the availability of housing and the delivery of health care and other support services to older adults. What follows is an overview of New York State's older adult population including aging trends, income levels and poverty rates, disability rates and living arrangements. Regional level analysis is reported if the data was available.

Population and Aging Trends

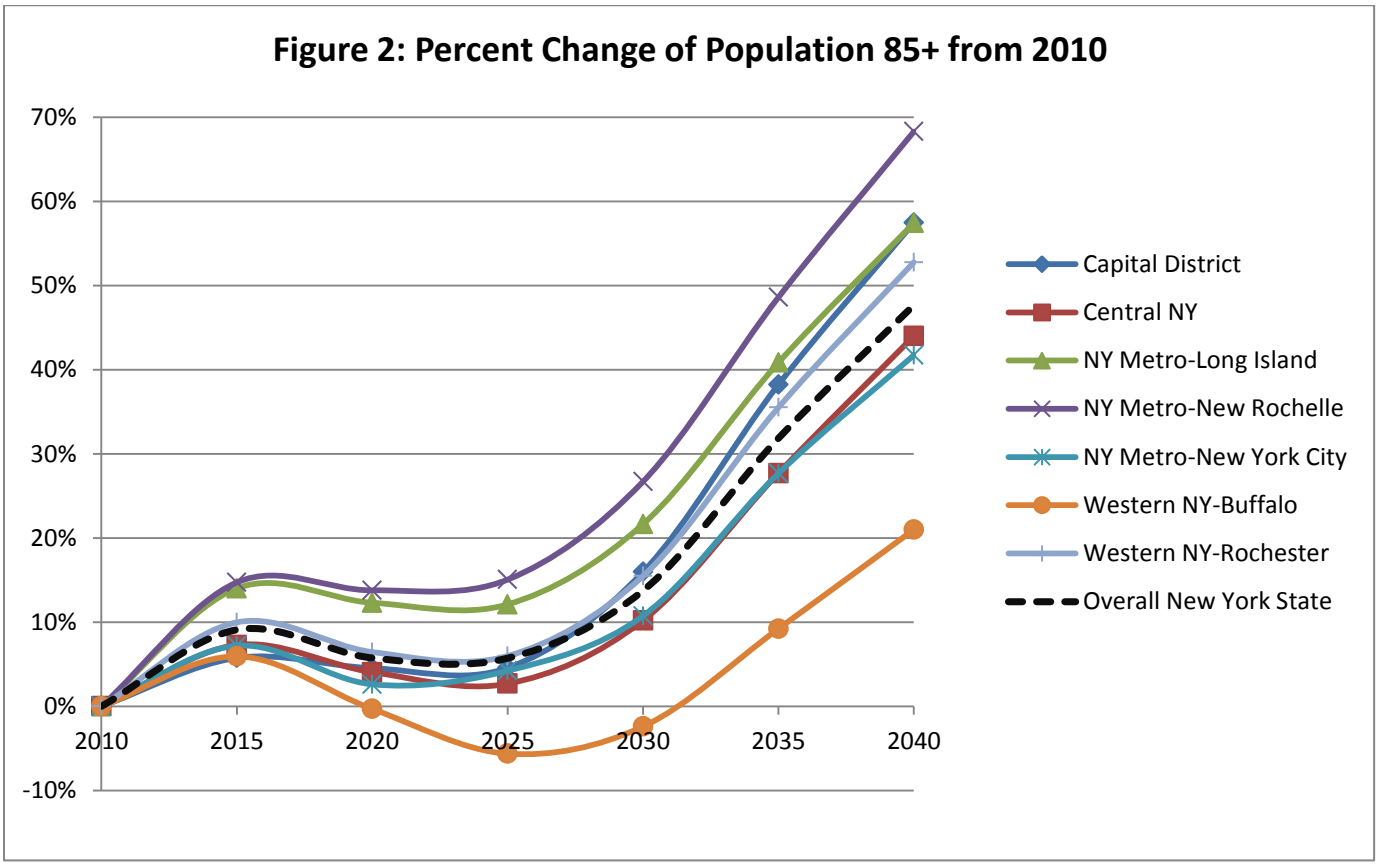
NYS follows the national aging trend; recent studies show the number of individuals aged 65 and older in the state will grow from approximately 2.6 million in 2010 to 3.6 million in 2040, a nearly 40% increase. This increase is a result of the large cohort of Baby Boomers (i.e., those born between 1946 and 1964) reaching the age of 65. During the same time period, the 85+ population will grow by 48% from approximately 368,000 in 2010 to over 543,000 in 2040 [3].

In analyzing population trends by NYS region, we find several significant differences. As Figure 1 illustrates, although the population aged 65 and older increases in all regions from 2010 to 2030, the increase is most pronounced in the Capital District (53%) and New Rochelle regions (50%). In the Buffalo region, over that same period, the increase is a more modest 33%. After 2030 the growth rate of the 65+ population begins to decline in all NYS regions, consistent with national projections.



Source: Program on Applied Demographics, Cornell University

When examining population trends in the "oldest old" age group, we again see the influence of the Baby Boom cohort. As shown in Figure 2, the 85+ population declines overall in NYS as well as in each region between 2015 and 2025, with the Buffalo region experiencing the most significant decline (12% lower than 2010). However, between 2025 and 2040 when the Baby Boomers begin to reach age 85, the oldest old population is projected to experience tremendous growth; when compared to 2010, there will be 48% more adults aged 85+ living in NYS in 2040. The most significant growth will occur in the New Rochelle region (70%) followed by the Capital District and Long Island regions (57%), suggesting that demand for long term care (LTC) services and supports in these regions will also increase dramatically.

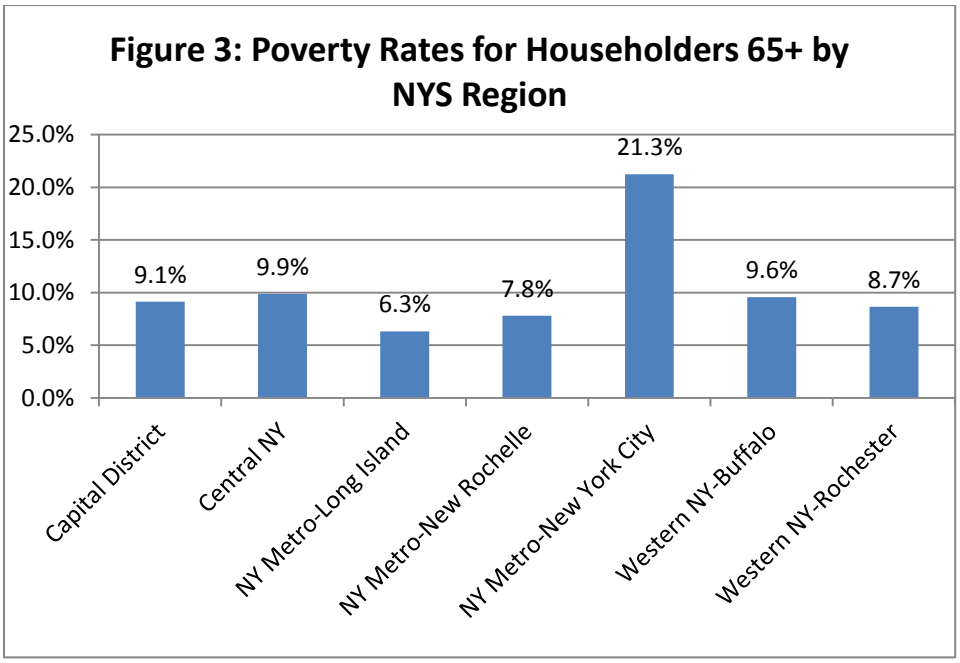


Source: Program on Applied Demographics, Cornell University

Income and Poverty

The median household income for NYS householders aged 65+ in 2010 was $33,960 [4]. However, an estimated 1 in 4 persons in this same age group relies on Social Security as their sole source of income, which averages $14,568 per year for an individual [5]. Furthermore, for nearly two-thirds of older adults, Social Security accounts for more than 50% of their income [6], demonstrating the importance of this federally-funded program to the economic security and well-being of many older adults.

While Social Security lifts approximately 813,000 NYS seniors out of poverty each year [7], 13.3% of individuals aged 65+ remain below the poverty threshold (defined in 2012 as $11,170 for single households and $15,130 for two-person households) [8]. In addition, 25.4% of individuals in this age group had income below 150% of the poverty threshold (i.e. $16,755) [8]. As illustrated in Figure 3, poverty rates vary widely across NYS regions. Particularly striking is that a relatively low percentage (6.3%) of 65+ householders residing in the Long Island region are below the poverty level, while in the neighboring New York City (NYC) region, an estimated 21.3% of older residents are considered poor. These statistics may help explain at least one reason for the staggering numbers of older adults on the waiting list in the NYC region for subsidized senior housing apartments.



Source: American Community Survey 2006-2010

Female householders aged 65+ in NYS face an even greater burden due to the fact that they are disproportionately poor. In 2008, 67% of NYS householders aged 65+ with income below the poverty level were widowed or non-married women [5]. Oftentimes this is a result of lower wages, lower lifetime earnings and fewer years in the workforce.

Living Arrangements

Currently 94% of the U.S. 65+ population lives in traditional community housing, 2% in community housing with services, and 4% in LTC facilities [9]. In NYS, approximately 3.8% of the population aged 65+ lives in nursing homes [10]. The percentage residing in LTC facilities increases with age but even among the oldest old population (those aged 85 and over), 75% still remain in traditional community housing [9]. This data supports a recent AARP survey that found 9 of 10 older adults express a strong desire to remain in their own home and/or in their local community for as long as possible [11].

Importantly, in the U.S. nearly 30% of all non-institutionalized older adults in 2010 lived alone. This group represents a potentially vulnerable population since those living alone are more likely to get sick without anyone to care for them. Living alone is more common in older women than in older men (37.3% vs. 19.1%) and the proportion increases with advanced age [2].

In NYS, the rate of living alone among older adults is the same as the national rate (30%). However, this proportion varies fairly significantly across the regions from 23.1% in Long Island to 34.1% in Buffalo (Table 1). And, data shows that along gender lines, a higher percentage of older women in NYS live alone (38.1%) than older men (21%) [3].

Table 1: 2010 NYS Population 65+ Living Alone

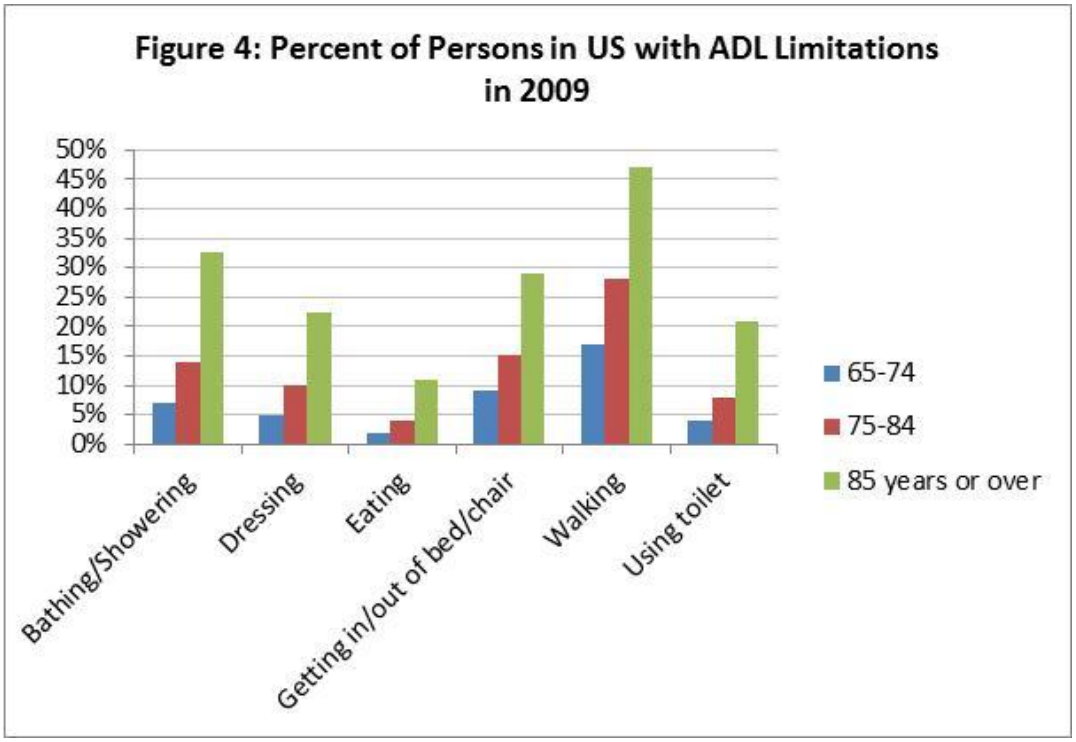
Region	% Living Alone
Capital District	31.3
Central NY	31.9
NY Metro-Long Island	23.1
NY Metro-New Rochelle	28.3
NY Metro-New York City	31.3
Western NY-Buffalo	34.1
Western NY-Rochester	31.5
Overall New York State	30.0

Source: Program on Applied Demographics, Cornell University

Disability, Functional Limitations and Chronic Disease

National data indicates that some type of disability (i.e. difficulty in hearing, vision, cognition, ambulation, self-care or independent living) was reported by 37% of older adults in 2010 [2]. Not surprisingly, reported disability increases with age; 56% of persons over the age of 80 reported a severe disability and 29% reported that they needed assistance with daily tasks. A common measure of ability/disability in older adults is the Activities of Daily Living (ADLs) scale which measures self-performance with everyday tasks including bathing, dressing, transferring, eating, grooming, and toileting. An individual's ability to perform ADLs is important for determining the type and frequency of LTC services an individual needs. As Figure 4 illustrates, there is a sharp increase in ADL limitations with increasing age. Nearly 47% of individuals aged 85+ have difficulty walking; 32% need assistance with bathing/showering; and over 1 in 4 has limited ability to get in and out of a bed or chair.

Moreover, older adults living in subsidized housing have been found to have even higher rates of functional limitations and impairments. For example, the 2002 American Community Survey found over half of respondents living in publicly assisted housing reported limitations in activities such as walking and climbing stairs and one-third reported difficulty with shopping [12]. A recent study conducted by the NYC Housing Authority found that 29% of residents in NYC public housing aged 65+ had at least one ADL limitation, and ADL limitations were associated with lower income and being female [13].



Source: AOA Profile of Older Americans 2011 Report

Additionally, chronic diseases are the major cause of illness, disability and death in the US; it is estimated that the cost of chronic diseases will reach $864 billion by 2040 [14]. A recent study found that the proportion of older adults reporting one or more chronic diseases (defined as hypertension, heart conditions, chronic lung disease, diabetes, stroke, cancer and arthritis) was 92.2% in 2008 and those reporting four or more chronic conditions was 17.4% [15].

Obesity is a major risk factor for a variety of chronic diseases such as diabetes, hypertension and arthritis, and is a major contributor to functional limitations. Recent studies have found obesity rates steadily increasing in the older adult population, especially in the "young old" age group (65-74 years old) [16]. In NYS, the percentage of individuals aged 65+ who were obese grew from 16.7% in 2000 to 22.2% in 2010, an increase of about one-third. As shown in Table 2, rates vary by region; Central NY and Buffalo have the highest obesity rates (over 26%) while New Rochelle has the lowest rate (18.9%).

Table 2: 2010 Obesity rates of NYS Population 65+ by region	
Region	**%**
Capital District	23.3
Central NY	26.6
NY Metro-Long Island	22.2
NY Metro-New Rochelle	18.9
NY Metro-New York City	20.2
Western NY-Buffalo	26.9
Western NY-Rochester	23.5
All	22.2

Data source: 2010 BRFSS

It is widely expected that home and community-based services will become increasingly important to support the higher numbers of older adults with functional limitations and chronic diseases [2].

CHAPTER 2: THE CURRENT LANDSCAPE OF SENIOR LIVING IN NYS

Definitions

Housing

Housing, in its broadest definition, refers to any shelter, lodging or dwelling where an individual resides. For purposes of this paper, we will use the term "housing" to mean rental housing for seniors, of which there are two basic types: *subsidized housing* involving a government subsidy of a developer and/or a resident in order to effectively reduce the monthly rent for income-eligible residents; and *market rate housing* in which rents are set by the owner/operator based on local market conditions. There are some *mixed financed* senior housing complexes that have both affordable and market rate housing on a single campus.

Senior housing operators must comply with the federal Fair Housing Act and state and local fair housing laws. The requirements of the fair housing laws are extensive and include prohibitions against taking actions or making statements because of a resident's protected status. These prohibited activities include refusal to rent or renew a lease, or taking other actions that discriminate against any person because of that person's race, color, religion, national origin, sex, disability or familial status. In addition to the federal protected classes, NYS protects persons based on creed, marital status, sexual orientation, age and military status. In general, evictions are allowed in senior housing only when a resident breaks the lease, rental agreement, or house rules or if it can be shown that he/she poses a danger to others. From a fair housing standpoint, a senior housing provider is first and foremost a landlord, and does not operate as a medical or personal assistance provider.

The ability to develop senior housing and rent to an "age-restricted" population is authorized through land use and zoning regulations. Localities can set aside specific areas as "retirement community districts" and municipalities must develop a comprehensive plan for their zoning, which provides a legal basis for their designations.

Senior housing may also be referred to as "retirement communities," "independent living communities," "active adult communities" and "senior apartments." While the cost, amenities and services offered in senior housing vary greatly, typical features and advantages include:

- *Home maintenance* – as seniors become older the ability to maintain a home can become a financial and physical burden. Most senior housing communities include common areas and apartment maintenance as part of the rental contract.
- *Socialization* – isolation becomes a critical concern for seniors. Senior housing allows residents to easily develop friendships and participate in shared activities with peers.
- *Transportation* – for seniors living in single-family homes or apartments, driving an automobile can become limiting or dangerous. Senior housing facilities may have their own transportation, be located close to public transportation, or be able to assist residents with arranging transportation.
- *Building features* – many senior housing communities are architecturally designed to address physical limitations that growing older may bring. For example, bathrooms may be equipped with handrails and grab bars, kitchen and bathroom sinks may have universally designed features, and/or elevators may be available for those with mobility issues.
- *Support services* – there is usually access in senior housing to some on-site amenities. For the purpose of this paper, "support services" are considered services other than personal care or health care that are available as part of the rental contract or for an additional fee.

- *Resident advisor/service coordinator* – staff may be available to assist residents in accessing information on insurance and public benefits they may be eligible for, and agencies that deliver services in the community. Access to information on locating and arranging for aging services in the community is often critical for seniors to remain independent.
- *Reduced housing costs* – congregate senior housing can result in considerable reduction in housing costs for seniors, especially for those who qualify for and are able to find a vacancy in subsidized housing.
- *Security* – staff and building amenities offer increased security for residents. Building security features can include locks, alarms, security guards, "pull cords" and personal emergency response systems to alert emergency responders and other security technologies that enhance resident safety.

Support services

Senior housing facilities vary considerably in the provision of support services. Some facilities provide only a place to live in an age-restricted community, with little or no support services available on-site. The resident directly accesses any needed support services from the local community. Other facilities have some on-site support services, which can be either included in the lease/residency agreement or paid for separately by the resident. There may be a resident service advisor/service coordinator available to residents to access on-site and community services.

Finally, other housing operators offer comprehensive on-site support services for residents that may be included in the lease/residency agreement. The housing community provides and arranges these support services and can offer several different packages varying in price and level of service. This model is found predominantly in market-rate housing, but subsidized housing communities are increasingly working with county aging agencies to offer more on-site support services to their residents.

The availability, delivery and coordination of support services in senior housing have a bearing on residents' ability to age-in-place. By having support services on-site, residents are able to minimize the need for off-site transportation and other costs/logistics. In addition, through economies of scale, these support services can often be delivered to residents at a lower cost on-site in a congregate setting than if each individual resident needed to separately access these same services in the community.

Support services in senior housing are defined in this paper as non-medical services (i.e., those not requiring NYS Department of Health licensure) which include, but are not limited to:

- *Dining* – full-service dining facility; home-delivered meals including "Meals on Wheels"; on-site amenities such as stores and cafes; and meal preparation.
- *Security/staff* – emergency response including personal emergency response systems (PERS); security staff (sometimes on a 24-hour basis); building security features and fire systems.
- *Resident services* - transportation to shopping, appointments and entertainment; personal laundry and linen service; resident shopping; housekeeping, light cleaning; and pharmacy delivery.
- *Education/entertainment* – recreational and social activities; wellness programs; educational programs; fitness centers/activities and social day programs.

NYSOFA Programs and Services

Support services are available for income-qualified seniors through the NYS Office for the Aging (NYSOFA) that can be delivered in private homes, congregate senior housing or other community locations such as senior centers. NYSOFA services primarily serve low-to-moderate income seniors and are often delivered or coordinated in subsidized senior housing. Specific examples include congregate and home delivered meals; nutrition counseling; Level I and II personal care services (i.e., housekeeping, preparing meals, shopping); transportation; health promotion; Elderly Pharmaceutical Insurance Coverage (EPIC); legal assistance; social adult day services; caregiver support; respite; senior centers; and Naturally Occurring Retirement Community supportive services.

NYSOFA services are funded through the federal Older Americans Act, state budget appropriations, local match funds and participant contributions. The services are administered through the local Area Agencies on Aging (AAAs) based on the county's local aging plan. Services are limited due to availability of funding, with most such programs in NYS having been level-funded or modestly reduced in recent years. For instance, there may be a waiting list for seniors to receive housekeeping or shopping services due to a high need in that geographic area.

While these services are available individually to qualified senior housing residents, they are not typically offered as a package of services in senior facilities. Some subsidized senior housing communities are attempting to partner with AAAs to offer a package of support services for their residents. For those that are not income qualified for the NYSOFA programs, the housing provider or AAA may broker a lower price for the support services from the service providers.

NORC and NNORC Programs

The Naturally Occurring Retirement Community (NORC) concept is based on a housing community that was not originally built for seniors, but that now is home to a significant proportion of older residents that have aged in place. NORC programs organize and locate a range of coordinated health care and social services and group activities both on-site and in the community. Program services may include case management, health care management, educational programs, recreational activities and transportation for participants.

The first NORC was established in 1986 at Penn South Houses in NYC. In 1995, NYS began providing state funding for the model, followed by NYC in 1999. In 2005, NYS legislatively recognized and dedicated funding for the Neighborhood NORC (NNORC) model. The NNORC takes the concept of the "vertical" NORCs and provides a "horizontal" NORC approach to serving seniors living in their own detached homes within a designated geographic area. NNORC program services have the flexibility of meeting the needs specific to the community as determined by community members.

Currently found in several states, NORCs are expected to become more common as the population ages. At present, 54 NORC programs operate in housing developments and neighborhoods across NYS in communities that are home to more than 50,000 seniors [17].

NYS funding for both NORC and NNORC supportive services has essentially stayed the same over the past several years at approximately $2 million total for each program. From these amounts, NYS provides funding to 34 NORC programs, which are located in housing developments of varying sizes. While many NORCs and NNORCs are supported by NYSOFA funding, additional funding includes in-kind contributions, housing partners, philanthropies, corporations, community stakeholders, and resident membership fees. Eligibility for services and programs is based on age and residence in the NORC/NNORC, rather than on functional deficits or economic status.

NORCs and NNORCs promote independence and healthy aging by creating public-private partnerships of social service and health care providers, housing managers or neighborhood representatives, and community residents, especially seniors. Furthermore, the NORC approach does not require new housing construction or resident relocation since it can be developed in existing neighborhoods as well as congregate housing facilities.

Health care services

Senior housing residents have access to a variety of health care services just as they would in single-family homes. Foremost are home and community-based services (HCBS), provided directly through home care or personal care agencies that deliver services to that location and through community-based programs such as adult day health care centers. Sources of payment for HCBS vary depending on the individual's income and eligibility, but include private insurance, out-of-pocket payment, private insurance, Medicare, Medicaid, and managed care plans. The following services are among the HCBS available to senior housing residents.

Home Care, Personal Care and Waiver Services

Home care consists of nursing, therapy or personal care services provided in an individual's home, and is regulated by DOH. Home care licensure categories include licensed home care services agencies (LHCSAs) (also referred to as "personal care providers"), certified home health agencies (CHHAs), and Medicaid Section 1915(c) waiver programs. The most common services provided are help with tasks (such as laundry, shopping, housekeeping, personal hygiene and meal preparation) as well as skilled nursing and therapy services. Home care can help individuals who have long term needs related to a chronic illness or disability, or short-term needs after a hospitalization.

LHCSAs provide hourly nursing care and homemaker, housekeeper, personal-care attendants and other health and social services. CHHAs provide part-time, intermittent health care and support services to individuals who need intermediate and skilled care. CHHAs can also provide long-term nursing and home health aide services, help patients determine the level of services they need; either provide or arrange for other services including physical, occupational, and speech therapy, medical supplies and equipment; and social worker and nutrition services.

At present, residents in senior housing who qualify for nursing home level of care can apply for Medicaid waiver services that offer an array of supports to help them remain in an the community. In NYS, these programs include the Long Term Home Health Care Program, the Nursing Home Transition and Diversion program and the Traumatic Brain Injury program. These waiver programs provide access to support services that Medicaid ordinarily would not cover. New York also has the Consumer Directed Personal Assistance Program which enables the consumer or a person acting on the consumer's behalf to assume direct responsibility for hiring, training, supervising, and – if need be – terminating the employment of persons providing the services.

As noted later on in this paper, the state's Medicaid redesign efforts will eventually require most seniors receiving services through home care, personal care and waiver programs to be enrolled in Medicaid managed care plans. This could significantly change how these services are authorized, funded and delivered in the future.

Adult Day Services

In NYS, adult day services are offered in two forms – adult day health care (ADHC), also known as medical model adult day care, and social adult day care (SADC). These programs offer a safe and secure environment for people who can live at home with informal supports, but need supervision during the daytime. Both ADHC and SADC programs are utilized by senior housing residents, with some programs actually located on-site in the housing facility.

ADHC programs are staffed by professionals including therapists and registered professional nurses who conduct assessments, administer medicine and perform other health care tasks. These programs are regulated by DOH and must be sponsored by a nursing home or a hospital. ADHC programs provide social activities in addition to medical services and arrange for transportation to and from participants' homes. As with home care, personal care and waiver services, ADHC services will also be affected by state mandates for most seniors to enroll in Medicaid managed care plans.

SADC programs are oriented toward the social aspects of life and may include games, memory orientation exercises, music, dancing and reading in a safe and supervised environment. These programs also provide a meal, some help with daily living activities, and offer supervised field trips and special events. SADC programs that receive state funding are overseen by NYSOFA but are not licensed and, as such, are considered "support services" as previously defined in this paper.

Service coordination

Some senior housing operators have staff available to assist residents in accessing information on services offered on-site and in the community. Titles for this staff person vary but include "service coordinator" and "resident service advisor." Having information on the options, cost and availability of support and health care services is often critical for seniors to remain in an independent setting and prevent or delay institutional placement. Residents have a choice on whether to access a service coordination program.

Service coordinators/resident service advisors act as a liaison for the resident with community programs and organizations; offer information to residents on community resources tailored to individual needs; and serve as an advocate for the resident when requested. Through service coordination, seniors and their caregivers can receive assistance on payment and eligibility issues with Medicare, Medicaid, other types of insurance, health care services, support services and other community programs from a professional knowledgeable in aging services.

While allowable activities for service coordination are somewhat unclear for independent senior housing entities as a result of the state's assisted living regulations, duties for service coordinators funded through the U.S. Department of Housing and Urban Development (HUD) under federal guidelines are quite specific.

HUD service coordinators assist senior housing residents in obtaining supportive services, coordinating service delivery to maximize independent living, and monitoring the quality and quantity of services to fit the wants and needs of residents. Originally authorized by Congress in the early 1990s, service coordinators have emerged as staff members at approximately half of the Section 202 communities across the country [18]. HUD regulations specify the major functions of service coordinators:

- Provide general case management (including intake) and referral services to all residents needing such assistance. May provide formal case management for a resident when such service is not available through the general community;
- Establish linkages with all agencies and service providers in the community; shop around to determine/develop the best "deals" in service pricing to assure individualized, flexible and creative services for the involved residents;
- Set up a directory of providers for use by both project staff and residents;
- Refer and link the residents of the facility to service providers in the general community;

- Educate residents on service availability, application procedures, client rights, etc., providing advocacy as appropriate;
- May develop case plans in coordination with assessment services in the community;
- Monitor the ongoing provision of services from community agencies and keep the case management and provider agency current on the individual's progress;
- Manage the provision of supportive services where appropriate;
- Help the residents build informal support networks with other residents, family and friends; and
- May educate other staff on the management team on issues related to aging-in-place and service coordination to help them to better work with and assist the residents.

HUD guidelines prohibit service coordinators from serving as an activities director, providing direct services to residents, or performing housing management responsibilities. With signed resident consent, HUD service coordinators can also monitor a resident's health care condition and communicate with and schedule appointments with the resident's service providers.

Due to the wide variety of individual support services and health care needs of senior housing residents, and the complexity of obtaining, contacting and coordinating these services, the service coordinator position is a vital service that allows many seniors to remain in an independent setting.

Types of Rental Housing

Market rate senior housing

There are several types of market rate senior housing in NYS that have been developed as age-restricted residences and charge rents at prevailing market prices. Market rate models include elder cottages, apartment buildings for seniors, active adult communities, retirement communities, continuing care retirement communities (CCRCs), senior co-operatives and condominiums. Some retirement communities are located on a campus with separate levels of care (including assisted living or nursing home) but others are separately incorporated from the housing facility.

Market rate housing does not receive government funding to subsidize resident rents, and residents typically sign a lease or residency agreement that stipulates the monthly fee and included services. Prices vary greatly depending on factors such as location, amenities, staffing and support services included in the rental charge. Support services may be offered for additional fees. Some market rate housing arrangements require an entrance fee that may be partially or fully refundable when the person leaves. Senior residential communities in NYS that require an entrance fee are required to file an offering plan with the NYS Department of Law. Similar to requirements imposed on developers of co-ops and condominiums, these plans disclose significant aspects of the community and its financing before the developer can market it to the public.

Continuing Care Retirement Communities

CCRCs are an all-inclusive market rate model that typically charge entrance fees and monthly fees for a range of services — independent living, adult care facility/assisted living, and skilled nursing care — all within one community. Residents have access to a full range of coordinated support services (including meals, transportation and housekeeping), medical care, social activities, recreational activities, and educational programming. CCRCs were first authorized in New York in 1989 under Article 46 of the NYS Public Health Law (PHL), and as most NYS CCRCs combine a health care and insurance product, they are regulated by both DOH and the NYS Department of Financial Services.

CCRCs encourage seniors who can afford to do so to invest their own resources in housing and health care services, rather than divesting assets and relying on Medicaid coverage. Yet New York's stringent legislative and regulatory requirements make it extremely challenging to develop and operate a CCRC. As a result, there are only 12 CCRCs in operation in NYS as compared to neighboring Pennsylvania where there are over 150.

Subsidized senior housing

Subsidized senior housing is regulated by federal and state housing agencies that provide funding and therefore oversight to ensure operators stay in compliance with financial, building and resident regulations.

The primary housing agencies governing facilities in New York are HUD for the Section 202 and Section 236 programs (and other small senior housing programs), and the NYS Homes and Community Renewal (HCR) which administers the Low Income Housing Credit ("LIHC" or "tax credits") program and the Mitchell-Lama program. HCR also distributes other funds that are sometimes used to finance senior housing including the Housing Trust Fund (HTF) and HOME, but these funds are typically used as "gap" financing in combination with tax credits and generally not as stand-alone funding. While there is no longer new funding for the HUD Section 236 and Mitchell-Lama programs, many existing properties built with these resources still operate as subsidized senior housing programs.

Eligibility for subsidized senior housing is partially determined by geographic location and therefore varies across NYS based on Area Median Income (AMI) which is updated annually. Eligibility is also based on the number of apartments set aside in that particular project for "low" (80% of AMI), "very low" (50% of AMI), and "extremely low" (30% of AMI) income individuals. Table 3 identifies the maximum income allowed to qualify a single individual for different types of income eligibility categories in selected regions of NYS as of 2012.

Table 3: HUD Income Standards by NYS Region (2012)

Region	Extremely Low Income (30% AMI)	Very Low Income (50% AMI)	Low Income (80% AMI)
NYC	$17,450	$29,050	$46,500
Westchester	$22,650	$37,800	$51,600
Albany	$16,450	$27,350	$43,750
Syracuse	$14,000	$23,350	$37,350
Buffalo	$13,900	$23,150	$37,050
Jamestown	$11,950	$19,950	$31,850

Source: HUD User: http://www.huduser.org/portal/datasets/il/il12/index_il2012.html
FY 2012 Income Limits are calculated using 2005-2009 5-year American Community Survey (ACS) data

Some subsidized apartment complexes may have a mix of "low" "very low" and "extremely low" income apartments, and some tax credit projects have apartments with income standards set at 60% of AMI.

Clearly, location is a significant variable in determining eligibility for subsidized senior housing. As shown in Table 3, a senior applying for residency in a subsidized senior housing complex that has apartments pegged to 50% AMI in Westchester County could have $17,850 (i.e., nearly 90%) more in yearly income than a comparable senior in Jamestown and still qualify for a subsidized unit. The income variance is intended to account for differential costs of land, construction, taxes and operations among regions.

Rental Assistance

Project-based Section 8 assistance, tenant-based Section 8 assistance ("Housing Choice Vouchers"), and Section 202 project rental assistance contracts (PRACs) are the federal government's major programs for rent subsidies to low-income seniors, families and the disabled. HUD can assign Section 8 assistance to public housing authorities to provide individuals with housing vouchers or private for-profit and not-for-profit operators of certain senior housing programs to provide project-based assistance.

Eligibility for rental assistance is based on the individual's total annual gross income (minus qualified medical expenses and a standard deduction) and is generally limited to U.S. citizens and specified categories of non-citizens who have eligible immigration status [19]. In general, for HUD Section 202 PRACs built subsequent to 1992, the resident's income may not exceed 50% of the AMI for the county or metropolitan area where the property is located. For pre-1992 Section 202 and 236 projects, resident income may not exceed 80% of AMI. For Section 202 housing, the resident pays 30% of his/her adjusted monthly income for rent, and HUD pays the owner/operator the remainder of the HUD approved comparable market rent for that unit.

Another type of rental assistance for seniors in the NYC metropolitan area is the Senior Citizen Rent Increase Program (SCRIE). SCRIE is intended to protect elderly residents in certain subsidized housing facilities from being priced out of their apartments because of rent increases.

Seniors often face fixed and diminishing incomes as they age, and find it difficult to afford rent over time without rental assistance. The availability of rental assistance can be a critical factor for the senior in order to find affordable housing; for the developer/financier to ensure future debt repayment; and for the operator to ensure operational expenses can be met.

The Low Income Housing Credit Program

The low income housing credit (LIHC) program, also known as the housing "tax credit" program, is the largest federal housing development and renovation program for affordable senior housing across the country and in NYS. It was created by the Tax Reform Act of 1986 and is administered by the U.S Department of the Treasury, the Internal Revenue Service (IRS) and through HCR in NYS. Over the past five years, HCR has itself allocated approximately $23-30 million annually in LIHCs while sub-allocating another $10-12 million annually to NYC's Department of Housing Preservation and Development.

The LIHC program is used to confer federal tax credits on developers and their partners, most typically over a 10-year period, based on a percentage of the "eligible basis" of a project (i.e., the cost of acquiring an existing building if there is one, plus construction and other construction-related costs to complete the project). The maximum annual tax credit allocations are most often capped at either 9% or 4% of the project's eligible basis. Nine percent credits are limited in number, competitive and provide a much higher funding yield, whereas 4% credits are more widely available throughout the year. In addition to senior housing, tax credits may fund family housing and a variety of "special needs" housing including housing for the homeless, developmentally disabled and mentally ill. Family projects may receive additional points for projects that assign a number of apartments to the "special needs" frail elderly population.

While a senior will pay 30% of adjusted income for rent in Section 202 PRAC projects, the percentage of income a senior pays for rent in a tax credit project may vary. In tax credit projects the rents are set based on the AMI, therefore a resident may be paying more than 30% of their income for rent.

Typically, LIHC tax credits do not fully fund a project and additional funding must be secured through HTF, HOME, Community Development Block Grant, NYS Low Income Housing Tax Credit Program, or other "gap" financing programs. From a developer/operator perspective, multiple funding applications and a complex and competitive financing process can make developing and operating tax credit projects difficult. Ensuring that rents will sustain the project's future expenses and multiple agencies providing regulatory oversight (including the IRS, HCR, the investors and HUD if a PRAC or Section 8 rental subsidy is involved) can add to operational complexity.

Nonetheless, the LIHC program provides affordable, safe housing for thousands of New York's seniors. Existing operators of HUD Section 202 (and other subsidized) properties are increasingly accessing the tax credit program to refinance and upgrade their buildings to improve resident quality of life and increase building efficiency and useful life for decades. For developers/operators who want to build, renovate and/or refinance low- to moderate-income senior housing, the LIHC program may be the most viable financing mechanism available.

HUD Section 202 Program

The federal Section 202 Supportive Housing for the Elderly program, first established in 1959, has changed several times over the years and is available only to not-for-profit housing owners. Since 1992 the Section 202 PRAC program has made capital grants and provided project rental assistance to develop housing for very low-income elderly households. Older buildings can have project-based Section 8 subsidies for all or some of their apartments.

A major advantage of Section 202 PRACs has been that project awards often cover much of the cost of constructing a housing facility. Yet, in most cases (especially in high cost areas such as NYC) additional funding is needed to complete construction. This "gap financing" can be provided through various state and local programs. For developers, the early Section 202 program was relatively easy to build under since a majority of the construction costs were awarded through HUD and all of the apartments were assigned rental assistance.

To be eligible for an apartment under HUD 202, individuals or their spouses must be at least 62 years of age, income qualified and meet residency criteria. The resident pays 30% of his/her adjusted gross income for rent (utilities are sometimes included in the calculations). HUD-financed senior housing properties may establish preferences for selecting applicants from their waiting lists to seniors who are, for example: (1) homeless or living in substandard housing, (2) paying more than 50% of their income for rent, or (3) qualify for a Program for All-inclusive Care for the Elderly (PACE) plan or other managed long term care plan.

The original intent of Section 202 and one of its distinct advantages is that it provides a platform for seniors to have access to support services and service coordination that allows for aging-in-place. Limited funding is available for service coordinators to help seniors access services in the community. National data indicate that many seniors in Section 202 housing have high health care and support service needs, with 38% of residents considered frail or near-frail, requiring assistance with basic activities of living, and thus at-risk for institutional placement [18].

Once the leading program for developing low-income senior housing, Section 202 funding for new projects has been decreasing the past several years, and funding was eliminated in fiscal year 2012 and may well be eliminated in fiscal year 2013. Table 4 below identifies the total Section 202 awards made for NYS projects between 2006 and 2011. Over this time period, 39 NYS projects comprising 1,976 units received a total of $275 million in HUD 202 capital advances.

Table 4: Section 202 Supportive Housing for the Elderly Projects in New York State from 2006-2011*					
	2006	**2007**	**2008**	**2009**	**2010 & 2011****
Capital Advance Funding	$57,107,400	$52,301,100	$50,633,400	$37,312,500	$78,427,200
Rental Subsidy (3 years)	$8,579,400	$7,251,900	$6,750,900	$5,158,800	$10,689,300
Number of projects	9	8	7	6	9
Number of units	489	382	352	252	501

Source: *http://portal.hud.gov/hudportal/HUD?src=/program_offices/administration/grants/fundingannouncement*

* HUD Section 202 Capital Advance funding was eliminated in 2012

** Section 202 awards were combined for years 2010 & 2011

As Table 5 shows, most of the Section 202 development in NYS over the past five years has been concentrated in the NYC metropolitan area and western NY, with very little activity in other regions.

Table 5: Section 202 Supportive Housing for the Elderly Projects by NYS Region from 2006-2011*					
Region	**2006**	**2007**	**2008**	**2009**	**2010 & 2011 ***
Capital District	1	0	0	0	0
Central NY	1	0	0	1	1
NY Metro – Long Island	0	1	0	0	0
NY Metro – New Rochelle	0	1	1	0	2
NY Metro - NYC	4	3	2	3	3
Western NY - Buffalo	2	2	4	0	2
Western NY - Rochester	1	1	0	2	1
Total	**9**	**8**	**7**	**6**	**9**

Source: *http://portal.hud.gov/hudportal/HUD?src=/program_offices/administration/grants/fundingannouncement*

* HUD Section 202 Capital Advance funding was eliminated in 2012

**Section 202 awards were combined for years 2010 & 2011

NYS Mitchell-Lama Housing Program

This subsidized housing program was created in NYS in 1955 to address the perceived shortage of housing for moderate-to-middle income families. A total of 269 developments with over 105,000 apartments were built under the program, many of which are senior housing.

While there is no new Mitchell-Lama funding, there are several facilities still operating offering affordable senior housing. However, several owner/operators (especially for-profit) of Mitchell-Lama properties have "opted-out" of the program, pre-paid the mortgages and privatized the buildings for market rate housing or other commercial development. Opting-out has been most prevalent in locations with strong real estate markets, especially in the greater NYC metropolitan area. For example, of the original 174 rental properties (69,800 units) developed in NYC under the program, only 78 properties (33,700 units) still receive subsidies and 26 (7,500 units) are currently eligible to opt out [20].

Public Housing

Another important subsidized option for seniors is housing administered through public housing authorities. Nationally, seniors represent about 31% of participating households in public housing (i.e., about 330,000 people) and over half live in projects specifically designated for seniors [21]. However, unlike Section 202, public housing was not intended to address the changing needs of seniors and a significant portion of these properties are becoming obsolete. No new units have been built since 1994. In NYC, more than 61,500 seniors live in public housing managed by the NYC Housing Authority (NYCHA). Most (83%) seniors living in NYCHA buildings reside in family developments; 13% live in senior developments and 3% live in mixed-family developments. Almost half (49%) of seniors living in NYCHA buildings are considered very low-income with less than $10,830 in annual income [13].

Demand for Subsidized Housing Capacity and Upgrades

With relatively high demand for rental assistance, prospective residents have difficulty accessing subsidized housing in many areas of NYS. This is particularly the case in the NYC metropolitan area, where there are long waiting lists for rental assistance and significant barriers to development of additional capacity in the form of high land and other costs, zoning issues and other challenges. For example, as of February 2012, there were 123,499 people on the waiting list for Section 8 housing in NYC and the waiting list has been closed since May 2007 [22].

However, in certain other areas of the state there is evidence of shorter or no waiting lists for subsidized housing and even some vacancies. This is the case, for example, in western New York where population trends suggest fewer absolute numbers and slower growth rates in the older adult segment. In these geographic areas, the concern is not so much demand for senior housing but rather the need to renovate existing older buildings in order to improve the physical structures and add amenities such as walk-in showers, Wi-Fi capability, dishwashers and laundry facilities to better accommodate current and future resident needs.

In fact, many senior living facilities were built in the 1970s or earlier, and now need significant renovation and modernization to comply with Americans with Disabilities Act standards and updated building codes. Additionally, many operators are seeking to respond to consumers' demands for new or expanded service lines that require new construction and investments in technologies.

Traditionally, not-for-profit operators have very limited equity capital, which they have derived from either private (e.g., grants, bequests or donations) or public (e.g., government grants, demonstrations and capital payments) sources. Access to low-cost capital is critical to their ability to transition or expand services, but these organizations are rarely considered investment grade borrowers and therefore have very limited financing options. As previously noted, existing subsidized housing operators are increasingly relying on tax credit programs to fund building upgrades, but these programs are difficult to use and often leave gaps in the financing plan that must be addressed with other sources of financing.

Under these challenging circumstances, many of these housing operators are forced to continue operations in older facilities that are inefficient and expensive to run without the building layouts, equipment and technologies needed for state-of-the-art service delivery.

Assisted Living

In NYS, there are currently 494 licensed assisted living facilities serving over 33,000 residents [23]. Seventy-six percent of assisted living residents are aged 65+ and 54% are 85+ years old. Nearly three quarters receive assistance with ADLs and approximately 42% have Alzheimer's disease or other dementias [24]. In NYS, there are a variety of categories and licensures under the umbrella of assisted living and related terms including adult homes, enriched housing programs, adult care facilities (ACFs), assisted living programs (ALPs), assisted living residences (ALRs), enhanced ALRs (EALRs) and special needs ALRs (SNALRs). Assisted living facilities are licensed by DOH, which conducts regular unannounced surveys and oversees virtually every aspect of the operation[1].

In 2004, NYS lawmakers enacted the Assisted Living Reform Act (ALRA), stipulating that any entity using the term "assisted living" or any other similar term must be licensed as assisted living. For purposes of this paper, we will use the term "assisted living" or "AL" generically to encompass any and all of the aforementioned categories of licensure because they all provide a similar core package of services and the term is familiar to the public. When necessary, we will refer to the specific category of licensure.

All AL options are similar in that they provide a fundamental package of services including residential care; assistance with the self-administration of medication; care plans; personal care; case management; supervision and monitoring; and activities.

To assist in better understanding these services and how AL compares and contrasts to senior housing with services, below are detailed descriptions.

Resident services in assisted living facilities

Residential Care, Including Room and Board

AL regulations specify the requirements for room, board and meal services provided. For example, the regulations govern facility safety features and specifications including square footage, egresses, adaptive features, furnishing and linens. Housekeeping is required, and there is guidance about staffing and housekeeping activities. The specifics of how many meals must be served differ by category of licensure, but most AL facilities provide three meals a day. All meals must be balanced, nutritious and adequate to meet the daily dietary needs of residents, and provided at regularly scheduled times. Menus must be publicly posted, prepared in advance and consider residents' dietary needs and food allergies. The regulations also prescribe the composition of each meal, frequency of certain foods on the menu, food purchasing, storage, preparation and service, and amount of time between meals.

[1] Adult homes are governed by regulations at Title 18 New York Codes, Rules and Regulations (NYCRR), parts 485, 486 and 487; Enriched housing programs are governed by Title 18 NYCRR, parts 485, 486 and 488; Assisted living programs are governed by Title 18 NYCRR, parts 494 and 505.35, as well as Title 10 NYCRR Subpart 86-7**.** Assisted living programs must also be licensed as an adult home or enriched housing program, and have a home care component, thus the additional applicable requirements will also apply. Assisted living residences, including the enhanced and special needs assisted living residence, are governed by Title 10 NYCRR, Part 1001. Assisted living residences must also be licensed as an adult home or enriched housing program, thus the additional applicable requirements will also apply.

Personal Care

All AL facilities must provide personal care sufficient to maintain good personal hygiene, carry out activities of daily living, maintain good health, and participate in the ongoing activities of the facility. Personal care includes providing direction or helping with grooming, dressing, bathing, toileting, walking, transferring, eating, monitoring weight, and assisting with the self-administration of medications. AL staff does not feed residents – this would only be allowed in the enhanced ALR if the provider is approved to provide that kind of service. Staff is also available to assist residents in serving, monitoring intake, and ensuring safety.

Medication Management

A fundamental AL benefit is that residents are able to receive help with managing medications. A recent national study indicates that the average AL resident takes approximately nine different medications and as many as 80% of residents require assistance with medication administration [25]. AL staff is responsible for keeping track of medications, reminding people to take them, renewing prescriptions, communicating with physicians and other issues around medication administration. Generally speaking, AL residents receive help with medication self-administration. There are some exceptions where medications can be administered with permission from the DOH, but it is expected that residents will be able to ingest, inject or apply the medication. Typically, residents need assistance with one or more of the following activities: correctly reading and interpreting the label on the medication container; correctly following instructions as to the route, time, dosage and frequency; opening the container; measuring or preparing medications, including mixing, shaking and filling syringes; and safely storing medication.

There are strict rules about the processes for assisting residents with medications, medication storage, medication labels, observing the resident taking the medication, notifying the physician if the resident does not take the medication, and documenting these activities. There are additional procedures related to all of the above procedures for narcotics. Individuals can take care of their own medication regime should they choose, but the AL provider has a responsibility to oversee. Such a plan requires close communication between the resident and the provider, and ongoing monitoring.

Care Plans and Case Management

All AL facilities have some sort of care plan which describes the service delivery. The specifics and formality of the care plan and who delivers the services can differ depending on the category of licensure. Care plans are updated periodically and when a resident's condition or needs change significantly. All AL residents have access to a case manager, who ensures the care plan is fulfilled.

All facilities are responsible for monitoring and managing the care of their residents, coordinating and arranging for additional services as necessary, and assisting residents in finding more appropriate services should their need exceed what the facility is allowed to provide. Case management is ongoing, but the regulations specifically require an initial evaluation and subsequent periodic evaluation of a resident's needs and the AL provider's ability to meet those needs. Case managers have a very active role in these facilities, interacting with families and residents as well as medical professionals and other providers.

Per AL regulations, case managers must provide the following services to residents as needed and/or desired:

- orienting a new resident and family to the daily routine and helping them adjust;
- encouraging a resident to maintain ties to family and community and participate in activities;

- establishing linkages with and arranging for services from public and private sources for income, health, mental health and social services;
- assisting residents in making application for, and maintaining, income entitlements and public benefits;
- assisting the resident in obtaining and maintaining necessary health care services, examinations, and reports;
- providing information and referral;
- coordinating with other providers within and outside of the facility;
- assisting residents in discharge or transfer plans; and
- assisting in engaging residents to participate in facility improvement activities, with a forum to address grievances.

Case managers must document actions taken to meet the above required activities and oversee the care plan to ensure the residents' needs are met.

Supervision and Monitoring

Assisted living facilities are responsible for supervising their residents – a broad, overarching responsibility to keep watch over them, focusing on various indicators of functioning as well as environmental safety. Regulatory requirements include maintaining knowledge of the general whereabouts of each resident; monitoring residents to identify abrupt or progressive changes in behavior or appearance which may signify the need for assessment and service; and monitoring and guiding residents in performing basic activities of daily living, including attendance at meals and maintenance of appropriate nutritional intake; personal hygiene and grooming activities; participation in facility and community programs; and basic money management and fulfillment of service needs.

Supervision also includes surveillance of grounds, facility, and activities of residents and staff to protect residents from harm, managing emergencies, conducting fire and evacuation drills, maintaining an emergency/disaster plan, and ensuring emergency call systems and equipment are working properly. Supervision also includes responding to emergencies and illness, arranging for necessary services, and investigation of incidents involving resident endangerment, injury or death. Lastly, the operator has various reporting requirements, depending on the issue, to a number of entities such as DOH, the family, the physician, and law enforcement when an incident or illness occurs.

Entities licensed as an ALR, EALR or SNALR are held to the above as well as the activity of monitoring, defined in regulation as the ability to respond to urgent or emergency needs or requests for assistance with appropriate staff, at any hour of any day or night of the week on site. This requirement helps articulate the difference between these categories of licensure and an enriched housing program, which is not required by regulation to have around the clock staff (but many choose to).

Activities

According to regulation, AL must have an organized and diversified program of individual and group activities which will enable each resident to engage in cultural, spiritual, physical, political, social and intellectual activities within the facility and the community. The regulations are prescriptive about many of the details, including ensuring that activities vary in terms of scheduling and format, and reflect the diverse characteristics of their residents. Activities must be scheduled for a minimum of 10 hours per week, and a monthly schedule of activities prepared in advance and posted in an area accessible to residents and visitors.

Additional characteristics of assisted living

In addition to the services noted above, AL facilities must meet additional regulatory standards in nearly all facets of their operations, and other distinctions worth noting include:

- *Licensure requirements:* Each entity must go through an application process with the DOH and become licensed. This process is very involved, and the applicant must demonstrate the capability to be successful in a variety of arenas, such as community need and financial feasibility, in order to receive licensure.
- *Resident criteria:* The regulations limit who AL can serve through admission and retention standards (i.e., criteria by which someone is deemed appropriate for AL), as well as indicators that a resident can no longer be served in AL and must move on to a higher level of care or specialized service. These criteria differ somewhat by licensure category, though generally speaking the following are indicators that someone is not appropriate for a typical AL facility: needing continuous medical/skilled supervision and intervention; is a danger to self or others; is chronically bedfast or chairfast and consistently needs assistance to transfer, walk, or navigate stairs; has chronic unmanaged incontinence, or is dependent on medical equipment that cannot be managed safely by the resident.
- *Consumer protections:* All AL residents have specific rights and protections articulated in regulation. All facilities must have admission agreements that outline the services that will be provided and the conditions under which the agreement will be terminated.
- *Building requirements:* All facilities must meet certain architectural requirements, which stipulate fire safety and accessibility features as well as square footage for the number of people in a living space. AL facilities must have emergency and disaster plans and conduct regular fire drills. There are also numerous facility maintenance requirements, and appliances, equipment, heating and cooling systems must be in good working order. All facilities must have housekeeping, and there are requirements related to the overall cleanliness of the building as well as bedding and linens for resident rooms. AL facilities must maintain certain temperatures for the comfort and safety of their residents.
- *Documentation and reporting requirements:* All AL providers must report to DOH on their census, certain characteristics of their residents and facility financial information on a regular basis. In addition, AL facilities must maintain significant documentation and utilize DOH forms to track additional information which is reviewed on survey. Lastly, facilities must report certain incidents to various state agencies or other authorities, which may result in further investigation or oversight.

Paying for assisted living

Cost dictates available AL options, since most residents pay for these services with private funds. Long term care insurance pays for services provided in some facilities, depending on the specifics of individual policies. However, a license (home care and/ assisted living) is generally required to access this benefit. In addition, veterans and spouses of veterans may be eligible for benefits that can help pay for some AL services.

There are some options for low-income individuals, though they are limited. Those who qualify for Supplemental Security Income (SSI) and reside in ACFs or AL facilities qualify for the SSI Congregate Care Level 3 benefit, which pays for room and board. However, a declining number of facilities will accept SSI as payment for services since it most often fails to cover the complete cost of providing care.

In NYS, an AL provider must be specially licensed as an ALP in order to receive Medicaid payment for services. The number of ALP units in the state has been limited, but recently growing. At the inception of the program in the early 1990s, it was limited to 4,200 beds statewide. Only in the last five years has the program grown through a variety of initiatives; currently there are 4,914 beds in operation and the program is expected to double in capacity over the next several years. The process of applying for an ALP is competitive, as this is currently the only way to access Medicaid dollars in assisted living. It is unclear at this time how the shift to a managed care environment will affect assisted living options for Medicaid-eligible seniors.

Medicare does *not* pay for assisted living; however, an assisted living resident can access Medicare-covered services, such as home care and primary care. All in all, there are limited options for low-income seniors to access assisted living. Those who do not qualify for Medicaid but have modest income and assets may not find any assisted living options they can afford.

Specialized services

In NYS, specialized AL services such as aging-in-place and dementia care can be provided with additional specific licensure.

Aging-in-Place

There are two aging-in-place programs in assisted living – the ALP and the EALR. These models allow an individual to remain in the facility as his/her needs increase, beyond the retention standards of the typical AL facility discussed above. Additional services are provided directly or arranged for by the AL provider. Specific licensure is required for each model, and each has a different set of regulations. The populations served in both are currently much the same; however the EALR *can* retain a resident longer than the ALP – enabling them to serve someone that would typically be in a nursing home. To date, we have not seen EALRs choose to do that, but the program is relatively new. The ALP can accept Medicaid payment, whereas the EALR cannot.

Dementia Care

NYS has long-standing specialized dementia care AL facilities; now termed SNALRs. These facilities require special licensure and must follow specific regulations. For example, the SNALR must have a specialized environment to ensure the safety of people with dementia or Alzheimer's disease, and have staff trained in the specialized needs of this population. People with dementia or Alzheimer's disease can reside in a typical AL facility, but if it is determined that they need a more secure environment, a SNALR would be appropriate.

CHAPTER 3: CURRENT STATE AND NATIONAL POLITICAL LANDSCAPE

The Assisted Living Reform Act and Senior Housing

The ALRA of 2004 created a variety of new requirements for assisted living, including the requirement that an entity be licensed in order to use the term "assisted living" or any derivation thereof. The statute (NYS Public Health Law (PHL) § 4651) exempts certain entities from having to apply for AL licensure, including:

- Naturally occurring retirement communities;
- Public or publicly assisted multi-family housing projects administered or regulated by HUD or HCR, or funded through the homeless housing assistance program that were designed for the elderly or persons with disabilities, or homeless persons, *provided such entities do not provide or arrange for home care, twenty-four hour supervision or both, beyond providing periodic coordination or arrangement of such services for residents at no charge to residents;*
- CCRCs, unless the CCRC is operating an ALR as defined by the statute; and
- Independent senior housing.

While the statutory exemptions helped to avoid unintentional licensure requirements for certain housing programs, the law and resulting DOH regulations have created areas of uncertainty and inconsistency. For example, the statute places a limit on the type of assistance that someone like a service coordinator may provide in certain housing settings. On the other hand, despite the exemption, most CCRCs in the state chose to apply for ALR licensure because they were providing the services and wanted to use the term "assisted living." In addition, the statute places a limit on the type of assistance that someone like a service coordinator may provide in publicly funded housing options. For purposes of this paper, however, the most critical policy piece is the independent senior housing exemption.

Independent senior housing defined

The statute directs DOH to define independent senior housing in regulation for the purposes of determining whether or not the housing entity should be licensed. The statute guides DOH by requiring that the definition be, "…based on whether the operator does not provide, arrange for, or coordinate personal care services or home care services on behalf of residents; and the facility does not provide case management services in a congregate care setting for residents." (PHL § 4651(1)(j)) The statute also states that a resident of independent senior housing can personally and directly obtain private personal care or home care services from a licensed or certified home care agency.

In 2008, DOH promulgated ALR regulations (Title 10 NYCRR Part 1001, and Part 1001.2(a)(10)) ostensibly to clarify at what point a housing entity must be licensed as AL. The first litmus test relates to the category of facilities underlying all assisted living models – the "adult care facility" licensure – which can be either an adult home or enriched housing. The regulations say that independent senior housing staff cannot provide, arrange for or coordinate long-term housing and either personal care or supervision for five or more residents of such housing setting unrelated to the housing provider. An individual or entity that provides housing and either personal care or supervision (either directly or indirectly) to persons unrelated to the operator must become licensed.

The standard for AL goes a bit further to incorporate the above, while also prohibiting independent senior housing operators from arranging or coordinating home care services, and prohibiting the use of "assisted living" or any similar term.

The DOH regulations also describe those services that independent senior housing may provide:

> "The provision, arrangement for or coordination of one or more of the following services shall not, in and of itself, require licensure as an adult care facility or assisted living residence: room, board, laundry, housekeeping, information and referral, security, concierge-like services, or case management services, including assisting tenants with housing issues, providing information to tenants regarding services and activities available in the community and assisting tenants in contacting such services and activities, and contacting appropriate responders in urgent and emergency situations." (Title 10 NYCRR Part 1001.2(a)(10)(iv))

This section further specifies that:

> "…case management services in independent senior housing shall not include case management in any setting in which an entity (a) provides, arranges for or coordinates housing, on-site monitoring and personal care services and/or home care services to five or more adults unrelated to provider; or (b) on a continual basis supervises or monitors the health status of five or more adults unrelated to the provider." (Title 10 NYCRR Part 1001.2(a)(10)(iv)(a))

In an attempt to provide more clarity, the regulations describe indicators that an entity or individual is providing or arranging for personal care services and/or home care services, and would thus require licensure:

- initiation, implementation or overseeing of a schedule of personal care or home care visits for residents; or
- overseeing the provision of personal care, home care or monitoring services to residents; or
- conducting initial and follow up health assessments of residents' health needs and functioning; or
- having a written contract or otherwise providing a statement under which the entity or individual agrees to provide, arrange for or coordinate the services discussed above.

Many organizations provide both housing and services (including personal care and home care services) within their system or corporate umbrella. The regulations speak to this circumstance:

> "Where a housing entity and a services entity are commonly owned or otherwise subject to the control of one or more entities or principals and work together to provide, arrange or coordinate housing and such services as are set forth in subdivision (a) or (b), such housing and services entities shall be subject to licensure…" (Title 10 NYCRR Part 1001.2(a)(10)(vi))

Lastly, the regulations affirm that a resident of independent senior housing shall have:

> "…the ability to obtain, personally and directly, personal care services or home care services from a home care services agency licensed or certified…".

While the ALR regulations provide guidance regarding what constitutes independent senior housing, there is still no clear definition. The lack of clarity has effectively limited senior housing providers from developing innovative programs and service models for their residents. Ultimately, a clearer policy should exist on where housing with services ends and licensed services begin. Particular points of confusion are the definition of terms used in the ALR regulations as they may apply to activities within senior housing including "supervision", "monitoring", "arranging", "coordinating", "case management", "in and of itself", and "either directly or indirectly".

Comparisons: senior housing and assisted living

To the consumer, it may be difficult to discern the differences between housing with services and AL. Indeed, AL strives for a home-like atmosphere which looks much like senior housing apartments, while senior housing with amenities will look much like AL. However, there are many significant differences in practice between these two models. Table 6 highlights major differences between senior housing and AL in NYS.

Table 6: Major Differences Between Assisted Living and Senior Housing with Support Services in NYS

	Assisted Living	Senior Housing with Supports
Personal Care Services	AL facility must provide or arrange for personal care services for their residents.	Resident can personally and directly choose and obtain personal care or home care services from any licensed home care agency or managed care plan serving that location. The senior housing entity does not provide personal care or health care services, nor are any such services covered in the residency agreement.
Regulations	Highly regulated, regardless of funding source, and includes requirements for care plans, personal care, resident oversight, medication oversight and building features. State oversight ensures that the facility complies with all requirements and meets the needs of its residents.	Regulations are based on the funding source and are primarily focused on financial, building, local ordinances, fair housing, and eligibility (for rental subsidies) requirements.
Service Integration	Offers a truly integrated package of both housing and services. This can be extremely important for someone who is not capable of or does not have family help to coordinate and monitor their service needs. AL is responsible for addressing the entirety of the resident's scheduled and unscheduled needs, and intervening and adjusting as they change.	Facilities may have a service coordinator or resident service advisor to provide information to the resident and links to community services when requested.
Monitoring & Supervision	AL facilities are required to provide constant monitoring of the resident and intervene in the event of an emergency.	While housing staff may "keep an eye on" a resident who is declining or provide assistance during an emergency, they are not responsible or liable for monitoring, supervision and intervention.
Aging-in-Place	Admission and retention standards limit who AL facilities can serve, spurring residents to move on as their needs increase beyond a certain point. Some residents experience a loss of freedom of choice. For example, even if the resident chooses to manage their own medications, they must share information and accept monitoring from the AL facility.	Provides more flexibility to the consumer than in AL. Generally speaking, senior housing does not have a limit on who may stay as a resident based on functional status. Residency is determined by compliance with the lease agreement and "house rules" based on fair housing regulations, including not posing a danger to others.

There is value in both models, and with better understanding consumers are more likely to understand which is right for them. It is important to understand too, that what is right for a consumer at one point may change over time.

New York State Medicaid Redesign

Medicaid Redesign Team and senior housing

Upon taking office in January 2011, Governor Andrew Cuomo established the Medicaid Redesign Team (MRT) by Executive Order, bringing together stakeholders and experts from throughout the state to reform the Medicaid program that provides health care coverage for low-income individuals.

In its first phase of work, the MRT submitted an initial report to meet the governor's Medicaid spending target contained in his 2011-2012 Executive Budget. The initial report included 79 recommendations to redesign and restructure the state's Medicaid program, and nearly all of these recommendations were enacted as part of the final 2011-12 state budget and are currently in various states of implementation.

Perhaps the most significant MRT phase 1 initiative is the state's plan to move nearly every Medicaid-eligible person into a managed care plan or care coordination model. This includes a mandate – currently in early stages of implementation – that most recipients aged 21+ years who are eligible for Medicaid and Medicare (i.e., "dual eligible") and need more than 120 days of LTC services in the community must enroll in a managed long term care (MLTC) plan.

This major move towards managed care/care coordination will affect senior housing because managed care plans will have financial and other incentives to keep their enrollees living in the community for as long as possible, as long as it remains cost-effective. This is likely to mean that Medicaid recipients living in senior housing may remain there longer and have services brought in and coordinated by managed care plans, rather than move on to a higher level of care such as an assisted living facility or nursing home. In addition, managed care entities may actually seek out affordable housing options for seniors enrolled in their plans, creating the possibility for some partnership opportunities.

The health home is another major MRT phase 1 initiative being implemented in NYS. A health home is not a physical location, but rather a care coordination model with specific requirements for communication between the providers of service for a particular individual, so that their comprehensive needs are met and coordinated. The state anticipates that a large number of the state's Medicaid recipients will be enrolled in health homes, typically to help manage multiple chronic health, behavioral health and/or mental health conditions. Health homes are a major building block of Medicaid redesign that could have broad implications for recipients, providers, housing operators and future supportive housing development in NYS.

Also among the MRT Phase 1 initiatives is a change in Medicaid eligibility to provide nursing home residents with a "housing disregard" if they are discharged back to the community and join a Medicaid MLTC plan. This change is intended to eliminate a barrier to community placement by allowing eligible Medicaid recipients to retain additional income under Medicaid rules to pay for housing. As of this writing, the federal government had just given the state approval for the change and DOH was in the process of implementing the program.

In its second phase, the MRT established ten work groups to focus in on specific key areas related to the redesign effort. Among the groups was the Affordable Housing Workgroup, comprised of stakeholders from various parts of the state with a particular interest and expertise in housing issues. This group made specific recommendations regarding investments in supportive housing, as well as recommendations aimed at ensuring that various state and local agencies (both governmental and not-for-profit) are working together to maximize the efficacy of all affordable housing programs. The group concluded that housing is a key component in the array of options available to seniors and other individuals, and that investments in supportive housing can be leveraged to save Medicaid dollars. Secondly, the changes and new initiatives in Medicaid will result in more people with high medical needs living in community settings including congregate senior housing facilities.

In its final report, the MRT Affordable Housing Workgroup noted the potential of senior housing for providing flexible options for seniors to obtain supportive services, and acknowledged the confusion in terminology within the ALR regulations by recommending that independent senior housing be clearly defined in regulation:

> "Currently, the variety of senior housing options is not well delineated and the landscape of offerings often confuses potential residents and their caregivers. Work group members seek to ensure that New York's aged individuals are not forgotten in the quest for adequate, safe and secure housing -- whether publicly supported or not." [26]

Furthermore, the term "supportive housing" in NYS is historically identified primarily with the behavioral health/mental health population. The workgroup acknowledged this by providing additional clarification that can be seen as an attempt to broaden the definition to include other populations, such as seniors:

> "Finally, it is important to note that where "supportive" housing is referenced throughout the below recommendations the term has meaning well beyond the housing-with-services-attached model in New York that this term is often used to describe. The creation of affordable, accessible and integrated housing for all New Yorkers who require publicly supported housing and related support services should be the priority objective of this workgroup's recommendations to ensure housing and community-based supports are provided in the most integrated setting appropriate to the individual being served, as required by the Olmstead Decision." [26]

The workgroup also recommended the state identify resources to develop and preserve quality independent affordable housing for seniors that can serve as a platform for services to maximize their ability to be maintained in their homes and communities.

To address broader concerns about financing supportive housing development, operations and services, the workgroup suggested a pilot program of "social impact investment bonds." A social impact bond is a contract between a private sector (often a not-for-profit) and public sector (a local or state government) entity in which the governmental entity commits to share its savings from improved social outcomes with the investors financing the venture. This mechanism to leverage private investment for the public good has begun to take hold in several communities. Similar programs have been undertaken in the UK and, in 2012, the city of New York financed a $9.6 million social impact bond for prisoner rehabilitation [27].

According to the final MRT Housing Workgroup report, Massachusetts is currently developing a request for proposals for not-for-profits to develop an intervention that would reduce the Medicaid costs associated with hospital and emergency room overuse due to chronic illness in the homeless population.

Based on workgroup recommendations, the 2012-13 state budget includes $75 million to be administered through multiple NYS agencies to expand access to supportive housing initiatives for high need and high cost Medicaid recipients. The funding is designed to create new supportive housing opportunities through leveraging other public and private investments to maximize potential Medicaid savings. There are no specific set-asides for senior housing, although it is possible that some seniors may benefit if they are considered high need/high cost Medicaid recipients.

Medicaid Redesign Team waiver proposal

Following up on the MRT recommendations, NYS submitted a request to the federal government in August 2012 to reinvest $10 billion in federal savings from the state's Medicaid reforms to restructure New York's health care system. The request comes in the form of a proposed five-year extension to the state's existing Partnership Plan Waiver, a Medicaid Section 1115 waiver. To justify the funding request, the state has estimated that the initial MRT initiatives will save the federal government $17.1 billion over the five-year period. As additional redesign initiatives are implemented, it is anticipated that even greater savings will occur.

The "MRT waiver," as it is being referred to, seeks to dedicate $150 million annually ($750 million over five years) to expand access to supportive housing services. Under this proposal, two programs would be created and funded at $75 million each per year – the Supportive Housing Capital Expansion Program (SHCEP) for capital projects, and the Supportive Housing Services Program (SHSP) to provide supportive housing services.
The MRT waiver application describes supportive housing as "housing coupled with appropriate individual-based services, which is an innovative and cost-effective model of care designed to provide an integrated solution for both housing and health care needs." [28] Funding would target high cost, high need Medicaid recipients who require supportive services to live independently, with a primary focus on the health home eligible population of chronically ill individuals who may also have behavioral health issues.

The SHCEP would fund capital projects to increase access to supportive housing and be administered through various state and local housing agencies. An estimated 3,000 new apartments would be created over the next five years. Allowable uses of SHCEP funds include development costs associated with upgrading existing housing to meet supportive housing standards; development and construction of new supportive housing apartments; capital funding to support home modifications; and co-location and integration of health care services with supportive housing. Co-location projects could include "free-standing" easily-accessible clinics for individuals in need of supportive housing services, as well as for serving individuals within the community.

The SHSP would provide access to support services in housing such as case management; patient navigation and care coordination services (including linkages with health homes); counseling; linkages to community resources; education and employment assistance; entitlement advocacy; and budgeting and assistance with legal issues. The SHSP would work in coordination with the SHCEP as projects would receive funds for both capital and supportive services. It is anticipated that funds would be disbursed as grants using a competitive review process.

While the MRT waiver is subject to federal approval, the state has made the case in its application that there is a strong connection between housing and Medicaid savings and that further housing investments are needed if Medicaid reform is to succeed:

- There is compelling evidence, both in New York and nationally, that for people coping with chronic illness or disability and behavioral health challenges, the lack of stable housing often results in avoidable health care utilization and, in turn, avoidable Medicaid expenses. Moreover, the lack of affordable housing, in combination with accessible health care, continues to be an obstacle to serving individuals in the most integrated setting;
- Over a decade of independent research has shown that transitioning individuals into supportive housing dramatically reduces immediate and long-term spending for Medicaid reimbursable expenses, as well as spending on other public programs; and
- Economic and demographic trends are reinforcing barriers to community-based care for low-income people with disabilities – particularly in NYC where the Fair Market Rent is equivalent to 166% of the average monthly SSI benefit. Housing costs in other downstate areas are similarly out of reach for disabled people on fixed incomes. Financial assistance for supportive housing services will provide the necessary wherewithal to allow low-income disabled individuals to live in the community.

The waiver application specifies that supportive housing could serve individuals who are homeless and/or have serious mental illnesses or behavioral health issues. Other targeted populations include residents of adult homes and nursing homes who prefer to return to the community; low-income disabled individuals enrolled in or eligible for MLTC plans or Consumer Directed Programs; and frail elderly individuals living in arrangements which create a potential for harm or neglect – all populations that could move into senior housing facilities. Yet it is important to note that these programs would fund only those housing projects that would target high cost, high need Medicaid residents with complex health and behavioral health conditions who require supportive services to live independently. Depending on how these supportive services would be arranged and delivered, it is conceivable that assisted living licensure could come into play.

Implications of Medicaid redesign for housing

Clearly, senior housing facilities are not direct Medicaid service providers, so what does NYS Medicaid reform mean for housing? These reforms will fundamentally change how services are delivered and paid for in New York, and that in turn will affect residents in senior housing, and not just those residents who are Medicaid recipients. The focus on managing chronic conditions and other illnesses in the community rather than in institutional settings is likely to lead to greater reliance on subsidized housing options, resulting in seniors moving into housing with greater health needs or staying in senior housing longer with support and health care services delivered or provided locally.

The composition of residents in senior housing facilities – at least those that serve Medicaid recipients – most certainly will change. They will have higher needs, and their care will be managed more intensely in the community. Managed care may result in a greater number of senior housing residents needing home care, personal care and support agency services coming through the front doors or remaining in the facility for a longer period of time.

While Medicaid eligible individuals receiving LTC services in senior housing will receive coordination of services through MLTCs and networks, other residents may not unless they or their family members can pay for the service privately or qualify for subsidized programs available through NYSOFA and HUD. As shown in Table 7, there are significant gaps between the income limits for subsidized housing and those applicable to the state's Medicaid program.

Table 7: 2012 HUD Income Standards vs. Medicaid Income Standard by NYS Region

Region	50% AMI	80% AMI	Medicaid Income Limit
NYC	$29,050	$46,500	$9,500
Westchester	$37,800	$51,600	$9,500
Albany	$27,350	$43,750	$9,500
Syracuse	$23,350	$37,350	$9,500
Buffalo	$23,150	$37,050	$9,500
Jamestown	$19,950	$31,850	$9,500

Note: Medicaid income limit reflects the standard for individuals who are blind, disabled or age 65+. In addition to annual income limits, individuals can retain up to $14,250 in other resources and still qualify for Medicaid. Higher income levels and resources may be retained by spouses of recipients residing in nursing homes or receiving services from PACE plans or 1915(c) HCBS waiver programs.

As implied by Table 7, there is a segment of the population that qualifies for low-income senior housing but does not qualify for Medicaid services. If these individuals need personal care or home care services, they would need to pay for the services with out-of pocket funds or LTC insurance proceeds, unless the services are incident to a Medicare qualifying stay in a hospital – in which case limited Medicare coverage may be available – or unless the individual qualifies for Veteran's Administration or other third party benefits. Private pay services can be expensive for low- to moderate-income seniors. Table 8 depicts the median statewide costs of selected services in NYS.

Table 8: LTC Costs by Service (2012 NYS Median Values)

Service	Per Hour/Day	Per Month	Per Year
Homemaker services	$20/hour	$3,813	$45,760
Home health aide	$22/hour	$4,195	$50,336
Adult day health care	$55/day	$1,192	$14,300
Assisted living	$122/day	$3,700	$44,400
Nursing home	$325/day	$9,885	$118,625

Source: *2012 Genworth Cost of Care report*

Note: Homemaker and home health aide annual costs assume $44 hours/week for 52 weeks. Adult day health care costs assume $55 daily rate for 5 days and 52 weeks.

While these are the median statewide rates, the actual rates could be substantially higher (or lower) depending on service location. Nonetheless, senior housing residents who must pay for these services out-of-pocket or who go without receiving needed services are at financial risk for needing Medicaid-funded services.

With its obvious focus on Medicaid recipients, the MRT Medicaid supportive housing expansion initiative is aimed at a low-income chronically ill and disabled population with high needs and the potential for significant Medicaid savings arising from the service model. However, as currently designed, the program will not expand the capacity of affordable housing and support services for seniors with a range of needs, particularly those who are relatively healthy and independent but may be at risk financially or health wise. For these individuals, an affordable aging-in-place model with access to service coordination and other support services could forestall or obviate the need for reliance on Medicaid funded health care services.

Changing Federal Housing Policy

While NYS is still struggling to define the differences between senior housing with supportive services and assisted living, HUD and other federal government agencies are supporting public policies and programs that encourage senior housing as a platform for delivering services.

Two initiatives that highlight the direction of HUD are the Service Enriched Housing (SEH) program within the HUD Assisted Living Conversion Program (ALCP), and the "guiding principles" proposed by HUD for future Section 202 senior housing funding.

The HUD ALCP: Service Enriched Housing

The ALCP is a grant program for previously built HUD Section 202, 236 and other HUD senior housing for building modifications to assist in delivering support services to residents. The funds can be used for common space and apartment modifications and upgrades to safety and emergency systems.

Prior to 2012, an ALCP applicant needed to be funded as HUD senior housing and licensed as a state assisted living facility (ALF). Very few New York Section 202 owners applied for the grant due to the difficulty of obtaining an assisted living license as a HUD senior housing project, complying with both state DOH and HUD regulations, and the inadequacy of Medicaid capital reimbursement for assisted living.

Yet, starting with the 2012 HUD ALCP Notice of Funding Availability (NOFA), an applicant for an ALCP grant could either be a licensed ALF or a SEH facility for elderly residents who are aging in place. Under HUD guidelines, SEH is housing that accommodates the provision of services to elderly residents who need ADL assistance in order to live independently. HUD defined these two programs in more detail in the 2012 NOFA:

- **Assisted living facilities** are designed to accommodate frail elderly persons and people with disabilities who need support services including assistance with eating, bathing, grooming, dressing, and home management activities. ALFs must provide support services such as personal care, transportation, meals, housekeeping, and laundry. A frail elderly person means an individual 62 years of age or older who is unable to perform *at least three* ADLs as defined by the regulations for HUD's Section 202 Supportive Housing for the Elderly Program at 24 CFR § 891.205. Assisted living is defined in Section 232(b)(6) of the National Housing Act (12 U.S.C. § 1715w).
- **Service-enriched housing facilities** are multifamily developments designed to accommodate elderly persons and people with disabilities with a functional limitation meaning being unable to perform *at least one* ADL. SEH is housing that makes available through licensed or certified third party service providers supportive services to assist the residents in carrying out ADLs such as bathing, dressing, eating, getting in and out of bed or chairs, walking, going outdoors, using the toilet, laundry, home management, preparing meals, shopping for personal items, obtaining and taking medication, managing money, using the telephone, or performing light or heavy housework, and which may make available to residents home

health care services, such as nursing and therapy. SEH includes the position of service coordinator, which may be funded as an operating expense of the property, and provides residents with control over health care and support services decisions. SEH is defined in 12 U.S.C. § 1701q-2(g), as amended by P.L. 111-372.

In addition, each senior housing applicant must develop and submit to HUD a Supportive Services Plan, which details the services and coordination of the supportive services to be offered in the ALF or the SEH by the appropriate state or local organization(s), which are expected to fund those supportive services. SEH may make available supportive services to assist the residents in carrying out ADLs through licensed or certified third party service providers.

Funding for the supportive services does not come from HUD but must be coordinated by the operators or residents, either directly or through a third party. Supportive services may include Medicaid services, an AAA program, Money Follows the Person funds (i.e., enhanced federal funding for nursing home residents transitioned to the community), state home health care programs, state assisted living services, service coordinator funds or similar programs.

Importantly, this approach indicates that HUD has recognized the efficacy of combining housing and support services and different levels of need for ADL assistance among residents. The SEH program is a more flexible approach enabling senior housing operators to receive ALCP grants if they work with third party licensed agencies to enable residents to receive services in their home. As previously suggested, assisted living arrangements are more structured, result in some loss of resident independence and can be more expensive for residents with less intensive needs.

HUD Section 202 reform

While Congress has drastically reduced and then eliminated funding for the Section 202 new construction in the past few years (while preserving funding for existing Section 202s), HUD has envisioned a transformation of the program to address budgetary concerns with the goal of redirecting Section 202 funding into a new program that would prioritize senior housing as a platform for delivering support services to residents. At an April 2012 stakeholder meeting, HUD outlined the "guiding principles" of their reform proposal for the Section 202 program:

1. **Create and sustain more elderly affordable units at a lower initial cost** by proposing to provide "operating assistance only" funding to support more units while taking advantage of state and local capital dollars for affordable housing including the LIHC program;
2. **Streamline and modernize the program** by increasing reliance on state housing agencies to make initial Section 202 awards concurrent with awards of other state funds, and reduce HUD's development and regulatory oversight of the program once awards are granted; and
3. **Ensure that new Section 202 housing serves as a platform for frail and at-risk elderly as well as those aging in place** by encouraging state housing agencies to collaborate with state health care agencies to target Section 202 funding to elderly populations most in need of assistance; encourage sponsors to develop partnerships with health care providers up-front, and not wait until existing residents have aged-in-place; and continue to recognize the need for every multifamily property assisted with Section 202 to serve a range of elderly – not just frail elders or those at imminent risk of frailty.

In addition to the SEH initiative, HUD envisions the Section 202 program being transformed to encourage: (1) partnerships in federal and state funding of subsidized senior housing for capital and ongoing operational expenses; (2) state housing, aging and health agencies to collaborate in developing service enriched housing; and (3) senior housing to offer supports to individuals with a wide range of needs to age-in-place.

CHAPTER 4: INNOVATIVE SENIOR HOUSING WITH SERVICES MODELS

New York State Models

Senior housing providers across the country are employing different strategies to allow residents to remain in their own homes independently and safely for as long as possible. In New York, we find many examples of unique housing with services models in both affordable and market-rate communities. The housing providers highlighted in the case studies below have found different ways in which to blend social care (e.g. senior centers, technology, wellness) with access to health care services (e.g. on-site health clinics, co-location of PACE programs) while being mindful of the challenging regulatory environment within which they operate and should serve as examples of the types of models that can be enhanced and expanded throughout NYS.

Selfhelp Community Services, Inc. (New York City, NY): Technology-enabled housing with services

Selfhelp Community Services, Inc. is a 76-year old not-for-profit organization dedicated to enabling older adults and other at-risk populations to live in their own homes, independently and with dignity. Currently over 20,000 individuals in four boroughs of New York City and Nassau County are served by a number of Selfhelp programs and services that include six senior housing complexes (a seventh is under construction and will be completed by year end 2012), four Naturally Occurring Retirement Communities (NORCs), three case management programs, two community guardianship programs, five senior centers including one of only ten Innovative Senior Centers in New York City, extensive home care services, a legal resources program and a robust client-focused technology program.

The case study we present here examines how one aspect of Selfhelp's stated mission to "…lead in applying new methods and technologies to address changing needs of its community" is being carried out through the variety of products and services they offer their clients as well as the development of one of the first technology-enabled affordable senior housing high-rise apartment buildings.

Technology Products/Systems

Virtual Senior Center: In partnership with Microsoft, the NYC Department for the Aging and the NYC Department of Technology and Telecommunications, Selfhelp created the Virtual Senior Center (VSC), a program that allows homebound and case managed older New Yorkers to engage in activities like discussion groups, museum lectures and music classes, while remaining in their own home. Specially adapted computer equipment along with special senior friendly software developed by Selfhelp, with integrated web cameras, are placed into homes and, along with other assistive technology that may be required by the senior, allows these individuals to connect to real events, lectures and other programming developed by Selfhelp. The VSC also provides an online chat room that allows users to connect with each other either individually or in a group setting; and allows for more frequent contact with social workers.

Health Monitoring Sensor System: Since 2005, Selfhelp has been installing QuietCare, a wireless motion sensing system, in senior housing units for all residents that request it. Motion detectors (i.e., no cameras or audio) are installed throughout the apartment; within a few weeks, the system "learns" the resident's typical activity patterns (i.e., wake-up time, bathroom usage frequency, refrigerator usage, etc.). Out-of-pattern behaviors are noted on an easy-to-read dashboard and color-coded for urgency. Alerting and monitoring is done by the QuietCare call center and action taken according to resident-directed instructions. In a pilot study conducted with 27 Selfhelp residents and clients, it was found that the system provided timely intervention and prevented many emergencies and life-threatening situations [29].

Telehealth Kiosks: In partnership with Jewish Home Lifecare (a NYC-based not-for-profit provider of elder health services), and with funding from Enterprise Community Partners, Selfhelp is piloting a telehealth kiosk program. Approximately 50 residents from each of two Selfhelp affordable senior housing buildings have volunteered to use a personalized swipe card to activate the touchscreen device and record vital statistics (i.e., blood pressure, weight, blood oxygen rates, etc.) on a regular basis. The kiosk provides individualized educational tips on exercise, weight control and health management based on the data inputted from each senior. Nurses from Jewish Home Lifecare monitor and track changes; residents are contacted when significant changes are observed.

Computer Learning Centers/Cyber Classrooms: Selfhelp provides computer learning centers in all five of its senior centers and several of its NORCs. Many hundreds of seniors have learned to use computers at these centers, ranging from acquiring basic skills (e.g., accessing the internet and using email) to more advanced skills (blogging, graphics and photo editing). Cyber classrooms have also been recently introduced. A large internet screen with a web camera is set up in the affordable housing community room; seniors can learn from a wide variety of instructors who can be physically located anywhere in the world. Recent programs conducted by Long Island University occupational therapy students include "Nutrition: Tips and Smart Food Choices to Healthier Eating", "Yoga/Laughing Therapy: Laugh Away Your Pain!" and "Relaxation and Visualization: Stress Management, Deep Breathing Techniques and Visualization".

Selfhelp K VII Apartments

Selfhelp's mission of helping seniors live independently and with dignity by providing them access to affordable housing, support services and state-of-the art technology will be further advanced by the opening of its 14-story, 92-unit affordable senior housing building in January 2013. Selfhelp K VII Apartments ("K VII") is the culmination of years of planning that will incorporate many of the technology-enabled products and services currently offered throughout the Selfhelp community, all under one roof. Each unit will be computer-ready, energy efficient, have a roll-in shower and be wired to allow for sensor monitoring, if desired. The community room will be equipped with video chat-enabled computer work stations, a cognitive strengthening unit and a health screening kiosk.

K VII is unique in several ways. First, Selfhelp's leadership team was committed from the beginning to creating a technology-enabled building and environment; thus, from the planning stage, the infrastructure was predicated on incorporating wireless capability throughout the building. The benefit of having this wireless capability is that it allows for more advanced technology to be deployed as it becomes available. Wiring was completed before the walls were closed and much thought and planning went into all the possible types of technology that could be brought into each room and community space that might allow older adults to live longer, more independent and safe lives.

Second, there was, and continues to be, an unparalleled level of dedication to securing numerous sources of funding to ensure the integrity of the project. Project partners include the NYC Housing Development Corporation, the Department of Housing Preservation and Development, JPMorgan Chase, Enterprise Community Partners, NYS Office for Aging, the Harry and Jeanette Weinberg Foundation, UJA Federation of New York and many other private foundations and sponsors. K VII has a total development cost of approximately $26 million and is being financed with a mix of tax-exempt bonds, low-income tax credits, state and private grants and City Capital funding. Due to the many different requirements of the various funding streams, the location of the building site (Flushing), and the complexities associated with managing such a large project, there have been countless challenges along the way. However, the project is slated to open on schedule and will serve as a model to other organizations looking to deploy building and resident technologies to assist older adults in maintaining their independence and accommodating different levels of service needs.

Weinberg Campus (Buffalo, NY): Co-location of Total-Aging-in-Place Program & Independent Senior Housing

The Weinberg Campus located in Getzville, New York (a suburb of Buffalo) offers a full continuum of programs and services for seniors that includes independent senior apartments, assisted living, skilled nursing, short-term rehabilitation, medical and social day programs, memory care, managed long term care (MLTC), licensed home care services, certified home health services, a long term home health care program, a diagnostic and treatment center and other community based services. Nearly 750 residents live on the 130-acre campus, many of whom live in multiple settings over a period of many years. The leadership and staff at Weinberg recognize that no two people experience the aging process the same. Their goal is to address each individual's unique situation and be able to adapt to people's changing needs in the program of their choice.

The case study described here focuses on the co-location of Weinberg's Stovroff Towers, a privately–funded, 119-unit independent senior apartment building and the Total Aging in Place program, a Medicaid MLTC plan.

Total Aging in Place Program

Total Aging in Place (TAIP) is a pre-PACE (Program of All-Inclusive Care for the Elderly) MLTC plan available to Erie County nursing home and Medicaid eligible individuals, 55 years of age or older, capable of living in the community who need LTC services for at least 120 days. Based on the results of an initial functional and cognitive assessment, an interdisciplinary care team develops a care plan for each member with the goal being for seniors to continue living safely in the setting of their choice. The full Medicaid package of services is available including, but not limited to, a social day program, care management, medical transportation, home care services, dental services, home-delivered meals, physical therapy, occupational therapy, speech therapy and social work services. TAIP is considered a pre-PACE program because its organizational structure meets all PACE requirements but at this time the plan does not offer the Medicare package of benefits that a full PACE designation would afford. However, if a TAIP member requires access to Medicare services, the case manager will help with that process and coordinate care needs. Currently, the TAIP program serves approximately 135 members, most of whom live on the Weinberg Campus in either the subsidized senior apartments (Amherst Glen and Amherst Towne) or Stovroff Towers. Depending on their care plan, members may access on-site health care services and day center activities up to five days per week in the TAIP building located on the Weinberg Campus.

Stovroff Towers

Built in 2012 with private funds, Stovroff Towers consists of 119 efficiency-style apartments and is adjacent to the TAIP building; a common hallway connects the two buildings. Each apartment has a living area with a small kitchen and a bathroom. A lease agreement is signed by the resident, which is separate from the TAIP enrollment agreement. Residents are required to provide their own meals, although home-delivered meals are an option for those who qualify. The majority of residents are women, 85+ years old, with an average of three to five chronic health conditions. Residents of the Stovroff apartments enrolled in the TAIP program are Medicaid recipients. The Stovroff apartments were designed to offer another type of independent living option to low-income, frail seniors as well as to create a critical mass for TAIP.

Benefits and Challenges of Co-location

There are a number of social benefits as well as economic efficiencies associated with the co-location of TAIP and Stovroff Towers. Residents benefit a great deal from increased socialization opportunities including structured activities as well as the more informal daily interactions with neighbors and staff. This daily contact allows for

health care staff to more easily recognize and address changes in status, providing an added sense of security for the resident.

The economic and staffing efficiencies achieved by having the TAIP program physically located "down the hall" from Stovroff Towers are significant. For example, transportation costs are drastically reduced. Residents whose care plan includes the day center can generally walk to the program; the same holds true for physician visits and other health care services, including physical, occupational, and speech therapy. Shared aides are staffed in Stovroff Towers allowing for more efficient delivery of home care services. End-of-life care is also provided; care plans are adjusted accordingly and residents are closely monitored by the interdisciplinary care team, with palliative care provided as necessary. Due, in part, to the close proximity of health care services and other support services, less than 5% of TAIP members reside in nursing homes at any given time, quite an accomplishment given the multiple and complex needs of this frail population.

Although there are many benefits to this co-location model, challenges do exist. For example, continued annual reductions to the capitated per member per month Medicaid premium make it increasingly difficult to sustain the full spectrum of high-quality services offered while still maintaining a positive bottom line. Also, making more people aware of the program and increasing enrollment is critical to its success, although with the state's plans to require recipients of LTC services to enroll in MLTC plans, this may become less of an issue as time goes on. In spite of these challenges, however, co-locating a program like TAIP with low-income, independent senior apartments provides a realistic, replicable model for targeting the high-cost, high-needs of the frail elderly population by integrating housing with services in a way that achieves efficiencies while still maintaining independence and dignity.

People, Inc. (Buffalo): Establishing community partnerships

People, Inc. was formed in 1970 to serve individuals with intellectual disabilities in Western New York. Since then the organization has expanded to include 30 day programs, over 100 residential sites, health services (including home health care) and 17 senior living apartment buildings. The senior apartment buildings house approximately 765 residents, average age of 77 years, approximately 80% female, predominantly white, and the majority located in the Buffalo suburbs. One bedroom, subsidized rental apartments are available in buildings that include a community room, onsite laundry, a live-in building caretaker and a service coordinator that provides assistance with benefits/entitlements and provides linkage and referral services to community service organizations. All are federally subsidized (HUD 202, HUD 202 PRAC, HOME) and residents must be income qualified to reside in the apartments (2011 federal Income limits: 1 person - $23,150/year; 2 people - $26,450/year). There is currently a 13-24 month waiting list for available apartments.

Several years ago, People, Inc. formed a unique partnership with the Town of Hamburg (about 15 miles outside of Buffalo), the site of two of its affordable senior housing complexes, Iris and Elm. These two apartment buildings are physically located next to each other; Iris was built in 1993 and consists of 49 apartments while Elm opened in 2008 and also has 49 apartments. Town of Hamburg officials recognized a few years ago that over 25% of the town's population was 62+ years old and, based on projected demographic data, this percentage would increase over time so they decided to relocate and expand their senior services department, including their senior center, to a shared site on Iris and Elm grounds. The town negotiated an agreement with People, Inc. to rent space for $1 per year.

The senior center benefits all older adults in Hamburg and includes a congregate meal setting, a fitness room, pool, and fitness and wellness classes. Additionally, the town is currently in the process of opening a technology center that will be located in Elm. This center will house a number of computer stations, be available to the community at large, and provide a variety of computer education classes. Seniors will be able to access email and the internet, and the thought is that it will eventually become a gathering place similar to an internet-café, offering both educational and socialization opportunities. Funding for the technology center is coming from a variety of different sources including a Community Development Block grant. The senior services department, also on-site, coordinates all county-run programs such as Meals-on-Wheels, the Home Energy Assistance Program (HEAP), and caregiver support.

This partnership exists and thrives due to the unique relationship developed between the Town of Hamburg and People, Inc. There was mutual interest in expanding opportunities for a growing older adult population and recognition that co-location of a variety of non-health related support services would benefit not only the residents of the two senior housing buildings but the greater community at large. The partnership has been so successful that plans are underway to replicate the model in People, Inc.'s Springville building.

People, Inc. began as a human services organization and has expanded into one of Western NY's largest affordable senior living development and management companies. If the HUD 202 program changes are implemented, People, Inc. will be significantly impacted in terms of both future development and current operations. Their model is one of affordable senior housing with a service coordination component but includes much more – access to a dementia adult day program plus other adult day centers, senior service outreach program, licensed and certified home health agency services and a health center. Residents living in the senior apartments have access to and choice of these types of services.

Loretto, PACE CNY and Forest View at Fayette (Central NY): Small group home for frail elderly with supportive and health care services provided by PACE CNY

Located in Central New York, Loretto is an extensive network of agencies providing long-term care services for approximately 6,000 older adults. Programs include senior housing, rehabilitation, skilled nursing, adult day health care programs, PACE program and other specialized programs, including dementia care. Loretto has a strong commitment to "transform elder care in Central New York by de-institutionalizing long-term care services and replacing them with home-like settings featuring person-centered care" [30]. Nowhere is that more evident than at Forest View at Fayette, a unique small-care home built by a local not-for-profit neighborhood revitalization company (Housing Visions) and funded primarily with 9% low income housing tax credits.

Opened in 2009, Forest View is located in a residential East Syracuse neighborhood, built in the same architectural style as the other homes in the area, and has 14 individual and shared bedrooms, 5 baths, furnished community rooms, laundry facilities, and a security system. Housekeeping and laundry are provided along with meal assistance. As stated in Loretto's application to receive tax credit funding, Forest View is dedicated to serving a low-income frail elderly population; strict income eligibility requirements apply to residents who want to live there and residents must have PACE CNY as their service provider. Forest View residents are a medically complex group; the average age is 91 years, with each resident having approximately 14 chronic conditions.

PACE CNY provides a full package of both Medicaid and Medicare services. As an MLTC, the program coordinates all health and LTC needs through its doctors, nurses, personal care attendants, home health aides, therapists and other members of the PACE CNY interdisciplinary team. Two day centers provide on-site medical care, nursing care, and rehabilitation therapy as well as a large activity area for meals, special programs and socialization. Although not required, most PACE CNY members attend the day center either monthly or weekly depending on individual care needs. All Forest View residents enrolled in PACE CNY attend the day center program at least weekly, often more frequently. In order to deliver services most efficiently to Forest View residents, there is a shared PACE CNY aide available 24/7 on-site.

Forest View at Fayette is an innovative housing with services model that addresses the needs of the low-income frail elderly population by combining the best of both worlds – providing high quality, all-inclusive, person-centered care in a home-like, small group setting. Replication of this model in other parts of the state should be explored although it will be important to consider the availability of PACE or pre-PACE services as well as community partners willing to fund and develop this type of affordable senior housing project.

Flushing House (Queens, NY): A market-rate housing provider offering a wide variety of on-site services that support healthy and active independent living

Flushing House, a not-for-profit organization owned and operated by United Presbyterian & Reformed Adult Ministries, opened in 1974 as one of the first retirement residences to combine independent living with on-premises support services. The 12-story, 319-unit residence consists of a mix of studio ($2,350 per month) and one-bedroom ($3,450 per month) apartments. The majority of residents are female and single; the average age at move-in is approximately 83 years and the average residency period is about 2.5 to 3 years. An income/assets evaluation is completed at admission; residents must have at least five years' worth of income/assets to qualify for an apartment.

A comprehensive array of services is included as part of the monthly fee: three meals per day, utilities, housekeeping, linens, maintenance, 24-hour security, recreational programs, comedy and musical entertainment, fitness facilities and classes, and access to a large media room, sports lounge and library. Concierge services including check cashing (up to $35), notary services, and the purchase of stamps are also available to residents. A full time director of resident services assists residents with information and referral to outside services, coordinates communication with family members, assists with move-in and with other resident requests as needed.

Flushing House recognized that an opportunity existed to use available building space to provide residents with convenient access to more amenities while at the same time generating a consistent revenue stream for the organization. Currently two independent licensed home health care agencies and a walk-in clinic run by Flushing Hospital lease space in the building. Residents, of course, are free to choose whether or not to use these services but the fact that they are available, easily accessible and generate revenue presents a unique model for other organizations looking to expand their offerings.

Having access to home care services and physicians on-site also allows for the possibility of residents to remain in their own apartment safely and independently for a longer period of time as their care needs increase. This may ultimately delay the need for residents to move into a higher level of care.

Flushing House was among the leaders who recognized that senior housing is more than just a roof overhead; having access to a wide variety of services and amenities onsite allows older adults to engage in a healthy, active and independent lifestyle. As the number of older adults in NYS grows, especially the 85+ population, it will become even more important to have options like the Flushing House available to seniors who are financially able to move into an environment that addresses the full spectrum of their physical, social and emotional needs.

National Models

Many other states have recognized that senior housing is a potentially cost effective and efficient platform to deliver supportive services to an increasingly older and frailer adult population. In particular, three states bordering New York (Vermont, Connecticut and Massachusetts) are in varying stages of implementing unique housing with services programs. A common theme emerging from each of these programs is the importance of working together with existing community service providers such as home care agencies, Area Agencies on Aging (AAAs), mental health providers and adult day health centers. Brief summaries of the programs are highlighted here.

Vermont: Supports and Services at Home (SASH) program

In 2009, with funding from the Vermont legislature, the MacArthur Foundation and the Vermont Health Foundation, Cathedral Square Corporation, an affordable senior housing provider located in Burlington, Vermont, pilot tested an innovative housing with services model called "Supports and Services at Home" (SASH). The goal of this new model was to transform housing providers from landlords into advocates that monitor the health and well-being of their older residents.

The model is based on a multi-disciplinary team approach that consists of a SASH coordinator, a designated nurse from the Visiting Nurses Association, a case manager from the local AAA, and representatives from the PACE program and community mental health agency. Baseline and periodic functional and quality of life assessments are conducted on residents, a "healthy aging plan" is developed if the resident so chooses, and multiple levels of care coordination are targeted at high-risk residents (i.e. multiple chronic conditions, transition from hospital).

During the one-year testing stage, it was found that SASH interventions helped reduce hospital admissions by 19%, no SASH participant who was discharged from the hospital experienced a readmission, and falls declined by 22% [31]. SASH recently received $10.2 billion in Medicare funds, as part of the Centers for Medicare and Medicaid Services' Multi-payer Advanced Care Practice demonstration program, to roll out the program to 112 housing sites throughout the state over a three-year period. With these additional funds, plans are underway to expand the program to serve older adults living in communities around SASH sites and to connect all sites to Vermont's health information exchange in order to facilitate sharing of health data among settings and health care providers.

Connecticut: Assisted living as a service in affordable and congregate senior housing

Connecticut's Congregate Housing for the Elderly Program (CHEP) offers housing and supportive services to frail low-income elders, aged 62+, in 24 properties located throughout the state. Residents must have temporary or periodic difficulties with one or more ADLs and must meet the established criteria set by a local selection committee, which is approved by the Department of Economic and Community Development (DECD). At a minimum, communities must provide one main congregate meal, light housekeeping, 24-hour security, service coordination, transportation and social activities. Residents pay a monthly base rent and congregate service fee, based on their adjusted income. Additionally, housing sites can choose to offer a more extensive package of assisted living services to residents who meet functional eligibility requirements.

In Connecticut, assisted living services are provided by licensed Assisted Living Service Agencies (ALSAs); the state Department of Social Services licenses the service provider (i.e., the ALSA), not the property. Assisted living services are provided in CHEP sites and HUD-funded subsidized senior housing through the Connecticut Home Care Program for Elders and paid for through either a Medicaid waiver or partially subsidized from state funds. The ALSA dedicates staff (nurse and aides) to the housing property and the property provides ALSA onsite office space. Services available through the assisted living program include an on-site nurse; an on-call nurse available 24 hours per day; core services (e.g. housekeeping, personal laundry, meal preparation); and personal services (e.g. hands-on assistance with daily activities including dressing, grooming, bathing, toileting, transferring, walking and eating). Participants are assigned one of four different service levels based on their need, ranging from an average of 2.5 hours per week of service, including .25 nursing hours (Level 1), to an average of 20 hours per week of services, including 1 nursing hour (Level 4). ALSAs are paid based on the individual's service level.

Anecdotally, affordable housing providers see both benefits and challenges to providing assisted living as a service in senior housing buildings. There are staffing and cost efficiencies to serving multiple people in one building and if resident's needs increase, it is more likely they can remain in their apartment and receive a higher level of service. However, home care is heavily regulated in Connecticut. ALSA providers are held accountable to both the Department of Public Health and the Department of Social Services, with sometimes conflicting regulations. Also, increasing the level of service for a resident can be difficult both from a process and regulatory perspective as well as convincing the resident and/or family members those additional services are required. Only 13 of 24 CHEP buildings and 4 HUD-subsidized senior housing properties currently offer assisted living services.

Massachusetts: Housing with supportive services

In 1999, the Massachusetts Executive Office of Elder Affairs and the Department of Housing and Community Development (DHCD) established the Supportive Housing Program (SHP) to strengthen coordination between housing and service agencies and to support aging in place by creating an "assisted living like" environment in state funded public elderly/disabled housing. The program is a partnership between local housing authorities (LHAs), the ASAP (the single point of entry to state and federal funded service programs) and a community service provider. Available services include service coordination and case management, 24-hour personal care, homemaker services, laundry, medication reminders, social activities and at least one meal a day.

The program currently operates in 22 subsidized public housing developments, and services are paid for by a range of state and federal funding sources based on an individual resident's eligibility. Although no formal evaluation has been completed on the program, a summary prepared by DHCD indicates that the SHP costs significantly less per month ($1,338) than assisted living ($2,153) or nursing home care ($3,896) [32]. Additional benefits of the program reported by state managers, housing authority directors and site managers, ASAPs and service providers include reductions in vacancy rates, substantial reductions in nursing home admissions, hospital admissions and unexpected resident deaths.

Conclusions from the recent study of the SHP indicate that the program has been enthusiastically supported by the key partners (i.e. LHAs, building managers, ASAPs, service providers, Medicaid staff); critical to its success has been this multi-agency collaboration [32]. The 24-hour availability of personal assistance for unscheduled visits allows residents to age-in-place, creates a safe environment and reassures family members that assistance will be available when needed.

Opportunities and Challenges for Replication of Different Models in NYS

Many opportunities exist for replicating and expanding elements of the senior housing with services models discussed here throughout NYS. For example, routinely integrating resident and building technologies that promote health and wellness into senior housing community rooms, senior centers and apartments – as Selfhelp is currently doing – has the potential to allow many more older adults to safely and independently age in place. However, a lack of public funding for technology may be a significant impediment to many organizations seeking to construct new technology-enabled facilities or upgrade existing properties.

Increasing on-site access to both health care and support services will become ever more important as the population ages and becomes less mobile. Organizations like Flushing House, People, Inc. and many other affordable and market rate communities in NYS have recognized the potential of offering these types of services to their residents. Models like these will likely become the norm rather than the exception as demand increases and government policy encourages coordination of supports. Furthermore, co-locating housing with a comprehensive array of support services and care management provided by a managed care plan such as PACE allows even the most vulnerable older adults with multiple health conditions to age-in-place. Expanding these models and programs to reach more seniors will become imperative.

Other states like Massachusetts, Connecticut and Vermont have all, to varying degrees, implemented programs that directly address the housing, support services and health care needs of low-income, high-risk seniors by bringing together multiple stakeholders including housing providers, health care professionals, and community based service organizations. Like New York, each of these states operates within their own unique regulatory and fiscal environments. However, current NYS ALR regulations and licensure requirements prevent, to a large degree, the ability to implement many of the highlighted housing with services models in neighboring states, specifically those that allow housing providers to coordinate and/or directly provide home and community based services.

CONCLUSIONS

Following a comprehensive review of literature and demographic data and a series of site visits to innovative housing models in New York State and neighboring states, we reached the following major conclusions:

1. ***New Yorkers are aging and there will be an increased future demand for senior housing, support services and home and community-based health care services.*** An estimated 1 in 5 NYS residents will be aged 65+ by the year 2040, while the 85+ age group will grow by nearly 48% between 2010 and 2040. Disability, cognitive impairment, and chronic disease all increase with age. Furthermore, 9 in 10 seniors express a strong desire to remain in their own home and/or in their local community for as long as possible. As a result, there will be a much greater future need for safe and affordable senior housing and support services as health care and lifestyle needs change.

2. ***There is already an unmet need in many areas of New York for subsidized senior housing with support services and upgraded building features.*** Prospective residents have difficulty accessing subsidized housing in many areas of NYS, particularly in the NYC metropolitan area where there are long waiting lists for rental assistance. In certain other regions, waiting lists are less of a concern than the need to modernize existing buildings to comply with current building codes and incorporate building features and support services to better accommodate current and future resident needs.

3. ***Federal funding for new subsidized housing development is waning, and other funding programs leave gaps and add complexity.*** Funding for the HUD Section 202 new construction program was eliminated in 2012. HUD is proposing historic reforms in the Section 202 program that necessitate combined state and federal financing and the need for additional "gap financing" for new construction and renovation of senior housing. Meanwhile, tax credit programs are increasingly being used to finance senior housing, but they are difficult to access, and add significant complexity to financing structures and ongoing operations.

4. ***Aging-in-place programs and partnerships can help to address shortages of subsidized senior housing.*** For example, programs such as naturally occurring retirement communities and partnerships between housing operators and area agencies on aging can bring together residents, service providers, government and community representatives to promote independence and healthy aging-in-place. These creative approaches do not require development of new housing capacity or resident relocation.

5. ***State assisted living regulations that define independent senior housing are unclear and confound the development of innovative housing with services models.*** New York's Assisted Living Reform Act created several requirements for assisted living, including mandatory licensure of any entity using the term "assisted living." The law directed DOH to define independent senior housing in regulation, yet the definition is unclear and inhibits creative combinations of housing and support services.

6. ***New York's Medicaid redesign initiatives will fundamentally change how services are delivered and paid for in New York, and that in turn will affect senior housing residents.*** The focus on enrolling every Medicaid recipient into a managed care/coordinated care arrangement will result in more chronic conditions being managed in the community rather than in institutional settings. This, in turn, is likely to lead to greater reliance on subsidized housing options, resulting in Medicaid-eligible seniors moving into housing with greater health needs or staying in senior housing longer with support and health care services delivered or provided locally.

7. ***There are important gaps in the availability of service coordination and support services.*** While Medicaid-eligible individuals receiving long term care services in senior housing will receive service coordination and support services through managed care plans and coordinated care arrangements, other residents may not have access to these services unless they or their family members can pay for the service privately, or they can qualify for subsidized programs available through the NYS Office for the Aging and/or HUD. There are significant differences between the income limits for subsidized housing and those applicable to the state's Medicaid program, and limitations on available state and federal funding for these services for low- to moderate-income individuals.

8. ***The state's proposed investment in supportive housing is focused on costly Medicaid recipients, rather than on an aging-in-place model for seniors.*** New York is seeking federal funding for a capital and ongoing supportive services program for supportive housing focused on high cost/high needs Medicaid recipients. Many older New Yorkers are not frail or do not yet qualify for Medicaid, but need supportive housing services including service coordination and are at risk for premature reliance on costly Medicaid services.

9. ***Federal regulations, funding and programs are promoting senior housing as a platform for delivering supportive and health care services.*** Federal senior housing policy, regulations and programs support housing with services models including the Service Enriched Housing Program within the HUD Assisted Living Conversion Program; the Section 202 reform proposal; and the service coordinator position.

10. ***Senior housing operators in New York State and around the country have developed creative housing with services models that should be studied and possibly replicated.*** Technology-enabled senior housing that allows older adults to participate in both active and passive health monitoring as well as socialization activities; partnerships between housing providers and community organizations that enhance opportunities for seniors to engage in wellness activities; co-location of managed long-term care providers and subsidized senior housing that allow chronically ill older adults to safely age-in-place; and transforming housing providers from landlords into advocates that monitor the health and well-being of their older residents are all examples of exciting new housing with services models that can serve as a blueprint for the future.

Further analysis is suggested to explore the inter-relationships between these conclusions, their broader system implications and the associated public policy ramifications. As these conclusions suggest, housing operators have an historic opportunity to meaningfully participate in the development of living arrangements that blend social supports, wellness programs and health care services in a way that enhances resident quality of life and promotes independence.

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GLOSSARY OF TERMS

Activities of Daily Living (ADLs) – routine self-care activities performed every day such as bathing, grooming, eating, toileting, and dressing. An individual's ability to perform ADLs is important for determining the need for long term care services and supports, and which specific services are appropriate to his/her needs. See also "IADLs."

Adult Care Facilities (ACFs) – an umbrella term in NYS which encompasses various types of residential facilities including adult homes and enriched housing programs. ACFs are established and operated for the purpose of providing long term residential care, room, board, housekeeping, personal care and supervision to five or more adults unrelated to the operator. Assisted living models in the state require ACF licensure as a foundation.

Adult Day Health Care Program (ADHCP) – a community-based program that provides comprehensive health care to the frail elderly, chronically ill and disabled individuals delivered in a congregate day setting. Registrants receive nursing care, case management, social work services, personal care, rehabilitation, therapeutic recreation, health education and nutritional services.

Adult Home – a congregate housing arrangement licensed by the NYS Department of Health that provides room and board, congregate meals, 24-hour supervision, personal care, assistance with medications, and activities for five or more unrelated adults. An adult home is one type of ACF in the state.

Aging-in-place – a concept that advocates allowing a resident to choose to remain in his/her living environment regardless of the physical and/or mental decline that may occur with the aging process.

Area Agencies on Aging (AAA) – county-based agencies, often referred to as "local offices for the aging," which administer NYS Office for Aging programs at the local level to assist seniors and their caregivers.

Area Median Income (AMI) – the mid-point in the family income range for a metropolitan statistical area or for the non-metropolitan areas of a state. This figure is often used as a basis to stratify incomes into low, moderate, and upper ranges for purposes of determining income eligibility for subsidized housing.

Assisted Living Conversion Program (ALCP) – a federal program that provides eligible operators of HUD senior housing with grants to convert some or all of the dwelling units in the project into state licensed assisted living or Service-Enriched Housing (SEH) for elderly residents aging in place. SEH is housing that accommodates the provision of services to elderly residents who need assistance with ADLs in order to live independently.

Assisted Living Program (ALP) – an aging-in-place assisted living model regulated by the NYS Department of Health. This is the only Medicaid-funded assisted living model in the state.

Assisted Living Residence (ALR) – similar to an ACF, ALRs provide residential services as well as housekeeping, supervision, personal care, and case management. Operators can choose to obtain an Enhanced ALR (EALR) certification to enable residents to age-in-place and/or a Special Needs ALR (SNALR) designation to offer a specialized unit for people with dementia, cognitive impairment or other special needs. SNALRs must meet specific programmatic, environmental and staff training requirements designed to meet the special needs of the population. Medicaid does not pay for these assisted living services.

Capitation – a method of paying for health care services under which managed care plans or providers receive a set payment for each person or "covered life" instead of receiving fee-for-service payment (i.e., based on the number of services provided and/or the costs of the services). Capitation can be adjusted based on geography, demographic characteristics (e.g., age and gender) or expected costs of the members.

Centers for Medicare and Medicaid Services (CMS) – the federal agency with oversight responsibility for both the Medicare and Medicaid programs.

Certified Home Health Agencies (CHHAs) – home care agencies that provide part-time, intermittent health care and support services to individuals who need intermediate and skilled health care in a home setting. CHHAs can also provide long-term nursing and home health aide services, help patients determine the level of services they need, and either provide or arrange for other services including physical, occupational, and speech therapy, medical supplies and equipment, and social worker and nutrition services. CHHAs can accept payment from Medicare, Medicaid, private insurances and private pay.

Community Development Block Grants (CDBG) – a federal program administered by HUD's Community Planning and Development Office. The purpose of CDBG funds is to improve communities by providing decent housing, a suitable living environment, and expanding economic opportunities—principally for persons with low and moderate incomes.

Consumer Directed Personal Assistance Program (CDPAP) – a Medicaid program for the chronically ill or physically disabled who have a medical need for help with ADLs or skilled nursing services. The consumer or the person acting on the consumer's behalf assumes full responsibility for hiring, training, supervising, and if necessary, terminating employment for the persons providing the services.

Continuing Care Retirement Community (CCRC) – a comprehensive living arrangement for retired persons that provides independent living units (apartments or cottages), social activities, meals, supportive assistance, personal care, and a range of health care services all on one campus. Types of CCRCs include the life care (lifetime guarantee for nursing home care as a part of its contract), modified and fee-for-service CCRC communities.

Dual Eligible – an individual who is eligible for both Medicare and some level of Medicaid benefits.

Enriched Housing Program (EHP) – a type of ACF licensed by the NYS Department of Health that provides some assistance with ADLs and IADLs to residents in a congregate setting. EHPs provide room and board, personal care, assistance with medications, supervision, activities, and some congregate meals. The EHP was originally designed to enrich housing with services, and thus has slightly lower regulatory requirements as compared to adult homes. Many EHPs operate to the higher adult home standard, however, while offering an apartment-like living space.

Expanded In-Home Services for the Elderly Program (EISEP) – a program administered by the NYS Office for the Aging and AAAs that assists seniors who need help with ADLs, want to remain at home and are not eligible for Medicaid. EISEP supplements and sustains informal care, and requires cost-sharing according to a sliding scale based on participants' income.

Fair Housing Act – establishes a broad national policy to provide for housing choice throughout the United States. Senior housing providers must comply with the federal Fair Housing Act and state and local fair housing laws. In addition to the federally protected classes, NYS protects persons based on creed, marital status, sexual orientation, age and military status.

Fee-For-Service (FFS) – a traditional method of paying for health care services under which medical professionals, facilities and agencies are paid for each service they provide, in contrast to capitation. Bills are either paid by the patient, who then submits them to the insurance company, or are submitted by the provider to the patient's insurance carrier for reimbursement.

Health Home – authorized under the federal Affordable Care Act and NYS law, a health home is a new model of care funded by enhanced Medicaid payments from the federal government to the states. A health home is not a physical location, but rather a care management service model with specific requirements for communication between the providers of service for a particular individual, so that their comprehensive needs are met and coordinated particularly during transitions of care. Health homes are an example of a "medical home" that is focused on the Medicaid population.

Home and Community-Based Services (HCBS) Waiver – services available under Medicaid through waiver programs to groups of individuals who would be eligible for Medicaid if institutionalized and, but for the services,

would be institutionalized in a hospital or nursing home. Under section 1915(c) of the Social Security Act, the federal government grants states waivers of requirements that otherwise apply to Medicaid "state plan" services, allowing additional services to be funded through Medicaid. In New York, these HCBS waivers include the long term home health care program, the nursing home transition and diversion waiver, and the traumatic brain injury waiver.

Home-delivered meals – meals delivered to seniors in their home to provide well-balanced options either on a temporary or long term basis.

Independent Senior Housing – a facility or dwelling consisting of apartments or cottages designed to enable elderly and/or disabled residents to live independently. Most are handicapped-accessible and are supervised by a housing manager.

Instrumental Activities of Daily Living (IADLs) – a series of life functions necessary for maintaining a person's immediate environment that include preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework, doing laundry, and using a telephone. See also "ADLs."

Licensed Home Care Services Agency (LHCSA) – a home care agency that offers services to clients who pay privately or have private insurance coverage. LHCSA aides provide assistance with ADLs and IADLs to people living in community settings. These agencies may also contract to provide services to Medicare/Medicaid beneficiaries whose cases are managed by another provider or entity, such as providing home health aide services to a CHHA or managed long term care patient or providing licensed nurses for Medicaid recipients requiring private duty nursing services.

Long Term Care (LTC) – a broad spectrum of social, custodial, health and medical services provided to individuals of all ages who need assistance with performing activities of daily living and may also have episodic or chronic health conditions that require treatment. LTC services are provided in individuals' homes, community settings, congregate facilities and campus settings by providers that are often required to be licensed and by individuals who are often certified to perform a particular scope of work.

Long Term Home Health Care Program (LTHHCP) – a Medicaid Section 1915(c) waiver program in NYS that coordinates medical, nursing, and rehabilitative care for people living at home who are medically eligible for nursing home placement. A wide range of services is provided and limited by a monthly budget of up to 75% of the average nursing home cost in the county. Local departments of social services determine eligibility and authorize services for the program.

Low-Income Housing Credit (LIHC) Program – a Federal subsidy established under the Tax Reform Act of 1986 to promote private sector involvement in the retention and production of rental housing that is reserved for low-income households. Many local housing and community development agencies use these tax credits to increase and preserve the supply of affordable housing in their communities.

Managed Long Term Care (MLTC) plans – a generic term describing Medicaid managed care plans in NYS providing long term care services predominantly to a senior population living in the community. Plans are regulated as insurers and are reimbursed on a capitation basis for providing a comprehensive and coordinated package of medical and other support services. Some models incorporate a Medicare managed care product as well (e.g., MAP and PACE). NYS is in the process of implementing a requirement for most dual eligible individuals who need home and community based services for 120+ days to enroll in and receive LTC services through a MLTC plan.

Market Rate Housing – refers to senior housing in which rents are set by owners/operators based on local market conditions.

Medicaid – a program jointly funded and administered by the federal and state governments that pays the health care expenses of people who are unable to pay for some or all of their own health care expenses. In NYS, local governments also contribute to the cost of the program and administer certain of its functions.

Medicaid Advantage Plus (MAP) – a type of MLTC plan in NYS for individuals 18+ years of age with both Medicare and Medicaid coverage who have a chronic illness or disability. Under MAP, the Medicaid managed care services are coordinated with the services provided under the enrollee's companion Medicare managed care plan.

Medicaid Managed Long Term Care (MMLTC) plan – a type of MLTCP that coordinates and provides coverage for all long term care services for Medicaid-eligible adults (age 21+). However, unlike PACE and MAP plans, MMLTC plans do not incorporate Medicare benefits.

Medicaid Redesign Team (MRT) – established in January 2011 by Governor Andrew Cuomo to bring together stakeholders and experts from throughout New York State to work cooperatively to reform the Medicaid system and reduce the state's Medicaid spending.

Medical Home – a team-based health care delivery model where patients receive comprehensive primary care services; have an ongoing relationship with a primary care provider who directs and coordinates their care; have enhanced access to non-emergent primary, secondary, and tertiary care; and have access to linguistically and culturally appropriate care. See also "health home."

Medicare – a national medical insurance program administered by CMS for individuals age 65+ and certain disabled people, regardless of income. Medicare Part A covers acute episodes and pays for certain short-term post-acute services provided by nursing homes, rehabilitation facilities and home care agencies. Other parts of Medicare provide coverage for primary care, outpatient services and some medications. Medicare is offered as either a traditional fee-for-service benefit or a managed care benefit through Medicare Advantage plans.

Medicaid Redesign Team (MRT) Waiver – New York's requested 5-year extension to its existing 1115 Partnership Plan Waiver to fully implement the MRT action plan (which includes investments in supportive housing) and prepare for the implementation of the federal Affordable Care Act. Section 1115 of the Social Security Act authorizes pilot or demonstration projects that promote objectives of the Medicaid statute. Terms and conditions are negotiated between the state and CMS, and waivers must be budget neutral to the federal government. As of the publication of this paper, the MRT waiver request is pending with CMS.

Mitchell-Lama Program – a NYS subsidized housing program created in 1955 for the purpose of building affordable housing for middle income residents. While there is no new Mitchell-Llama funding available, there are many facilities still operating buildings developed under this program that offer affordable senior housing.

Naturally Occurring Retirement Community (NORC) – a collaboration between housing providers, social services agencies, health care providers and government to bring appropriate services to seniors living in apartment complexes that, while not originally designated as senior housing, have a large proportion of residents over age 60. Neighborhood NORCs (NNORCs) are geographically defined areas in a municipality containing certain numbers of elderly people in low-rise buildings and single/multi-family homes.

New York State Department of Health (DOH) – the state agency responsible for licensure and oversight of health care providers and for administration of the state's Medicaid program.

New York State Homes and Community Renewal (HCR) – the designated state agency responsible for administering New York State housing policies and programs, including Mitchell-Lama and low income tax credit senior housing.

New York State HOME Program (HOME) – a federal grant program administered by the NYS Housing Trust Fund Corporation designed to expand affordable housing within the state. The HOME program funds a variety of activities through partnerships with counties, local governments, private developers, and not-for-profit housing organizations. Among the many eligible purposes, HOME funds are used to provide secondary funding for senior housing development and renovations.

New York State Housing Trust Fund Corporation (HTFC) – a corporation established under NYS Homes and Community Renewal that administers loans and grants to construct, develop and preserve low-income housing. Several state and federal housing programs are administered through the HTFC.

New York State Low-Income Housing Tax Credit Program (SLIHC) – signed into law in 2000, SLIHC is generally modeled after the federal program and administered pursuant to the Internal Revenue Code and HCR's Qualified Allocation Plan.

New York State Office for the Aging (NYSOFA) – the state agency that administers programs and services such as home and congregate meals, transportation assistance, caregiver assistance, and health promotion and prevention programs that help seniors maintain their independence. NYSOFA services also help older New Yorkers navigate the LTC system and understand their benefits, and are funded through the federal Older Americans Act, NYS budget appropriations, local government support and recipient cost-sharing.

Notice of Funding Availability (NOFA) – notices issued in the Federal Register that announce funding availability for a variety of government programs and the process required to apply for the funding. For purposes of this paper, NOFA refers to the funds HUD makes available under the Section 202 and Service Coordinator programs.

Nursing Home – also known as a skilled nursing facility, a nursing home provides 24-hour medical, nursing and other services. These facilities are licensed and regulated by the NYS Department of Health. A nursing home offers a protective, therapeutic environment for those who need rehabilitative care or can no longer live independently and require around-the-clock care and supervision.

Nursing Home Transition and Diversion (NHTD) Waiver – a NYS Medicaid Section 1915 (c) waiver program available to seniors and others with disabilities, designed to allow for the delivery of services in the community rather than in a nursing home. While offering services similar to a LTHHCP, this waiver is administered through a network of Regional Resource Development Centers, each covering specific counties throughout the state.

Patient Protection and Affordable Care Act (ACA) – enacted into law in March 2010, the ACA puts into place many health care reforms including the development of state health insurance exchanges, a mandate for health insurance for individuals, provision of tax credits for small businesses, disallowing insurance companies from denying care for pre-existing conditions, and a requirement that plans that offer dependent coverage for adult children. Several demonstration programs and new models of care (e.g., health homes) were enacted within the ACA that could allow seniors in housing to remain in independent settings.

Personal Care Services – the provision of some degree of assistance with personal hygiene, dressing, feeding, nutritional/environmental support functions and to assist an individual with ADLs and IADLs.

Personal Emergency Response System (PERS) – an in-home electronic monitoring system that alerts others if the person being monitored has encountered a problem that requires outside help (e.g., a fall) or the person has been inactive for a specified duration of time.

Program of All-Inclusive Care for the Elderly (PACE) – a managed long term care plan that provides a comprehensive system of health care services for dual-eligibles age 55+ who are otherwise eligible for nursing home admission. Both Medicare and Medicaid pay for PACE services on a capitated basis. Enrollees use PACE physicians and an interdisciplinary team develops care plans and provides on-going care management. The PACE is responsible for directly providing or arranging all primary, inpatient hospital and long term care services required by enrollees.

Project Rental Assistance Contract (PRAC) – A HUD funding program designed to cover the difference between what affordable housing residents pay for rent and the HUD-approved expense to operate the project.

Public Housing – rental housing built and owned by the government for the purpose of providing safe and affordable places to live for low-income families, the elderly, and people with disabilities. Public housing programs are operated by local public housing authorities.

Section 8 Housing – a type of housing subsidy that authorizes the payment of rental housing assistance by the government to private landlords In the Section 8 Program, tenants pay about 30 percent of their income for rent while the subsidy makes up the difference between the tenant payment and the contract rent established by HUD. Subsidies are either attached to specific units in a property (project-based), or to individual tenants (i.e., Housing Choice Vouchers).

Section 202 Housing – a subsidized housing program designed for elderly low-income individuals. Section 202 facilities are developed either through a direct loan or a capital advance grant from HUD, and typically offer rental assistance for seniors who meet specific income and eligibility requirements of the particular program or property.

Section 236 Housing – a subsidized housing program that provided mortgage insurance and mortgage interest reductions (and sometimes operating subsidies) to create housing opportunities for lower-income households. The program is designed to assist private owners to build and operate rental housing that may be wholly or partially for the elderly, typically with 10 percent of the units designated for people with mobility impairments. No Section 236 construction has occurred since January 1973.

Senior Center – a congregate program that provides socialization, nutritious meals, case management, other supportive services, health screenings, informational seminars and activities to older adults.

Senior Citizen Rent Increase (SCRIE) – a program intended to protect elderly residents in certain subsidized housing in the New York City metropolitan area from being priced out of their apartments because of rent increases. Eligible applicants do not pay rent increases as long as they meet program eligibility requirements.

Service Coordinator (or Resident Service Advisor) – a person often hired by a senior housing operator to provide assistance to residents with accessing information on support and health care services offered on-site and in the community.

Social Adult Day Care (SADC) – a community-based program that provides organized activities, socialization, personal care, supervision, nutritionally balanced meals, and a safe, stimulating environment for senior citizens or disabled persons, but no ongoing health care services. SADC is intended to alleviate the need for higher levels of care through good nutrition, routine monitoring and early intervention.

Subsidized Housing – A housing arrangement that includes a government subsidy of a developer and/or a resident in order to effectively reduce the monthly rent for income-eligible residents.

Supportive Housing Capital Expansion Program (SHCEP) – a proposed program under the MRT Waiver to provide funding for capital projects to increase access to supportive housing that includes new development, renovations and home modifications.

Supportive Housing Services Program (SHSP) – a proposed program under the MRT Waiver to provide funding to access support services in housing such as case management; patient navigation and care coordination services; counseling; linkages to community resources; education and employment assistance; entitlement advocacy; and budgeting and assistance with legal issues.

U.S. Department of Housing and Urban Development (HUD) – the federal agency with responsibility for administering housing and community development policies and programs including Housing Choice Vouchers, Section 202, project-based Section 8 and public housing programs.