—A WHITE PAPER FROM AN EXPERT SUMMIT—

Making Quality Assisted Living an Affordable Community-Based Care Option

Identifying Roles, Risks and Recommendations for Medicaid and Other Public Subsidies

The Center for Excellence in Assisted Living

Acknowledgements

The Center for Excellence in Assisted Living (CEAL) convened an expert Summit to discuss making quality assisted living an affordable community-based care option. CEAL gratefully thanks the experts who participated and enriched the Summit through their insights of a complex issue and contributions to the discussions resulting in this White Paper. The Summit was held at the Hart Senate Office Building in Washington, DC on August 23, 2005.

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CEAL gratefully acknowledges NCB Development Corporation – Coming Home Project for the cover photographs.

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Introduction

This paper presents the summary proceedings and results of panel and participant discussions on affordable assisted living sponsored by The Center for Excellence in Assisted Living (CEAL) in Washington, DC on August 23, 2005. The purpose of the meeting was to bring diverse public and private stakeholders together to discuss the role of Medicaid in creating and supporting affordable assisted living[i] (AAL) in a time when significant Medicaid program redesign is being discussed by states and the Federal government. Specifically, the meeting's purpose was to elicit recommendations from the stakeholders on the best activities for CEAL to pursue in the Medicaid debates to:

- Leverage CEAL's unique partnership between providers, consumer advocates, and related senior
  housing and long-term care professionals
- Meet its mission to improve the quality and affordability of assisted living in the United States.

Specific goals of this day-long meeting included:

- Identifying barriers to expanding the supply of AAL
- Identifying Medicaid's current capacity to support AAL philosophy, quality, and operations
- Identifying the current issues and ideal role for Medicaid in the expansion of AAL
- Summarizing the overall strengths and weaknesses of the Medicaid program in relation to AAL

Participants included experts in state and federal aging policy, housing development and finance, senior housing, and research (see Appendix 1: Summit Participants). The report is divided into sections based on the panel discussions and participant recommendations.

[i] For the purpose of the meeting, CEAL defined affordable assisted living (AAL) as a project where 25% or more of the residents are receiving Medicaid supported long-term care services in apartment style assisted living settings.

Background

CEAL was formed as a result of a recommendation of the Assisted Living Workgroup (ALW), a broad group of stakeholders that convened to address quality issues in assisted living as the result of a U.S. Senate Special Committee on Aging hearing held in April 2001. The ALW's 2003 report is available at http://www.aahsa.org/alw.htm. Approximately 50 national organizations participated in the ALW. Eleven of these organizations chose to formalize the collaboration begun during the ALW, founding the CEAL to provide a cooperative and balanced partnership between providers, consumer advocates, and related professionals to support high quality assisted living (See Appendix 2: CEAL Board).

The mission of CEAL is to foster access to high quality assisted living by:

- Creating resources and acting as an objective resource center to facilitate quality improvement in assisted living
- Increasing the availability of research on quality in assisted living
- Providing a national clearinghouse for information on assisted living
- Building upon the work of the ALW

Affordability was one of the eight topics addressed by the ALW and adopted by the CEAL as a primary focus.

SECTION I: MEETING DESIGN, COMPONENTS, PARTICIPANTS AND REPORT ORGANIZATION

A. Meeting Design

The meeting began with an introduction by CEAL Chair Doug Pace, a discussion of the role of affordable assisted living in long-term care by Don Redfoot of AARP (see Section II), and a definition of affordable assisted living by Robert Jenkens of NCB Development Corporation (see Section III).

During the morning session, two expert panels facilitated by Charlie Reed, the former Assistant Secretary, of the Washington Department of Health and Social Services, addressed topics related to developing and financing AAL. The panels were followed by case studies of three successful AAL programs and their approaches (see Section IV for case study summaries). The morning panels, case studies, and discussions were organized to provide participants information and a common understanding of AAL and its development and operational needs. This common understanding provided a foundation for participants' afternoon discussions and recommendations regarding CEAL's optimum role in providing information for the upcoming Medicaid reform debates. The full meeting agenda is provided in Appendix 5.

B. Components

Panels

The first panel, Opportunities, Benefits, & Issues, discussed Medicaid's ability to support AAL philosophy and quality through daily operations. The panel represented Federal, state, and provider perspectives, including representatives from CMS, state aging directors, providers, and an AAL operations expert. The second panel, Is Iit Too Hard? Assembling the Team, Subsidies, and Partners, focused on Medicaid's capacity to support AAL development and viable on-going operations from the perspective of owners, developers, lenders, and investors. Panelists included owners, developers, lenders, financiers, and a housing with services technical expert (see Appendix 3 for panelists).

Case Studies

After the panel discussions, three case studies provided successful examples of diverse approaches to combining affordable housing and service subsidies to create AAL. The first case study, The Gardens at Osage Terrace in Bentonville, Arkansas, demonstrated

how low-income affordable housing tax credits, HUD HOME funds, Federal Home Loan Bank Affordable Housing Program Funds, foundation funding, and conventional debt could be combined with 100% Medicaid supported services to support individuals at an SSI income level. The second case study, Cathedral Square in Burlington, VT, provided an example of converting a portion of an existing HUD 202 affordable senior housing project to AAL using a HUD Assisted Living Conversion Grant, Medicaid funding, low-income housing tax credits, and a combination of Medicaid and private pay service funding. The third case study, America House in ???, southeast Michigan, showed how HUD housing choice vouchers and Medicaid service funding can be combined to create affordability. While each case study showed a solution using existing programs, each also illustrated the complexity of the model, the exceptional skills and commitment required to complete the projects, and the reliance on limited programs and their availability to AAL based on often differing interpretations of regional program staff.

Breakout Groups

Using the information and discussion provided in the morning sessions, participants divided into breakout groups constructed to provide diverse perspectives on developing AAL, including providers, state policy and federal policy and program staff, lenders, and advocates. Breakout groups used a facilitated process to identify five barriers and/or issues important to the creation of AAL. For each barrier, breakout groups identified action steps required to facilitate rapid development and broad provision of AAL.

Priority Identification

Breakout groups reported their top five recommendations to meeting participants and what CEAL's unique role in the solution could be. To develop overall recommendations, meeting participants were asked to vote for the top five concerns presented by all breakout groups. These recommendations are described in detail in Section 5. [Additional barriers, issues, and action steps are listed in Appendix 4.]

SECTION II: SUMMARY PROCEEDINGS

A. Consumer Preference for Assisted Living (Donald Redfoot, AARP)

Nationally, assisted living has developed in response to consumer demand for an alternative to nursing facilities. Although the term "assisted living" describes a wide range of housing with service models, surveys indicate that the typical resident is a woman in her mid-80s who requires assistance with personal care tasks like bathing or dressing in addition to assistance with medications and monitoring one or more chronic health conditions.

Early promoters of assisted living responded to consumer demand for a nursing home alternative. Assisted living has been described as "the driver for social and cultural change in long-term care." The model of assisted living developed in Oregon, often cited as a national model, was based on a combination of environmental psychology theories, the disability rights movement, and on housing with home care rather than the hospital model followed by nursing homes. Assisted living has evolved into a few state-specific models, but most of them emphasize consumer values such as resident choice, independence, privacy, and dignity. In addition, although licensed and monitored at the state level, many proponents argue for flexible regulations that allow for creativity in response to consumer preferences. In most states, the majority of consumers are private payers, and many assisted living providers argue that accepting Medicaid payments will bring the "strings" of added regulatory requirements that will jeopardize the principles that make this setting attractive to increasing numbers of older persons who require assistance with daily activities.

Assisted living facilities were introduced in the late 1980s and have increased in numbers, especially since the mid-1990s, and these increases indicate consumer demand for the combination of housing with services offered. During this same time period, the number of nursing facility residents has declined relative to the population of persons aged 65 and older. For example, while the number of persons over age 65 increased by 8% between 1994 and 2004, the number of elderly nursing facility residents decreased by almost 5%. Notably, during this time states began offering Medicaid waivers for home and community-based care, and the number of Medicaid-financed nursing facility clients decreased by 8.6%. Looking back to 1985, Don Redfoot reported that had the percentage of older persons living in nursing facilities remained constant, there would now be 41% more older nursing facility residents than there now are. While a number of individual and societal reasons can explain the lower than expected numbers of nursing facility residents given the increasing population of older persons, the availability of assisted living can be pointed to as one such explanation.
As noted above, one very real concern debated by assisted living providers and advocates is the effect of Medicaid, in the form of increased regulatory requirements, on the model of assisted living promoted by the ALW, NCAL, and ALFA among others. While recognizing that the one mission of the Centers for Medicare and Medicaid Services includes assuring public accountability and quali-

ty long-term care services, especially those subsidized by the Medicaid program, some assisted living advocates believe that reliance on existing nursing facility regulations will essentially recreate assisted living into nursing facilities. Other advocates maintain that regulations are important to assure quality and that the goal should be to set realistic but flexible standards.

B. Defining Affordable Assisted Living (Robert Jenkens, NCB Development Corporation)

The CEAL meeting used the ALW definition of AAL which states that assisted living is a state-regulated and monitored residential long-term care option that includes a full range of personal and health care services to meet the scheduled and unscheduled needs of residents, including providing awake staff 24-hours a day. Central to the ALW definition are a set of consumer-focused principles: "A resident has the right to make choices and receive services in a way that will promote the resident's dignity, autonomy, independence, and quality of life" (from Part A of the ALW definition of assisted living). Due to financing sources available and prevailing consumer preference, AAL most often includes private occupancy apartments.

C. Medicaid and Affordable Assisted Living Operations and Development

Opportunities, Benefits, and Issues (Panel 1)

Representatives from Arkansas, Michigan, and Vermont presented lessons from their experience with affordable assisted living. Herb Sanderson from the Arkansas Department of Human Services Division of Aging and Adult Services (DAAS), Nancy Leake from the non-profit Community Development Corporation of Bentonville/Bella Vista, Inc. (CDC), and Patrick Flood Commissioner of the Vermont Department of Disabilities, Aging & Independent Living each described the development of affordable assisted living facilities under the Coming Home Program, a national demonstration of the Robert-Wood Johnson-foundation and NCB Development Corporation. Following is a brief description of each program. More details about these and other examples of affordable assisted living demonstration programs are available at www.ncbdc.org and have been described by Jenkens, Carder, and Maher (2005). [Other resources are listed in Appendix 6]

Is it Too Hard?: Assembling the Team, Subsidies, and Partners (Panel 2)

Participants, including lenders, developers, and technical experts who work in affordable housing, were asked to address the following questions: How is affordable assisted living

developed? Can federal, state, and local level efforts simplify the Medicaid waiver process for both lenders and providers? Why would a provider undertake development of affordable assisted living? Are there enough experts?

How is affordable AL developed? Making AL affordable to low-income persons requires reducing the monthly expenses, including the costs of the housing (in the form of rent) and the cost of the services (in the form of personnel). Medicaid can be used to pay for the health and personal care services on behalf of individuals who meet eligibility criteria, but Medicaid does not pay for either the housing or food costs of these individuals. Finding sources of equity to build affordable AL is a major challenge for developers. One of the most important sources is low-income housing tax credits (LIHTC), a real estate development program. In order to raise development capital, non-profit developers of affordable housing must compete to qualify for tax credits that are then purchased by corporate investors. The capital reduces the debt/equity requirements for the developer, and this reduces the rental rate charged to residents. Tax credits may account for 50 to 60% of total development costs, and the remaining costs are usually subsidized by state and local sources. It often requires three to five equity sources to finance one AAL project, and this complexity, combined with the limited number of sources that provide such equity, increases the difficulty to non-profit organizations, especially those that lack technical experience. Tax credit investors are cautious about purchasing LIHTC from developers of AAL because they are unfamiliar with housing that includes personal and health care services. To investors and lenders who have experience with affordable housing, assisted living looks like a nursing home, and they do not want to finance health care facilities. Some of the very goals of assisted living, such as promoting aging in place, are at odds with LIHTC requirements that limit the type of care that can be provided in a setting that is defined as residential. If an AAL development fails, or stops serving low-income persons, the investors lose the tax credit, and this is a financial risk they are unwilling to accept. In addition, investors worry about the future availability of Medicaid funding for residents of AAL. Medicaid, typically through a Home and Community Based Services waiver and/or a state plan, pays for the services of AL residents who qualify for nursing home level of care. Most states limit the number of Medicaid waiver slots and the time span of waiver programs is less than the duration of the loan finance repayment period (e.g., 5 years versus 30 years). States differ in their use of these programs and in their financial and medical eligibility requirements, and the state has the duty to monitor facilities for quality care, which could result in a facility being penalized or even closed by the state. Although this is obviously important to protect the health and safety of residents, it represents yet another source of uncertainty to prospective investors who are unfamiliar with AL. The Medicaid program pays for

all rent, food, and health service costs of nursing home residents, but only the services provided in assisted living. Some of the participants questioned whether Medicaid should cover all monthly costs of assisted living. These requirements and state-based differences present a huge challenge to all of the parties involved in developing AAL. For example, an underwriter who becomes familiar with the AL regulations and Medicaid requirements in Minnesota will have to learn an entirely new set of rules to finance an AAL in Michigan (or any other state).

Can federal, state, and local level efforts simplify the Medicaid waiver process for both lenders and providers? Some of the risks to investors include uncertainty over whether Medicaid reimbursement rates will increase over the term of a loan and the disparity between private pay rates and Medicaid rates. One of the underwriters on the panel explained that lenders attempt to calculate the certainty of a loan being paid back, and lenders have not been able to assess the capacity of AAL operators to run a financially secure facility over time. For example, operational expenses such as food, personnel, and liability insurance tend to increase over time, but revenue that comes in the form of Medicaid and the resident's SSI payment, remain relatively flat over time.

Specific suggestions made by the panel participants to address the above barriers include:

1) Establishing some degree of uniformity between the major subsidy programs (e.g., LIHTC, Medicaid) in order to simplify the regulations for providers to remain in compliance and to help lenders better understand the regulatory process; and
2) Training technical assistance experts, investors, and non-profit developers on the range of subsidy program rules and requirements.

Why would a provider take on such a difficult challenge? The panel participants, and the case studies (described in the following section), explain that despite real obstacles, there are providers willing to develop AAL because they have a social mission to provide housing and services to vulnerable populations, including low-income older persons. Merely having a strong social mission, while important, may not be enough to overcome the barriers without significant technical assistance on housing development and subsidies, AL regulations, and personal care subsidies.

Fortunately, there are already experts in both housing and long-term care services who can address these uncertainties, and CEAL could work to connect such individuals with developers and operators of AAL. However, the number is small and the demand is increasing. State agencies, including housing finance, community development, Medicaid, and aging services need to support the creation of technical experts within their offices.

Charlie Reed summarized the theme of these panel discussions by noting that developing affordable assisted living requires the coordination of "many moving parts." Broadly speaking, the moving parts refer to the various programs required to subsidize housing development (e.g., LIHTC) and those required to subsidize long-term care services (e.g., Medicaid or state plans).

Case Studies

1. *Arkansas: The Gardens at Osage Terrace.*

   Herb Sanderson and Nancy Leake described the collaboration between public agencies and private, non-profit organizations that resulted in a regulatory environment supportive of affordable alternatives to skilled nursing facilities and the development of the state's first AAL, The Gardens at Osage Terrace. Public partners included three primary state agencies: the Arkansas Department of Human Services Division of Aging and Adult Services, the Office of Long-Term Care and the Arkansas Development Finance Authority. Private agencies included the CDC and Mercy Healthcare, with NCBDC providing technical assistance throughout the process.

   Mr. Sanderson explained that the state recognizes that older persons are individuals with different needs and wants, and that the DAAS wants to respond to them. Many older people both want and need community-based alternatives, and the state has found that assisted living is more cost-effective than nursing facilities. In order to set the policy environment for AAL, the state had to adopt assisted living rules, apply for and receive a Medicaid 1915 (c) waiver to pay for home and community-based services (HCBS). In addition, they arranged an agreement with the state Finance Development Authority to create a Low Income Housing Tax Credits (LIHTC) set aside for qualifying affordable assisted living facilities and to designate a percentage of its HOME program allocation.

   The Gardens at Osage Terrace is a new development with 45 private apartments, all designated for individuals with low incomes, including some with incomes as low as $564 per month (the Federal SSI payment amount in 2004). The Gardens uses a combination of Medicaid and real estate subsidy programs to provide this level of affordability. A total of six financial programs had to be combined in order to finance this program, including a predevelopment loan from the Coming Home Program, LIHTC, a private mortgage, a Federal Home Loan Bank Affordable Housing Program grant, a HOME loan, and a private foundation grant. The LIHTC accounted for more than 50% of the development costs.

Mr. Sanderson and Ms. Leake explained that the LIHTC, HOME, and AHP programs each have unique rules and requirements for resident eligibility, building design, and operational considerations. These capital subsidy programs are needed in order to reduce the overall development costs so that lower rents can be charged of residents. Individuals who qualify for Medicaid must pay their monthly rent and food costs out of their own resources. For many individuals, this payment comes from their monthly SSI (Supplemental Security Income) check.

In the case of The Gardens at Osage Terrace, the concerns of lenders and investors required the developer to create two feasibility models, one that showed that the project would survive as independent housing should it fail as assisted living. The CDC had a strong background in real estate development but no experience with service delivery; services are provided through a partnership with a non-profit health care organization that had Medicaid experience. This partnership gave additional confidence to the financial underwriters. Ms. Leake explained that she had developed $300 million mixed-use projects in the past, but that this 45-unit, $2.7 million project, was the most difficult development project of her life. However, she emphasized that the process was worth it because The Gardens offers a real alternative to residents in her community who would otherwise have to move to a nursing home.

Mr. Sanderson said that the CMS streamlined waiver application simplified the process. The largest barrier facing nonprofit groups currently attempting to develop AAL in several Arkansas communities is in securing development equity.

2. *Vermont: Cathedral Square Assisted Living*

Patrick Flood described Vermont's first affordable assisted living program and the new Medicaid 1115 waiver. He explained that the state's policy goals include supporting affordable community-based alternatives to skilled nursing facilities that allow individuals to age in place. Assisted living is one of several options. However, the rural nature of the state adds to the challenge of creating affordable housing with services.

The state's Housing and Urban Development published a Consolidated Plan for 2000-2004 that indicated a need for at least 2,000 units of affordable senior housing. Concerns included the lack of support services for older persons in subsidized housing, a reduction in the number of residential care units and a caregiver shortage. In response, the Department of Aging and Disabilities organized an affordable assisted living roundtable including the Cathedral Square Corporation (a non-profit developer and manager of affordable senior housing), the Department of Social Welfare (DSW), the Vermont Housing Finance Authority (VHFA), and the Agency of Human Services.

Cathedral Square Assisted Living is the first project in the state to receive a HUD Assisted Living Conversion Program award. The building, a HUD 202 project, now has 80 units of independent living and 28 units of affordable assisted living in addition to seven market rate independent living units financed through an agreement with HUD.

Mr. Flood explained that an on-going policy issue concerns setting an adequate reimbursement rate for providers. They currently have two public payment options for low income disable adults, one is a rate for skilled nursing facility-eligible individuals, and the other is a pre-skilled nursing facility rate for individuals who are at risk of institutionalization. The latter is a bundled package of services paid for under a state plan. It includes some nursing, assistance with ADLs, and activities. However, he said that the state needs to set a higher rate in order to attract high quality providers. The current rate for nursing home-eligible clients is about two-thirds that of nursing facilities. The state has faced problems in setting a rate and a medical-eligibility screen for pre-nursing home clients.

The state's experience thus far with assisted living has been positive. They do not have major quality concerns. The surveyors review both nursing and assisted living facilities, but he said that this has not been a problem because the surveyors are flexible and consumer-oriented.

When asked why more states do not have Medicaid waivers to pay for assisted living, Mr. Flood explained that barriers include: legislative resistance to offering an entitlement that will overwhelm the state's finances, safety concerns that are based in a medical and paternalistic model of senior services, nursing home quality problems that cause some states to resist adding yet another long-term care option for frail seniors, resistance from the nursing home industry, and uncertainty about whether affordable assisted living is possible. He said that while some people worry about a "woodwork effect," costs can be controlled under a waiver program. In addition, with increased home and community-based programs, more people are able to stay in their homes rather than in expensive nursing homes. Vermont's state plan has not grown in five years despite an aging population.

Like other states, Vermont pays an increasing amount of its state budget on Medicaid. The state recently received approval from CMS for a Section 1115 Waiver to establish a demonstration program that will include about 4,500 Medicaid adult recipients who have physical disabilities. The five-year waiver sets an annual budget for services covered by Medicaid, as opposed to the more common open-ended entitlement plan, and is designed to save the state money while providing needed services to more people. Home and com-

munity based services, including assisted living, are a major component of the state's plan to shift costs from more expensive institutional settings. The waiver will expand such services to individuals who are at risk of institutionalization but would not ordinarily qualify for long-term care services. Under specified criteria, the plan permits the spouse of a participant to receive compensation for providing personal care services. Although the waiver was only approved in June, 2005, other states are looking to Vermont as a model for Medicaid-subsidized long-term care.

3. *Michigan: America House*

American House Senior Living Residences, a set of residences located in southeast Michigan, uses a combination of subsidy programs to provide affordable rental units to about 500 individuals. The specific programs they use include the MI Choice Medicaid waiver program that pays the cost of meals, housekeeping and personal care services for qualifying individuals, the HUD Traveling Section 8 voucher, Veteran's Affairs Aid and Attendance Pension, Low Income Housing Tax Credits, and shared housing. In addition, American House feasibility models allow for a mix of 70% market rate and 30% subsidy clients. Personal care services are offered on an a-la-carte basis, with residents choosing the services they want assistance with, and these services are provided by an on-site home care agency. Coordinating services through a home care agency reduces personnel costs to American House and provides residents the services they need on an as-needed basis.

Case Study Summary:

These three case studies show that affordable assisted living is possible despite the complexities identified by the panel participants. A variety of organizational and financing strategies for achieving success were used. Arkansas and Vermont took similar steps to define assisted living as a setting that provides a high level of services, including medication assistance, limited nursing, and assistance with all activities of daily living. America House separates the housing from the service component of assisted living. All three of these settings strive to promote aging in place in a non-institutional setting.

SECTION III: TOP FIVE BARRIERS/ISSUES AND ACTION STEPS IN CREATING AFFORDABLE ASSISTED LIVING

Following are the top five barriers/issues that affect the supply of quality affordable assisted living. All participants in this CEAL-sponsored panel discussion had the opportunity to vote for their top five concerns out of a larger set of topics identified during six breakout groups.

1. Inadequate financing for housing and services for people with low to moderate incomes.

Throughout the day, panel and audience participants discussed financial barriers, some real, others perceived, that serve as obstacles to the financing of affordable housing with services. The programs available to finance affordable housing, including capital subsidy programs like Low Income Housing Tax Credits and HOME, have different assumptions, requirements, and objectives than do the programs that finance the service component. These differences have resulted in a great deal of uncertainty among lenders and underwriters who understand the housing market, but not assisted living. Lenders and underwriters are not certain that Medicaid will continue to be available to AAL residents, and if the operational pro forma of a given facility depends on the receipt of service subsidies, this uncertainty results in a shortage of lenders. Thus, AAL developers may not be able to locate financial support for the real estate portion of their projects.

Given these barriers, the discussion revolved around issues related to Medicaid and to housing finance. Participants suggested setting adequate reimbursements for long-term care services that are based on service need (e.g., personal care, medical oversight, monitoring) rather than the setting type; linking Medicaid reimbursement rates to provider quality/performance; and debating whether Medicaid should reimburse for room and board in assisted living just as it does for nursing facilities.

On the housing side, participants suggested creating a stable funding source so that state policy makers, consumers, housing planners and developers will have confidence that subsidies will be available over the long-term; increasing SSI rates to cover the real cost of rental housing; and permitting family supplementation of monthly rents and related living expenses.

Recommended CEAL Action Steps: 1) Educate policy makers about the lack of reliable and sustainable development and operations funding, possibly by getting involved in a speaker's circuit (e.g., NGA, NCSL); 2) Educate policy makers about adequate reimbursements based on the true costs of operating high quality AAL, possibly through the development of a Business Case for AAL and by hosting a week-long Academy on AL and Medicaid; 3) Promote coalitions among policy makers, providers, and experts in long-term care services and housing development and finance; 4) Work with states that have a track record in HCBS; and 5) Work with states to develop recommendations for supporting AAL.

2. Need for LTC reform that recognizes the need to blend housing and services in creative and logical ways to provide consumer choice

This discussion, which builds on the above issues, addressed the lack of a national, coordinated system of long-term care that meets the needs and demands of consumers. Several participants explained that the current reliance on skilled nursing facilities as the primary form of subsidized long-term care for low-income persons is the result of unintended consequences rather than an organized plan for addressing the needs of very frail individuals. Several states have implemented programs to rebalance long-term care to a mix of community-based and institutional options.

Recommended CEAL Action Steps: 1) Endorse the development of a demonstration project that promotes consumer choice and control; 2) Develop policy recommendations to align various programs within housing and services; 3) Develop training modules to facilitate new projects; and 4) Create audience-specific packages that show how to implement a consumer-driven program (e.g., packages for real estate lenders and underwriters, developers, service providers, public subsidy programs, Medicaid, policy makers).

3. Lack of information on cost/benefits to build case for AAL

State and federal policy makers may be hesitant to increase reimbursement rates because they lack evidence about the real costs of operating affordable housing with services, the relationship between costs and quality, and the total costs to Medicaid for residential care. A couple of participants referred to policy makers who worry about creating a "woodwork effect" by subsidizing alternatives to nursing facilities. That is, some policy makers do not want to create or expand home and community-based alternatives because they worry that individuals will "come out of the woodwork" to use the services and thus overwhelm the state's finances. Information about the true costs and benefits of operating AAL could serve as a powerful response to such concerns.

Recommended CEAL Action Steps: 1) Literature review; 2) Identification of priorities; 3) Form collaborations among entitites; 4) Secure funding; 5) Promote iIndependent research to identify essential components of blended projects, (private pay – Medicaid blend) and research that compares SNF population to AL; and 6) disseminate research findings.

4. Lack of standardization in AL prevents stable real estate development funding, risk evaluation, and performance measures

This discussion focused primarily on the barriers to financing the development of AAL. As noted above, lenders and underwriters have reservations about assisted living, in part because it is neither housing nor healthcare, but rather a hybrid. This issue is further complicated by the range of assist-

ed living regulations across the states. The variability in definitions literally requires lenders to become experts in assisted living regulations. As noted earlier, many assisted living advocates do not support regulatory standardization because they believe it will hinder consumer choice in favor of institutional conformity. However, some participants suggest that some area of standardization will help lenders better understand what type of assisted living they are financing, and this could result in better options for consumers as well. A common definition of AL would allow CMS and financiers to craft specific programs to fund, evaluate risk, and assess performance and thus remove some of the current barriers to developing AAL.

Recommended CEAL Action Steps: CEAL needs to 1) Explore alternate definitions of AL; 2) Endorse a national definition; and 3) work with CMS to support the definition at the state level rather than at the federal level.

5. Knowledge gaps between consumers, funders, providers, policy makers; need for technical assistance on housing and service programs

Throughout the day, participants recognized that information about affordable housing and services is fragmented. Few individuals or organizations possess comprehensive understanding of the public policies, financing, development, and operations of AAL. These knowledge gaps likely cause many of the barriers and issues presented above and affect not only the supply, but also the quality of AAL. There is a need for expertise in both housing and service delivery and subsidies that result in programs that respond to the needs and preferences of consumers and their families.

Recommended CEAL Action Steps: 1) Sponsor CEAL summit sessions on affordability and, provide Web-based information (e.g., operations proformas, development proformas, case studies);, 2) Identify funding sources to train and provide technical assistance with the goal of creating a list of technical experts in AAL;, 3) Educate providers and Medicaid funders about the need for technical assistance; 4) Promote education for lenders and equity financiers; 5) Create a training module to facilitate project development with information packets for different audience types (e.g., finance, Medicaid, etc); and 6) Simplify funding streams by researching the benefits of AL and AAL funding, designing model streamlined funding programs, and creating market and lender buy-in.

SECTION IV: SUMMARY

The panel discussions and assignment of priority areas related to affordable assisted living made clear that there is one problem – namely an inadequate supply of affordable service-based housing – with two disconnected solutions. One solution focuses on providing affordable housing (e.g., subsidized rents, subsidized development), while the other solution focuses on the long-term care needs of individuals (e.g., public financing of nursing home and personal care services). These two disconnected solutions, housing and services, can be merged into a comprehensive answer for low-income, disabled individuals, as indicated by the three case studies presented above. However, meeting the larger demand, an estimate of 63,000 new affordable housing plus service units needed during the next decade and a half, will require coordinated efforts to combine programs, policies, and expertise.

Throughout the panel presentations and participant discussions, strategies for achieving quality care were emphasized. For example, while many people recognize that there is a relationship between adequate reimbursement and high quality assisted living, information about what makes for "adequate" reimbursement and the definition of "quality" is often lacking. These issues, and related topics like consumer choice, and balancing autonomy and safety, remain central to the future of high quality affordable assisted living.

APPENDIX 1: SUMMIT PARTICIPANTS

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    Des Plaines, IL

24. Connie Row
    AAHCP
    Edgewood, MD

25. Tom Clark
    ASCP
    Alexandria, VA

26. Terri Sult
    Vista Senior Living, Inc.
    Folsom, CA

27. Scott Hoekman
    Enterprise Social Investment Corporation
    Columbia, MD

28. Patrick Flood
    Vermont Department of Aging and Disabilities
    Waterbury, VT

29. Ted Johnson
    Marathon Senior Living
    Bellevue, WA

30. Sheryl Zimmerman
    UNC – Sheps Center for Health Services Research
    Chapel Hill, NC

31. John Cutler
    US Office of Personnel Management
    Washington, DC

32. Linda Aufderhaar
    NAPGCM
    Fairfax, VA

33. Lisa Yagoda
    NASW
    Washington, DC

34. Susan Ganson
    CARF-CCAC
    Washington, DC

35. Sunny Worsley
    CWCapital
    Bellevue, WA

36. Nancy Leake
    CDC of Bentonville/BellaVista
    Bentonville, AR

37. Rosalie Kane
    University of Minnesota
    Minneapolis, MN

38. Kathy Fiery
    Health Care Association of New Jersey
    Hamilton, NJ

39. Karen Love
    CCAL
    Fairfax, VA

40. Michael DeShane
    Concepts in Community Living
    Portland, OR

41. Keren Brown Wilson
    Jessie F. Richardson Foundation
    Portland, OR

42. Rhona Limcangco
    AHRQ
    Rockville, MD

43. Chris Honn
    Fannie Mae
    Chicago, IL

44. Dan Timmel
    CMS
    Baltimore, MD

45. Bob Gillette
    American House Senior Living Residences
    Bloomfield Hills, MI

46. Margaret Scott
    Fannie Mae
    McLean, VA

47. Charlie Reed
    Olympia, WA

48. Herb Sanderson
    Arkansas Division of Aging Adult Services
    Little Rock, AR

49. Jerry Cooper
    NCALA
    Raleigh, NC

50. Ann McDermott
    ALFA
    Fairfax, VA

51. Paul Williams
    ALFA
    Fairfax, VA

52. Maribeth Bersani
    Sunrise Senior Living
    McLean, VA

53. Stacey Stordahl
    U.S. Senate Aging Committee (minority)
    Washington, DC

54. Ken Van Pool
    U.S. Senate Aging Committee (majority)
    Washington, DC

55. Dina Elani
    CMS
    Baltimore, MD

APPENDIX 2: CEAL BOARD

AARP
American Assisted Living Nurses Association (AALNA)
American Association of Homes and Services for the Aging (AAHSA)
American Seniors Housing Association (ASHA)
Assisted Living Federation of America (ALFA)
Alzheimer's Association
Consumer Consortium on Assisted Living (CCAL)
National Center for Assisted Living (NCAL)
NCB Development Corporation (NCBDC)
Pioneer Network
Paralyzed Veterans of America (PVA)

APPENDIX 3: PANELISTS

Panel 1: Medicaid and AAL Operations and Development: Opportunities, Benefits, and Issues

Panel Participants:

Herb Sanderson, Arkansas Division of Aging and Adult Services
Patrick Flood, Vermont Department of Aging & Disabilities, Waterbury, VT
Dina Elani, Centers for Medicare and Medicaid Services, Baltimore, MD
Michael DeShane, Concepts in Community Living, Portland, OR
Bob Gillette, American House Senior Living Residences, Bloomfield Hills, MI
Terri Sult, Vista Senior Living, Folsom, CA

Panel 2: Medicaid and AAL Operations and Development: Is It Too Hard? Assembling the team, Subsidies, and Partners

Panel Participants:

Nancy Leake, Community Development Corporation, Bentonville/Bella Vista, AR
Chris Honn, Fannie Mae, Chicago, IL
Sunny Worsley, CW Capital, Bellevue, WA
Scott Hoekman, Enterprise Social Investment Corporation, Columbia, MD

Panel Moderator: Charlie Reed, former Assistant Secretary of the Washington Department of Health and Social Services

APPENDIX 4: ADDITIONAL BARRIERS, ISSUES AND ACTION STEPS IDENTIFIED BY SUMMIT PARTICIPANTS

- Lack of coordination between multiple actors, including lenders, underwriters, service delivers, oversight agencies, and providers. ACTION = develop policy recommendations to align various programs for housing and services with models for AAL, quality measures, eligibility criteria

- Unclear relationship between quality and reimbursement: ACTION = develop transparent and accountable operational performance figures to reveal the true costs and to promote quality. Research the relationship between consumer choice and quality, choice and safety.

- Challenges of aging in place. Must have a qualified work force to meet the needs of individuals as they age; incompatible program requirements between housing subsidy (e.g., LIHTC) and AL regulations.

- Lack of leadership or grass roots consumer-driven voice. To date there has not been a strong and consistent organization that advocates on behalf of low-income persons. Can lessons be drawn from the disability rights community.

- Should AL be an entitlement? Should low-income folks have access to AL? These questions were raised because for over three decades, federal policy has defined nursing homes as an entitlement to qualifying individuals. Whether AL should replace nursing homes as an entitlement is a valid question but not one that has been addressed.

- Money follows the person as a potential model for subsidizing the cost of affordable housing with services.

- Need for a rational housing plus services plan (instead of the accidental one we now have).

- Effect of regulations on AL – too much, too little. Although many AL proponents claim that federal regulations will stifle the flexibility, creativity, and consumer-driven nature of AL, the actual impact of regulations has not been systematically studied.

APPENDIX 5: MEETING AGENDA

Making Quality Assisted Living an Affordable Community-Based Care Option: *Identifying Roles, Risks, and Recommendations for Medicaid and Other Public Subsidies*

Meeting Date: 23 August 2005
Time: 8:30 AM – 5:00 PM
Location: Hart Senate Building SH-902

Agenda

8:30 – 9:00 **Breakfast**

9:00 – 9:30 **Introduction & Purpose**

- Welcome: Doug Pace, CEAL Chair
- Role of Affordable Assisted Living (AAL): Don Redfoot, CEAL Board Member
- Making Assisted Living Affordable – Overview and Agenda: Robert Jenkens, CEAL Board Member
- Facilitator Introduction: Charlie Reed introduced by David Schless, CEAL Board Member

9:30 – 12:15 **Medicaid and Affordable Assisted Living Operations and Development**

A Panel Discussion with Participants

9:30 – 10:45 Opportunities, Benefits, & Issues

Facilitator: *Charlie Reed*

Overview: *Charlie Reed*

Panelists:

- Federal Perspective: CMS Staff – *Dina Elani*
- State Perspective: Medicaid Waiver Directors – *Herb Sanderson and Patrick Flood (VT – 1115 state)*

- Provider Perspective: *Michael DeShane, CCL and Bob Gillette, America House*
- AAL Operations Expert: *Terri Sult, Vista Senior Living*

Issues: Role and future of Medicaid in AAL

- Medicaid and its ability to support AL philosophy
- Medicaid and maintaining quality
- Medicaid reimbursement, operational efficiencies, and regulation
- Other Approaches

10:45 - 11:00 Break

11:00 – 12:15 *Is it Too Hard? Assembling the Team, Subsidies, and Partners*

Facilitator: *Charlie Reed*

Overview: *Robert Jenkens*

Panelists:

- Owner/Developer: *Nancy Leake*
- Development Consultant: *Ted Johnson*
- Lender/finance: *Chris Honn, Fannie Mae & Sunny Worsley, CW Capital*
- Technical Expert: *Scott Hoekman, ESIC*

Issues:

- Medicaid and AAL development
- Medicaid and housing finance
- Medicaid and risks to investors and lenders
- Other approaches

12:15 – 1:30 Lunch

12:15-12:45 LUNCH

12:45 – 1:30 Three case study presentations:

- Gardens at Osage Terrace, Bentonville, AR - LIHTC
- Cathedral Square, Burlington, VT – 202 building
- America House, MI – Market rate w/Housing Choice Voucher & Medicaid

1:30 – 3:00 **Breakout Groups**

Six breakout groups of 8 people and CEAL facilitator. Workgroups will develop next step recommendations for CEAL on the priority issues identified in the morning session, including areas where AAL needs assistance and CEAL's role in the assistance.

3:00 – 4:15 **Priority Identification** (Facilitator: *Charlie Reed*)

3:00 – 3:30 Five-minute summaries of workgroups' top four AAL priorities, CEAL's role, and action steps.

3:30 – 4:00 Participant priority voting (dots)

4:15 – 4:30 **Next Steps and Closing Remarks** (*CEAL Chair*)

APPENDIX 6: ADDITIONAL RESOURCES ON AFFORDABLE HOUSING WITH SERVICES

American Association of Homes and Services for the Aging. (1997). Affordable assisted living: options for converting or expanding housing to assisted living: four case studies. Washington, DC: AAHSA.

Commission On Affordable Housing And Health Facility Needs For Seniors In The 21st Century. (2002). A Quiet Crisis in America. Washington, DC. Available at: www.seniorscommission.gov

Golant, S., Salmon, J. (2004). Unequal availability of affordable assisted living units in Florida's counties. Journal of Applied Gerontology, 23(4), 349-369.

Golant, S. (2003). Political and organizational barriers to satisfying low-income U.S. seniors' need for affordable rental housing with supportive services. Journal of Aging and Social Policy, 15(4), 21-48.

Gulyas, R. (2002). How states have created affordable assisted living: what advocates and policy-makers need to know. Washington, DC: AARP.

Jenkens, R. (2002). Bringing home affordable assisted living. Assisted Living Today, 9(7), 32-35.
Kochera, A. Redfoot, D., Citro, J. (2001). Section 8 project-based rental assistance: the potential loss of affordable federally subsidized housing stock. Washington, DC: AARP.

Martin, A. (2004). Affordable solutions. Assisted Living Today, 11(4), 19-21.

National Council on Disability. (2004). Livable communities for adults with disabilities. Washington, DC: NCOD.

Pynoos, Jon (Ed.); Feldman, Penny Hollander (Ed.); Ahrens, Joann (Ed.) (2005). Linking housing and services for older adults: obstacles, options, and opportunities. Binghampton, NY: Haworth Press.

Scheutz, J. (2003). Affordable Assisted Living: Surveying the Possibilities. Prepared by the Joint Center for Housing Studies at Harvard University for Volunteers of America. Available at: http://www.jchs.harvard.edu/publications/seniors/03-1_schuetz.pdf

Wilden, R., Redfoot, D. (2002). Adding assisted living services to subsidized housing: serving frail older persons with low incomes. Washington, DC; AARP.

The Center for Excellence in Assisted Living
www.theceal.org