A Quiet Crisis in America

A Report to Congress by the

Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century

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A Report to Congress by the

Commission on Affordable Housing and Health

Facility Needs for Seniors in the 21st Century

Submitted to the

Committee on Financial Services

Committee on Appropriations

United States House of Representatives

And the

Committee on Banking, Housing and Urban Affairs

Committee on Appropriations

United States Senate

Pursuant to Section 525(f) of Public Law 106-74, as Amended

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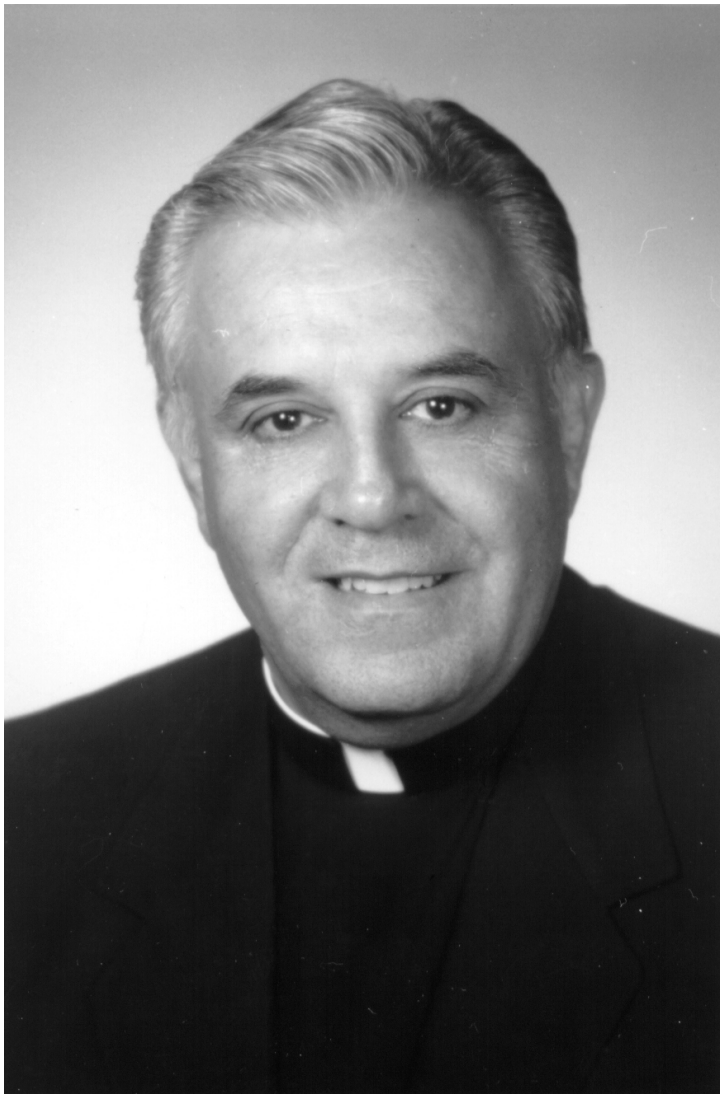
Dedication



January 29, 1943 – April 9, 2002

The Commission hereby dedicates this Report to the memory of The Reverend Monsignor Henry Gugino. Since his untimely passing on April 9, 2002, all of us have greatly missed him. His presence on the Commission was irreplaceable. Our dear colleague, Henry, led a life of distinguished service to his home community, his State, and our Nation. We join Monsignor Gugino's neighbors in Buffalo, New York, and all who were touched by his life's work, in mourning the loss of this inspiring leader, tireless advocate, and good friend.

Commissioners

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Nancy Hooks, Co-Chair
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PREFACE

The Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century (hereafter, Seniors Commission) was established by Congress on October 20, 1999, under the Mandates of Public Law 106-74.[1] Then Housing and Community Opportunity Subcommittee Chairman Rick Lazio and Ranking Member Barney Frank, of the House Housing and Financial Service Committees, announced creation of the Commission and the appointed Commissioners on January 2, 2001. The Commission held its first organizational meeting on April 29 and 30, 2001.

The Seniors Commission was created to study and report back to the Congress on housing and health facility needs for this and the next generation of seniors in America. It was empowered to offer specific policy and legislative recommendations to increase affordable housing and improve health-related service options for seniors now and as the Baby Boomer generation reaches retirement age. Existing and commissioned research — along with expert and public testimony compiled at field hearings across the United States — have been used to compile this report.

As detailed in the legislative Mandate, as amended, the Commission was required to submit to the Congress by June 30, 2002, a report that:

- "compiles and interprets information regarding the expected increase in the population of persons 62 years of age or older, particularly information regarding distribution of income levels, homeownership and home equity rates, and degree or extent of health and independence of living;
- provides an estimate of the future needs of seniors for affordable housing and assisted living and health care facilities;
- provides a comparison of estimate of such future needs with an estimate of the housing and facilities expected to be provided under existing public programs, and identifies possible actions or initiatives that may assist in providing affordable housing and assisted living and health care facilities to meet such expected needs;
- identifies and analyzes methods of encouraging increased private sector participation, investment, and capital formation in affordable housing and assisted living and health care facilities for seniors through partnerships between public and private entities and other creative strategies;
- analyzes the costs and benefits of comprehensive aging-in-place strategies, taking into consideration physical and mental well-being and the importance of coordination between shelter and supportive services;
- identifies and analyzes methods of promoting a more comprehensive approach to dealing with housing and supportive service issues involved in aging and the multiple governmental agencies involved in such issues, including the Department of Housing and Urban Development and the Department of Health and Human Services; and
- examines how to establish intergenerational learning and care centers and living arrangements, in particular to facilitate appropriate environments for families that consist only of children and a grandparent or grandparents who are the head of the household."

In addressing these matters, Congress directed the Commission to define and frame issues more precisely and to provide potential solutions. The Commission sought to:

- Assess the existing Federal role in senior housing, health, and supportive services;
- Explore means for Federal, State, and local governments to coordinate resources through joint collaboration;
- Encourage public-private partnerships (with proprietary and non-profit groups) to address capital formation issues for seniors' housing with a health care infrastructure;
- Educate the public and private sectors on seniors' capital housing and health care needs;
- Craft or develop new models and approaches to delivering seniors' housing that link housing and services;
- Develop strategies to make better use of single-family housing as a long-term care resource (most seniors reside in their own homes, and accessible features will influence their ability to age in place and affect the costs of caregiving); and
- Explore the financing strategies that can be employed to promote supportive housing and aging in place through home and community-based services.

To inform its work, the Commission held public hearings in:

- Syracuse, New York, on July 30, 2001;
- Columbus, Ohio, on September 24, 2001;
- San Diego, California, on November 7, 2001;
- Miami, Florida, on January 14, 2002; and
- Baltimore, Maryland, on March 11, 2002.

A number of Commissioners also participated in a Public Forum in Boston, Massachusetts, on March 1, 2002.

The Seniors Commission established Task Forces on Financing Strategies, on Needs Assessment, and on Housing and Health Strategies to address specific elements of the Mandate. Each task force was given responsibility for Mandate requirements and individual hearings. The task forces worked with the staff to select witnesses who would provide useful testimony for the essential elements of the Commission Report. Commission Co-Chairs Ellen Feingold and Nancy Hooks served as *ex officio* members of each task force. The Commission contracted with several leading researchers and firms to conduct original research; the significant findings of their papers are included in the Appendix to this report.

Contemporaneous with the Seniors Commission, Congress also established the Millennial Housing Commission. Congress directed that Commission to identify, analyze, and develop recommendations that highlight the importance of housing, improve the housing delivery system, and provide affordable housing for the American people, including recommending possible legislative and regulatory initiatives. The two Commissions maintained appropriate liaison and they shared information, while respecting their individual Mandates.

The Seniors Commission findings, recommendations, and policy analyses are contained in this final report to the Congress.

All appropriate records of the Commission and its work will be available to the public through the National Archives. Its report is available online at www.seniorscommission.gov.

Ellen Feingold
Nancy Hooks
Co-Chairs

SENIORS COMMISSION REPORT

We, the Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century, are pleased to transmit our Report – A Quiet Crisis in America. This report is presented by the Majority of the Commissioners and contains recommendations for Federal policy that we believe will allow this Nation to appropriately plan for and meet the needs of seniors in the 21st Century.

Our Congressional Mandate was broad and encompassing. The Congress asked not only that we identify existing and future needs, but that we recommend creative, yet realistic approaches to address these needs. As expected, the growth in the numbers of seniors is staggering – today, one in twelve persons is 65 years of age or older. In the year 2020, it will be one in six. Some of this growth – from 35 million seniors today to 53 million in 2020 – is attributable to the aging of the Baby Boomers, but some of it is due to advances in medicine and improvements in our health care systems – resulting in longer life spans. Regardless, this "aging of America" will challenge our Nation's resources.

The Commission is a diverse group, encompassing providers, developers, researchers, advocates, clergy and lenders – each Commissioner brought a different perspective and a different experience base to our mission. As we worked through the past eighteen months to fulfill our Mandate, we experienced a common bond in our caring, compassion, and concern for the Nation's seniors. Ideology and partisanship aside, we shared a common vision that government at all levels should promote policies that allow for choice.

Our commonalities far exceeded our differences, but even though we had consensus on many of our ideas, we could not reach consensus in the interpretation of our Mandate. Thus, the Seniors Commission Report is submitted by seven of the thirteen Commissioners, bipartisan in our views, even though most of the recommendations were developed, with consensus, by the entire Commission. Some Commissioners have elected to sign a Minority Report, which follows the Seniors Commission Report in this document.

As a Majority, we believe that:

- Congress sought our ideas for addressing future needs, not our counsel on funding sources – for broad-brushed, proactive ideas, not prescriptive solutions.

- Congress asked us to address the impending needs of *all* seniors, regardless of income. We believe that the needs of poor elderly are indeed the most urgent, but we also believe that difficulties associated with the process of aging itself affects all seniors, regardless of their income strata. We heard the pleas of the "forgotten elderly" – incomes too high to qualify for low-income housing and Medicaid, but too low to afford private housing and health care.

- Additional resources are needed to meet the pressing needs of seniors, both today and in the future. We stop short, however, of setting production goals or advising the Congress on the commitment of Federal resources to specific programs. We believe, demographic facts in hand, evolving market demand, and weighing national priorities, that Congress must decide the appropriate allocation of resources.

- Seeing the trend of high homeownership rates among seniors, our Nation must be creative in assisting seniors in preserving this valued asset and using their equity wisely.

The Majority also struggled with the reliability of data available to us to develop our recommendations. Absent other resource data, we relied on data interpolated from the 1999 Annual Housing Survey. Such data is self-reported and must be used with caution. Further, no data can accurately predict unknowns – the economy, homeownership equity, technological advances or consumer preference. To predict with accuracy the economic and demographic profiles of the next generation of seniors is simply not possible.

Anticipating the diversity of needs and demands by 53 million individuals, the Majority sought approaches that would create options and maximize choices for seniors. Accordingly, we developed recommendations that create foundations and building blocks – with flexibility to change as the market changes, from today's survivors of the Great Depression to tomorrow's Baby Boomers. We sought to build upon what exists, and we do not propose major program restructuring or radical reform. We propose, insofar as is possible, solutions that support individual choice rather that government prescription. We propose flexibility and simplicity in regulations and avoid categorical programs with rigid guidelines. This challenge does not have a "one size fits all" solution.

Our Recommendations are far-reaching and they are economically sound. We challenge the Government Sponsored Enterprises and HUD to step out of their "silos" and be part of broad-based solutions, not just in urban areas, but in the rural parts of our country as well. This will require changes in Federal policy; it will not require Federal funds.

We challenge the institutional bias of Medicaid and propose its greater use in less costly alternative residential and community environments. We propose effective ways of linking existing housing and health care resources rather than creating new expensive, categorical programs. We call upon the Congress to preserve our existing senior communities – aging buildings as well as their aging residents need attention. All of these measures would conserve, rather than expend, resources.

Addressing the needs of seniors in the 21st Century will be a monumental task. It is a challenge addressed to all Americans – it cannot be borne by the Federal government alone. We appeal to the Federal government to lead, to serve as a catalyst for change, to make it easier for local governments and the private sector to serve. Through sound policy, governments at all levels can provide incentives and tools. Through flexible policy, we can get these tools in the hands of the people most capable of making a difference.

Our Commission is Federal in scope, but many of the measures we propose will need to be implemented in the Nation's diverse neighborhoods and communities. We encourage partnerships among and between proprietary and non-profit providers, faith-based organizations, community lenders, private investors, and all the many parts of our local, state and Federal government. We ask Congress to create a policy framework for an aging America, and to provide the opportunities and means for change.

It is with appreciation for the opportunity to contribute our services that we, the Majority of the Commission Members, submit this Report.

Respectfully Submitted,

Nancy C. Hooks, Co-Chair
Jane O'Dell Baumgarten
John Erickson
M'Liss Solove Houston
James E. Introne
Diana McIver
James H. Swanson

EXECUTIVE SUMMARY

A QUIET CRISIS IS LOOMING FOR AMERICA'S SENIORS

Eighteen short years from now, 53 million Americans (one in six United States residents) will be aged 65 or older. Today, 12.4 percent of the U.S. population is 65 or older; in 2020, that figure will approach 20 percent. America needs to prepare for these changing demographics: this is the "Quiet Crisis."

Senior Americans, whether rich, poor, or somewhere in the middle, face many barriers to an old age in which very basic human desires for physical safety, appropriate health care, and maximal independence are met. For some, crucial family supports will disappear as they outlive spouses or children move to distant places. For others, limited resources will prevent them from identifying and purchasing needed services. Many will lose their homes — long a symbol of their independence — due to rising property taxes and maintenance costs. Living alone, isolated from services and perhaps coping with disabilities that prevent social interactions, a large and growing number of seniors will face triple jeopardy: inadequate income, declining health and mobility, and growing isolation.

"There's a lack of affordable housing alternatives to meet the demand, and many…do not have options."

Rene Rodriguez, Executive Director, Miami-Dade Housing Agency, at hearings before the Commission, January 14, 2002, Miami, Florida.

In the face of unprecedented growth in the proportion of the population who are seniors, we believe that this Nation has both a moral obligation and a financial imperative to establish a more rational long-term care system. A system that drives seniors to needless, premature institutionalization and expensive, preventable medical interventions will burden both seniors and those who must bear the costs for their care. Senior individuals who are able to remain in the community should receive the services they need to be as independent as possible. Those who must move from their preferred setting should have viable and affordable alternatives that ensure their well-being. Neither institutionalization nor neglect should be the only alternatives they must accept.

"…A lot of older persons live in housing without supportive features. Over 5 million older households have one member with a functional limitation. Over 1 million of these households report needing modifications. These are primarily old, old persons."

Dr. Jon Pynoos, Associate Professor of Gerontology, Ethel Percy Andrus Gerontology Center, at hearings before the Commission, November 7, 2001, San Diego, California

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In a Nation characterized by care and compassion for the least fortunate of its citizens, the stark reality is that many seniors, after years of contributing to their country's defense and prosperity, find themselves seriously at risk of being ignored, forgotten, or destined for a room in a skilled care facility. The simple fact is that this country lacks a national policy that addresses humanely and cost-effectively the needs and preferences of seniors who have diminished abilities to care for themselves. All too often, seniors with chronic illnesses and declining mobility have limited care and financial alternatives, when what they want is to live in their homes with appropriate support.

How the Quiet Crisis Has Developed

The Commission found that the Quiet Crisis has been developing over time as a result of numerous trends and economic factors. Some of our key findings regarding this evolution are the following:

- In 1900, seniors accounted for less than 5 percent of the total U.S. population; numbering 35 million, seniors now represent 12.4 percent. By 2030, the senior population will double to 70 million, or 20 percent of the U.S. population.[2]
- Nearly 20 percent of seniors have significant long-term care needs. In 1997, more than 5.8 million or 18 percent of non-institutionalized people age 65 and older required assistance with everyday activities, and about 1.2 million (3.7 percent) were severely impaired, and required assistance with three or more activities of daily living (ADLs).[3]
- Many seniors across the income spectrum are at risk of institutionalization or neglect due to their declining health and the loss or absence of support and timely interventions. The risk is greatest for those with lower incomes.[4]
- There are nearly six times as many seniors with unmet housing needs as are currently served by rent-assisted housing.[5] Waiting lists for many types of subsidized housing are long. For example, "in 1999, approximately nine elderly applicants were on waiting lists for each Section 202 unit that became vacant within a year" compared with eight applicants in 1988.[6]
- The Nation's affordable housing stock is in danger of losing significant numbers of units. According to Commission research, 324,000 Section 8 assisted units in senior properties are currently at risk of "opting out" of the HUD program.[7]

What the Quiet Crisis Will Bring

The Commission found, based on the best research and forecasts available, that by the year 2020:

- The number of senior households will have grown by nearly 53 percent;
- More than 80 percent of senior householders will be homeowners;[8]
- Nearly three-fourths of senior households with unmet housing needs will likely be homeowners; [9]
- Almost 44 percent of senior householders will be age 75 or older;[10]

- Even if current rates of disability continue to decline, the number of seniors with disabilities will have increased from 6.2 million in 2000 to 7.9 million;[11] and
- The need for home- and community-based services (HCBS) will have increased due to the desire of seniors to age in place;[12]

Current policies and programs for seniors are an accumulation of unrelated decisions and unintended consequences. Housing assistance programs are implemented with little reference to health care or supportive service needs. Medicare remains centered on acute care and episodic medical interventions, while the need to manage chronic care for the senior population has emerged as the most formidable challenge. Medicaid, which was designed to ensure access to health care for low-income persons, now provides an imperfect reimbursement mechanism for the Nation's long-term care facilities and the skeleton of a payment system for much-needed home- and community-based care.

"For any older American to suffer after working hard all of his or her life is a national disgrace."

Honorable Elijah E. Cummings, Member of Congress, Seventh Congressional District of Maryland, at hearings before the Commission, March 11, 2002, Baltimore, Maryland

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This Nation, despite competing demands for national resources, must respond to the critical need for affordable housing and home- and community-based supportive services, with a substantial financial commitment and effective policies. First, seniors most at risk of neglect or inappropriate institutionalization must receive the care they need. Second, all seniors, no matter what their individual circumstances and resources, should be able to continue to live where they prefer regardless of income, with the services they need to maintain personal dignity and quality of life.

"We just had a tragedy in this country where … immediately, all the money that was necessary to deal with that problem was provided…. We've got Baby Boomers coming. If they don't want to deal with it now, what do you think they're going to do then? "

Andrew Montgomery, senior and former Chairman of the Commission on Aging for the city of Oakland, California, at hearings before the Commission, November 7, 2001, San Diego, California.

A VISION FOR AMERICA

The Seniors Commission believes that all older Americans should have an opportunity to live as independently as possible in safe and affordable housing and in their communities of choice. No older person should have to sacrifice his or her home or an opportunity for independence to secure necessary health care and supportive services.

The Commission further believes that:

- An individual's final years need not and should not be a time of fear, loneliness, and pain;
- Today's exceptions of excellence in seniors' housing and health care services must become tomorrow's norm;
- Seniors should be entitled to a coordinated system of healthy, affordable, and ethical long-term care without needing to spend down to Medicaid standards of eligibility; and
- This Nation has the capacity not only to protect its most vulnerable citizens from the challenges associated with long lives, but also from the loss of dignity and independence that millions of seniors face.

CONVERGENCE: A CALL FOR COORDINATION OF SENIORS' HOUSING AND HEALTH CARE

The most striking characteristic of seniors' housing and health care in this country is the disconnection between the two fields. With few exceptions, seniors obtain their housing from one source and their health care and supportive services from a completely different source.

Witness after witness before the Commission testified to this problem and the consequences of its continuation. Through such exchanges, Commissioners came to appreciate that:

- Some policy disconnects have long histories and may not be easily reconciled;
- Poor communication, differing vocabulary, and few opportunities to share experiences separate professionals, policymakers, academics, and even the media in the two fields;
- Lack of coordination and integration between housing and health care is characterized by different and distinct financing systems and regulatory structures; and
- Most difficult of all, government is structured, at both legislative and administrative levels, in ways that inhibit coordination.

…"Even for long-time professionals, the current 'crazy-quilt' tapestry of services and shelter options make it difficult to fully grasp their complexities, let alone try to access them. The result [is] confusion amongst consumers, duplication of service delivery, government agencies not knowing who supplies what service or that some services even exist, reduction in qualified service workers, regulations that impede dedicated service providers from providing the service they were hired and want to perform…"

Janice C. Monks, Executive Director, American Association of Service Coordinators (AASC), at hearings before the Commission, September 24, 2001, Columbus, Ohio.

A Call for Coordination

The Nation can no longer afford the inefficiency of the current disconnect between housing and health service systems for seniors. The time has come for coordination among Federal, state and local agencies and administrators. Coordination should begin in the halls and committee chambers of Congress and should spread through all branches of government and society.

The now distinct worlds of housing and health care must begin to acknowledge each other, listen to and speak to each other, and learn to integrate efforts for their mutual benefit and the benefit of their senior clients. Such understanding and coordination are essential underpinnings to the success of reforms proposed in this report and in many other forums.

Realities for Seniors Formed the Basis of our Recommendations

The Commission received its Mandate from Congress; however, its major messages come directly from seniors across America.

The world of seniors in America today is insufficiently reported in the print media or pictured on television — aside from the occasional special report. Advocacy groups speak well for the needs of seniors, academics detail the results of their research, and Congress and State legislative bodies contain several experts (many of whom are seniors) in the field. But public attention to the coming crisis is minimal.

Commission members resolved, therefore, to find out for themselves about the world of seniors in America today. We held public hearings in Baltimore, Maryland; Columbus, Ohio; Miami, Florida; San Diego, California; and Syracuse, New York; and we attended a community forum in Boston, Massachusetts. We heard formally and informally from many of the country's leading authorities on housing and health care options for seniors — heads of advocacy groups, recognized experts in senior services and leaders of government at all levels. We talked with providers, consumers, financiers, and regulators. We commissioned some of the Nation's leading researchers to conduct original studies and we listened to seniors themselves.

From this work, stretching over 12 months, we began to form the conceptual framework for our recommendations to Congress. We developed concepts that flowed from the hearings' testimony, Commission meetings, informal conversations, and research. Five guiding principles emerged, illustrated here by testimony from hearings and supported by research and other documentation received by the Commission. The Commission's five guiding principles are as follows:

1. **Preserve the existing housing stock**

   …"*Currently, neither the Federal or State governments recognize the critical nature of preserving affordable senior housing. Estimates are that there have been 300,000 units lost between 1997 and 1999. It is easy to see that we are*

losing units faster than we are gaining them. Many of these projects could be preserved with … the infusion of dollars far less than the cost of new construction. We estimate that new construction costs in our 202 portfolio are approximately $70,000 per unit. We are seeing renovation projects only in the range of $20-$30,000 per unit. The difficulty is that there is little energy for preservation at the Federal and State level; however, there is often a great deal of energy at the local level..."

Thomas W. Slemmer, president, National Church Residences, September 24, 2001, testimony before the Commission in Columbus, Ohio.

First and foremost, the Nation must save what it has. Affordable senior housing is, like its occupants, experiencing an aging process. The challenge lies in both preserving seniors' homes and simultaneously meeting their changing needs.

Principle No. 1 is addressed by seven specific recommendations that encourage the preservation, renovation, and refinancing of existing affordable and public housing projects and their potential conversion to service-enriched housing. These recommendations seek to preserve the existing stock of Section 202 units, encourage the renovation and refinancing of Section 202 projects, and support programs for senior homeowners to maintain their homes, maximizing their ability to age in place for as long as possible. Manufactured housing is recognized as an affordable housing option, and reliable financial products are encouraged for this type of housing. In addition, they encourage utilization of HOPE VI modernization funds to build new independent and assisted living facilities for seniors and to retrofit existing housing stock to better serve seniors.

2. Expand successful housing production, rental assistance programs, home- and community-based services, and supportive housing models.

"Monies have to be allocated for senior programs…there should be a whole senior division from U.S. HUD. We're getting older; this Nation is getting older…every year, we see less and less money allocated…we opened our fifteenth building. It's located in the heart of Little Havana on 22nd Avenue and Calle Ocho.

We thought that we were going to have a lot of people applying for the building, so we decided to do a lottery and announced through the papers and television that we were going to give applications for a period of two weeks. People usually camp out from a month before to fifteen days to get these applications. Through rain, through storms, people get robbed in the streets.

So we decided to try to do something because we thought there would be a lot of people… Six thousand eight hundred and ninety-seven people showed up for applications. We spent another two weeks qualifying these persons.

We finally drew up a lottery with the press present and a hundred fortunate people got apartments..."

Jose Fabregas, executive director, CODEC, January 14, 2002, testimony before the Commission in Miami, Florida.

A housing crisis is on the horizon, and more housing units must be created in response. The Commission recommends the production of a variety of housing types, serving persons of low, moderate, and middle incomes, ranging from single-family home communities to service-enriched senior apartments to Continuing Care Retirement Communities.

Principle No. 2 is addressed by ten specific recommendations that include funding and modifying the Section 202 Program to keep step with the forthcoming growth in seniors population, increasing annual production to meet the needs of future generations of seniors, assuring Medicaid funding to support quality care and adequate payments across all settings. Recommendations also include modifying rural housing programs to provide ample funding to more appropriately serve seniors and assuring that home- and community-based services and supportive senior housing are available in rural areas.

3. Link shelter and services to promote and encourage aging in place.

"How do we have this continuum of care and services and coordinate them? What this [Commission] will do for us…is help us to look at this holistically…you can't just have housing…people have different needs, they have different resources, and…how important is this medical component as we wind up with 55 or 60 million people in this country who are going to need both pretty substantially."

Congressman James Walsh, Chair, House Appropriations Subcommittee for VA-HUD and Independent Agencies, July 30, 2001, statement before the Commission in Syracuse, New York.

In the area of long-term care services, public programs must move away from institutionally based models of service delivery. Seniors want choices in the services they receive. Public programs must provide services that are based on the needs and preferences of the individual.

Principle No. 3 is addressed by seven specific recommendations that include urging Congress to appropriately fund service coordination in all federally subsidized housing with senior populations and supporting demonstrations in assistive living technologies. The recommendations urge Congress to direct the General Accounting Office to evaluate interdepartmental operations between HUD and HHS and provide recommendations on how to coordinate their programs for seniors more effectively. These recommendations also urge Congress to help facilitate safe environments for grandparents raising grandchildren and call for improving transportation options and accessibility for seniors with limited mobility.

4. Reform existing Federal financing programs to maximize flexibility and increase housing production and health and service coverage.

"Although Freddie Mac and Fannie Mae have existing programs and have become very responsive to us, their target is a very narrow property type…their

programs accommodate properties that are generally servicing the middle and upper middle-income population that is largely Brookdales' clientele. An issue that we have grappled with at Brookdale over the years is how to create a more affordable product for the vast population of seniors that cannot afford an upscale retirement community, yet has too much income to qualify for Section 8 or tax credit housing."

Mark Schulte, Chairman/CEO, Brookdale Living Communities, September 24, 2001, testimony before the Commission in Columbus, Ohio.

Government-Sponsored Enterprises are the backbone of a housing system that has led to 68 percent of all Americans' owning their own homes. With HUD, they should be major players in expanding housing and care facilities, particularly for seniors with incomes between 30 percent and 80 percent of area median income — a market segment with far too few options. Joined with Medicaid and Medicare, they can help meet the housing and service needs of many of the most needy seniors, now and into the future.

Principle No. 4 is addressed by ten recommendations that include calling on GSEs to develop and actively promote appropriate credit products to help expand private sector participation in senior housing, modernizing and redesigning FHA programs to work together seamlessly, and establishing higher HUD fair market rent standards for units in assisted living facilities.

These recommendations call on Congress to increase the Medicaid matching rate for home and community based service (HCBS) waiver services and ask Congress to institute a Medicaid shelter allowance as a requirement in Medicaid HCBS waiver programs, with incentives for state implementation. In addition, the recommendations support worker training in long-term care and urge the modernization of Medicare to address the growing needs of seniors with chronic conditions.

5. Create and explore new housing and service programs, models, and demonstrations.

…"Council for Affordable and Rural Housing (CARH) … members own or operate affordable housing across rural America…. If there is one thing we have learned it is that there is no more effective method of delivering affordable housing than a public-private partnership between government and its citizens. We have also learned that too often the special needs of seniors and the disabled are not properly addressed...

Robert P. Yoder, Sr., past president, Council for Affordable and Rural Housing (CARH), July 30, 2001, testimony before the Commission in Syracuse, New York.

Yesterday's demonstration and pilot programs often become today's most successful approaches to the delivery of service-enriched housing for seniors. Principle No. 5 is addressed by eleven specific recommendations that include creating a clearinghouse of information about state Medicaid programs that

deliver home- and community-based services and a national database of senior housing, encouraging the broader implementation of the Programs of All-Inclusive Care for the Elderly (PACE) model, developing enhanced private sector and rural housing programs, creating an incentive for the purchase of long-term care insurance and establishing a prescription drug benefit for seniors under the Medicare program.

Challenges to Meeting Future Needs

The Commission also learned that national efforts to meet the future needs of seniors will face numerous challenges. Principal among those challenges is the need for resources. Committed investment in affordable housing has declined over the past three decades[13] and resources devoted to home- and community-based services pale in comparison to resources dedicated to facility-based, skilled nursing care. The Commission's key findings on the challenges to addressing the growing affordable housing and health services crisis are:

- One-third of senior households are expected to have housing needs;
- Almost one-fifth of seniors will likely have service needs, and existing programs are not well structured to meet those needs;
- Current production of affordable housing does not begin to meet demand;
- Subsidized rental units are being lost due to expiring Section 8 project-based rental assistance contracts and mortgage prepayments; and
- Federal housing and health policies are not synchronized, often leading to premature institutionalization as a more costly, yet practical option.

The Commission has developed more than 40 recommendations to address the health and housing challenges of a dramatically increasing senior population. A full Table of Commission Recommendations appears in the Appendix to this Report.

Though the Commission’s recommendations seek to respond to its Congressional Mandate, the Commission believes that these recommendations address the entire Nation on issues that many government leaders, providers, developers, advocates and consumers face. It is essential that these challenges be addressed proactively.

PART I. SETTING THE CONTEXT: THE ELEMENTS OF CHANGE

A. A Quiet Crisis Is Looming for America's Seniors

As Baby Boomers Age, Millions of Seniors Will Lack Affordable Housing and Health Care Services

A crisis is looming for America's seniors. It is a quiet crisis and most people seem unaware of its dimensions. Those who will be affected are not talking about it. Little is being done to prepare for it. Time is running out.

When the first of America's Baby Boomers reach age 65 in a mere nine years, the number of older Americans will begin to increase dramatically. Numbering 35 million seniors today, by the year 2020, one in six Americans — 53 million men and women — will be age 65 or older.[14] The Nation is not ready for this surge in the senior population.

This is the same generation that overloaded schools, challenged the health care system, and overburdened the transportation network. Many of these seniors will need housing and health care services that may be neither available nor affordable unless the Nation acts now.

Congress saw this crisis on the horizon and established this Commission with a Mandate as broad as the crisis itself. At the outset, the Commission recognized the size and scope of the challenge — to examine two of the largest fields in America, housing and health, in light of this dramatic increase in seniors. We hope that our report is a first step toward the development of a sound national policy for seniors, but we know that many more studies and explorations of options must follow. It is important that the task has been identified, that the problem has been defined, and that work on finding solutions has begun.

Challenges to Meeting Future Needs

The Commission also believes that a national effort to meet future needs of seniors will face numerous challenges. Principal among those challenges is the need for resources. Committed investment in affordable housing has declined over the past three decades[15] and resources devoted to home- and community-based services pale in comparison to resources dedicated to facility-based, skilled nursing care. The Commission's key findings on the challenges to addressing the growing affordable housing and health services crisis are:

- One-third of senior households are expected to have housing needs;
- Almost one-fifth of seniors will likely have service needs, and existing programs are not well structured to meet those needs;
- Current production of affordable housing does not begin to meet demand;

- Subsidized rental units are being lost due to expiring Section 8 project-based rental assistance contracts and mortgage prepayments; and
- Federal housing and health policies are not synchronized, often leading to premature institutionalization as a more costly, yet practical option.

The Commission has developed more than 40 recommendations to address the health and housing challenges of a dramatically increasing senior population. A full Table of Commission Recommendations appears in the Appendix to this Report.

Though the Commission's recommendations seek to respond to its Congressional Mandate, the Commission believes that these recommendations address the entire Nation on issues that many government leaders, providers, developers, and consumers face. It is essential that these challenges be addressed before the Nation is overwhelmed with the needs of the retiring Baby Boomer generation.

The Causes of the Crisis Are Clear

In America today, most people are living longer and many are enjoying their later years more, contributing as seniors to their families, communities, and country in countless ways. The reasons are simple: advances in medicine and health care, broader public understanding of good nutrition and healthy lifestyles, and a major reduction in environmental pollutants have contributed to a steady rise in life expectancy.

Commission research based upon U.S. Census and American Housing Survey data shows, however, that almost half of seniors today are likely to have a low-income (under 50 percent of area median income) and one-third of those seniors pay more than 50 percent of their income for housing. Witnesses repeatedly told this Commission of long waiting lists for affordable housing, especially in growing urban areas. Families of seniors told of needing to move into costly institutional settings because of the lack of affordable and appropriate housing in the community. They told of the shortage of health care facilities or supportive services associated with their housing. The level of investment in this area has been inadequate for the past quarter century; neither market incentives nor political imperatives have generated sufficient private or public investment to meet even today's need. If the situation is dire now, it will be desperate in the year 2020.

Barriers May Tarnish the Later Years

Americans — poor or not — face many barriers to a secure aging process. In addition, a growing number of seniors are finding that they have to work in their "golden years" due to insufficient retirement plans, rising costs of health care/prescription drugs and lack of safe, affordable housing alternatives. For some, family supports disappear when they outlive spouses or when children move to a distant place. For others, old age is a time of discovering that, with a declining or fixed income, they are simply unable to purchase the goods and services they need. Rising property taxes and maintenance costs may make their home, long a symbol of independence and often their most valuable asset, too costly to retain.

Seniors may face declining health, including the loss of ability to care for themselves and to live independently. They may live alone, lack family support, be unable to drive, be isolated from services they need, suffer disabilities that confine them to home, or be unable to enjoy friends and the social interactions so vital to their sense of dignity and well-being. While medical advances continue to increase life expectancy, the cost of medical insurance, long-term care, medications, and other needs for later life need to be within reach of seniors' ability to pay. Many will spend what resources they have to meet their personal care and health needs until, impoverished, they meet Medicaid eligibility requirements.

For those fortunate enough to have caring families nearby, their caregivers may face more stress than they can endure. When family, friends or caregivers search for help, they often encounter confusing requirements and eligibility standards as well as exorbitant costs. Those in rural areas face a dearth of available services, and the high cost of travel inhibits the use of what services are available.

Seniors who live in private homes and require assistance could greatly benefit from the intervention of a professional who is able to facilitate service linkages, in the same way that resident service coordinators do in federally assisted housing. Furthermore, those seniors who are able to stay in their private homes may not be able to afford home modifications necessary for their safety and accessibility (for example, wheelchair ramps, wider halls and doorways, and grab bars). Even if they have the resources necessary to pay for nursing and personal care, labor shortages may make such assistance impossible to obtain. Premature and inappropriate institutionalization is also an inadvertent and very costly outcome of the current system.

Sound public policy at all levels of government is essential to the development of solutions to these problems.

This Nation Needs a Policy for the Elderly

The Commission believes that a comprehensive national policy for affordable senior housing, coordinated with health and supportive services, is urgently needed.

A specific concern of the Commission is to ensure that the government – at all levels – promotes policies that allow for choice. Seniors who need affordable housing, want to remain in their home and community, need assistance in caring for themselves, lack the resources to keep their homes and maintain their independence, or desire to live in senior communities should be supported in these options by sound government policy. Remaining at home is a cost-efficient housing choice, thereby allowing the most needy an increased opportunity to access the limited supply of subsidized housing.

If there is inadequate housing, if what is available is not affordable, if health care or supportive services are too limited, seniors have little choice. If private and public resources are too few to provide for people who cannot provide for themselves, choice is

an illusion. The Commission acknowledges that too many seniors find themselves at risk of being ignored, forgotten, or inappropriately housed in an institutional setting.

"If we fail to meet these challenges," Chairman, AARP Board of Directors, Keith Campbell testified to the Commission, "the likely result will be a crisis in both affordability and availability in housing, creating the possibility that we will see an America with a significant increase in underhoused, underserved older citizens. And a result of this could be a substantial increase in costly and premature institutionalization of older people."

Individual Americans are compassionate and care about the lives and welfare of seniors. National policy should be grounded on that caring and compassion, but, for this to be so, change must occur on many levels. Policies for seniors need to be coordinated and integrated, from the top levels of government to the service delivery level. Demand for existing facilities already outstrips supply, and the current pace of construction of new facilities will not meet future demand. Millions of seniors will face critical, yet bleak, choices unless the Nation acts soon.

The Commission offers the following Vision as a conceptual guide for a national policy in the 21st century, a guide that finds its origins in the many voices that we heard.

B. A Vision for America

The Seniors Commission traveled across America to listen to men and women of all generations talk about the housing, health, and supportive service needs of seniors. From coast to coast, we visited with seniors and learned about their lives. We also heard from leading researchers, housing, health, and service providers, and government officials at all levels and from all points along the political spectrum.

The picture of seniors in America that emerges is both inspiring and alarming. As individuals and as a Commission, we commend the vigor, imagination, and creativity that Americans are bringing to solve the problems of affordable housing and health care for the Nation's seniors.

We found, as we stated in the preceding section on problems, that current efforts are falling short of developing what will soon be needed — indeed, they fall short of providing what is needed today.

Based on what we saw and heard the Commission developed this Vision for America.

Ours is a land in which seniors should enjoy an array of opportunities for affordable housing, health care, and supportive services. By mobilizing its private and public sectors in a spirit of community, and drawing on its vast resources, the Nation has the capacity to enable seniors, regardless of economic status, to maximize their independence, promote their health and safety, and preserve their dignity.

Seniors should have access to quality care within a coordinated and comprehensive system that delivers healthy, affordable, and ethical long-term care. They should not have to impoverish themselves to be eligible for Medicaid.

Seniors want and should have the opportunity to exercise informed choices about their care and their caregivers, and to grow older in their home, community, or other setting they select. Seniors should not have to face fear, uncertainty, or loneliness because of their limitations of income, illness, or disability. Nursing facilities should be places that care for the very ill and not the only alternative for people who cannot afford to live elsewhere.

Special attention should be paid to those most vulnerable in society — the seniors who are poor, who live alone, who have lost their financial independence and perhaps even their homes, who may have debilitating health conditions, and who may have lost their very spirit. An adequate supply of community-based affordable housing and quality services can enable seniors to look forward to a safe, secure, and dignified old age.

Today's exceptions of excellence should become the norm, and flexible programs should be tailored to the needs of individuals. Greater Federal, State and local resources should be committed to affordable housing and quality care with a focus on wellness, not illness. Government at all levels should coordinate and consolidate funding and programs. A new flexibility in administration should be balanced by accountability to the taxpayers. Application and reporting requirements should be simplified and unified.

The private and public sectors should work together to ensure appropriate care and services for seniors. Private business, faith-based and other non-profit organizations, government, and private foundations should form powerful and goal-driven collaborations and enter into creative partnerships for the effective and efficient use of private and public resources.

Communities should develop a better understanding and appreciation for the seniors who live within them. State and municipal government should rewrite use and building regulations to encourage facilities and amenities for seniors resulting in, for example, walkable neighborhoods and town centers, expanded transit services, retrofitted homes, and essential services for seniors who live alone. In response, bold and exciting new design concepts for homes and other environments, focused on the special daily living needs of seniors, would emerge.

Americans have the foresight to support the initiatives and programs to implement this Vision. America has the means to achieve this Vision. We see an America that dedicates time, energy, and resources sufficient to address the housing and service needs of seniors in the 21st century.

PART II. CONVERGENCE: A CALL FOR COORDINATION OF SENIORS' HOUSING AND HEALTH CARE

Housing and Health Care Operate as Separate Systems; Policies and Programs Are Disconnected and the Need for Coordination Is Clear

The most striking characteristic of seniors' housing and health care in this country is the disconnection of one field from the other. With few exceptions, seniors obtain their housing from one source and their health care and other services from a completely different source.

Witness after witness before this Commission testified to this problem and the consequences of its continuation. "This lack of coordination and integration results in enormous inefficiency in the use of economic and social resources," William L. Minnix, president of the American Association of Homes and Services for the Aging, told the Commission at its San Diego hearing. Commissioners themselves, experienced in both housing and health care, found that those with expertise in one field had inadequate understanding of the other. In that, they mirrored their counterparts across the country.

Through exchanges in their own meetings, Commissioners have come to appreciate that:

- Some policy disconnects have long histories and may not be easily resolved;
- Poor communication, differing vocabulary, and few opportunities to share experiences separate professionals, policymakers, academics, and even the media in the two fields;
- Lack of coordination and integration between housing and health care is characterized by different and distinct financing systems and regulatory structures; and
- Most difficult of all, government is structured at both legislative and administrative levels in ways that inhibit coordination.

The historical disconnect between housing and health care demands attention before the Baby Boomers reach retirement age. Coordinating these systems will take considerable time, effort, and commitment.

Two Views Divide Housing and Services

How does a housing provider deal with the concept of "aging in place"? How does a health services provider deal with a senior's desire to "live in the community"? Even casual conversations with these providers begin to show the first signs of separation — language.

Housing professionals speak of dwelling units, turnover rates, replacement schedules, and subsidies. They want to know seniors' income as a percentage of area median income

(AMI). Health services professionals speak of beds, length of stay, and insurance. They want to know seniors' activities of daily living (ADL), their maintenance needs allowance (MNA), and their ability to access and pay for community service options. One witness, Arthur Y. Webb, president and chief executive officer of Village Care of New York, told the Commission about the confusion that surrounds models for care that exist, citing uncertainty about the meaning of "assisted living, continuing care retirement communities, life care communities, supportive housing, adult care facilities…."

History, finances, and even legislative structures play a role in extending housing and health service disconnects. Federal housing and health issues are, for example, assigned to different committees in Congress, and State authority in these fields falls within the jurisdiction of different committees in State legislatures. The programs are administered in different departments — housing principally in the U.S. Department of Housing and Urban Development and health principally in the U.S. Department of Health and Human Services. Their headquarters, only a few blocks apart in Washington, are miles apart in understanding each other or working collaboratively. As one seasoned former HUD executive told the Commission, "There's no coordination because it's nobody's job to coordinate."

The U.S. Supreme Court decision in *Olmstead* v. *L.C.* (1999), affirming the right of persons with disabilities to live and receive services in the least restrictive setting they desire if at all possible, gives even greater urgency to the issues of government coordination.

Private and non-profit housing and health service providers face a bewildering array of funding sources: the private markets for a mortgage or equity loan, perhaps a municipal bond issue, or the credit sale, and — often most important of all — government funding from half a dozen different programs. Government programs are most often Federal in origin, but some are administered through State agencies. Each program has its own eligibility requirements, application deadlines, funding schedule, and recipient reporting requirements, to name only a few. One program's maximums might be another program's minimums. Witnesses before the Commission spoke of many consultants who make their living by advising sponsors on how to apply for these programs, how to write applications and reports, how to "cobble" together a layered funding package, and how to keep up with the relentless demand for more and more reports. Needless costs are associated with this complexity.

The ultimate consumer — the senior citizen — faces the daunting task of obtaining shelter and care from these two disconnected sources. Confronted with complex entry requirements, insurance coverage limitations, and high costs, many seniors become overwhelmed just when they need help the most. The shelter and care one needs should not require understanding complex systems. Shelter with services should not demand that providers work with multiple programs and funding sources. A senior with financial resources may navigate these passages more easily than one without, but in many instances, particularly in rural areas, the shelter and care options may simply not exist at any price.

A Call for Coordination

The crisis in housing and services for seniors demands a new approach. The Nation can no longer afford the inefficiency of the current disconnect between housing and health service systems for seniors. The time has come for coordination among Federal and State agencies and administrators. Coordination should begin in the halls and committee chambers of Congress and should spread through all branches of government and society. In the private sector, housing and health services providers are aware of the disconnect, but they need help in making the critical connections.

A first step in coordinating programs is to develop a common vocabulary, common age for eligibility, common definition of poverty, and common standards for programs.

The now distinct worlds of housing and health care must begin to acknowledge each other, listen to and speak to each other, and learn to integrate efforts for their mutual benefit and the benefit of their senior clients. Such understanding and coordination are essential underpinnings to the success of reforms proposed in this report and in many other forums.

PART III: KEY DEMOGRAPHIC FINDINGS AND PROJECTIONS

The next three decades will see a tremendous increase in the size of the senior population as the Baby Boom generation ages and the lifespan of Americans increases. In meeting elements of its Mandate, the Commission conducted independent research, including original analysis of the American Housing Survey and other data sources,[16] hearings, and reviews of scholarly work. The Commission's research included groundbreaking work using U.S. Census Bureau data from the American Housing Survey, analysis of the Current Population Survey (CPS), and the Survey on Income and Program Participation (SIPP). The Commission noted several important trends regarding current and future seniors and their housing and health services needs. (Note: In general, seniors means persons 65 and older unless otherwise noted. Data describing today's housing are based on 1999 information.)

The Present

- In 1900, the senior population was less than 5% of the total U.S. population. Numbering 35 million seniors, it is now 12.4%. By 2030, the senior population will double to 70 million, or 20% of the U.S. population.[17]
- Nearly 20% of seniors have significant long-term care needs. In 1997, more than 5.8 million or 18% of non-institutionalized persons age 65 and older required assistance with their everyday activities, and about 1.2 million (3.7%) were severely impaired and required assistance with three or more activities of daily living (ADLs).[18]
- Many seniors across the income spectrum are at risk of institutionalization or neglect due to declining health and the loss or absence of support and timely interventions. The risk is greatest for those with lower incomes.[19]
- There are nearly six times as many seniors with unmet housing needs as are currently served by rent-assisted housing.[20] Waiting lists for many types of subsidized housing are long. For example, in 1999, nine applicants were waiting for each Section 202 unit that became vacant within a year[21] compared with eight applicants in 1988.[22]
- The affordable housing stock is in danger losing significant numbers of units. There are 324,000 Section 8 assisted units in senior properties that are at risk of "opting out," according to Commission research. [23]

The Future

The Commission developed projections of the future needs for housing and services between now and 2020 based on existing and contracted research. The Commission's research led to the following key findings about the future senior population.

By 2020:

- The number of senior households is expected to grow by nearly 53%.

- More than 80% of senior householders will be homeowners.[24]
- Nearly three-fourths of households with housing needs will likely be owners of their housing. [25]
- Almost 44% of senior householders will be age 75 and older.[26]
- Even if current rates of disability continue to decline, the number of seniors with disabilities is expected to increase from 6.2 million in 2000 to 7.9 million.[27]
- The need for Home- and Community-Based Services (HCBS) will grow substantially owing to the desire for seniors to age in place.[28]

The number of seniors in need of affordable housing will also increase at a steady pace. In 2020, 730,000 additional rent-assisted units[1] will be needed to accommodate the senior households age 65 and older who are likely to have housing problems at the same 5.8 to 1 ratio at which they are accommodated today.[29]

The data shows that current and future populations of seniors require creative and diverse use of significant resources to meet their needs. The following demographic data shed light on the breadth of current and future needs.

Housing and Health Characteristics of the Senior Population[30]

Housing

Seniors currently occupy a diverse array of housing types. Their housing reflects both economic decisions and life circumstances such as the purchase of a house in middle age, new retirement lifestyles, the disability or death of a spouse, and/or changes in financial well being, personal health, and mobility.

Just over 21.4 million or almost 82% of older (age 65 and older) American householders live in conventional homes that they own or rent. Although homeownership is the norm, more than 16% of senior householders rent their accommodations, with most (70%) living in private market-rate housing, rather than government-subsidized or rent-assisted housing (Exhibit 1).

In 1999, the AHS database enumerated a total of 6.2 million rent-assisted units in the United States — 1.2 million (or 20%) of which, were occupied by age 65 and older households and another 200,000 or 2% of which were occupied by age 62 to 65 households.[31]

[1] Rent-assisted is a term used in the American Housing Survey to reflect not just governmental rental subsidies, but also government subsidies that are provided in the form of grants or loans with favorable interest rates, resulting in a more affordable rent structure.

Exhibit 1: Major Types of Housing Occupied by Senior Householders and Persons (Age 65 and Older) in the United States, 1999

Type of Housing	Number of Units[a]	Percentage Distribution	Number of Persons	Percentage Distribution
CONVENTIONAL HOUSING UNITS: SENIOR HOUSEHOLDERS [b,c]	**21,423,000**	**81.5**	**29,138,000**	**84.5**
Total Owner-Occupied Units	17,196,000	65.4	24,216,000	70.2
I-unit attached or detached	14,846,000	56.5		
2-49 units	836,000	3.2		
50+ units	259,000	1.0		
Manufactured homes	1,255,000	4.8		
Unsubsidized Rental Units	3,011,000	11.5	3,584,000	10.4
Government-Subsidized Rental Units	1,216,000	4.6	1,338,000	3.9
CONVENTIONAL HOUSING UNITS: YOUNGER HOUSEHOLDERS (Under Age 65) OCCUPIED BY AT LEAST ONE OLDER (Age 65 and older) PERSON[c]	**2,166,000**	**8.2**	**2,336,000**	**6.8**
Owner-occupied dwellings	1,789,000	6.8	1,931,000	5.6
Renter-occupied dwellings	377,000	1.4	405,000	1.2
SUPPORTIVE SENIORS HOUSING UNITS	**2,691,266**	**10.2**	**3,002,377**	**8.7**
Congregate Care and CCRC[d] independent living	644,852	2.5	818,962	2.4
Assisted Living[e]	507,414	1.9	644,415	1.9
Skilled Nursing[f]	1,539,000	5.9	1,539,000	4.5
TOTAL UNITS/PERSONS OCCUPIED BY SENIORS[g]	**26,280,266**	**100.0**	**34,476,377**	**100.0**
All older householders	24,114,266		32,140,377	
All younger householders with senior occupants	2,166,000		2,336,000	

[a]Numbers all refer to units except for skilled nursing which are reported in terms of beds and treated as one-person households.
[b]The householder is the first household member listed on the questionnaire who is an owner or renter of the housing unit.

[c]An unknown, but probably small, percentage of the units in this category are probably counted twice, because the U.S. Census erroneously treats them as households rather than "group housing" and they are also being counted in the "Supportive Seniors Housing Units" category. As this percentage increases in size, it artificially increases the relative share of dwelling units considered as "conventional housing units."
[d]CCRC: Continuing Care Retirement Communities

[e]Includes Board and Care facilities.

[f]Includes hospital-based facilities, private-pay facilities, and facilities managed by Department of Veterans Affairs

[g]Including both "Conventional Housing Units" and "Supportive Seniors Housing Units"

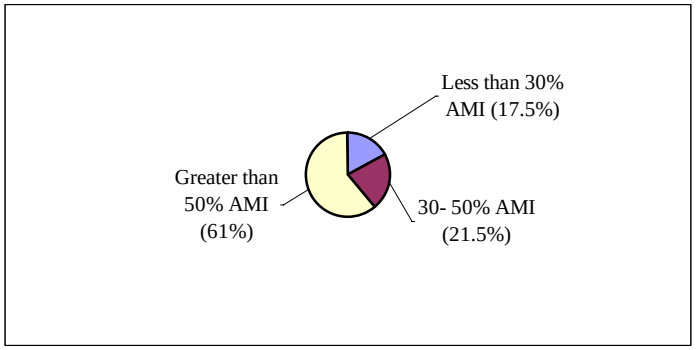
Notes for computing households: *For the Congregate Care and Independent living units in CCRCs, an occupancy rate of 94.1% was computed. For assisted living facility units, an occupancy rate of 89.4% was computed. Occupancy rates obtained from financial indicators reported in unpublished data from National Investment Conference. A nursing home occupancy rate of 88.35% was computed and the share of beds occupied by age 65 and seniors in nursing facilities was computed as 90.29%* ***See:*** *Gabrel, C. and A. Jones. 2000. The National Nursing Home Survey: 1997 Summary, National Center for Health Statistics. Vital Health Statistics 13(147). Washington: U.S. Government Printing Office. To count only senior occupants, the number of assisted living units was reduced by 3.1% and the number of independent living units was reduced by 2.9%.*
Notes for computing number of persons: *The following assumptions were made. First, of the 2,166,000 nonsenior households occupied by seniors, 170,000 households were occupied by two or more persons. For computation purposes, only two seniors per households were computed. This will understate the number of seniors to the extent that some households will contain 3 or more seniors. To estimate the number of persons occupying supportive senior housing units other than nursing facilities, it was assumed that there were l.27 persons per unit.*

Source: Supportive Seniors Housing Units data is modified from original tabulations found in Promatura Group, LLC. 2000. *NIC National Supply Estimate of Seniors Housing & Care Properties.* Annapolis, Maryland: National Investment Center for the Seniors Housing & Care Industries.
Conventional housing unit data from U.S. Census Bureau. *Current Housing Reports, Series H150/99, American Housing Survey for the United States: 1999.* Washington, DC: U.S. Government Printing Office.

Senior Income

Income distribution is an important factor in determining need and eligibility for assistance for both housing and health programs. In some instances, those with incomes of less than 80% of area median income (AMI) are eligible for housing assistance. Those with incomes below 50% of AMI are, however, more likely to apply for and receive such assistance.[32] Given that most seniors have fixed incomes due to retirement or decreased participation in the workforce, it is not surprising that nearly 40% of senior households reported incomes below 50% AMI, i.e. the lowest income quartile, according to Current Population Survey data (Exhibit 2).

Exhibit 2: Income Distribution of 65+ Population, 2000 by Area Median Income



Source: The Lewin Group tabulation of the Current Population Survey (CPS) 2001 March Supplement (which reports income data for 2000) for the Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century, 2002.

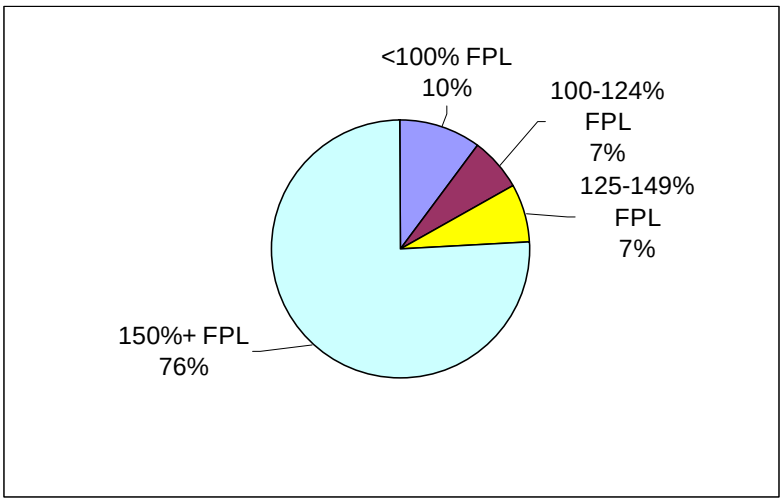
The Medicaid program uses variations of Supplemental Security Income (SSI) eligibility levels or the Federal Poverty Level (FPL) to determine eligibility. About 10% of seniors live at or below the FPL and another 14% live below 150% of that level (Exhibit 3).

One of the principle challenges to public policy is to reconcile the multiple standards. AMI is a local standard used by HUD to determine eligibility for many of its subsidized rental programs, while the SSI level is largely a national standard with 100% SSI equal to about 74% FPL.[33] The maximum income eligibility for HCBS under Medicaid is generally 300% SSI, although variations exist among States.[34]

Although some States have higher and lower levels for eligibility for Medicaid or other services, and HUD and other agencies have higher and lower standards for subsidized housing eligibility, 300% SSI and 50% AMI are the most useful eligibility standards for broad comparisons.[35] Therefore, for evaluation purposes, seniors with incomes below 300% SSI are compared with seniors at 50% of AMI to demonstrate potential eligibility discrepancies (Exhibit 4). Even this comparison is fraught with inadequacies because

any national compilation of AMI leads to averaging that does not reflect vast differences in AMI at the local level.

Exhibit 3: Income Distribution of the Age 65 and Older Population, 2000 by Federal Poverty Level



Source: The Lewin Group tabulation of the Current Population Survey (CPS) 2001 March Supplement (which reports income data for 2000) for the Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century, 2002.

Exhibit 4: Estimates of the Number of Households Headed by an Individual Age 65+ Meeting Alternative Housing and Service Income Eligibility Criteria, 1999 (in thousands)[36]

Typical Income Eligibility Criteria for Medicaid Home and Community-Based Waiver Services:	Typical Income Eligibility Criteria for Subsidized Housing		
	<50% National AMI Row % Column %	>50%National AMI Row % Column %	Total Row % Column %
<300% SSI Row % Column %	7,923 76% 95%	2,467 24% 19%	10,390 100% 48%
>300% SSI Row % Column %	460 4% 5%	10,653 96% 81%	11,113 100% 52%
Total Row % Column %	8,383 39% 100%	13,120 61% 100%	21,503 100% 100%

Note: AMI levels are assessed against household income, while poverty and SSI levels are assessed against family income.

Source: The Lewin Group tabulations of the March 2000 Current Population Survey matched to HUD Section 8 income limits from http://www.huduser.org/datasets/il/fmr99rev/index.html for the Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century (March 2002).

Many seniors who are eligible for one type of assistance may not be eligible for the other, based largely on where they live in the Nation or even in a particular region of a State. In high-cost areas, many seniors qualify for housing assistance but not for Medicaid because the median incomes in those areas are quite high and do not compare well with the 300% SSI standard.[37] Likewise, although many seniors qualify for housing assistance, the shortage of affordable rental housing units or home repair and maintenance assistance compels them to "go without."[38] Finally, in some areas, because of very-low median income levels, seniors may qualify for services but not for housing assistance even if it is available.

Just as noteworthy as the discrepancies regarding income is the percentage of seniors who have incomes above these limits (Exhibits 2 &. 3). These seniors represent a large group, many of whom have moderate incomes but do not qualify for housing assistance or appropriate health and services assistance.[39]

Health- and Service-Related Data

In 1999, more than 1.5 million seniors lived in skilled nursing facilities.[40] In addition, recent data show that more than 5.8 million or 18% of persons aged 65 and older, who did not reside in institutions such as nursing facilities, had difficulty performing either their everyday activities of daily living (ADLs) — or their instrumental activities of daily living (IADLs) — without assistance. This included about 3.18 million or 10% of seniors with at least one IADL limitation involving the following activities: preparing meals, doing light housework, taking a prescribed amount of medicine, keeping track of money or bills, and going outside the home. It also included about 2.61 million or 8% of seniors with at least one ADL limitation involving the following activities: getting in and out of bed or a chair, taking a bath or shower, dressing, walking, eating, and using or getting to a restroom. A smaller share of these seniors, 1.19 million or 3.7%, were especially impaired with limitations in three or more ADLs (Exhibit 5).

Exhibit 5: Age 65 and Older Persons
By Poverty Status in Percentages (1996)

Poverty Level Threshold	No ADL or IADL Disabilities	1 to 2 IADLs	3 to 6 IADLs	1 to 2 ADLs	3 to 6 ADLs	Total	At least one IADL Disability	At least one ADL Disability
Below 100%	71.2	13.6	3.2	7.0	4.9	99.9	16.8	11.9
100% to 149%	73.7	12.0	3.0	6.0	5.4	100.1	15.0	11.4
150% and above	85.2	6.2	1.7	3.7	3.2	100.0	7.9	6.9
All Income Levels	81.9	7.9	2.0	4.4	3.7	99.9	9.9	8.1

Source: The Lewin Group Projections from the 1996 Survey of Income and Program Participation, Wave 5, prepared for the Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century, 2002.

A little more than 2.6 million or 8% of seniors have a mental disability that seriously interferes with their everyday activities.[41] Older seniors are more likely to suffer from these limitations. A little more than 15% of those age 75 and older have IADL

impairments, almost 13% have ADL impairments, and just under 12% have a mental or cognitive disability that interferes with everyday activities.[42]

Proportionally, subsidized renters are the most likely to have impairments and homeowners are the least likely (Exhibit 6). As an aggregate, however, because of the large number of senior homeowners, there are four times as many with impairments as unsubsidized renters and nearly ten times as many as subsidized renters. Therefore, the Nation faces a challenge in serving seniors in diverse settings, including their own single-family homes, rental housing, retirement communities, and homes of family members.

Exhibit 6: Disability Among Seniors by Housing Tenure, 2000

	All	%	Owners	%	Unsubsidized Renters	%	Rent-Assisted	%
Total 65+	33,328,000	100.0	27,158,000	100.0	4,858,000	100.0	1,397,000	100.0
No ADL or IADL	27,130,000	81.4	22,581,000	83.1	3,670,000	75.5	929,000	66.5
Any ADL or IADL	6,198,000	18.6	4,577,000	16.9	1,188,000	24.5	468,000	33.5
At least one IADL	3,372,000	10.1	2,469,000	9.1	629,000	12.9	290,000	20.8
At least one ADL	2,826,000	8.5	2,109,000	7.8	549,000	11.3	177,000	12.7
With a mental disability	2,742,000	8.2	2,055,000	7.6	528,000	10.9	163,000	11.7

Source: The Lewin Group Projections from the 1996 Survey of Income and Program Participation, Wave 5, prepared for the Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century, 2002.

Because nearly one-fifth of all seniors have impairments, the availability and affordability of health and services is vitally important to their well being and quality of life.

Future Housing Needs of Seniors

According to Harvard Joint Center for Housing Studies projections, from 2000 to 2020 the number of senior households is expected to grow by nearly 53%. Owner households are expected to grow by more than 60% and renter households by 22% (Exhibit 7).[43] The growth in both groups will impact an already overburdened housing and health care system extensively, requiring flexible responses to meet the needs of renters and homeowners.

Research into the unmet needs of seniors was conducted by the Commission using American Housing Survey data and Harvard Joint Center projections. AHS and HUD use specific formulas to gauge and describe needs, found in the box below.

Exhibit 7: Household Growth Projections 2000-2020

Age Groups and Year	Owner Households	Renter Households	Total Households	Ownership Rate
2000				
Age 65-75	9,470,000	1,972,000	11,442,000	82.80%
Age 75 and Older	8,784,000	2,637,000	11,421,000	76.90%
2000 Totals	18,254,000	4,609,000	22,863,000	79.80%
2020				
Age 65-75	16,880,000	2,790,000	19,670,000	85.80%
Age 75 and Older	12,424,000	2,838,000	15,262,000	81.40%
2020 Totals	29,304,000	5,628,000	34,932,000	83.80%

Source: "State of the Nation's Housing 2001," Joint Center for Housing Studies, Harvard University (2002).

PRIORITY PROBLEMS: Refers to households with a serious housing cost burden[44] who pay 50% or more of their monthly income on their housing costs or that occupy dwellings with severe physical problems.
LESS SERIOUS PROBLEMS:[45] Refers to households with a moderate housing cost burden who pay 30% to 49% of their monthly incomes for their housing costs or that occupy dwellings with moderate physical problems.[46]

AHS data are self-reported and suffers from the shortcomings related to underreporting of income and assets.[47] Nevertheless, it is the most comprehensive national data set available for analyzing of the scope of the housing challenges seniors face, now and in the future (Exhibit 8). Those who have "priority" and "less serious" problems are considered "at-risk" in terms of their housing costs and quality.

Currently, 1.2 million rent-assisted units are occupied by age 65 and older households.[48] There is an at-risk population of 7.1 million households (owners and renters) who are not receiving rental assistance identified as having priority or less serious housing problems.[49] This translates into 5.82 *unassisted* senior households with problems for every one existing rent-subsidized unit now occupied by a senior household.

To estimate the number of rent-assisted units that will be needed to accommodate at-risk low-income senior households by 2020, the analysis makes two general assumptions. First, projections are based on the number of rent-assisted units necessary to accommodate the growth of all current age 65 and older *unassisted* owners and renters with priority or less serious problems (of all urgencies) — a total of 7.1 million households. Second, the projections assume that these owner and renter groups of households will grow at the same rate for all senior owners and renters.[50]

Exhibit 8: Current and Projected Number of Low- and Higher-Income Age 65 and Older Households in Unaffordable or Poor Quality Dwellings (by Housing Tenure, 1999 to 2020)

	1999			2020		
Income Group	**Total**	**Owners**	**Renters**	**Total**	**Owners**	**Renters**
All Income Levels						
With priority problems	3,890,000	2,468,000	1,422,000	6,099,070	4,205,761	1,893,309
With less serious problems	3,868,000	2,667,000	1,201,000	6,140,905	4,543,177	1,597,729
With all problems	7,758,000	5,135,000	2,623,000	12,239,976	8,748,938	3,491,038
Extremely Low-income						
<30% AMI with priority problems	2,699,000	1,630,000	1,070,000	4,202,353	2,777,711	1,424,642
<30% AMI with less serious problems	1,406,000	995,000	411,000	2,242,819	1,695,597	547,222
<30% AMI with all problems	4,105,000	2,625,000	1,481,000	6,445,171	4,473,308	1,971,864
Very-Low-income						
<50% AMI with priority problems	3,375,000	2,064,000	1,311,000	5,262,817	3,517,298	1,745,519
<50% AMI with less serious problems	2,662,000	1,795,000	867,000	4,213,250	3,058,890	1,154,359
<50% AMI with all problems	6,037,000	3,859,000	2,178,000	9,476,066	6,576,188	2,899,878
Low-income						
<80% AMI with priority problems	3,713,000	2,331,000	1,382,000	5,812,348	3,972,297	1,840,051
<80% AMI with less serious problems	3,382,000	2,274,000	1,107,000	5,349,067	3,875,163	1,473,905
<80% AMI with all problems	7,095,000	4,605,000	2,489,000	11,161,416	7,847,460	3,313,956
Higher Income						
≥81% AMI with priority problems	177,000	137,000	40,000	286,722	233,464	53,258
≥81% AMI with less serious problems	486,000	392,000	93,000	791,838	668,014	123,824
≥81% AMI with all problems	663,000	529,000	133,000	1,078,560	901,478	177,082

Source: Stephen Golant, "Housing Problems of the Future Elderly, Table 8.

Based on these assumptions, the Commission developed three possible rent-assisted unit growth scenarios (Exhibit 9):[51]

Scenario One: For the number of rent-assisted units for senior households to expand at the same rate between 1999 and 2020 as that projected for senior renters, generally there would be a need for 1.6 million rent-assisted units in 2020.

Scenario Two: For the number of rent-assisted units for senior households to expand at a rate that maintains the same 1999 ratio of unassisted senior households with problems to rent-assisted units, there would be a need for 1.95 million rent-assisted units in 2020.

Scenario Three: Given the current shortage of rent-assisted units for those eligible, reducing the ratio of unassisted senior households with a priority or less serious problem from 5.8 to 1 to 5 to 1, there would be a need for 2.3 million rent-assisted units.

Exhibit 9: Subsidized Housing Projections

Current Status and Projection Assumptions	Total Households	Total Number of Owner-Occupied Households with Any Problems	Total Number of Unassisted Rental Households with Any Problems	Total Number of Owned and Unassisted Rental Households with Any Problems	Number of Rent-Assisted Households	Ratio of Unassisted Households with Problems to Rent-Assisted Households
Number of Age 65 and Older Households, 1999						
Current Status, 1999	21,423,000	5,135,000	1,940,000	7,075,000	1,216,000	5.82
Projected Number of Age 65 and Older Households and Rent-Assisted Units in 2020						
Rent-Assisted Unit Projection Scenarios						
1. U.S. Census/Harvard Projected Household Growth Trends (1999-2020)	34,932,000	8,750,642	2,582,995	11,333,637	1,619,032	7.0
2. Maintain 1999 Ratio of Households with Problems to Rent-Assisted Units	34,932,000	8,750,642	2,582,995	11,333,637	1,947,669	5.82
3. Proposed New Ratio of Unassisted Households with Problems to Rent-Assisted Households	34,932,000	8,750,642	2,582,995	11,333,637	2,266,727	5.0

Notes: Unlike previous household tabulations, these include senior households at all income levels.

The growth of all household categories, regardless of rent-assisted unit projection assumption, is based on U.S. Census-/Harvard-projected household growth rates.

Source: Stephen Golant, "Housing Problems of the Future Elderly," Table 17.

The demand for rent-assisted housing will increase substantially. Programs such as Section 202, Section 8, Low-Income Housing Tax Credits, Section 515, and other Federal programs as well as State and local programs must be used to erase shortfalls and meet expanding need.

Given the large number of homeowners and the expressed desire of the vast majority of seniors to remain in their homes for as long as possible, meeting the needs of the nearly 9 million 2020 senior homeowners with housing needs in 2020 will be a daunting challenge as well. Some will be able to use home equity to finance improvements, accommodations, or relocations.[52] For those with little equity or overwhelming housing problems, flexible forms of assistance, like those funded by the HOME and CDBG programs, will need to be expanded and targeted to help senior homeowners adapt and maintain their homes and avoid the rolls of more costly long-term institutional settings.[53]

Future Health and Services Needs of Seniors

To predict the future number of seniors (age 65 and older) who will suffer from physical and cognitive limitations, the Commission assumes a declining annual disability rate based on recent studies and evidence.[54] That rate also assumes that the senior population will grow at the U.S. Census Bureau's intermediate rate of population projections.[55] Based on these assumptions, the Commission projects that by 2020 there will be 4.3

million seniors with IADL limitations, 3.6 million seniors with ADL limitations, and 3.6 million seniors with mental and cognitive disabilities. (Exhibit 10).

Exhibit 10: Number and Growth of Age 65 and Older Low-Income Persons Having Physical or Mental Disabilities, 1996 to 2020 (Incomes Below 150% of Poverty)

Type of Disability	1996	2000	2010	2020	1996 to 2000	2000 to 2010	2010 to 2020	2000 to 2020
Total Below 150% of poverty	8,249,452	8,603,591	9,636,990	12,952,292	4.3	12.0	34.4	50.5
No ADL or IADL disabilities	5,993,167	6,189,880	7,090,412	9,861,142	3.3	14.5	39.1	59.3
At Least one IADL disability	1,293,889	1,371,834	1,440,181	1,755,068	6.0	5.0	21.9	27.9
At least one ADL disability	962,396	1,041,878	1,106,396	1,336,081	8.3	6.2	20.8	28.2
With a mental disability	948,517	1,002,988	1,059,319	1,307,688	5.7	5.6	23.4	30.4

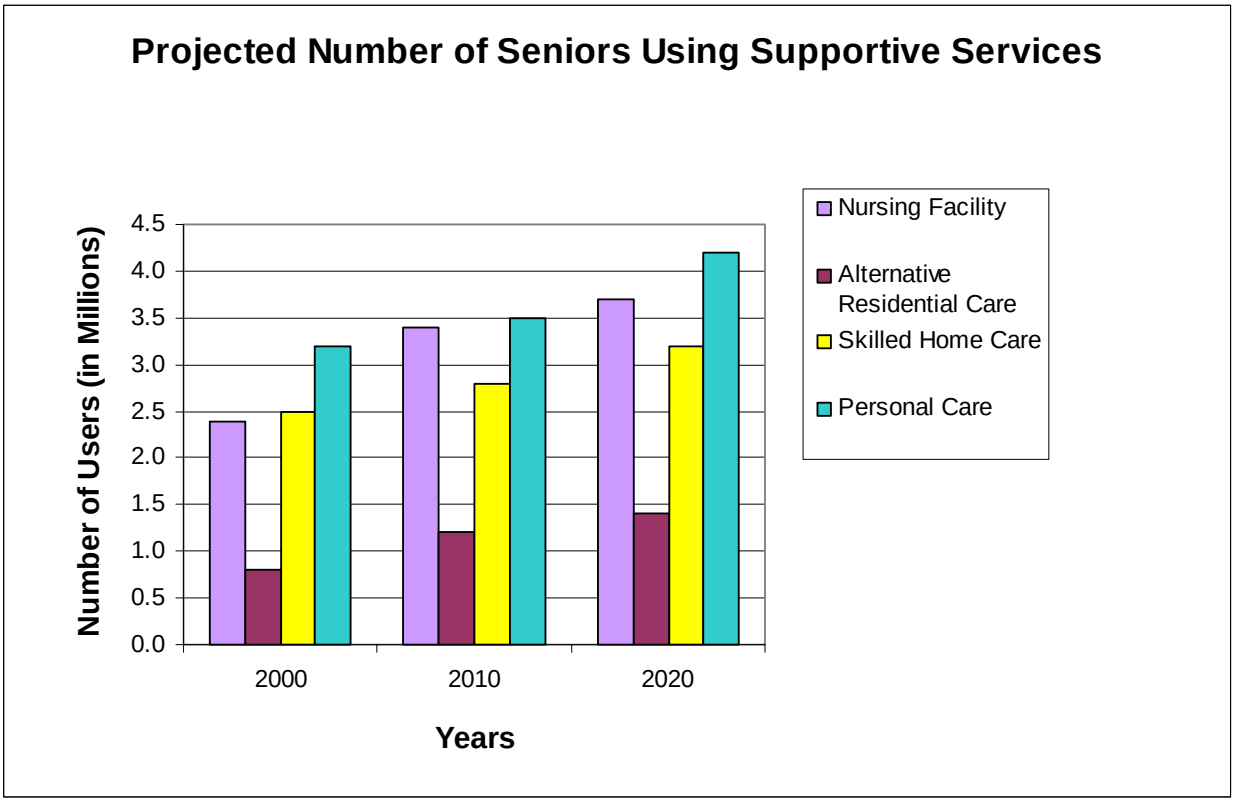
Source: Projections were computed by Tne Lewin Group. Note: Several important assumptions underlie the above projections. First, it is assumed that both the ADL and IADL disability rates will start to decline in the period 1997-2000 at an annual rate of 1.00%. This rate of annual decline is projected to decrease by 0.1% every five years through 2020. The annual rates of decline are as follows: 2000-2005, 0.90%; 2005-2010, 0.80%, 2010-2015, 0.70%, 2015-2020, 0.60%. It assumes that the older population subgroups with incomes under the 150% poverty level will grow at the same rate as the older population overall.

Further analysis of long-term care data developed by the Lewin Group indicates that 9.1 million seniors now utilize some level of personal care, ranging from skilled nursing to personal care in the home. The Commission projects that the aggregate need for such care will rise dramatically to approximately 12.5 million, although the increase will occur at less than the rate of growth in the senior population.

In addition to current service usage, Lewin provided the Commission with projections of future use based on their Long-Term Care Financing Model (LTCFM).[56] The LTCFM simulates nursing facility and home care use and expenditures for seniors age 65 and older to the year 2030. It permits analyses of alternative assumptions about the nature of the senior population in the future (e.g., declining disability rates) and policy scenarios (e.g., tax incentives for long-term care insurance or changes in Medicaid eligibility). Exhibit 11 shows current and future service use and needs.

The income level breakdown of those in need of services is critical, because in most instances, income level determines eligibility for government programs. Along with income level, knowledge of the range of services required is also important because it enables informed policy decisions regarding vital services that must be covered to ensure that the health and health-related needs of seniors are met.

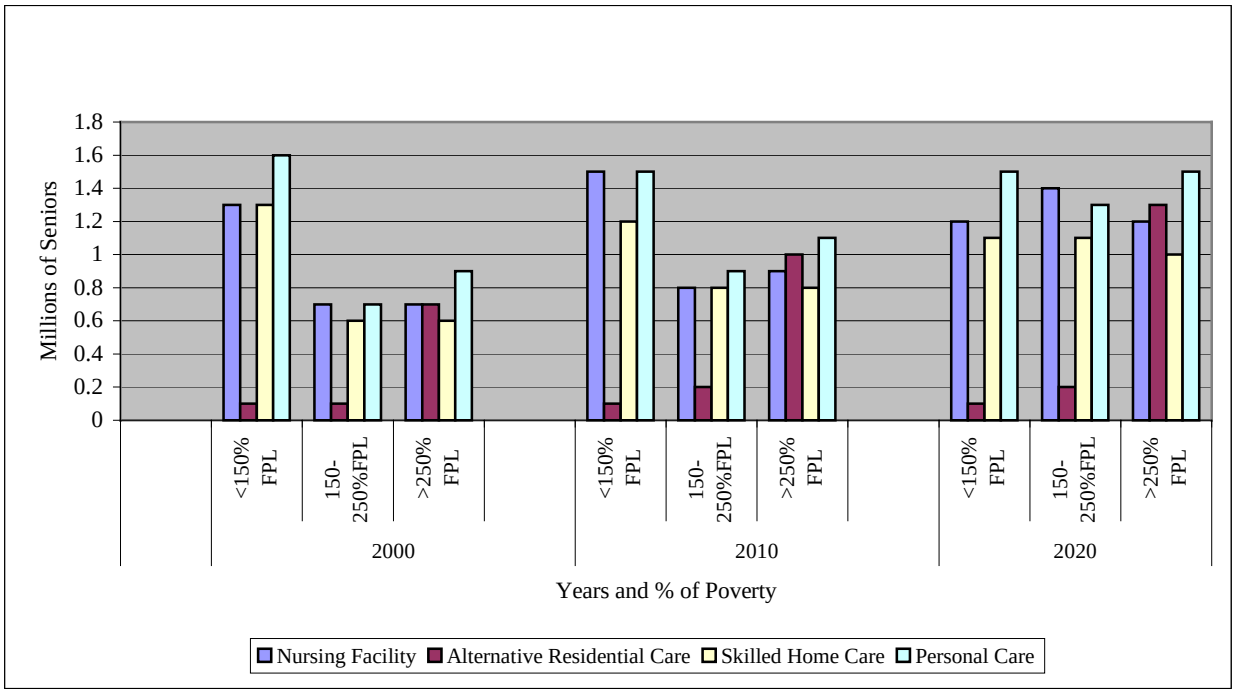
Exhibit 11: Projected Number of Seniors Using Supportive Services, 2000 to 2020



Source: The Lewin Group analysis of Long-term Care Financing Model supplemented by the National Long-term Care Survey, prepared for the Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century, March 2002.

In 2000, 4.1 million seniors with incomes below 150% of the poverty level required health and health-related services (Exhibit 12).[57] That number is expected to decline to 3.7 million in 2020 as a result of the decline in the number of seniors who fall within this population group. For those in the 150% to 249% of poverty range, 2.1 million required services in 2000. By 2020, that number is expected to nearly double to 4 million as a result of growth in this population. Under current policy, many in this group are not eligible for Medicaid.[58] This is critical because of differences in eligible services under Medicaid and Medicare. Finally, of those with incomes that exceed 250% of poverty, 2.9 million currently require services: that number is expected to increase to 5 million in 2020. Although many in this group have sufficient income or insurance to provide for necessary services, a large number do not,[59] and the Medicare program does not cover most of the services required to meet the long-term care needs of eligible seniors.[60]

Exhibit 12: Service Needs by Income Level 2000-2020



Source*:* The Lewin Group analysis of the Long-Term Care Financing Model supplemented by the National Long-Term Care Survey, prepared for the Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century, March 2002.

A large percentage of those who live in rent-subsidized housing (27%) are likely to have service needs. The largest aggregate group of those in need of services is likely to be homeowners (Exhibit 13). This group faces two-fold challenges because their environment may not be conducive to service provision and they may face housing quality challenges that drain the income available to purchase services or necessary modifications. Finally, seniors who live in unsubsidized rental housing will likely face the challenge of both inadequate income and lack of access to services. Increased supply of service-rich subsidized housing would alter the distribution of those in need of services and those likely receiving such services.

The data indicate potential vast disparities between the number of seniors in need of services and the subsidized services available, either because of income or choice of residence. Although the statistics are daunting with many issues to be addressed, if the right policies are adopted and obstacles overcome, the housing and health needs of future generations of seniors can be addressed effectively.

Predicting Assisted Living Growth

Providing housing options for the growing number of seniors with disabilities will require markedly increased efforts to provide housing options that include supportive services. Because of the integration of housing and services found in assisted living facilities, we present projections of the growth in assisted living facilities for 2020.

Exhibit 13 - Projected Number of Seniors with Disabilities by Housing Tenure, 2000 to 2020

Dwelling Tenure and Type of Disability	Number of Persons			
	1996	2000	2010	2020
Total Owners	**26,202,110**	**27,158,000**	**30,399,000**	**41,232,000**
No ADL or IADL	21,921,872	22,581,000	25,639,000	35,429,000
Any ADL or IADL	4,280,238	4,578,000	4,760,000	5,802,000
IADLs only, no ADLs	2,329,497	2,469,000	2,562,000	3,140,000
At least one ADL	1,950,741	2,109,000	2,198,000	2,662,000
With a mental disability	1,944,134	2,055,000	2,134,000	2,635,000
Total Unsubsidized Renters	**4,536,431**	**4,858,000**	**5,610,000**	**7,692,000**
No ADL or IADL	3,460,783	3,670,000	4,327,000	6,151,000
Any ADL or IADL	1,075,648	1,178,000	1,282,000	1,541,000
IADLs only, no ADLs	577,902	629,000	671,000	804,000
At least one ADL	497,746	549,000	611,000	737,000
With a mental disability	492,137	528,000	580,000	715,000
Total Rent-Assisted	**1,320,098**	**1,397,000**	**1,610,000**	**2,235,000**
No ADL or IADL	885,161	929,000	1,111,000	1,641,000
Any ADL or IADL	434,937	467,000	499,000	595,000
IADLs only, no ADLs	273,011	290,000	307,000	370,000
At least one ADL	161,926	177,000	192,000	225,000
With a mental disability	156,815	163,000	181,000	226,000
All Age 65 and Older Persons	**32,058,639**	**33,328,000**	**37,619,000**	**51,159,000**
No ADL or IADL	26,267,816	27,130,000	31,077,000	43,221,000
Any ADL or IADL	5,790,823	6,198,000	6,541,000	7,938,000
IADLs only, no ADLs	3,180,410	3,372,000	3,540,000	4,314,000
At least one ADL	2,610,413	2,826,000	3,001,000	3,624,000
With a mental disability	2,593,086	2,742,000	2,896,000	3,575,000

Source: The Lewin Group Projections from the 1996 Survey of Income and Program Participation, Wave 5, prepared for the Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century, 2002.

Estimating the growth and number of assisted living facilities in the year 2020 is a difficult task. The clientele of assisted living facilities can conceivably be seniors who would otherwise deal with their impairments in their homes or those who would otherwise occupy nursing facilities. Thus, the future demand for the assisted living facility alternative depends on other projections—the future number and share of seniors who will enter nursing facilities and those who will cope with their needs in their own homes. Estimating both of these needs is a challenging task in its own right.

Accurate predictions of the number of seniors who will be income and asset-qualified to enter these facilities are also required because the bulk of these facilities are not subsidized significantly.[61] This, in turn, requires predictions of the income distributions of future seniors and of the future cost of this alternative.[62] In addition, corollary estimates of the number of seniors who will not qualify to enter these facilities on the basis of income, but will be able to pay for this alternative by way of intergenerational transfer payments from their children are also required.

The future supply of this alternative will also depend on State policies that regulate the supply of nursing facilities, the care requirements in assisted living facilities and the availability of affordable home and community based care. Many States have placed caps on their nursing home expansion, which suggests that institutional care alternatives will receive an increasingly smaller share of the long-term care dollar as States seek to accommodate their frail seniors less expensively through home- and community-based care alternatives and by subsidizing the cost of assisted living facilities.

Providers of assisted living facilities themselves have not been accurate forecasters. The industry badly misjudged the demand for assisted living facilities. In many regions of the county, markets are now overbuilt and oversaturated and have relatively low-occupancy rates.[63] Thus, most of the major corporations have postponed often ambitious expansion plans. There have been many bankruptcies, and several company consolidations. Increasingly, a smaller group of corporations is controlling a larger share of ALF units throughout the country.

There are also three important senior consumer trends that suggest a dampening of demand for this alternative. The first is the aforementioned expected decline in the disability rate of the next generation of seniors with the obvious implications for future demand, although in absolute terms, the number of people with disabilities will increase. The second is the projected higher share of seniors who will be homeowners and the stronger attraction of the conventional dwelling as a place to accommodate their care needs. The third is the predicted slower growth of the age 75 and over group (and the 85 and over group) in each of the next two decades (2000 to 2010 and 2010 to 2020) than was the case in the 1990s.

Two projection scenarios are offered to predict the number of assisted living facilities in 2020. A third set of projection scenarios are also reviewed from the National Investment Center (Exhibit 14).

Scenario One

This scenario is organized around the following four assumptions:[64]

1. The growth of the senior population (age groups 65-74, 75-84, and 85+) between 2000 and 2020 will be consistent with U.S. Census middle-series projections.[65]
2. Between 1999 and 2010, the percentage of age 65 and older persons that occupy nursing facilities will remain unchanged.
3. Between 2010 and 2020 (but not between 2000 and 2010), an expected decline in the disability rate of seniors will depress the growth of seniors occupying nursing facilities with the result that a smaller percentage of this group will occupy this institutional alternative in 2020.
4. Between 1999 and 2020, the ratio of assisted living units to nursing home beds occupied by seniors will remain unchanged.

Exhibit 14: Assisted Living Facility Projection Scenarios of Number of Units Occupied by Age 65 and Older Persons in the United States, 1999 to 2020: Alternative Scenarios

Assisted Living Projection Scenarios	Number of Units[a]		
	1999[c]	2020	% Growth Rate
Assisted Living Facility Projection Scenario 1	507,414	712,707	40.5
Assisted Living Facility Projection Scenario 2	507,414	755,302	48.9
NIC[b] Conservative	511,163	673,911	31.8
NIC Base	511,163	720,299	40.9
NIC Optimistic	511,163	874,585	71.1

[a]Numbers all refer to units except for skilled nursing which is reported in beds and treated as one-person households.

[b]NIC demand models are focused on "individuals" rather than "units" and thus will produce artificially higher estimates than the first two scenarios. They also only include private-pay residents. NIC numbers are for the year 2000.

[c]NIC estimates are for the year 2000.

Source: Scenario 1 and Scenario 2 are from Stephen Golant, Stephen, *The Housing Problems of the Future Elderly Population*: A Report Prepared for the Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century. January 2002. NIC projections are from National Investment Conference, 2001, *The Case for Investing in Seniors Housing and Long-term Care Properties*. Annapolis, Maryland: National Investment Conference for the Senior Housing & Care Industries.

The 1.5 million nursing home beds occupied by seniors in 1999 are projected to grow to 2.2 million beds by 2020, an almost 41% increase. In 1999, there were about 2.9 senior-occupied nursing home beds for every senior-occupied assisted living unit. Maintaining this ratio (and growth rate) would result in the number of *senior-occupied*[66] assisted living units increasing from 507,414 units to 712,707 units between 1999 and 2020.

Scenario Two

This scenario is organized around the following three assumptions:[67]

1. The growth of the senior population (age groups 65-74, 75-84, and 85+) between 2000 and 2020 will be consistent with U.S. Census middle-series projections.[68]
2. In 1999, the age distribution of the assisted living population was as follows: 3% under age 65; 8.7% age 65 to 74; and 88.3% age 75 and older. Based on U.S. Census middle-series and Harvard household projections, the number of persons in each of these age groups will grow in size to 2020
3. Between 1999 and 2020, the disability rate of the older population will remain constant.

Using this methodology, there is a projected need that 507,414 units of assisted living occupied by age 65 and older persons in 1999 will grow to 755,302 or by 49% in 2020.

The National Investment Center (NIC) produced three alternative projections of the number of seniors likely to demand assisted living in 2020. These are referred to as conservative, base, and optimistic estimates.[69] The lowest number of seniors[70] occupying assisted living is predicted by the "conservative" projection and the highest by the

"optimistic" projection." All residents are estimated to be private pay. The optimistic estimate differs from the conservative demand model in that it assumes constant homeownership rates through 2010 and then somewhat *declining* homeownership rates; and it assumes fairly constant ADL deficiency rates between 2000 and 2010 and then a slow *decline* in these ADL deficiencies through 2020. An important new assumption of all three alternative projections is that income-eligible seniors may have annual incomes as low as $15,000 — and even lower — if they have assets greater than $50,000 (because they are capable of spending down these assets). The optimistic model assumes that between 2000 and 2020, the percentage of seniors with incomes greater than $15,000 or net worths of more than $50,000 will gradually increase. Based on these assumptions, the NIC estimates that from 674,000 to 875,000 seniors will want assisted living facilities in 2020, resulting in growth rates that range from 32% to 71%.

The allocation of resources by government and the private sector, as well as the incomes of seniors and the choices they make will greatly affect both the growth of assisted living and how the industry's product is shaped over the next 2 decades.

Challenges to Meeting Future Needs

The principal challenge to meeting future demand is the need for resources to address growing and changing housing and health requirements of seniors. Committed investment in affordable housing has declined over the past 3 decades[71] and resources devoted to Home- and Community-Based Services pale in comparison with resources dedicated to facility-based skilled nursing care. Below are the Commission's key findings on the challenges to addressing the growing affordable housing and health services crisis.

- One-third of senior households are expected to have housing needs;
- Almost one-fifth of seniors will likely have service needs, and current programs are not well structured to meet those needs;
- Current production of affordable housing does not meet demand;
- Subsidized rental units are being lost due to expiring Section 8 project-based rental assistance contracts and mortgage prepayments; and
- Federal housing and health policies are not synchronized, often leading to premature institutionalization as a more costly, yet practical option.

The Commission has developed numerous recommendations to address the health and housing challenges of a growing senior population. It is essential that these challenges be addressed before the Nation is overwhelmed with the needs of retiring Baby Boomer generation.

PART IV. PROGRAM INFORMATION AND OTHER CONSIDERATIONS

The need for appropriate and affordable housing and the need for accessible, high-quality services are equal partners in creating a workable equation for successful aging. A person's ability to function can be enhanced or impeded by his or her physical and social environment.[72] As people age, independence and quality of life can depend on their ability to access and pay for the housing and services they need in the environment that best supports an appropriate balance between autonomy and safety.

Since the 1930s, the Federal Government has created an array of programs to encourage the development of affordable housing, ranging from grants to direct loans to mortgage insurance to rental assistance and other types of incentives. Similarly, it has created entitlement, grant, loan, and discretionary programs to meet the health and supportive service needs of seniors, including Medicare, Medicaid, and the Older Americans Act programs.

The Commission presents here brief descriptions of existing Federal programs of particular importance to seniors.

FEDERAL HOUSING PROGRAM DESCRIPTIONS

Section 202 Supportive Housing for the Elderly

Created by the Housing Act of 1959,[73] today's Section 202 program provides capital advances (grants) and project-based rental assistance — to non-profit sponsors for the development and construction of supportive housing for very-low-income seniors, age 62 and older. Through 2001, the Section 202 program provided housing for approximately 381,000 senior or disabled households in more than 9,000 facilities

Initially, the Section 202 program provided a below-market interest rate loan. In 1968, however, that program was phased out and replaced by the Section 236 program. The initial program was, however, reinstated by Congress in 1974, at which time it was targeted to households with incomes of less than 80 percent of AMI. Project-based Section 8 rental assistance was made available for up to 100 percent of the units, in most cases, for 20 years. The presence of Section 8 units in such projects permitted owners to serve very-low-income seniors. (The majority of pre-1975 projects relied on tenant income to pay the debt service and served moderate-income residents.)

In 1990, Section 202 funding was changed from direct loan to capital advance (grant) for the development and construction of supportive housing for seniors, but continued to include project-based rental assistance that ensures that no resident pays in excess of 30 percent of income for rent and utilities. Eligible residents must be 62 or older and have incomes at or below 50 percent of AMI. Eligible sponsors are private non-profits. HUD opens competition for funding once each year. Because of its rental assistance component, this program has an exceptional ability to reach extremely low-income

seniors — individuals with incomes at or below 30 percent of AMI. Funding is, however, limited. In the Notice of Funding Availability (NOFA) issued on March 26, 2002, HUD estimated that funding was available for the production of 5,816 units, nationwide.

Section 202 is the only affordable housing program dedicated exclusively to seniors and, as such, can serve as the linchpin between housing and service delivery. It also has the advantage that it can serve a range of housing and service needs while promoting maximum independence among residents. Although originally designed as an independent living program, the modifications resulting from the 1990 Housing Act encourage service to a frail population. According to a recent AARP study,[74] the average age of the residents is 75, a large proportion of whom are frail.

Section 202 projects can also be designed or retrofitted to provide a continuum of care services as residents age, thereby allowing older residents to age in place without fear of displacement due to frailty. This is an often-cited problem with existing assisted living facilities.

Although a highly popular and successful program, as indicated by the chart below, funding for the Section 202 program has dropped from an annual production level of 20,000 units in 1977, to today's production level of approximately 6,000 per annum.

Exhibit 15: Units Funded by Year (Elderly) -- Section 202*

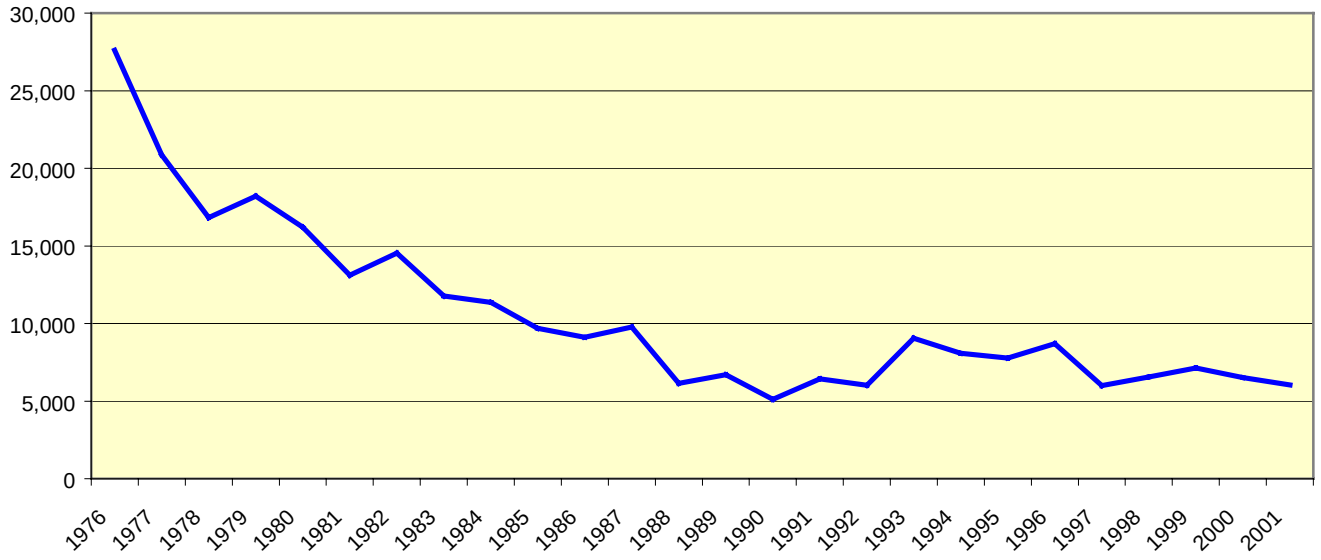


***Chart prepared using HUD data**

Public Housing

Created by the 1937 Housing Act, our system of public housing is administered at the local level by local housing authorities. Utilizing a system of construction grants and operating subsidies, hundreds of thousands of units of rental housing were developed across the country and made available to the poorest Americans. It is estimated that between 600,000 and 700,000 persons age 62 and older live in public housing, but only about one-half of those live in "seniors only" public housing.[75] Much of this housing stock needs modernization. Because no new incremental public housing units have been created for more than a decade, however, at present this program is not a resource for meeting the growing need for new senior housing.

Since 1993, HOPE VI has provided financial incentives to Public Housing Authorities (PHAs) to modernize, renovate, demolish, and replace dense public housing communities with mixed-use, mixed-income units. HOPE VI grant funds can also be used to pay for supportive services and service coordinators for seniors and many PHAs have incorporated senior housing into their HOPE VI revitalization projects. The Commission views this as a good source for intergenerational living for seniors. Still, a net loss of units available to low-income seniors often results from a HOPE VI development, because the program does not require "one for one" unit replacement.

Housing Choice Vouchers

Administered by local housing authorities, Housing Choice Vouchers (a tenant-based rental assistance program which was formerly the Section 8 certificate and voucher program), is available to help with rent affordability for very-low-income and extremely-low-income persons in existing private rental housing. Although this program does not produce new units, it is a valuable resource where a supply of appropriate units for very low-income seniors already exists. According to the 1999 American Housing Survey, the most important consideration in the choice of neighborhood for seniors who moved recently was convenience to friends or relatives. A voucher program may permit an older person to relocate closer to family and community support. HUD estimates that approximately 1.5 million vouchers are currently in use and that 17 percent of voucher holders are elderly households.

Seniors may encounter significant difficulty in locating acceptable units. Housing Choice Vouchers are limited in their utility for older seniors with physical impairments or transportation problems. These difficulties are compounded in areas of the country with low vacancy rates or where fair-market rents lag behind market rents. In a recently released HUD-commissioned study, 7 percent of respondents were elderly households. Of those respondents, persons age 62 and older had only a 54 percent success rate in finding appropriate housing using the voucher program. By contrast, households headed by persons under age 25 had a 73 percent success rate and households headed by persons aged 25 to 62 had a 68 percent success rate.[76]

The following table shows the amount of new, incremental vouchers funded by Congress from 2000 through the President's FY 2003 budget proposal. HUD does not collect

demographic information on the types of households that receive these new vouchers. For purposes of illustration, however, the HUD estimate of 17 percent senior voucher holders was assumed.

Exhibit 16: Incremental Vouchers

Fiscal Year	Number of New, Incremental Vouchers	Number Used by Elderly Households*
2000	60,000	10,200
2001	79,000	13,430
2002	26,000	4,420
2003 (proposed)	34,000	5,780

*Chart prepared from HUD data

Recently, HUD has allowed PHAs to use up to 20 percent of their vouchers in housing developments, as project-based subsidies. This decision will assist both the seniors who are searching for subsidized housing and senior housing providers who are attempting to increase the stock of affordable housing.

HOME Investment Partnership Program

HOME, a federally funded program for housing, was enacted in 1990 as part of the National Affordable Housing Act (NAHA). The program is intended to foster partnerships among Federal, State, and local governments, and the private sector. Funds are allocated annually to States and local governments on a needs-based formula. This formula includes the number of low- and very-low-income families, the number of homeless, local housing conditions, and local economic conditions. Typically, 40 percent of HOME funds are allocated to the State unit of government and 60 percent to local Participating Jurisdictions , generally, the larger cities. To receive funds, States and localities must generate a Consolidated Plan — a planning tool that documents housing statistics and sets housing goals, as part of a comprehensive strategy. HOME could be an important resource for seniors in that it is locally administered and could potentially combine services with housing. For example, in FY2000, State agencies were awarded almost $72 million in funds for a range of housing activities targeted to seniors.[77] HOME is not, however, a program that is dedicated exclusively to seniors and it is typically used as “gap” financing to create affordability in projects that rely on mixed-financing.

Community Development Block Grant Program (CDBG)

Enacted by the Housing and Community Development Act of 1974, the Community Development Block Grant (CDBG) program provides a flexible source of annual formula grant funding for local governments to address their particular development priorities. HUD provides grant funds to States and local governments based on relative needs. To receive both CDBG and HOME funds, States and localities must generate a Consolidated Plan, as described above.

CDBG funds support a wide range of activities intended to further community and economic development directed toward neighborhood revitalization, economic development, and the provision of improved community facilities and services. CDBG activities are initiated and developed at the local level based on a community's perceptions of its needs and priorities and potential benefits to the community. CDBG projects must benefit low- and moderate-income families, prevent or eliminate slums and blight, or meet other urgent community development needs.

Approximately 70 percent of CDBG funds go directly to local governments with 50,000 or more residents. Remaining funds go to the States, which then allocate the funds among less populated localities. CDBG funds can be used to benefit seniors through the:

- Reconstruction or rehabilitation of affordable senior housing;
- Construction of public facilities and improvements, such as senior centers; and/or
- Provision of public services, such as congregate meals and transportation.

States and local governments often use CDBG funds to match Older Americans Act (OAA) formula funding to help provide OAA Title III services.

Low-Income Housing Tax Credit Program

Currently, more affordable housing is produced through the Low-Income Housing Tax Credit Program (LIHTC) than any other Federal housing program. Created by Congress in 1986 — under Section 42 of the Internal Revenue Code — the program provides a tax credit to those who invest in affordable housing. To be eligible for the credit, 20 percent of the applicable housing units must be affordable to persons with incomes at or below 50 percent of AMI, or 40 percent of the units must be affordable to persons at or below 60 percent of AMI. Although LIHTC program rents must be "affordable," the rents are not subsidized i.e., the individual resident's rent is not capped at 30 percent of income. Because of this, the "band of affordability" in tax credit housing is considered to be persons with incomes between 40 percent and 60 percent of AMI.

Although the enabling legislation for Section 42 establishes basic ground rules, the housing tax credit program is administered by each State through the State's Qualified Allocation Plan (QAP), which reflects the goals and principles of that State. The Commission finds that this model of Federal/State partnership works well, with State and local governments better able to determine local needs and adjust for changes in demographics. Many states have established "set-asides" or have provided additional points in their scoring systems to provide incentives for developers who produce senior

housing under the tax credit program. Some States require services in senior housing developments as well, or provide additional points for housing owners who are willing to commit to offering services on a long-term basis. The Commission believes that States that include senior housing as a priority should be commended and that other States should be encouraged to move in that direction.

Although not a program targeted exclusively to senior housing, each year about 13,200[78] units of senior housing are being created through the LIHTC. A recent 40 percent per capita increase in tax credit authority to the States should [result in an increase in senior housing production levels under this program.

Mortgage Revenue Bonds and 501(c)(3) Tax Exempt Bonds

Senior facilities, including independent living and health care facilities are also financed with multifamily bonds. These are tax-exempt bonds developers use to obtain more favorable interest rates. As a result of reduced interest expense, they are able to set lower rents. Generally, multifamily bonds take two forms: 501(c)(3) bonds that are exclusively available to non-profits and have no upper limits on how much can be issued; and private activity bonds, which can be used by private developers and are generally combined with a 4 percent tax credit that is subject to a State's bond cap.

Multifamily bonds are issued on a project-specific basis. Regardless of the sponsor/developer, a public entity such as a State or local housing finance agency or PHA must be involved in the issuance of these bonds. Taxable bonds may also be issued to provide additional funds for the production of affordable rental housing.

The Internal Revenue Code requires that at least 80 percent of the units financed with housing bonds be rented to persons with incomes at or below 80 percent of AMI, and that non-501(c)(3) bonds meet one of the following more stringent tenant income requirements:

- At least 20 percent of the units in a bond-financed project must be rented to tenants with incomes at or below 50 percent of AMI; or
- At least 40 percent of the units must be rented to tenants with incomes at or below 60 percent of AMI.

Health facility bonds are also used to finance assisted living and long-term care facilities, but do not carry the same affordability test, as do multifamily bonds.

Government Sponsored Enterprises

Because Government Sponsored Enterprises (GSEs) — Fannie Mae, Freddie Mac, and the Federal Home Loan Banks — are chartered as a private enterprise by Congress they are able to access the capital market at lower costs. GSEs are a critical part of the Nation's financial delivery system and their actions have direct bearing on the availability and cost of housing finance, including housing for seniors. Again, although they are not designed to help fill needs for senior housing exclusively, they are useful sources of

financing for moderately priced senior housing. Both Fannie Mae and Freddie Mac offer forward commitments for projects utilizing LIHTC, and Fannie Mae is one of the largest purchasers of housing tax credits. The Affordable Housing Program of the Federal Home Loan Bank is a good example of GSE participation in affordable housing as a frequent supplement to mixed-financed projects, including those projects that are making use of housing tax credits.

HUD Mortgage Insurance

Pursuant to the Housing Acts of 1954 and 1959, HUD offers Federal Housing Administration (FHA) mortgage insurance for housing and health care facilities under a variety of programs. Sections 221(d)(3) and 221(d)(4) of the Housing Act provide insurance for the construction or rehabilitation of housing for low- and moderate-income families. Section 232 provides insurance for nursing facilities, board and care homes, assisted living facilities, and projects that combine two or more of those types of housing units. The regulations that govern all three of programs are quite similar. HUD mortgage insurance offers a number of advantages to the potential housing provider. With HUD insuring the loan, the risk to financing institution(s) is reduced, which means lower interest rates for the housing provider. FHA programs, although not direct subsidy programs, are an important potential resource in the delivery of housing and health care services for seniors.

Home Equity Conversion Mortgages (HECM)

Also known as "reverse mortgages," Home Equity Conversion Mortgage (HECM) loans enable older homeowners to convert the equity in their homes into monthly income streams or lines of credit.

Homeowners aged 62 and older can receive reverse mortgage loans for single-family homes, one-to-four unit owner-occupied dwellings, condominiums, planned unit developments, and manufactured homes. The borrower must, however, participate in counseling from a HUD-approved counseling agency prior before filing an application for this type of mortgage. Approved Direct Endorsement Lenders process all aspects of the loan application and submit it to HUD for insurance endorsement. HUD insures lenders against loss on these loans.

Section 515 Rural Rental Housing Program

Section 515 is a multifamily direct-loan program administered by the Rural Housing Service (RHS) of the U.S. Department of Agriculture. Although Section 515 served as a major funding source for rural housing for a number of years, in recent years, Congress severely limited funding. Currently, the program receives allocations of only approximately 1,000 units per annum. Traditionally, projects intended for very-low and extremely low-income seniors receive about half of this allocation. Under the program, housing developers receive loans at 1- percent interest for a 50- year term for the purpose of developing affordable rental housing in rural communities. Rents are set at Basic (based on 1 percent debt) and Market rate (assuming a market rate loan). In new Section

515 projects, 95 percent of tenants must have very-low-incomes. In existing projects, 75 percent of new tenants must have very-low-incomes. Project-based rental assistance can be made available, because of scarcity, however, newer facilities are less likely to receive such assistance. Developers may restrict their housing to occupancy by persons age 62 and older.[79] It should be noted that:

- Approximately 40 percent of Section 515 developments are built and operated as senior housing properties that may contain community rooms that accommodate service delivery;
- 57.8 percent of all Section 515 units (in both elderly and family properties) are currently occupied by elderly or disabled households; and
- 55 percent of Section 515 households receive Section 521 Rental Assistance and 7 percent receive project-based Section 8 assistance administered by HUD.

Section 504 Home Repair Loan and Grant Program

The Section 504 Home Repair Loan and Grant Program is an RHS program offered to elderly persons and very-low-income families who own homes that need repairs. Seniors may use grant funds to repair, improve, or modernize their dwellings, or to remove health and safety hazards. Such activities include: repairing or replacing a leaking roof; adding insulation; installing electric lines; replacing a wood stove with central heating; installing running water, a bathroom, or a waste-water disposal system; or making a home accessible to family members with disabilities.

Homeowners who are at least 62 can receive home improvement grants of up to $7,500 if they cannot afford a loan at the 1- percent interest rate.

Community Facility Loan and Grant Program

RHS provides grants, direct loans, and guaranteed/insured loans to construct, enlarge, extend, or otherwise improve community facilities that offer essential services to rural residents through the Community Facility Loan and Grant program. . Eligible facilities include hospitals, clinics, assisted living facilities, nursing facilities, medical rehabilitation centers, group homes, community centers, and public buildings.

Exhibit 17: Summary of Income Eligibility for Programs of Housing Assistance

Income Level	Extremely Low 30% of Median and Below	Very-Low 31% – 50% of Median	Low 51% – 80% Median	Moderate 81%+
Programs currently financing new construction or rental assistance vouchers	• Section 202 • Housing Choice Vouchers • HOME • Section 515 • Public Housing / HOPE VI	• Section 202 Housing Choice Vouchers • LIHTC • HOME • Section 515 • Public Housing/ HOPE VI • 501(c)(3) Bonds (partial)	• LIHTC (up to 60%) • HOME (up to 65%) • 501(c)(3) • Bonds • GSEs	• HUD Mortgage Insurance • GSEs • 501(c)(3) • Bonds (partial)

FEDERAL HOUSING AND SERVICE INTEGRATION PROGRAMS AND GUIDELINES

Service Coordinators in Multifamily Housing

Service Coordinator positions in multifamily assisted housing were authorized in the 1990 Cranston-Gonzalez National Affordable Housing Act. HUD currently provides funding for service coordinators through three mechanisms: a national competition with other properties for a limited amount of grant funding; the use of the development's residual receipts or excess income; and budget-based rent increases or special rent adjustments.

Owners of Section 202, Section 8, Section 221(d)(3) below-market interest rate, and Section 236 developments may apply for grant funding. Eligibility for funding is limited to those developments designed for the elderly and persons with disabilities, including any such building within a mixed-use project originally designed for them or where the owner — with HUD approval — gives preference to the elderly or persons with disabilities in tenant selection.

Service Coordinator program funding covers service coordinator salaries and benefits as well as administrative and training expenses. Service coordinators routinely assess resident needs, identify and link residents to appropriate services, and monitor the delivery of services. Services involve activities of residents' daily living, such as eating, dressing, bathing, grooming, transferring, and home management. A service coordinator may also educate residents about what services are available and how to use them or help residents build informal support networks with other residents, family, and friends. The service coordinator may not require any elderly or disabled family to accept supportive services.[80]

Resident service coordinators provide an essential role for seniors by:

- Enabling individuals to remain in the least restrictive environment;
- Affording those who suffer from early- to mid-stage dementia and chronic disabilities an alternative to relinquishing their independence;
- Coordinating the most basic of health care needs with community service providers, preventing the pre-emptive movement of seniors to a higher than necessary level of care;
- Navigating the complex array of existing supportive services and eligibility guidelines; and
- Preventing the potential occurrence of acute medical episodes and costly treatments through early detection of apparent changes in health status.

In December 2000, Congress expanded the role of service coordinators through legislation that allows them to also assist low-income elderly or disabled families living in the geographic vicinity of eligible federally assisted housing properties.[81]

Resident Opportunities and Self-Sufficiency Program (ROSS)

The Resident Opportunities and Self-Sufficiency (ROSS) program links public housing residents with resident empowerment activities, supportive services, and assistance in becoming economically self-sufficient. The program is consistent with HUD's goal to focus resources more effectively on welfare-to-work and independent living for the elderly and persons with disabilities.

ROSS incorporates three basic funding categories: technical assistance/training support for resident organizations; resident service delivery models; and service coordinators. The last two categories specifically serve seniors as follows:

(1) Resident Service Delivery Models for the Elderly and Persons with Disabilities. Eligible activities include, but are not limited to:

- Providing personal assistance with daily activities;
- Transporting residents to medical appointments, shopping, and other locations;
- Helping residents maintain their health through nutritional meals, wellness programs, health education, and referrals to community resources;
- Providing congregate services, and
- Making physical improvements to the housing development in order to provide space for supportive services.

(2) Service Coordinator Grants.

These grants enable PHAs to employ Service Coordinators to assist elderly and disabled residents in maintaining independent living. Grant funds may be used to pay salaries, fringe benefits, and related administrative costs (i.e., training, office equipment, and utilities). Since FY 1999, HUD has provided Service Coordinator extension funding under ROSS for grants originally awarded in FY1995. ROSS does not fund new Service Coordinator programs.

Each year, HUD awards grants to PHAs through a competitive grant process set forth in annual NOFAs.

Assisted Living Conversion Program (ALCP)

The FY2000 VA- HUD and Independent Agencies Appropriations (Public Law 106-74) authorized the Assisted Living Conversion Program (ALCP), as a program of grants to non-profit providers of Section 202 facilities to cover the physical conversion of common spaces and some or all residential units within existing projects to operate as assisted living facilities. In 2001, Congress expanded this program to include HUD Section 221(d)(3) BMIR, Section 236 and senior developments with project-based Section 8, including RHS Section 515 projects. Although funds may be used to renovate and reconstruct units and common spaces, no grant funds may be used to pay for or deliver services. The funding level for FY2000 and FY2001 was $50,000,000 per year, with

FY2000 authority carried over to 2001. Due to difficulty in qualifying for and implementing the program, funds have not been fully utilized in either funding cycle.

Congregate Housing Services Program (CHSP)

Congress created the Congregate Housing Services Demonstration (CHSP) program in 1978, and made it a permanent, discretionary grant program in 1990. Each year, Congress provides extension funding for existing CHSP grantees, but has not appropriated funding for new grants since 1994.

CHSP grants subsidize the cost of service coordination and onsite supportive services (i.e., home and community based services) for frail elderly and disabled residents of HUD and RHS subsidized senior housing. The goal of CHSP is to enable aging in place and to prevent premature or unnecessary institutionalization. It was among the first initiatives developed by the Federal Government to provide a comprehensive housing and supportive services package within a subsidized housing environment.

CHSP grant funds are matched through contributions from grantees and private and public funding sources, and through participant fees. This coordinated effort to provide housing and supportive services has given to frail elderly persons whose incomes, and therefore housing and service options, are limited, a higher-quality of life than they would have had without it. CHSP can serve as an alternative to nursing facility placement for many participants.

FEDERAL HEALTH CARE SERVICE PROGRAM DESCRIPTIONS

Medicaid Waivers and Demonstrations

The Federal Government may waive certain Medicaid State plan requirements to allow States to operate specific programs. These programs are referred to as Medicaid waivers. In general, Federal law allows States to enact two types of Medicaid waivers:

- Program Waivers [1915(b), 1915(c), 1915(b)/1915(c) concurrent waivers]; and
- Research and Demonstration Waivers[1115 waivers].

Program waivers, the most common waivers used to support seniors living in the community with services, include the following:

- **1915 (c): Home and Community Based Service Waivers.** Since 1981, Medicaid home and community based services (HCBS) waivers afford States the flexibility to develop and implement creative alternatives to placing Medicaid-eligible individuals in hospitals, nursing facilities or intermediate care facilities for persons with mental retardation.

The HCBS waiver program recognizes that many seniors at risk of being placed in these facilities can be cared for in their homes and communities, preserving their independence and ties to family and friends at a cost no higher than that of institutional care.

Under section 1915(c) of the Social Security Act (the Act), States may request waivers of certain Federal requirements if they wish to develop Medicaid-financed alternatives to home- and community-based care. The three requirements that may be waived are statewide applicability, service comparability, and community income and resource rules for the medically needy. As a result, Medicaid HCBS waivers may allow States to deliver services to persons with incomes that are greater than those allowed under general Medicaid eligibility rules.

To illustrate, in most States, seniors are eligible for Medicaid benefits if their incomes are no higher than the SSI limit. The basic Medicaid benefit provides coverage for services such as primary health and acute care. But Federal Medicaid law allows States to apply special income rules for nursing facility care and the most often applied rule to determine Medicaid nursing facility eligibility permits coverage for seniors with incomes of up to 300 percent of SSI — the "300 percent rule." In 2002, 300 percent of SSI equated to $1,635 per month or $19,620 per year. Under HCBS waiver programs, States may, as with nursing facilities, allow seniors to have incomes up to 300 percent of SSI to qualify for Medicaid HCBS. Medicaid eligibility limits for all covered services are, however, set at the discretion of each State. Consequentially, disparities within and among States exist in Medicaid nursing facility eligibility income limits when compared with HCBS eligibility limits.

Section 1915(c) of the Social Security Act specifically lists the following seven services that can be provided in HCBS waiver programs: case management, homemaker/home health aide services, personal care services, adult day health programs, habilitation, and respite care. A broad range of other services, may also be provided on requested of the State — subject to CMS approval — if they are needed by waiver participants to avoid placement in a medical facility. .

States have the flexibility to design each waiver program and select the mix of waiver services that best meets the needs of the population they wish to serve.[82] HCBS waiver services may be provided statewide or may be limited to specific geographic areas. To be eligible for home- and community-based waiver services, individuals must require the level of care provided in skilled-nursing, intermediate-care, or intermediate-care facilities for the mentally retarded. To obtain approval to implement HCBS waiver programs, State Medicaid agencies must assure CMS that the cost of providing home-and community-based waiver services to persons eligible for waiver services will not exceed the cost of care for the identical population in an institutional setting. The Medicaid agency must also document that safeguards are in place to protect the health and welfare of beneficiaries.

- **1915(b) Freedom of Choice Waivers.** States are permitted to waive statewide applicability and service comparability, and to restrict beneficiaries' choice of provider. These types of waivers are limited in that they apply to existing Medicaid eligible beneficiaries. In addition, authority under the waivers cannot be used for eligibility expansions. There are four types of 1915(b) Freedom of Choice Waivers:

  (b)(1) mandates Medicaid Enrollment into managed care;
  (b)(2) utilizes a "central broker;"
  (b)(3) uses cost savings to provide additional services; and
  (b)(4) limits the number of providers for additional services.

No State can use these waivers to serve beneficiaries beyond Medicaid State Plan Eligibility.

Concurrent Waivers (Combining HCBS with Freedom of Choice Waivers)

Some States are interested in providing long-term care services in a managed care environment or using a limited pool of providers. In addition to providing traditional long-term care State plan services (e.g., home health, personal care, institutional services), some States propose to include nontraditional home and community-based "1915(c)-like" services (e.g., homemaker services, adult day health programs, and respite care) in their managed care programs. No authority is provided under 1915(b) to cover individuals in a special eligibility category (the 42 CFR 435.217 group) who are only Medicaid eligible through a link to a 1915(c) waiver. For these reasons, several States have opted to utilize authorities of the 1915(b) and 1915(c) programs simultaneously to provide a continuum of services to disabled and/or elderly populations. In essence, States use the 1915(b) authority to limit freedom of choice, and the 1915(c) authority to provide home- and community-based services and to expand Medicaid to cover individuals in the special eligibility category listed above.

Nursing Home Transition Grants Program

Beginning in 1998, the Health Care Financing Administration (HCFA – now CMS) solicited proposals from States for the development of programs to assist then current nursing facility residents with the transition to home- and community-based settings. Although many States have developed procedures for diverting prospective nursing facility residents from institutions, far fewer have attempted to design programs that assist nursing facility residents in returning to their communities. The Nursing Home Transition Grant program's purpose is twofold: to provide administrative and service resources to help States develop transition programs; and to set aside technical assistance grant funds for at least one State that is willing to collaborate with one or more Independent Living Centers (ILCs).[83]

Two primary goals of this grant initiative are to establish community support systems and a comprehensive set of choices that will enable current beneficiaries who are residing in

nursing facilities to live safely, maintain and improve their health status, and participate in community life to the fullest extent possible. States need to consider the range of services and supports that will enable people with all levels of disability, including significant disability, to meet those goals and to eliminate barriers that may impede success.

Appropriate housing options are of particular importance. Barriers to effective transition are sometimes found in the regulations, policies, or the organization of the provider network. For example, no provision for nighttime services may exist, assistive technology may be difficult to obtain, or there may be no training available in how to use it. Alternatively, there may be gaps in the supply of quality providers (i.e., attendants or transportation services) or a lack of opportunities for persons with disabilities to direct their own services. As part of the solicitation, States are encouraged to explore ways to develop consumer controlled and other community-based providers, fostering voluntary supports, and create housing opportunities for nursing facility residents who will participate in the transition program.

Medicare Home Health Benefit

Medicare is the largest single payer of home care services. In 1999, Medicare paid for about 26 percent of total estimated home care expenditures. There are very specific eligibility criteria for Medicare home health. Medicare home health provides skilled nursing and related personal care services provided by a certified home health aide to those who meet the need for skilled and intermittent care, and are homebound. Beneficiaries who meet these criteria may also receive needed personal care services. Services must be provided by a certified home health agency.

During the early 1990s, the home health benefit grew rapidly, in part because of changing demographics. This unanticipated growth led Congress to reduce home health expenditures under Medicare by $16 billion over the past five years by limiting annual per-person benefits to home health care agencies, and reducing payments for services. Overall, CMS estimates that almost 900,000 fewer Medicare beneficiaries received services in 1999 than in 1997.

Social Services Block Grant (SSBG)

Administered by the Administration for Children and Families of HHS, Social Service Block Grant (SSBG) funds enable each State to furnish those social services that best suit the needs of individuals who reside in their State.

SSBG funds may be used to provide services directed toward one of five goals:

- To prevent, reduce, or eliminate dependency;
- To achieve or maintain self-sufficiency;
- To prevent neglect, abuse, or exploitation of children and adults;
- To prevent or reduce inappropriate institutional care; and
- To secure admission or referral for institutional care when other forms of care are not appropriate.

HHS allocates SSBG funds to the 50 States, the District of Columbia, and the U.S. Territories, by formula. Section 2003 of Title XX of the Social Security Act specifies how the allotments for each State and jurisdiction are determined. Each State is entitled to payments in an amount equal to its allotment for that fiscal year.

Exhibit 18 shows expenditures for Long-Term Care Services from public and private sources in 1998.

Exhibit 18: Expenditures for Long-Term Care Services

	Nursing Facilities (1998 $billions)	Home Care (1998 $billions)
Medicaid	$40.6	$14.8
Medicare	$10.4	$10.4
Other Public	$2.1	$0.1
Private Insurance	$4.7	$4.0
Out-of-Pocket	$28.5	$6.0
Other Private	$1.6	$3.7
Total	$87.9	$39.0

Source: Citizens for Long-Term Care 2001.

STATE HEALTH CARE SERVICE PROGRAMS

Medicaid Personal Care Services: State Plan Option

Under the Medicaid State plan, personal care services are an optional benefit. . Although individuals who are not undergoing treatment in a hospital on an inpatient basis, or residing in a hospital, nursing facility, intermediate-care facility for the mentally retarded, or institution for mental disease may receive services, such services must be:

- Authorized for the individual by a physician or other health professional in accordance with a plan of treatment or service delivery must be approved by the State;
- Provided by a qualified individual who is not a member of the individual's family; and
- Furnished in a home or other location.

Personal care services may include a range of human assistance provided to persons with disabilities and/or chronic conditions of all ages, enabling them to accomplish tasks that they would be able to complete in the absence of a disability. Assistance may be in the form of hands-on assistance or cueing so that the person is able to perform the task. Such assistance most often relates to performance of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs), such as eating, bathing, dressing, toileting, transferring, personal hygiene, light housework, medication management, etc. Personal care services can be provided on an episodic or continuing basis. . Skilled

services that may be performed only by a health professional are not considered personal care services.

Unlike Medicaid HCBS waiver services, personal care services are available only to individuals who meet Medicaid's basic income eligibility criteria (generally SSI- level income for the elderly). To receive personal care services, however, an individual is not required to demonstrate need for nursing facility level of care. In 2000, 27 states provided personal care coverage under their State plans.[84]

Title III—State And Community Programs

The Older Americans Act of 1965, as amended (OAA) authorizes a range of programs that offer services and opportunities for older Americans, especially those at risk of losing their independence. Under Title III - State and Community Programs, the Administration on Aging (AoA) oversees a nationwide network of agencies that focus on aging, including Regional offices, State Units on Aging (SUAs) and Area Agencies on Aging (AAAs). These agencies plan, coordinate, and develop community-level systems of services that meet the unique needs of older persons and their caregivers.

Title III supports services designed both to assist older persons at risk of losing their independence and to enhance the lives of active older persons. Through Title III, AoA advocates for the needs of the elderly in program planning and policy development by, providing technical assistance and by issuing best practices guidelines.

AoA awards funds for Title III to the 57 SUAs, which are located in every State and territory. Program funding is allocated based on the number of older persons in the State.

Most states are divided into Planning and Service Areas (PSAs) so that programs can be effectively developed and targeted to meet the unique needs of the elderly residing in those areas. Nationwide, some 670 AAAs receive funds to plan, develop, coordinate, and arrange for services in each PSA from their respective SUAs.

AAA's contract with public or private groups to provide services. More than 27,000 service provider agencies operate nationwide, and in some cases, they AAA may act as the service provider, if no local contractor is available.

Although the Act directs that priority be given to serving those with the greatest economic and social need —with particular attention to low-income minority older persons — all individuals age 60 and older are eligible for services. Limits in program funding often result in waiting lists for OAA services.

Until recently, no mandatory fees existed for services. Recent legislative changes, however, now allow States to implement participant cost sharing for services received. Older persons also are encouraged to make voluntary contributions to help defray the costs of services. Under current law, these contributions are used to expand services. Volunteer support is also an integral component of the service system.

Title III- B Supportive Services

In FY 2002, Congress appropriated $357 million for supportive services and senior centers. Most supportive services fall under three broad categories:

- Access services, such as transportation, outreach, information and assistance, and case management;
- In-home services, including homemaker and home health aides, chore maintenance, and supportive services for families of older individuals who have Alzheimer's disease; and
- Community services, such as adult day programs, legal assistance, and recreation.

Supportive services are designed to maximize the informal support provided by caregivers and to enhance the capacity of older persons to remain self-sufficient. During FY 1999, information and assistance services were provided to more than 12 million older persons and their caregivers. More than 8 million outreach contacts were also made to identify older persons in need of access to services. Transportation continued to be one of the most heavily used services. The OAA funded nearly 46 million trips by older persons to their doctor, clinic, senior center, or other location. Of Title III participants, 19 percent were minorities and 51 percent were low-income.[85]

Title III-C Congregate and Home-Delivered Meals

Nutrition services are provided under Title III-C of the Older Americans Act. The title contains two Parts, Congregate Meals (C-1) and Home-Delivered Meals (C-2). The services provided under these two parts are similar, however, Congregate Meals are targeted to active seniors, while Home-Delivered Meals are delivered to the homebound.

There is substantial private sector, State, and local financial and volunteer support for meal programs. Although older participants are not charged a fee, they are encouraged to make voluntary contributions to help defray the cost of services. Under current law, these contributions are used by local programs to expand services. In FY 2002, Congress appropriated $390 million for Congregate Meals and $176.5 million for Home-Delivered Meals. In FY 1999, nearly 884,000 seniors received Home-Delivered Meals and nearly 1.8 million received Congregate Meals.[86]

National Family Caregiver Support Program

The Older Americans Act Amendments of 2000 enacted the National Family Caregiver Support Program. This program calls for all States to provide five basic services for family caregivers, including:

- Information about available services;
- Assistance in gaining access to supportive services;
- Individual counseling, organization of support groups, and caregiver training to assist caregivers in making decisions and solving problems relating to their caregiving roles;

- Respite services to give caregivers temporary relief from their responsibilities; and
- Supplemental services, on a limited basis, to complement the care provided by caregivers.

In FY 2002, Congress appropriated $141.5 million for this program.

OTHER CONSIDERATIONS

Market Rate Housing

Market rate (i.e., moderately priced) housing fills an important niche for our Nation's seniors. Many properties offer amenities tailored to senior households, such as security, community rooms, wellness centers, dining, and other supportive services. Most are not subsidized in any significant way, and for the most part use private financing; however, some non-profits rely on tax-exempt financing to develop market rate apartments.

Many types of market rate products fill the two major categories of market rate housing — apartments that provide housing only in a secure environment; and apartment communities that offer services in addition to housing. These community alternatives generally address the housing needs of seniors whose incomes are too high to qualify for subsidized senior housing admission, yet not high enough to afford either assisted living facilities or continuing care retirement communities. A recent analysis by the America Senior Housing Association estimated that approximately 1.1 million apartments of this type now exist nationally, providing a valuable resource in reaching the moderate-income senior market.[87]

Continuing Care Retirement Communities[88]

Continuing Care Retirement Communities (CCRCs) describe a diverse group of campus type retirement communities that provide a continuum of housing, health care, supportive services, amenities and activities. CCRCs can be made up of apartments, cottages, or a variety of other independent living spaces located in a single community. They may be urban, suburban or rural, and may range from garden style to high-rise structures. CCRCs are not homogenous; each has an array of differences, while preserving the core elements that allow them to be described as a “CCRC.”

A key way in which CCRCs differ is in the degree of health care coverage included for the resident. Extensive or “full life care” agreements generally include housing, residential services, amenities and unlimited, yet specific health-related services for the life of the resident. Such agreements may feature little or no substantial increases in monthly payments for enhancements such as additional meals or incidentals; however, there may be periodic increases for normal operating costs or adjustments for inflation.

Modified agreements generally include housing, residential services, amenities and a limited, specified amount of skilled nursing care. A number of variations may be found in these contracts; however, substantial increases in monthly payments are not common.

Fee-for-service agreements, which are often termed "*a la carte*," generally include housing, residential services and amenities as specified in the individual agreement. Health-related services are commonly paid for as they are needed and utilized.

Access to and availability of health care services either within or in close proximity to a CCRC are at the heart of the CCRC care concept. Health-related services may include the following:

- Emergency response systems;
- Resident health clinic;
- Wellness and health education programs;
- Hospice services;
- Nursing consultation;
- Primary and specialty physician services;
- Podiatric and dental care;
- Pharmacy or pharmacy services;
- Physical, occupational and/or speech therapies;
- Assisted living; and
- Skilled nursing care.

Although significant variations in service delivery may occur, typical services that may be available at a CCRC include the following:

- Meals, including prescribed diets;
- Grounds and unit maintenance;
- Routine and/or heavy housekeeping;
- Social, physical, religious, recreational, cultural and activity programs;
- Scheduled transportation;
- Bed and bath linens;
- Security systems; and
- Social services and counseling.

Amenities may include banking, exercise rooms or postal services - to name a few.

CCRCs ownership is equally diverse. Non-profits, for-profits, partnerships, syndicates (i.e., a number of investors), residents or an individual may be involved in the ownership of a CCRC. Many are accredited by the Continuing Care Accreditation Commission (CCAC), an independent entity sponsored by the American Association of Homes and Services for the Aging (AAHSA) that evaluates quality and a variety of other factors before issuing its seal of approval to communities.
CCRC's are affordable to moderate-income seniors, especially those who own their own homes and can convert that asset to accommodate entry fees. Fee structures for CCRCs are as diverse as the CCRCs themselves. Many have different structures depending on the level of services required. Entry fees are usually tied to the size of the living unit.

Hundreds of thousands of seniors have availed themselves of the CCRC option and their popularity is growing. Creative structuring of agreements and other cost-saving

mechanisms will likely make this option more widely available to future generations of seniors.

Comparing Costs in Promoting Aging in Place

In accordance with our Mandate, the Commission reviewed the comparative costs of housing production and housing vouchers in promoting aging in place.

In January 2002, the General Accounting Office (GAO) released a report that compared the costs of various Federal housing programs. [89] The study covered all active Federal housing programs, estimated the 30-year lifecycle costs of each,[90] and found that the Housing Choice Voucher program is less costly than production programs.

In metropolitan statistical areas (MSAs), GAO found the average total 30-year cost of a one-bedroom unit to be $140,000 for vouchers, $151,000 for Section 811, $157,000 for Section 202, and $167,000 for tax credit projects. According to the Report, "for all of the programs except tax credits, the Federal Government pays the largest percentage of the average total per-unit costs (from 65 percent for vouchers to 71 percent for HOPE VI over 30 years). Under the tax credit program, the tenants pay the largest share of the total cost (54 percent over 30 years); however, they have higher incomes, on average, and pay a larger percentage of their income for rent than other assisted households."

The Commission recognizes the importance of cost comparisons among Federal housing programs, but believes that both rental assistance and the production of new housing units are needed. In a response to the GAO study, David Smith states,[91] "The biggest message of the study is not that the costs are different, but that they are roughly the same. Hence the focus should be less on choosing one form over the other, and more on providing a better mix of programs within markets and making each one work as efficiently as it can given its mission and parameters…The bottom line is that housing very poor households is expensive for the Federal Government under all programs."

In addition, the GAO comparison, by focusing on housing costs only, does not take long-term health care costs into consideration. In assessing the benefits of the Section 202 program and other affordable housing programs relative to their costs, it is important to factor into the equation the longer-term financial consequences of inadequate health maintenance on other government programs serving the elderly such as Medicare and Medicaid. All too often, cost-benefit analyses in housing do not adequately evaluate the benefits of services.

Thus, a service-enriched project such as one sponsored under Section 202 can result in a cost saving to the government that is not immediately evident in an analysis of housing costs alone. Similarly, other production programs such as LIHTC, HOME, and CDBG programs, and RHS Section 515 programs can result in cost-savings if they can be redesigned to provide services and health maintenance programs to achieve these benefits. These programs are not exclusively dedicated to serving seniors, although the housing facilities produced through them can be "seniors only" facilities.

Olmstead Decision

The *Olmstead* decision provides a legal basis to advocate for community-based alternatives to institutional placement — including an expansion of housing- and community-based service options.

In July 1999, the Supreme Court issued the *Olmstead v L.C.* decision — a decision that upheld Title II of the Americans with Disabilities Act (ADA), which required that States administer their services, programs, and activities "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." This decision creates a challenge to Federal, State, and local governments to increase opportunities for qualified individuals with disabilities to return to, or stay in, the community and to receive appropriate community-based services.

Medicaid is an important resource for helping States meet these goals because it is such an important source of funding for long-term care services. But, the decision's scope is not limited to Medicaid beneficiaries. ADA and the *Olmstead* decision cover services, programs, and activities provided or made available by public entities — government agencies at all levels — to all qualified individuals with disabilities, regardless of age or income.

Long-term Care Insurance

Private long-term care insurance (LTCI) was introduced during the past 2 decades and is, thus, a relatively new product. Sales of LTCI policies have grown substantially over the past 5 years, encouraged, in part, by the enactment of the Health Insurance Portability and Accountability Act (HIPAA). HIPAA established favorable tax treatment for "federally qualified" policies that meet certain consumer protection standards and developed minimum disability criteria needed for the beneficiary to trigger benefits. As of 1999, more than 6.8 million LTCI policies were sold in the United States. Private insurance pays for less than 7 percent of all long-term care costs. Thus, it plays only a small role in financing long-term care.

The cost of LTCI is substantial, especially for persons who wait until they are in their 70s to make a purchase. Policies are generally sold with a "level premium" — meaning that the insurer may not raise premiums based on individual circumstances, such as increasing age or the onset of disability. In practice, however, insurers can, and often do, raise premiums for "classes" of individuals; when this happens, the policy may become unaffordable. In addition, policyholders who let their insurance lapse generally lose their entire investment, and are left without coverage when they are most likely to need it.

Policies are most affordable if purchased during the policyholder's 50s or 60s. These younger purchasers should expect to pay premiums for 20 or more years, because the risk of disability is greatest at age 80 and older. This fact makes the purchase of inflation protection critical; however, it also contributes to a more costly product. In 1999, average annual premiums for a policy that included inflation protection were $1,800 for purchase at age 65 and $5,900 for purchase at age 79.[92] The cost of private LTCI is

unaffordable for many, if not most, seniors. Many applicants are disqualified because they are unable to meet medical underwriting standards.

Despite its limited role, LTCI has a number of advantages. Persons who can afford coverage can insure themselves against the high cost of long-term care, preventing depletion of their assets and preserving an inheritance for their children. In addition, they preserve choices as to the type, setting, and provider of care — should they become disabled. LTCI enables individuals to act responsibly in planning for their future needs, thereby preserving limited Medicaid funds for the most needy.

Congressional legislation has been introduced to allow full deductibility of LTCI insurance premiums for individuals who have maintained continuous coverage over several years. Encouraging people who can afford to plan for their future by purchasing insurance and developing more affordable products can be part of an overall long-term care financing strategy that addresses the needs of persons with moderate incomes.

PART V: RECOMMENDATIONS

Between now and the year 2020, this Nation must begin to meet one of the most profound domestic challenges it has faced in a century. America must provide — through public and private means — housing, health care, and supportive services for tens of millions of men and women who will reach their senior years as the Baby Boomer generation ages.

Fortunately, the United States has the capacity to meet the needs of an aging population. It takes time, however, to plan for a societal shift of this magnitude. Planning must begin now. In Part V, the Commission presents guiding principles and recommendations that respond to the Mandates in the authorizing legislation.

Understanding the Needs of Seniors

In seeking to understand the needs of seniors, the Commission drew on testimony of witnesses, research reports, informal conversations with the country's leading authorities on housing and health care facilities for seniors, leaders of advocacy and faith-based groups, and many others. *Accessibility*, *affordability*, and *availability* became key words in describing not only seniors' housing needs, but their service needs as well. *Accessibility* is a physical environment free of barriers and open to supportive services, through transportation, service coordination, and local service networks. *Affordability* is low-cost housing accommodations and the inexpensive purchase of services and health care that contribute to independent living. In many communities — urban and rural alike — *availability* of housing, services, and health care is a major problem; services are simply not there and no amount of money can buy them.

Commission members repeatedly heard a key message through the words of our witnesses: the importance of their homes to seniors' dignity and well being cannot be overstated. A senior cannot be healthy or maintain quality of life without a decent home. The home — an apartment, an assisted living residence, a single-family dwelling, or a manufactured home — is central to a senior's life.

The Commission heard the merits of living in one's own single-family dwelling in the community as well as the benefits of living in a "seniors only" community. Witnesses shared the positive experiences of intergenerational communities and told of the challenges associated with homeless seniors. Witnesses asked for more flexibility in Federal programs, and told of the current confusing and often conflicting array of program rules. We heard that there are simply not enough resources committed to meeting the housing, health, and supportive services needs of seniors. Seniors who had elected to move to a specialized senior living community told of their reasons for that move — death or illness of a spouse, companionship and socialization, the need to be in an environment that is safe and secure, transportation services, affordability, and access to services**.**

Developing Policy Responses to Seniors' Needs

Maximizing independence, staying in control of one's life decisions, aging with dignity – these are qualities that Americans value as they age. Surveys reveal that, even as people age and begin to need assistance with daily tasks, they want to stay in their own homes for as long as possible. Fear of entering a nursing facility is a serious concern of many seniors, not only because of the high cost of institutional care, but also because of the perceived loss of autonomy and control. Seniors also fear becoming dependent on others, and want to avoid being a burden to their families. This strong desire of Americans — for a healthy and dignified old age is at the heart of this Nation's long-term care debate.

The Commission's recommendations recognize that appropriate and affordable housing and accessible, high-quality services are equal partners in creating a workable equation for quality of life during the aging process. A person's ability to function can be enhanced or impeded by his or her physical and social environment. As people age and begin to need help with daily tasks, independence and quality of life can depend on their ability to access and pay for the services they need, in the environment that best supports an appropriate balance between autonomy and safety.

The Commission came to understand the necessity of flexibility in responding to seniors' needs. For example, diverse paths can lead to a senior's need for long-term care and supportive services. These paths usually lead the senior, first, to increasing contact with the health care system and the medical professions. Eventually, this path may also lead the senior to a reconsideration of "home" — and a heart-wrenching decision about whether or when to leave for institutional care.

Numerous factors influence an aging senior's life including chronic and progressive health conditions, such as multiple sclerosis, diabetes, or Parkinson's disease, any of which can lead to loss of function and mobility. A sudden event, such as a fall or a stroke, can result in long-term functional disabilities. Cognitive impairments, such as Alzheimer's disease, can make it unsafe for an individual to live in an unsupervised setting. Health conditions such as arthritis, heart disease, and severe vision or hearing loss — alone or in combination — can make it progressively more difficult for seniors to engage in self-care, mobility, and housekeeping tasks.

In addition to physical conditions, economic realities may begin to close in on the senior. Loss of a spouse can diminish or end family income. Taxes and maintenance on the home may rise above ability to pay. Supportive family members may move away. The home itself, lacking appropriate accommodations for senior occupants, may become unsafe or unsuitable for a senior. Failing eyesight or other limitations may prevent the senior from driving — a dramatic change in mobility for anybody, and even more consequential for many seniors. The aging process brings to seniors changing realities both in personal health and in home accommodations.

The Commission found that the first step in developing guiding principles and recommendations is to understand what seniors want, what seniors themselves are ready to do on their own behalf, and where the seeds of solutions can be found. Therefore, the

Commission's approach centers on choice. The Commission believes that seniors should have opportunities to choose the services they use, where and how they receive services, and where they live.

The Commission recommends financing tools and linkage systems that promote choice. Its recommendations take into consideration the projected need for choice in housing and the importance of supportive services to maximize independence.

Based on these considerations, the Commission developed five guiding principles for its recommendations:

> **Preserve** the existing housing stock;
> **Expand** successful housing production, rental assistance programs, home- and community-based services, and supportive housing models;
> **Link** shelter and services to promote and encourage aging in place;
> **Reform** existing Federal financing programs to maximize flexibility and increase housing production and health and service coverage; and
> **Create and Explore** new housing and service programs, models, and demonstrations.

The Commission follows this formula, recommending policies that preserve existing stock, recommending expansion to policies that work, recommending linkages to remove barriers, recommending reforms to improve policies, and recommending new policies to meet changing needs.

RECOMMENDATION NO. 1
PRESERVE THE EXISTING HOUSING STOCK

First and foremost, we must save what we have. Just as the production of new units is critical and necessary to meet the future needs of seniors, so also is the simultaneous need to focus on preserving and improving existing affordable senior housing. While the goal of preservation may be obvious, it is not always clear how this stock can be held in the affordable inventory and be recapitalized and renovated. Affordable senior housing, like its occupants, is undergoing an "aging process." Much of it was developed through private/public partnerships more than three decades ago and much of the stock is itself in need of updating and repair. In many cases, use restrictions requiring low-income occupancy are expiring. Not surprisingly, as the average age of the population in this housing has climbed, so have the needs of seniors. The dilemma that confronts us is how to both preserve their homes and, simultaneously, meet their changing needs.

This country is losing affordable senior housing in alarming numbers. A report prepared for this Commission by the National Housing Trust noted that 250 properties serving primarily seniors have either prepaid their HUD mortgages or opted out of their Section 8 contracts since 1996, resulting in a loss of 20,000 units of senior housing.[93] Moreover, the Trust determined that at least 4,400 older properties, consisting of more than 324,000 Section 8-assisted apartments, are "at risk" of being converted to market rate rentals.[94]

Exhibit 19: Analysis of Primarily Senior Housing and Units Currently At Risk[95]

Financing Type	Primarily Senior Properties		Units Lost through FY2001		Units at Risk of Loss (Rents <=110% of FMR)		Ability to Refinance[96]		Ability to Refinance AND at Risk of Loss	
	Prop.	Units	Prop.	Units	Prop.	Units	Prop.	Units	Prop.	Units
202s[97]	4,468	285,356			2,000	125,692	1,674	99,271	358	23,616
236 & 221(d)(3) BMIR	657	91,956	99	11,024	545	52,820	532	51,934	532	51,934
Other Section 8[98]	5,344	425,790	155	9,040	1,864	145,489	375	31,205	80	7,347
TOTAL	10,469	803,102	254	20,064	4,409	324,001	2,581	182,410	970	82,897

The States with the greatest potential losses are California with 37,356 units, New York with 25,330 units, Massachusetts with 21,648, Michigan with 19,492 units, and Ohio with 18,448 units. In addition to being at risk of being lost from the affordable housing inventory because of government policy that allowed the prepayment of the mortgages after a certain compliance period, in many cases, these affordable housing units are in need of repair and renovation. Much of the previously constructed senior housing stock did not include space for supportive services and virtually all of the early design was not barrier-free, making it difficult for these developments to serve the frail seniors.

A great many States are already devoting considerable resources, including the creation of "set-asides" under the Low-Income Housing Tax Credit (LIHTC) program, for the preservation of the subsidized housing stock; however, much more can be done. The data reveal that this problem will grow in the coming decades. The Federal Government has

an important role to play, including encouraging State and local governments to direct resources to maintaining this unique housing stock.

Congress needs to take immediate steps to ensure that this Nation does not continue to lose its existing stock of senior units as we prepare to meet the coming need for new units in the next two decades.

RECOMMENDATION 1.1: ENCOURAGE THE PRESERVATION, RENOVATION, AND REFINANCING OF AFFORDABLE HOUSING PROJECTS

The Commission is greatly concerned about the potential loss of hundreds of thousands of affordable senior units and has developed the following recommendations to ensure the preservation of existing housing stock.

1. Congress should enact legislation to support preservation, renovation, and refinancing of federally assisted housing for low- and moderate-income seniors, including providing specific appropriations.

2. HUD should establish an ongoing database with project-specific information on primarily seniors, subsidized properties that have a) Section 8 contract rents at or below market, b) loans with significantly high current interest rates, c) low REAC scores, and/or d) high vacancy rates. These properties are potentially at high risk of mortgage prepayment and should be placed on an "early warning" list to be shared with HUD regional offices, State housing finance agencies, the Rural Housing Service (RHS), and the general public.

3. HUD should preserve the Section 236 senior housing stock, through (a) providing information to owners of existing HUD-insured, Section 236 properties primarily serving seniors, including a simple explanation of how the owner can refinance using the value of the Section 236 Interest Reduction Payments (IRP) to leverage additional debt for the purpose of rehabilitating the property and keeping it affordable, and (b) creating a program for use of the recaptured IRPs that are now in a pool at HUD, and using at least a third of these funds for the preservation and improvement of existing HUD-insured, Section 236 properties serving primarily seniors.

RECOMMENDATION 1.2: PRESERVE THE EXISTING STOCK OF SECTION 202 UNITS AS AFFORDABLE SERVICE-ENRICHED HOUSING AND ENCOURAGE THE RENOVATION AND REFINANCING OF SECTION 202 PROJECTS.

The Section 202 program is 43 years old and has financed more than 300,000 units for low-income seniors over the years. The Commission received significant testimony regarding not only the need to preserve the older Section 202 stock because of its physical condition, but also the need to preserve its affordability. The majority of Section 202 mortgages have clauses that require HUD's permission to prepay, but nearly 100,000

units built from 1977 through 1981 had mortgages allowing prepayment *without* HUD's permission.

In an effort to provide incentives to Section 202 sponsors to retain affordability and to finance needed repairs and renovations, HUD has issued guidelines for refinancing those projects that have the right to prepay their mortgages. For those projects requiring HUD's permission to prepay, HUD guidelines for prepayment approval and refinancing require (a) continuing the project's non-profit status, (b) executing a Use Agreement assuring long-term affordability, (c) honoring the Section 8 rental assistance contract, (d) maintaining a certain level of reserves, and, more recently, (e) making at least half of the resulting Section 8 savings available to the owner to cover the costs of retrofitting buildings (1) to provide supportive services , (2) to build new service facilities in or adjacent to the building, and/or (3) to build affordable assisted living facilities that could be accessed by the Section 202 residents.

Congress also authorized ownership of a 202 development by a limited partnership, provided a private non-profit organization is the sole general partner of the partnership. This change was intended to allow Section 202 non-profit sponsors to take advantage of the equity that can be raised through the sale of Low-Income Housing Tax Credits (LIHTC). However, HUD has so far implemented this important provision of the legislation only for new Section 202 developments.

In order to preserve this important segment of the senior housing market and to take full advantage of private sector equity and loan resources, the Commission requests the Congress to:

1. Direct HUD to encourage retrofitting of buildings to include necessary space for services and programs, to accommodate an aging, frail population. This is particularly important to projects funded between 1982 and 1989, when HUD introduced a series of cost-containment measures, including a requirement that one-fourth of the units be efficiency units. Projects built during this period have few design features and limited common space for supportive service provision.

2. Direct HUD to streamline and expedite mortgage prepayments and refinancing opportunities that may result in improved quality of life for the senior residents.

3. Direct HUD to utilize its authority to allow limited partnership ownership structures in accordance with legislative authority. This will allow Section 202 projects access to the LIHTC program.

4. Direct HUD to promulgate regulations that allow the Section 202 debt to be subordinated to new debt brought in with tax credits. This would allow some of the earlier Section 202s with interest rates ranging from 3 percent to 8 percent to keep current mortgages in place yet avail themselves of new equity.

5. Encourage HUD to prepare and distribute information to Section 202 owners regarding the comparative costs and benefits of prepaying loans with 501(c)(3) bonds or refinancing with new debt and LIHTCs.

6. Revisit whether to waive all or part of the existing debt on Section 202 properties supported by Section 8, similar to the current 202 PRAC program.

RECOMMENDATION 1.3: CONTINUE TO ENCOURAGE THE RENOVATION OF OUR AGING PUBLIC HOUSING STOCK AND ALLOCATE RESOURCES TO HOUSING AUTHORITIES TO PROVIDE SERVICE-ENRICHED HOUSING

It is estimated that between 600,000 and 700,000 persons over 62 years of age live in public housing.[99] This number will increase in the coming years due to the aging of those currently living in public housing. In addition, the number of seniors eligible for public housing will dramatically increase.

Public housing for seniors was designed as independent housing. The characteristics of the stock do not make it easy for residents to age in place. Moreover, two-thirds of senior public housing residents live in buildings that are over 30 years old. According to a HUD study, funding the backlog of modernization applications for senior public housing developments will cost $4.8 billion. Some public housing agencies are beginning to make inroads by creatively combining other resources with agency funds to develop service-enriched housing and assisted living facilities. Some interesting examples identified by the Housing Research Foundation include:

- The Miami-Dade Housing Agency in Florida has linked Medicaid waiver funding with low-income housing subsidies to provide basic assisted living and health services to low-income seniors living in an assisted living facility. The Miami-Dade Housing Agency reports that the yearly cost to support one resident is $12,000 versus $38,000 in a nursing facility.

- The Housing Authority of the City of Milwaukee, Wisconsin, transformed an independent living development into a continuing care facility by partnering with local service providers, which provide onsite health care and supportive services.

- The Littleton Housing Authority of Colorado used tax credits, bonds, and its own funds to develop assisted living apartments[100].

Other examples from testimony before the Commission include:

- The Syracuse Housing Authority has converted numerous units to make them more accessible and has partnered with a local continuum of care provider to ensure access to supportive services for its senior residents.

- The Cambridge, Massachusetts, Housing Authority took over an obsolete city old age home and converted it into an assisted living development using low-income housing tax credits, HUD 232 mortgage insurance, historic tax credits, CDBG and HOME funds, and other funding sources including State, city and Federal Home Loan Bank funds. It is also building a small new nursing facility nearby to replace capacity still needed.

These are noteworthy examples, and Congress and HUD should allocate resources to allow other PHAs to emulate these successful models. One such vehicle could be the Elderly Housing Plus Health Support Demonstration Act, which is legislation pending in Congress.

RECOMMENDATION 1.4: ENCOURAGE UTILIZATION OF HOPE VI MODERNIZATION FUNDS TO BUILD NEW INDEPENDENT AND ASSISTED LIVING FACILITIES FOR SENIORS AND TO RETROFIT HOUSING STOCK TO MAKE THE NECESSARY UNIT AND PHYSICAL PLANT IMPROVEMENTS TO BETTER SERVE SENIOR AMERICANS. REQUIRE THE DEVELOPMENT OF A RELOCATION PLAN FOR SENIORS THAT ASSURES EACH DISPLACED SENIOR AN AFFORDABLE, ACCESSIBLE LIVING UNIT WITH APPROPRIATE SERVICES.

The HOPE VI program, which is used to demolish and revitalize distressed public housing, is the only public housing program that has received significant funding in the Past few years. Between 1996 and 2001, $293 million was appropriated to demolish the housing, and $4.8 billion was dedicated to its reconstruction or revitalization.

Because HOPE VI requires significant displacement, however, it has frequently had a negative impact on senior residents. A comprehensive relocation program for senior residents should be an essential component for approval of any HOPE VI development plan. Because it is the main source of new funding for housing authorities, HOPE VI funds should accommodate the needs of future elderly residents - which includes an affordable, accessible living unit - providing an exemplary model of intergenerational communities.

RECOMMENDATION 1.5: CONGRESS SHOULD FUND THE MODERNIZATION AND REPLACEMENT OF OUT-OF-DATE CAPITAL ITEMS AS WELL AS ADDITIONAL SPACE FOR SUPPORTIVE SERVICES AND PROGRAMMING.

Many senior housing facilities have "aged" and need modernization and/or retrofitting. Congress should provide authority and funding for grants to HUD and RHS multifamily assisted senior housing developments to fund the modernization and retrofit of out-of-date capital items (such as elevators, heating and cooling systems, roofs, plumbing, and sprinkler and security systems) in order to accommodate supportive services to aging residents and assure quality of life, accessibility, and marketability.[101] These developments are often facing critical repair and modernization needs. Neither HUD nor RHS is now able to provide direct funding to ameliorate these problems. Although CDBG and HOME funds do pay for such activities, these funds are administered by State and local governments and are available to any low-income housing needing rehabilitation. As a result, HUD and RHS developments do not generally benefit from these block grant funds.

In many cases, such rehabilitation is also necessary to meet new, more stringent architectural accessibility requirements and to provide space for the provision of

supportive services. This assistance will maintain a high-quality living environment for the senior residents and will preserve much-needed senior housing stock.

RECOMMENDATION 1.6: CONGRESS SHOULD CONTINUE TO SUPPORT PROGRAMS FOR SENIOR HOMEOWNERS TO MAINTAIN THEIR HOMES AND MAXIMIZE THEIR ABILITY TO LIVE THERE AS LONG AS POSSIBLE.

For most seniors, their housing choice is to remain in their own homes as long as possible. An AARP study finds that more than 80 percent of seniors would prefer to stay in their current dwellings and never move. Approximately 68 percent of Americans now live in homes they own, primarily single-family dwellings, and fewer than 20 percent of seniors live in apartments. [102]

Many seniors may not have supportive service needs, but their ability to remain in their homes is threatened by health and safety issues resulting from poor maintenance or disrepair. The 1999 American Housing Survey indicates that about 5 percent of senior owners (809,000) and 11 percent of senior renters (447,000) occupied dwellings with either severe or moderate physical problems. Not surprisingly, housing disrepair correlates directly with housing age, the poverty of its occupants, and their age.[103] Often, a small infusion of financial assistance can enable senior homeowners to make essential repairs or modifications, thus giving them the option to safely remain in their homes much longer.

Currently, the Federal Government funds a number of programs that provide home repair, modification, rehabilitation, and weatherization assistance to senior homeowners and renters and to rental housing owners. These programs include HUD's CDBG and HOME Investment Partnership programs; the Rural Housing Service's Section 533 Housing Preservation Grants, Section 504 Rural Housing Repair and Rehabilitation Loans and Grants; the Department of Health and Human Services' Older Americans Act Title III programs and Medicaid; and the Department of Energy's Weatherization Assistance for Low-Income Persons.

At the State level, for example, the New York State Division of Housing and Community Renewal (DHCR) has developed a competitively funded home repair grant program called the Emergency Home Repair Program for the Elderly (RESTORE). Thus far, over 150 groups covering 57 counties have received RESTORE awards to repair over 1,500 homes.[104]

The most significant issues seniors face that can be helped by home modification and assistive technology are: getting in and out of the house, walking up and down stairs, and safely using the bathroom. The most frequently needed modifications are faucet and cabinet adaptations, stair lifts or elevators, bathroom access, ramps, and curbless or roll-in showers.[105] A well-insulated home or a structure free of physical deterioration allows seniors to focus on other more important aspects of their lives and gives them the freedom to remain safely in their homes.

Moreover, some seniors can be helped by innovations in assistive technology (AT) that can actually be used to substitute for long-term care services in the home and prevent the

need for institutionalization. In testimony to the Commission, Johns Hopkins University Professor Sandra Newman noted that, "…housing modifications and assistive devices promote independent living (but)…it is difficult for the consumer to find the right source of help, and (there are) inconsistent standards of need and little coordination among funders."

Investments in new assistive technologies hold promise for cost savings and better delivery of services. The range of AT is becoming extensive and innovative. Basic assistive devices can include a bath seat or a shower grab bar. The latter may allow the senior to bathe without the help of a caregiver and will decrease the probability of a fall in the shower. Technological devices include in-home personal computers that can be used for telemedicine and teletherapy purposes. Evidence is building that AT can substitute for or lessen the frequency of caregiver visits, both formal and informal. Homes that have been modified to meet the changing needs of seniors can help them safely maximize the years spent in their preferred setting.

RECOMMENDATION 1.7: RECOGNIZE MANUFACTURED HOUSING AS AN AFFORDABLE HOUSING OPTION AND ENCOURAGE REASONABLE FINANCING PRODUCTS.

More than 2.5 million senior households live in manufactured housing.[106] That represents significantly more seniors than all of those served by all of HUD's assisted housing programs, including public housing, Section 202, Section 236, and Section 8. While manufactured housing is not subsidized by the government and does not have income limits for residents, it serves many lower income households because it costs less than most other homeownership options.

As is evident by findings in a report prepared for the Commission in Appendix G, policymakers at the Federal and local levels need to recognize manufactured housing as an affordable housing option, particularly for low- and moderate-income seniors. As is the case of seniors living in other types of housing, residents of all types of manufactured homes must be protected to ensure that their homes meet basic housing quality and safety standards both in manufacture and installation. In order to keep housing costs stable and affordable, the Commission recommends that financial institutions provide long-term financing of manufactured housing with long-term amortizations and without balloon payments.

RECOMMENDATION NO. 2
EXPAND HOUSING PRODUCTION AND SERVICES

A housing crisis is on the horizon. The dramatic, unparalleled increase in the sheer numbers of persons over age 65 will do more than challenge our housing resources – it will exhaust them, unless we are ready. A major effort at increasing the public and private production of housing designed for seniors *must begin immediately* if the Nation is to meet the needs of increasing numbers of seniors, especially for those seniors requiring services.

While the Commission first recognizes and urges preservation of existing housing stock, we believe that more housing units must be created. We recommend the production of a variety of housing types, serving persons of low, moderate, and middle incomes, ranging from single-family home communities to service-enriched senior apartments to Continuing Care Retirement Communities (CCRCs).

Financing this broad and far-reaching level of production will be a challenge. At the Federal level, the Commission looks to the Section 202 program and Housing Choice Vouchers to serve extremely low-income seniors. Through recent increases in the *per capita* allocations on housing tax credits and housing bonds, and emerging State priorities for senior housing, the Commission is encouraged that seniors with low and very low-incomes will benefit from increased housing production. Through Commission recommendations for reform of the HUD mortgage insurance programs, and for greater participation by Fannie Mae, Freddie Mac, and the Federal Home Loan Banks, we expect increased production that will help meet the housing needs of low- and moderate-income seniors.

As the number of older age seniors increases, so does their need for health care and supportive services. In 1997, 18 percent of seniors age 65 and over living in the community required assistance with everyday activities--that is, Activities of Daily Living (ADL) or Instrumental Activities of Daily Living (IADL). As seniors age, their need for assistance increases significantly. For seniors 65-74 years old, 1.8 percent needed assistance with three or more ADLs, compared with 5 percent of the 75-84 year old seniors and 11 percent of the 85+ year old seniors in 1997.[107] Buildings need to be designed to accommodate the delivery of services to this vulnerable group.

Reliable data about the number of new units being produced each year for seniors is difficult to obtain and, in some instances, nonexistent. Today's production programs that serve predominantly seniors with incomes below 80 percent include HUD's Section 202 program, the LIHTC, HOME, and projects funded with tax-exempt housing bonds. The Section 202 program is currently producing 5,800 units per year. The LIHTC program is currently producing an estimated 13,200 rental units for seniors[108] each year, and a recent 40 percent increase in the tax credit program could increase this production level to 18,000 units beginning in 2002.

Although not a production program, Housing Choice Vouchers can provide unit affordability for seniors, thus addressing an important need where a suitable housing unit is available, but not affordable. Only 17 percent of Housing Choice Vouchers now in use are held by senior households, and a recent HUD-commissioned study indicates that

senior households have only a 54 percent success rate in locating suitable housing under this program.

Through the two major Federal production programs – Section 202 and LIHTC – the Nation has the current capacity to address the needs of an estimated 22,800 new senior households each year. No statistics are available on the number of seniors assisted through home repair programs, HOME, and tax-exempt bond programs. Even more importantly, no statistics are available on the number of seniors served through State and local resources, although the Commission heard of several highly successful programs.

The seniors of America are not going to simply fade away. Their numbers are growing, and with that growth, the challenges presented by senior individuals without the resources to afford appropriate housing and necessary services are going to present themselves. One way or another, unless Americans are willing to abandon their Nation's fundamental values, they will respond to those challenges, and our society, both privately and publicly, will bear the cost of that response.

RECOMMENDATION 2.1: THE COMMISSION RECOMMENDS AN INCREASE IN THE ANNUAL PRODUCTION OF ALL TYPES OF ASSISTED HOUSING IN ORDER TO MEET THE NEEDS OF FUTURE GENERATIONS OF SENIORS.

As indicated in Section III of this Report, data drawn from the American Housing Survey suggest that the projected rise in senior population will require approximately 730,000 additional affordable rental units by 2020 to serve seniors with unmet housing needs (i.e., those who are living in substandard housing or who pay in excess of 30 percent of income for housing expenses either in homes they own or rent). Obviously, due to the issues associated with the interpretation of any complex data set and the difficulties of drawing global conclusions for circumstances that vary widely in their local manifestations, any such projections should be used cautiously.

For instance, this estimate of need is based on a subset of individual housing and affordability needs and does not reflect that some seniors will move to a senior community for reasons other than substandard housing and affordability; for example, the need for services such as transportation, meals, home chores; the need for socialization, possibly due to the death of a loved one; the need for health-related services; or the inability to maintain one's home.

Moreover, this estimate cannot factor in uncertainties related to economic conditions and their impact on future income, homeownership rates, and most importantly seniors' choices, nor can it address the geographical distribution of production programs, geographical shifts in demand, or potentially uneven levels of demand over the next two decades.

Although some of this need can be met through home repair programs, Housing Choice Vouchers, senior developments financed with tax exempt bonds, and state and local programs, the balance will need to be met through increased production under the Federal Section 202, HOME and housing tax credit programs.

The Commission believes that if the Federal government encourages an array of financing tools, with sufficient flexibility capable of serving low- and moderate-income seniors in settings that encourage a continuum of services, then actual market and economic conditions can dictate the levels of need and how resources are distributed.

RECOMMENDATION 2.2: THE SECTION 202 PROGRAM IS THE PRIMARY PRODUCTION PROGRAM SERVING EXTREMELY LOW-INCOME SENIORS, AND FUNDING FOR THIS PROGRAM SHOULD BE INCREASED TO KEEP PACE WITH THE DEMAND.

The most urgent need is that of providing housing and services to seniors with extremely low-incomes, that is, those with incomes at or below 30 percent of area median. The Commission calls on Congress to increase funding for the Section 202 program, the principal production program designed with resources capable of reaching those seniors of greatest need.

HUD's Section 202 Program is the flagship housing program for seniors and one that has withstood the test of time. Despite an escalating demand, the production of Section 202 units is at one of the lowest points in its history, and falls far below even today's need.

In the spring of 2002, HUD issued a Notice of Funding Availability totaling only 5,800 units of 202 nationally, an average of fewer than 120 apartments per state. Only year 1990 had a lower production level. The peak production period was 1976-1990, when 197,000 units of Section 202 housing came on line, an average of 13,134 units each year. Since 1990, annual production levels under the Section 202 program have averaged 7,120 units.

The demand for Section 202 has always exceeded supply. Clearly, the very low number of units now funded each year cannot meet either current or future need. According to a survey of Section 202 facilities by AARP,[109] "...in 1999, approximately nine senior applicants were on waiting lists for each Section 202 unit that became vacant within a year." Based on this strong demand, the Commission calls on Congress to increase funding for this valuable production program.

RECOMMENDATION 2.3: HUD SHOULD INCREASE THE SECTION 202 PER UNIT FUNDING ALLOCATION TO COVER THE REALISTIC COST OF DEVELOPMENT, INCLUDING THE COST OF PUBLIC AND ADMINISTRATIVE SPACES. HUD SHOULD ESTABLISH REASONABLE OPERATING COST STANDARDS TO COVER SERVICE COORDINATION AND OTHER RELATED EXPENSES.

To improve program efficiency, the Commission recommends that Congress direct HUD to make the following program modifications:

1. Establish reasonable cost limits. The Section 202 program was designed to be a simple, one-stop financing program that covered 100 percent of acquisition, rehabilitation, or development costs associated with creating a new 202 property. In recent years, however, due to stringent budget ceilings and accelerating development costs in many parts of the country, the current Section 202 capital advance amounts

often fall far short of meeting up-front development costs. In addition, Section 202 developments require substantial common space to provide for supportive programming and staff for residents aging in place.

Although HUD issued increased base cost limits in 2001, concurrently, HUD reduced the multipliers used to reflect geographic differences resulting in lower overall limits in most parts of the country.

Inadequate per unit funding has led to the need for highly complex, layered financing that greatly increases "soft costs" for these projects and also increases processing times. Providing adequate per unit financing will reduce the overall cost of the housing and make possible supportive environments that enable seniors to continue living in their homes and avoid moving to higher care facilities.

If other sources of funding are not available, housing sponsors are left to create "bare bones" housing structures. However, in an environment when most developers understand that housing must be built to accommodate onsite supportive services, the inclusion of common space in new seniors housing is absolutely essential.

2. Establish reasonable operating cost standards. Operating cost standards in PRAC programs need to reflect the costs of operating a building with integrated supportive services. This should include the funding of a service coordinator, as well as a reasonable amount for services such as transportation. Additionally, the PRAC funding should not be limited to 75 percent of the anticipated operating budget.

   Several independently conducted program studies[110] conclude that service coordinators provide an important service and are strong determinants of the extended well being of residents. Service coordinators should be fully funded in Section 202 operating budgets. Moreover, existing HUD guidelines for service coordinators should be fully integrated into the training component of the operating budget.

RECOMMENDATION 2.4: CONGRESS SHOULD PROVIDE GREATER CLARIFICATON ON THE RECENT CHANGES THAT PERMIT COMBINING SECTION 202 AND THE LOW-INCOME HOUSING TAX CREDIT.

In 1999, Congress modified the Section 202 program to encourage and foster the creation of mixed-income, mixed-financed senior communities by enabling sponsors to combine their Section 202 allocations with the Low-Income Housing Tax Credit (LIHTC) program. These significant changes make it possible for the development of mixed-income communities for seniors, particularly beneficial in urban areas where larger projects can now be developed and in rural communities where a mix of incomes create enough qualified occupants for a single, feasible project.

Although HUD permitted applicants in the 2001 funding round to combine the two programs, only eight of the funded applicants indicated a desire to do so. To date, none of these has actually combined the programs. The uncoordinated timing of the tax credit applications in conjunction with the Section 202 awards appears to pose an obstacle, along with some technical issues.

At the Commission's hearing in Ohio, testimony[111] was received about the need for technical changes to ensure that the Section 202 Project Rental Assistance Contract is not treated as a Federal grant and subtracted from eligible basis (making it ineligible for tax credits) and also that the PRAC rent subsidy is given the same status as a Section 8 subsidy in considering rental income.

Therefore, the Commission recommends the following:

1. Federal Grants. Add the following at the end of section 42(d)(5)(A): "For the purpose of this section, Federal grants shall not include payments made pursuant to a Project Rental Assistance Contract under section 202 of the Housing Act of 1959."

2. Computation of Permitted Rents. Add a new subsection (v) at the end of section 42(g)(2)(B): "(v) does not include any payments made pursuant to a Project Rental Assistance Contract under section 202 of the Housing Act of 1959."

RECOMMENDATION 2.5: AMEND THE LOW-INCOME HOUSING TAX CREDIT PROGRAM TO PROVIDE A CREDIT BOOST OF 15 PERCENT FOR SERVICE-ENRICHED SENIOR HOUSING.

The Low-Income Housing Tax Credit program provides a "credit boost" of 30 percent for housing developments that are located in Qualified Census Tracts (QCTs) – very low-income census tracts – and Difficult to Develop Areas (DDAs), in recognition of the higher costs associated with development in these jurisdictions. As a result, affordable housing developments in these qualifying areas are given 30 percent more tax credits than a similar project located outside a QCT or DDA, thus increasing the amount of equity available to the project.

The Commission recommends that Congress develop a credit boost for senior housing that takes into consideration the significantly higher costs associated with service-enriched senior housing. Some of these higher costs are based on accessibility issues; (e.g., the developer must to either construct single story housing, with significantly higher foundation, roofing, and land costs, or multistory structures with elevators). Units are predominantly one- and two-bedroom units, resulting in higher square footage costs than multifamily complexes with mostly two- and three-bedroom units. These facilities include safety features such as grab bars, emergency call systems, accessible showers and bathtubs, special cabinetry, and accessible and adaptable appliances, all of which add to costs. In addition, common spaces are needed in order to provide services allowing seniors to age in place, so it is fairly typical for senior housing developments to cost 15 percent to 20 percent more than their multifamily counterparts.

To qualify for the credit, the housing would have to meet accessibility standards, offer a program of services for residents, and limit its occupancy to persons at or above 55 years of age.

RECOMMENDATION 2.6: HUD SHOULD REVISE ITS SECTION 202 ALLOCATION SYSTEM TO MORE APPROPRIATELY TARGET GEOGRAPHIC AREAS OF GREATEST NEED.

The current allocation system for Section 202 takes into account the number of seniors, substandard housing, and poverty rate, but not waiting lists and vacancy rates. As a result, there are a few communities in which Section 202 properties suffer from vacancies, yet, there are many other places where the existing supply of housing for seniors cannot begin to meet the demand. For example, a senior housing provider testifying in Commission hearings in Miami reported that 6,800 persons lined up to apply for one nearly completed Section 202 building.[112] HUD's distribution formula should be modified to more appropriately target areas of greatest need.

To better allocate these limited resources, HUD should develop a formula for fund allocation that factors in:

- Waiting lists and turnover ratios of other existing senior housing developments in the area;
- Occupancy and vacancy rates in existing comparable housing;
- Percentages of seniors with incomes at or below 50 percent of Area Median Income (AMI), with higher weights assigned to the numbers of seniors with incomes at or below 30 percent of AMI;
- Demographic trends;
- States with high poverty rates among their senior residents; and
- Substandard housing.

RECOMMENDATION 2.7: MEDICAID FUNDING SHOULD BE ADEQUATE TO SUPPORT QUALITY CARE. PAYMENTS SHOULD BE CONSISTENT WITH FEDERAL QUALITY STANDARDS AND SHOULD BE ADEQUATE ACROSS ALL SETTINGS.

If the Medicaid program is to deliver high-quality care, its reimbursement rates must adequately compensate providers in all delivery settings. Currently, when agencies provide services under Medicaid contract, they must accept Medicaid's rate of reimbursement, regardless of their actual costs. States determine the level of reimbursement for providers, and currently there is wide variation in the adequacy of Medicaid payments. Inadequate reimbursement rates make it difficult to attract and retain quality providers. When payment rates are inadequate, the quality of services delivered often suffers.

When quality providers choose not to participate in Medicaid, there is the risk of a two-tiered system of health care delivery in which low-income people may receive inadequate care. Poor quality care can lead to deterioration in health conditions, ultimately resulting in higher overall costs to the system. Taking steps to ensure that adequate reimbursement rates exist in all settings will help to minimize both geographical variations in service quality and variations by type of setting.

RECOMMENDATION 2.8: CONGRESS SHOULD MODIFY RURAL HOUSING PROGRAMS TO MORE APPROPRIATELY SERVE SENIORS AND FUND THEM REALISTICALLY.

The Commission has found that senior residents in rural areas, especially those located in remote, lightly populated communities have unique circumstances that set them apart from seniors living in metropolitan or suburban areas. Although seniors in rural areas are more likely to be homeowners, their homes are often in poor condition and the value of their homes is relatively low. Many rural seniors live below the poverty level, their homes are widely dispersed and isolated, and the distance to services, supplies, and medical care is a serious problem.[113]

Many rural communities lack adequate independent or assisted living facilities, as well as health and supportive services for seniors. As rural communities begin to confront the reality of a growing number of seniors, financing of housing and community facilities will be required, as will programs to assist single-family homeowners and renters who live in rural communities. However, with added private sector investment and supportive government programs, seniors in rural areas will be able to choose housing and services that address their needs.

In the multifamily housing developments funded under the Section 515 program of the RHS, 56 percent of the residents are over 62 years of age,[114] and the Commission expects that number that will increase in coming years. The Commission supports full funding for RHS rental housing programs as a general principle; however, given the challenges that lie ahead, the RHS programs will require significant resources and policy changes so that the funds are used optimally. Below are some areas in which changes are needed to meet the current and future needs of seniors:

1. The Section 515 program project budgets need to parallel actual development costs, including the provision of common and administrative spaces for supportive services and health-related programs. If the RHS program does not offer full funding of development costs, program standards should be flexible enough to reflect the reality of leveraged financing and accommodate the programmatic requirements of other subsidy sources such as the Low-Income Housing Tax Credit, HOME programs, and private sources of financing. For example, if Section 515 does not cover 100 percent of actual costs, RHS should allow subordination[115] of Section 515 project debt commensurate with the percentage of RHS funds in the project.

2. Service coordinator grant legislation should be amended to permit Section 515 facilities, and other rural developments serving senior residents at 60 percent area median income and lower, to apply for HUD service coordinator grants. To facilitate partnerships among senior housing providers, HUD and RHS should encourage federally assisted facilities, including Section 515, Section 202 and other facilities whose residents are at 60 percent area median income and below, to jointly apply for service coordinator grants.

3. The RHS Section 538 mortgage insurance program has been designed as if it were a competitive subsidy program. Although Section 538 was intended to fill in financing gaps in rural areas and attract private sector financing, the program has failed to meet its objective. A key obstacle making it difficult to attract significant developer and lender interest is that insurance commitments are considered in eight funding cycles followed by a 60-day period for review and approval. This design feature is burdensome to the lender, adds costs to the development, and may impede affordable housing developers from securing favorable interest rates, thereby jeopardizing the project or increasing housing costs to borrowers. The program should be redesigned to operate similar to the way the FHA mortgage insurance programs work, that is, with a window open for applications at all times.

4. A large percentage of the housing stock in rural areas consists of owner-occupied, single-family homes. In rural areas, many homes are in poor condition. This is particularly the case in the rural South, where 15 percent of seniors occupied rural housing has moderate to severe physical problems.[116] Rural home repair and modification programs, such as the RHS Section 504 repair grants for seniors are essential to ensure that senior homeowners age in place in decent, safe, and affordable housing. This program should be supported.

RECOMMENDATION 2.9: INCREASE THE AVAILABILITY OF APPROPRIATE HOME- AND COMMUNITY-BASED SERVICES IN RURAL AREAS. CONGRESS SHOULD ENACT A NEW FLEXIBLE RURAL WAIVER DEMONSTRATION PROGRAM THAT AUTHORIZES TARGETED FUNDS TO STATES AND THEIR RURAL COMMUNITIES.

In order to adequately serve seniors who live in rural areas, Medicaid Home- and Community-Based Services (HCBS) services should be addressed by a waiver program, initiated on a demonstration basis. We recognize that seniors living in rural areas face housing and supportive service problems that are not encountered by their counterparts living in urban and suburban communities. Existing models of service delivery that may be effective in urban settings are seldom practical in rural areas, generally due to the inability to achieve the economies of scale necessary to offer services at a reasonable cost. In some cases, such economies can be achieved through the building of supportive housing and/or assisted living facilities that are associated with and located on the same campus as a nursing facility, hospital, or other health care facility. This ability to mass costs can contribute to greater efficiency of human and technological resources as well.

In testimony to the Commission, Anne McKinley, consultant to the Institute for Applied Gerontology, noted the most common barriers and challenges affecting the provision of appropriate housing and supportive services in rural areas as: isolation, economic deprivation, and few, if any, economies of scale.

Operating HCBS programs and providing supportive services in senior housing facilities in rural areas is inherently inefficient, and needs to be recognized in terms of setting public policy and providing financial support. Often there exists an earnest willingness and mission to develop HCBS services and supportive senior housing, but the financial

shortfalls prevent it. Optimizing the resources of other health care providers and recognizing the regional variations in service costs will greatly increase the ability to provide services to seniors living in rural areas.

Flexibility and creativity are the keys to addressing the needs of rural seniors. In order to effectively accommodate these unique needs, Federal and State governments need to consider more flexible service standards and targeted demonstration programs and to encourage innovation, e.g., assistive technology and telemedicine.

Seniors living in rural areas face housing and supportive service problems not encountered by their counterparts living in urban and suburban communities. Existing models of service delivery that may be effective in urban settings often are not practical in rural areas.

RECOMMENDATION 2.10: THE COMMISSION STRONGLY SUPPORTS EXISTING EFFORTS BY FANNIE MAE AND FREDDIE MAC TO DEVELOP SINGLE-FAMILY PROGRAMS THAT MEET THE NEEDS OF SENIORS WHO DESIRE TO AGE IN THEIR OWN HOMES.

For many senior Americans, their home is their greatest source of net worth. For senior homeowners with equity in their homes, reverse mortgages and flexible equity lines of credit can serve as a source of income. The Commission encourages the GSEs to continue to develop products that allow seniors to access their equity under flexible terms, thereby enabling seniors to borrow small amounts for home repair and modifications. The Commission also acknowledges the role that GSEs have in protecting the home equity of seniors by preventing predatory lending practices.

RECOMMENDATION NO. 3
LINK SHELTER AND SERVICES

In the area of long-term care services, it is critical that public programs look beyond institutionally based models of service delivery. Seniors want choices as to the type and location of services they receive. Public programs should provide services that are based on the needs and preferences of the individual whenever possible; services that can be delivered in the locations seniors prefer — be they private homes, apartments, or assisted living units.

The goal of allowing seniors to remain active and independent for as long as possible will also be facilitated by expanding transportation options, improving services in rural area, and building upon successful innovations that integrate a range of services needed by seniors whose independence is threatened.

RECOMMENDATION 3.1: CONGRESS SHOULD TAKE ALL NECESSARY STEPS TO IMPROVE AND FUND SERVICE COORDINATION IN FEDERALLYASSISTED SENIOR HOUSING.

The Commission urges Congress to:

- Assure funding for service coordination in all federally subsidized housing with senior populations;[117]

- Continue and expand the existing HUD service coordinator grant program, especially for HUD and RHS housing developments without project-based subsidies; and provide resources to allow eligible developments to incorporate a service coordinator position into their operating budgets. This provision includes transferring grant-funded programs to operating budgets.[118]

The first stage in providing a continuum of housing and service choices for seniors often is in-home supportive services. Individuals with ample resources have the greatest choice in how and from whom they receive these services. Those with low-incomes are more reliant on publicly or privately funded services. Publicly subsidized services are often overburdened and available resources often cannot meet demand.

In addition, navigating a system of segmented service providers and benefits is difficult for many seniors. Service coordination is a profession that acts as a bridge between housing and an array of available services and providers.

In the early 1990s, HUD created service coordinator programs to help seniors in subsidized housing find appropriate providers and services. Service coordinators are members of a housing development's management team. Their role is to assist residents in obtaining affordable supportive services provided by community agencies. The service coordinator facilitates the receipt of home and community-based services to residents in their own homes, thereby promoting aging in place and preventing premature

institutionalization. Service coordination also influences the cost of caring for seniors by allowing them to remain in non-institutional settings longer.

Unlike case managers working in the health care field, service coordinators are based at housing sites. They may often be involved in creating new services or educational programs, advocating for residents, working with resident councils to improve the development's community life, assisting with community outreach, and educating housing management staff on aging issues. They may also act as a broker for services that cannot be obtained through public resources.

Currently, service coordinators work in various types of federally subsidized housing. Although many residents of developments benefit from this program, funding is not permanent and many housing facilities and individuals are still not served. At present, many HUD housing developments must compete for funds each year, with concerns of not being able to continue the program once it is established, because of a complex grant process.

The service coordination movement has grown exponentially over the past 10 years, due to its success with residents and housing managers alike. Service coordinators and housing management staff report noticeable improvements in both the community's environment and in the everyday lives of residents and their families. In the coming years, service coordination is poised to play an ever more significant role in the services-enriched housing component of the continuum of care options for seniors. In testimony to the Commission, Janice Monks, executive director, American Association of Service Coordinators, stated that, "almost every property that has added a service coordination component to its operation has benefited from significant improvements."[119]

RECOMMENDATION 3.2: REVISE THE ASSISTED LIVING CONVERSION PROGRAM (ALCP) TO FACILITATE ITS USE BY HOUSING SPONSORS.

The HUD Assisted Living Conversion Program (ALCP) program provides grants to non-profit providers of projects serving seniors and which are receiving Federal assistance through the following programs: HUD Section 202, 236, 221(d)(3) BMIR, and projects receiving project-based Section 8 rental assistance, including Rural Housing Service 515/8 projects. Funds may be used to pay for the physical costs of converting some or all of the units to assisted living, as well as renovating or reconstructing necessary community spaces generally associated with assisted living facilities.

The first ALCP grants, authorized in the HUD 2000 appropriations bill, were available for Section 202 developments only. Fifty million dollars was appropriated in FY 2000, and again in FY 2001, but the program was undersubscribed in both years. According to testimony received by the Commission from the Elderly Housing Coalition, the program is difficult to use and the application requirements are cumbersome. "A regulatory requirement that resulting units meet assisted living licensing requirements has increased the cost and discouraged use of the program. Indeed, failure to use all of the ALCP's allocation is due to lack of funding for services," commented the Coalition.[120] A witness before the Commission in Florida reported that another factor making assisted living conversions infeasible was high insurance costs.[121]

The most feasible projects are those in States that have Medicaid waivers available to help pay the health care and supportive service costs. However, even States with waivers do not fully reimburse the costs of the required/licensed assisted living services. In addition, some States address assisted living reimbursement in their State Plans (e.g., New York and Ohio), and therefore, do not meet the threshold application criteria for the ALCP grant.

The statute establishing the ALCP cross references Section 232 (a) of the National Housing Act (at 12 U.S.C. 1715(w)(a)) for the definition of assisted living facilities and establishes standards for personal care and assisted living. The statute also requires that assisted living facilities be licensed by a State, or, in the absence of State licensing, by a local political subdivision. This requirement has proved to be very difficult and costly to implement.

Congress should authorize the Department of Housing and Urban Development to develop standards that protect residents, but are not so prescriptive as to prevent full utilization of ALCP funds. These standards should enable ALCP funds to be used, under the statute's "or related use" language, for projects demonstrating intent to facilitate the delivery of enhanced levels of services to help keep at-risk seniors out of more costly institutional settings, but do not necessarily go all the way to a licensed assisted living facility, requiring local/State licensure.

In order to accommodate all rural seniors, ALCP funds should not be limited to those Section 515 projects supported by Section 8 rental assistance, but all Section 515 projects should be eligible to qualify for ALCP funds. Program administrators should ensure that the RHS is compatible with the ALCP and other service delivery programs.

RECOMMENDATION 3.3: THE DEPARTMENT OF HEALTH AND HUMAN SERVICES AND THE DEPARTMENT OF LABOR SHOULD DEVELOP COLLABORATIVE INITIATIVES TO TARGET WORK INVESTMENT ACT AND OTHER FEDERAL DOLLARS TO THE LONG-TERM CARE FIELD.

The development of a responsive, quality long-term care system requires a prepared, committed, and stable workforce to deliver services and supports. Consequently, the Nation must ensure that Federal and State policies and provider practices include positive financial incentives, appropriate training and support, and working conditions conducive to recruiting and, more importantly, retaining a quality workforce.

Currently, providers across all long-term care settings are experiencing significant recruitment and retention problems, particularly with respect to nursing staff and direct care workers, such as certified nurse aides, home care workers, and personal care attendants. Low wages and limited benefits, difficult and unsupportive working conditions, high injury rates, heavy workloads, and the stigma attached to long-term care jobs make recruitment and retention of workers problematic, even when unemployment rates are relatively high. According to testimony by Dr. Edward Salsberg, executive director, Center for Health Workforce Studies, School of Public Health, State University of New York at Albany, "Most of the factors contributing to health worker shortages

have not been addressed, and the Nation's changing demographics will put great pressure on the system."[122]

The specific issues in the long-term care workforce demand solutions that are targeted to this area. Issues such as worker dissatisfaction, high turnover, inadequate life skills, and clinical training and quality problems, such as medical errors, must be addressed. The Federal Government invests more than $8 billion annually to prepare primarily low-income and unemployed individuals for new and better jobs.[123] The Federal Work Investment Act establishes a flexible State framework for a national workforce preparation and employment system and offers opportunities for experimentation with training initiatives in the long-term care field. The Departments of Health and Human Services and Labor must work together to ensure that these dollars are made available to providers and educational organizations at the State and local levels.

RECOMMENDATION 3.4: CONGRESS SHOULD DIRECT THE GENERAL ACCOUNTING OFFICE (GAO) TO CONDUCT A COMPREHENSIVE EVALUATION OF INTERDEPARTMENTAL OPERATIONS BETWEEN HUD AND HHS AND GIVE RECOMMENDATIONS ON HOW TO MORE EFFECTIVELY COORDINATE THE PROVISION OF HOUSING AND SERVICES TO SENIORS.

At the very heart of this Commission's work is the recognition that the housing and service needs of seniors traditionally have been addressed in different "worlds" that often fail to recognize or communicate with each other. The Commission performed telephone interviews with and held a workgroup meeting of former HUD and HHS officials. Practicable recommendations better to bridge senior housing and service programs and policies were sought from these experts. A clear message from this investigative process was that, while policymakers have struggled to be responsive to the needs of seniors, the very structure of Congressional committees and Federal agencies often makes it difficult to address complex needs in a comprehensive and coordinated fashion. For example: medical needs of seniors are addressed by Medicare and Medicaid; social service needs are addressed by Medicaid, the OAA, and other block grant programs; housing programs are administered by HUD and the Department of Agriculture's RHS; and transportation programs are administered by the U.S. Department of Transportation (DOT).

The GAO should examine the broad range of programs that provide housing and services to seniors with disabilities and evaluate attempts that have been made to coordinate services and housing. Recommendations could cover improving the funding and use of the OAA system to coordinate access to housing and services. Because the Area Agencies on Aging (AAAs) are a central focus for seniors in many communities, they could, with adequate funding, be well suited to provide housing information and education to the public.

RECOMMENDATION 3.5: CONGRESS SHOULD RECOGNIZE AND FACILITATE INTERGENERATIONAL LIVING ENVIRONMENTS.

As part of its Mandate, the Commission heard from witnesses about the increasing number of families headed by grandparents, and the merits of intergenerational living.

This increase has been significant. In 1997, approximately 3.9 million children lived in households maintained by a grandparent, an increase of 76 percent since 1970.[124] This new family structure and an expressed preference by some seniors for intergenerational living environments deserve consideration by Congress. The Commission suggests the development of several demonstration programs, including:

(1) The development of a Demonstration Program for Intergenerational Families within the Section 202 program, similar to that embodied in legislative proposals. To accomplish this would involve several waivers to the current program regulations, including the development of two- or three-bedroom units and the inclusion of amenities directed towards serving children.

(2) The development of a Demonstration Program within the Public Housing Program, particularly as part of a HOPE VI development.

Demonstration programs can provide opportunities for creative intergenerational activities. The program should look at the efficacy of combining intergenerational learning and care centers and social activities within low-income housing communities. Most PHAs provide a variety of social services and programming for their residents, and many may already be operating successful intergenerational programs.

The Commission heard from witnesses who have successfully developed the first housing specifically designed for grandparents raising grandchildren. They told of the skepticism lenders had and the difficulties this produced in obtaining affordable financing. In addition to demonstration programs, Congress should urge HUD and the GSEs to encourage lenders to participate in these developments.

RECOMMENDATION 3.6: CONGRESS SHOULD CONTINUE TO SUPPORT STATE AND LOCAL TRANSPORTATION PROGRAMS ENABLING COMMUNITIES AND OTHER SPONSORS TO OFFER PRIVATE TAXIS, HANDICAPPED ACCESSIBLE VANS, RIDESHARING, AND OTHER CREATIVE TRANSPORTATION ASSISTANCE ESPECIALLY IN RURAL AREAS.

One of the most significant challenges associated with growing older is reduced mobility. Seniors lose their ability to drive or walk long distances to use public transportation. According to the Community Transportation Association of America, millions of seniors do not have access to or ownership of transportation they can afford. Identifying methods of transportation is particularly difficult for those 5.7 million senior householders in rural America where health facilities, grocery stores, pharmacies and other necessities are often tens of miles away.[125]

The ability of seniors to age in place in a healthy manner is greatly diminished if they cannot easily access transportation for both health and social aspects of their lives. Whether unable to visit the doctor or participate in normal social activities, the end result is the same — physical, mental, and emotional deterioration. This condition not only decreases quality of life and care, but also increases risk of premature institutionalization.

RECOMMENDATION 3.7: CONGRESS SHOULD EXPAND THE DEPARTMENT OF TRANSPORTATION/DHHS COORDINATING COUNCIL ON ACCESS AND MOBILITY TO INCLUDE ALL APPROPRIATE FEDERAL AGENCIES THAT CAN FACILITATE THE REMOVAL OF BARRIERS TO A COORDINATED, ACCESSIBLE TRANSPORTATION NETWORK FOR SENIORS.[126]

The complex interaction of different agencies and transportation providers requires flexible policy solutions. Congress should expand the Department of Transportation/DHHS coordinating council on access and mobility to include all appropriate Federal agencies that can facilitate the removal of barriers to a coordinated, accessible transportation network for seniors**.** As the senior population grows, it is more important than ever that the Nation incorporates their transportation needs into public policy at the Federal, State, and local levels. In the reauthorization of the next Transportation Efficiency Act, Congress should pay special attention to the needs of seniors in both metropolitan and rural areas and continue to provide significant funding and impetus to States and localities to meet the needs of the senior population. States, localities, and other sponsors should continue their efforts to better coordinate transportation resources.[127]

RECOMMENDATION NO. 4
REFORM THE FINANCIAL DELIVERY SYSTEM FOR HOUSING AND SERVICES FOR SENIORS

Witnesses before the Commission spoke ardently about the need for reform in existing Federal programs and the importance of the private/public partnerships in meeting the needs. Financing involves risk and it has been the role of the Federal Government to create programs to share or reduce risk to attract private sector involvement. At the beginning of the 20th Century, mortgages could only be obtained for 11 to 15 years with a balloon payment at the end of the term. The housing market was considered to be too risky. To create confidence and liquidity in the market, the Federal Government established the Federal Housing Administration and the Federal Home Loan Bank System.

Subsequently, Congress chartered the secondary market Government Sponsored Enterprises, now known as Fannie Mae and Freddie Mac. These systems have been the backbone of a housing system that has led to 68 percent of all American households owning their own homes, and 65 percent of all senior households owning their own homes.[128] These systems continue to be the main engine of housing production for moderate and middle income Americans.

The Commission calls on the Government Sponsored Enterprise (GSEs) such as Fannie Mae, Freddie Mac, and the Federal Home Loan Bank to be major players in expanding housing and care facilities, particularly for seniors with income between 50 and 80 percent of area median income, a market segment with far too few options

HUD, too, can serve this market by redesigning its mortgage insurance products to work together seamlessly. In rural areas, the ability to combine hospital, assisted living, and senior apartment financing together could result in housing and service options where none exist. Ease regulations, encourage creativity, allow more decision making at the local level – these were repeated mantras from witnesses before the Commission.

One promising trend in the delivery of long-term care services is called “consumer direction,” in which seniors have the flexibility to choose their own caregivers. Providing more support for informal caregivers, who currently are the mainstay of the long-term care system, will also keep ensure that seniors receive the services they need and want. Congress should improve the ability of Medicare to meet the needs of seniors with chronic and long-term health needs including care coordination and adequate payment.

RECOMMENDATION 4.1: THE GOVERNMENT SPONSORED ENTERPRISES (GSEs) NEED TO INCREASE THEIR INVOLVEMENT AND BECOME MAJOR PLAYERS IN FINANCING HOUSING FOR THE GROWING NUMBER OF SENIORS.

The GSEs (Fannie Mae, Freddie Mac, and the Federal Home Loan Banks) have significant, but underutilized capacity to stimulate private capital investment in all areas of senior housing. The GSEs should play a leading role in meeting existing and future national demand for financing of service-enriched housing for seniors, and should develop and promote products that assist seniors to age in place in decent, safe, and affordable housing with services appropriate to their needs, both in urban and rural settings.

Fannie Mae and Freddie Mac should:

- Support the financing of a wide array of housing types such as independent living facilities (with or without services, as appropriate) assisted living facilities, and continuum of care facilities; and
- Establish and actively promote credit products for the development of projects that are characterized by mixed funding sources (government and private), mixed uses, and mixed incomes, to serve low- and moderate-income seniors.

The GSEs will need to develop loan purchase standards that support innovative underwriting to finance service-enriched housing, requiring consideration of less traditional sources of project income such as health care payments, tenant payments, rental assistance vouchers, or income from affiliated ventures in continuum of care facilities. In addition, the Commission encourages Fannie Mae and Freddie Mac to provide "forward commitments"[129] for service-enriched seniors projects, similar to those already provided for affordable multifamily projects. Such commitments of permanent financing reduce risk to construction lenders, making construction capital more available.

The GSEs should actively partner with the private sector to transfer the benefits of their favorable rating agency status in order to expand private sector participation in senior housing.

As a result of their government sponsorship, the GSEs have favorable ratings from the leading Nationally Recognized Statistical Rating Organizations (NRSROs) that lower their costs of raising capital in the capital markets. By partnering with lenders and developers of housing and services for seniors, the GSEs can pass on this benefit to secure financing for innovative projects, or to bring down the cost of project financing. For example, the Federal Home Loan Banks can enhance loans through their letters of credit, which brings AAA rating to the financing and lowers financing costs. The secondary market GSEs can purchase a security representing the non-mortgage portion of a service-enriched project, thereby enabling the financing of an ancillary service facility to go forward.

RECOMMENDATION 4.2: THE FEDERAL HOUSING ADMINISTRATION (FHA) SHOULD MEET THE CHALLENGES OF THE 21ST CENTURY BY RE-ALIGNING EXISTING MORTGAGE INSURANCE PROGRAMS IN ORDER TO PLAY A SIGNIFICANT ROLE IN SENIOR HOUSING AND HEALTH FACILITY LENDING.

Although better known for its housing programs, such as the Section 221(d)(4) multifamily mortgage insurance program, FHA has played an important role in insuring

mortgages for nursing and assisted living facilities and hospitals. Under Section 232, FHA has insured approximately 2,000 mortgages on such facilities, and under the Section 242 program FHA has insured more than 300 hospital loans for rural and urban communities. As a testament to their overall performance, and as an indication of their net positive contribution to the Federal Treasury through insurance premiums and fees, these programs have been scored in a positive manner (i.e., credit subsidy negative) by the Office of Management and Budget.

Despite a climate with few affordable private sector alternatives, the nursing and assisted living facilities program under Section 232 and the hospital program under Section 242 are little recognized, but stand as very important potential resources for bridging the financing gaps between housing and health-related services for seniors. In fact, these FHA programs have pivotal roles to play in ensuring that the private sector, working together with government, is able to respond to the capital formation needs of housing, health service, and continuum of care facilities required to serve the aging population most effectively and economically.

The Section 232 and 242 programs have remained basically unchanged since their inception. Yet in the past 30 years, much has changed in society and health care delivery. Today there is greater emphasis on health maintenance, prevention, and chronic care management through home- and community-based services to allow seniors to age in place. These diverse services, when taken together, become what is commonly referred to as the "continuum of care." It is an overarching goal to develop this continuum to be as seamless as possible for seniors to access and navigate.

The FHA Section 232 and 242 programs of the 20th Century must now be modernized in order to address the realities of senior housing and health service delivery in the 21st Century.

Specifically, the Commission recommends the following actions that would modernize these programs and allow them to work together seamlessly:

1. The FHA 221(d)(4) multifamily program and the FHA Section 232 and 242 nursing and assisted living facilities and hospital programs need to be modernized to accommodate service enriched housing and continuum of care facilities. A "modern" FHA seniors program would simultaneously insure the housing portion of the complex as well as the ancillary capital improvements that house the health care and services portion of the facility. For example: The FHA could insure a campus with any combination of the following components: a multifamily independent living building, an assisted living facility, a health facility, and an adult day care program or a hospital or hospital-based integrated service facility. The seamless integration of these programs would allow them also to function in rural communities where the economies of scale are more difficult to achieve.

2. The Commission recommends the following modifications to the Section 232 program: (a) change existing definitions to support continuum of care health facilities and integrated service facilities; (b) change the existing Certificate of Need requirements for nursing facilities to permit HUD to establish alternate

means for determining need and feasibility for facilities in States having no Certificate of Need laws or implementing agencies so that such facilities are no longer automatically excluded from participation; and (c) allow FHA to develop alternative underwriting standards in States without assisted living licensing requirements.

3. The Commission encourages the following changes in the Section 242 Program: (a) change the definition of "hospital" to eliminate outdated patient day tests and other exclusions; (b) add insurance authority for mortgages covering hospital-owned integrated service facilities so that community clinics and outpatient facilities can be funded, in keeping with continuum of care methodology; and (c) change the existing Certificate of Need requirements for hospitals to permit HUD to establish alternate means for determining need and feasibility for facilities in States having no Certificate of Need laws or implementing agencies so that such hospitals are no longer automatically excluded from participation. The Commission also recommends that HUD promulgate and implement regulations allowing the refinancing of hospitals as authorized under Section 223(f).

4. FHA programs should be redesigned to ensure compatibility between FHA programs and other housing finance and subsidy programs. For example, the FHA 221(d) (4) multifamily program should be able to work well with the Low-income Housing Tax Credit program. The HUD subsidy layering standards should not be rigidly applied to the FHA insurance programs, nor should they be overly rigorous in projects in which HUD has a shallow subsidy. Subsidy layering standards should not jeopardize other, more substantial, sources of project financing.

RECOMMENDATION 4.3: CONGRESS AND HUD SHOULD CONTINUE TO SUPPORT AND IMPROVE THE REVERSE MORTGAGE PROGRAM AND HOME EQUITY PROGRAMS

Information provided to the Commission indicates that currently 68 percent of Americans are homeowners and this trend of homeownership is increasing. Reverse mortgage and home equity programs may be an important way to assist seniors in paying for health care costs. Specifically, the Commission finds:

In the single family FHA program area, the Home Equity Conversion Mortgage (HECM) reverse mortgage program can be an important resource for senior homeowners, 82 percent of whom own their homes without encumbrance.[130] FHA should be encouraged to continue its current trajectory of innovation in allowing seniors to access the equity in their homes.

In addition, the Commission encourages the development of secure mortgage and loan products that assist seniors to access their equity for home repairs and modifications.

RECOMMENDATION 4.4: THE FHA AND THE GSEs SHOULD STRENGTHEN EFFORTS TO PROTECT SENIORS FROM ABUSIVE LENDING PRACTICES. POLICIES TO ASSURE SECURITY OF SENIOR HOMEOWNER MORTGAGES SHOULD BE VIGOROUSLY ENFORCED.

Many senior homeowners have significant equity built up in their homes. For many, this is their only source of substantial equity. While equity in their home can be a tool to help seniors meet their needs in later years, it is also a target for opportunists to take advantage of seniors and make windfall profits through abusive lending practices. While efforts have been made to correct such problems, particularly within the Home Equity Conversion Mortgage (HECM) program, more needs to be done to ensure that assets such as home equity remain a useful tool and that such assets, so vital in later years, remains safe and secure.

Additional vigilance will be required to guard against abusive lending practices on the part of participating lenders or their affiliates, and, if such practices are found, to take immediate action, such as strengthening and enforcing laws, to preclude their further participation in senior programs.[131]

Specifically, the Commission supports the following:

(1) Improve consumer literature and disclosures to seniors;
(2) Prohibit harmful sales practices in the mortgage market; and
(3) Restrict abusive lending terms and conditions on seniors.

RECOMMENDATION 4.5: HUD SHOULD ESTABLISH HIGHER FAIR MARKET RENT (FMR) STANDARDS FOR UNITS IN ASSISTED LIVING FACILITIES AND OTHER SERVICE-ENRICHED HOUSING [132] THAN THE FMR CURRENTLY ESTABLISHED FOR COMPARABLE INDEPENDENT APARTMENTS.

Under a policy issued in 2000, HUD allows Housing Choice Voucher (Section 8) holders to use their rental subsidy in market-rate assisted living facilities. The objective of this policy is to supplement the Medicaid Home- and Community-Based Waiver program to make assisted living facilities accessible to seniors with low-incomes. HUD subsidizes the housing cost portion of monthly fees. Medicaid, resident contributions, and other third-party funds pay the cost of meals and supportive services.

This new provision takes a significant step toward making assisted living facilities affordable to seniors with low-incomes. Because of current program requirements, however, the Fair Market Rent (FMR) standards now issued by HUD, which are used to establish the maximum subsidy in Section 8 programs, do not accurately reflect the costs of assisted living facilities or of other service-enriched environments. In order to meet the aging in place needs of residents, senior communities require additional common areas (e.g., activity areas, dining areas, commercial kitchens, wellness centers) and specialized barrier-free design incorporating safety features. Providing these extra facilities significantly increases the construction and operating costs for this type of housing. As a result, it is difficult or impossible for low-income senior households to use

Housing Choice Vouchers to obtain housing in service-enriched senior housing or assisted living communities."[133] A realistic FMR is needed, reflecting these higher costs.

RECOMMENDATION 4.6: CONGRESS SHOULD INCREASE THE MEDICAID MATCHING RATE FOR HCBS WAIVER SERVICES, SO THAT STATES HAVE AN INCENTIVE TO EXPAND SERVICES TO INDIVIDUALS WHO LIVE IN THEIR OWN HOMES OR IN ALTERNATIVE RESIDENTIAL SETTINGS, SUCH AS CONGREGATE HOUSING OR ASSISTED LIVING.

Most seniors who need long-term care services prefer to remain in their own homes for as long as possible. Many seniors who need home care must turn to public programs for help, if they cannot afford to pay for all the services they need. The major public program that pays for long-term care services is Medicaid, but 73 percent of all Medicaid spending for long-term care pays for care in nursing facilities.[134] Medicaid law requires States to provide nursing facility services, but the provision of home- and community-based services (HCBS) is optional. Although all States currently use Medicaid funding to provide some level of home care services to seniors with disabilities, these programs need to be expanded. Testimony before the Commission presented by William L. Minnix, president of the American Association of Homes and Services for the Aging, aptly stated, "Most seniors obtain services in the settings under which costs can be covered by government programs, rather than according to what would best meet their needs."

Increasing the Medicaid matching rate for HCBS would help States move toward having HCBS, not nursing facilities, become the standard service offered under Medicaid. There is a clear need to expand Medicaid home care services in the community. An enhanced Federal matching rate will help States to manage this expansion.

RECOMMENDATION 4.7: ALL SENIORS WHO RECEIVE HOME- AND COMMUNITY-BASED SERVICES (HCBS) UNDER MEDICAID SHOULD BE OFFERED THE OPTION OF ARRANGING THEIR OWN SERVICES AND CHOOSING THEIR OWN PROVIDERS, WHERE APPROPRIATE.

A movement is growing in the delivery of home care services called consumer direction. This model allows seniors with disabilities to arrange and manage their own care, rather than using a care manager who authorizes service delivery through a home care agency. Many of these programs include a "counseling" component to help consumers manage their services, including related payroll and other administrative tasks. Preliminary evaluations from a Federal demonstration called "cash and counseling," currently operating in Arkansas, Florida, and New Jersey, have been positive. Many other States have developed similar programs that allow beneficiaries to choose their own workers.

Seniors who prefer to arrange for their own care and select their own service providers should be given the opportunity to do so. Consumers who prefer to use the existing care management model could retain that option. This action would make Medicaid more sensitive to consumer preferences and expand the pool of available workers, rather than being limited to workers provided through agencies, often at greater cost.

RECOMMENDATION 4.8: CONGRESS SHOULD REQUIRE THE STATES TO AUTHORIZE A MEDICAID SHELTER OR HOUSING EXPENSE ALLOWANCE IN DETERMINING MEDICAID ELIGIBILITY FOR ALL HCBS WAIVER PROGRAMS, PROVIDING NECESSARY FEDERAL FINANCIAL ASSISTANCE TO STATES THROUGH ENHANCEMENT IN THE MEDICAID MATCHING FORMULA.

Home- and community-based services under Medicaid are an empty promise if people who meet the eligibility criteria cannot afford to stay in their own homes. Many State Medicaid programs have a "medically needy" eligibility provision that allows people to deduct their medical expenses in order to qualify for services. These provisions often are not practical for HCBS waiver beneficiaries in the community, because many States do not allow them to retain enough income to maintain their own homes. States are, however, allowed to establish deductions for costs, such as shelter, that can make it more feasible for community-based residents to take advantage of HCBS waiver services for which they are functionally eligible.[135] Currently, nine State waiver programs allow a shelter deduction of some amount.[136]

A related issue pertains to the manner in which Medicaid funds long-term care services. Medicaid payments for nursing facility care cover the resident's room and board costs, as well as the services he or she receives. Medicaid is prohibited from paying for room and board costs in non-institutional settings. As a result, the inability to meet room and board costs of affordable residential alternatives, such as assisted living, put these options out of reach for many low-income seniors. A restructuring of Medicaid's guidelines for paying room and board costs could level the playing field between nursing facilities and other residential options. For example, payments could be restructured so that separate pools of financing for services and for housing costs would follow the senior with disabilities, regardless of the setting in which care is delivered. This approach could, however, shift costs from the Federal Social Security Income (SSI) program to State Medicaid programs, because Federal SSI payments can finance room and board for Medicaid-eligible assisted living residents[137].

Including a shelter deduction in determining Medicaid financial eligibility for HCBS waivers would make home-based services more accessible to seniors with low-incomes. This provision would help both homeowners and renters preserve their ability to remain at home while receiving the services they need to lead healthy, safe lives. According to testimony by AARP President and Board Chairman Keith Campbell, "…we need…a national commitment to treat a senior's residence, whether owned or rented, as a legitimate venue for the delivery of supported services."[138]

RECOMMENDATION 4.9: CONGRESS SHOULD MODERNIZE MEDICARE TO ADDRESS THE GROWING NEEDS OF SENIORS WITH CHRONIC CONDITIONS BY:

- Establishing adequate payments to primary care physicians who play a role in coordinating care;

- Compensating managed care plans for the higher costs involved in caring for frail and at-risk seniors with complex conditions;

- Maintaining adequate funding for the Medicare home health benefit;

- Monitoring the implementation of the prospective payment system for Medicare home health to ensure that individual case payments are sufficient to maintain adequate care; and

- Repealing the 3-day prior hospitalization requirement for Medicare skilled nursing facility eligibility.

As people age, they often need an array of medical and long-term care services, addressing both acute and chronic health conditions, as well as help with everyday tasks. According to the Century Foundation's 2001 report on improving Medicare, the scope of health care benefits covered under Medicare has not kept pace with changes in the health care field and benefits offered in the private insurance market, and should be expanded to include elements that can prevent or detect disease and manage chronic conditions. For example, Centers for Medicare and Medicaid Services (CMS) recently issued a program memorandum clarifying that providers may not automatically deny services to Medicare beneficiaries based solely on a diagnosis of dementia. This important clarification provides that services must be reasonable and necessary considering the beneficiary's overall medical conditions, not just the dementia condition.

Although the Medicare home health benefit provides a source of care to many seniors with post-acute and/or chronic health conditions, its scope and eligibility criteria can hinder the efficient and effective delivery of care. Reductions to the Medicare home health benefit, enacted as part of the Balanced Budget Act of 1997, have cut the level of services to beneficiaries beyond initial projections. As a result, these reductions have had a deleterious effect on the health of seniors with chronic and long-term health needs. Testimony before the Commission by Jeff Kincheloe, representing the National Association for Home Care, stated that, "Home health has decreased as a percent of Medicare outlays from 9 percent in FY 97 to 4 percent in FY 2001…[and] 900,000 fewer home health patients received services in 1999 than in 1997." Deeper reductions that are planned, but have not been implemented, could worsen the situation. It is important that people with complex medical conditions have access to integrated and coordinated care delivery. Medicare payment systems need to take into account the higher costs of caring for people with complex and/or chronic health conditions.

While Medicare covers skilled nursing facility (SNF) care of limited duration, it does not pay for long-term care. Currently, Medicare's SNF eligibility is contingent upon a prior 3-day hospitalization. This requirement limits access to SNF coverage for people who fail to meet the hospital requirement, which can result in unnecessary hospitalizations.

Improvements in Medicare home health can prevent the deterioration of beneficiaries' health status and ensure that people with chronic conditions receive the help they need. In addition, better coordination among Medicare home health and programs that deliver

long-term care will lead to a more seamless system of health and supportive service delivery.

RECOMMENDATION 4.10: THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) SHOULD EXPLORE WAYS IN WHICH STATE MEDICAID PROGRAMS CAN INCREASE REIMBURSEMENT RATES PAID TO PROVIDERS AND ENSURE THAT THESE INCREASES ARE REFLECTED IN THE WAGES OF LONG-TERM CARE WORKERS.

Low wages and lack of benefits for direct care workers are major issues in recruitment and retention. Poorly trained workers and frequent turnover can affect the quality of service delivery. Low reimbursement rates under Medicaid can exacerbate these problems, resulting in deterioration in health status among Medicaid long-term care beneficiaries. Providers have few incentives to invest aggressively in quality improvement activities when reimbursement barely covers the costs of operation. Because Medicaid is the major public payer for services, it has a profound influence on the quality of service delivery.

The vast majority of long-term care workers are women, many of whom lack health insurance coverage for themselves and their children. A disproportionate number of long-term care workers are minorities. A recent study[139] found that health care workers, including those employed by nursing facilities and other long-term care providers, have lost insurance coverage over the past decade. Given the fact that access to health insurance has been identified as a reason for staying in a job, a critical step toward improving worker retention would include taking steps to provide worker benefits. In addition, because many of these workers are low-income, they may qualify for Medicaid and supplemental State programs.

Access to health insurance coverage for workers and/or their dependents may increase job satisfaction, and encourage frontline caregivers to remain on the job. Increased retention, in turn, will help improve the staffing in long-term care settings and ultimately lead to better quality of care. The HHS should also take steps to maximize the use of the current State Children's Health Insurance Program (SCHIP), in order to assure coverage for long-term care workers and their dependents.

RECOMMENDATION NO. 5
CREATE AND EXPLORE NEW HOUSING AND SERVICE PROGRAMS, MODELS, AND DEMONSTRATIONS

Yesterday's demonstration and pilot programs have often become today's most successful ways to deliver service-enriched housing to seniors. Creative efforts on the part of many housing providers across the country have assembled today's programs to provide seniors with housing accompanied by services they need and offer models for tomorrow's new programs.

RECOMMENDATION 5.1: CREATE AND MAINTAIN A CLEARINGHOUSE OF INFORMATION TO GATHER AND DISSEMINATE INFORMATION ABOUT STATE MEDICAID PROGRAMS THAT DELIVER HCBS.

The Federal-State design of the Medicaid program results in wide variations in service design and delivery. There is no consistent mechanism by which States can access information about innovations and successes in State programs. It is critical that States have better information about effective ways to meet the needs of people with disabilities. One promising development is a recent initiative at Centers for Medicare and Medicaid Services (CMS) that has funded "systems change" grants to the States. These grants are designed to help States improve their delivery of Medicaid HCBS. New efforts should build upon the findings of the States' experience.

One area of particular concern is the issue of service delivery to seniors in rural areas. For example, some areas have implemented innovations in telemedicine that have been used to improve rural service delivery. There needs to be a better way to disseminate such information to all States, and to foster establishment of additional program models.

This clearinghouse should be funded by CMS and should include the following information:

- State functional eligibility criteria;
- State financial eligibility criteria;
- State methodologies used to count income and assets;
- Innovations/best practices in HCBS service delivery;
- Characteristics of State Medicaid programs, such as the availability of services in assisted living and other residential alternatives;
- Numbers of individuals served by setting and disability category, and numbers of individuals waiting to receive services.

Establishment of a clearinghouse will make it easier for successful innovations, including those funded by CMS through the systems change grants, to be replicated in other States. Access to clearinghouse information could be made available not only to Medicaid offices, but also to Older Americans Act offices, local housing authorities, and other providers of services to seniors with disabilities.

Better coordination will result in the senior consumers experiencing less frustration in locating and accessing the full range of services for which he or she is eligible. It also will prevent unnecessary and ineffective duplication of effort.

RECOMMENDATION 5.2: REQUIRE HUD TO DEVELOP AND MAINTAIN A NATIONAL DATABASE OF SENIOR HOUSING.

In the course of its research efforts, the Commission found that no comprehensive database of government-assisted senior housing has been compiled. The Commission recommends that the Congress direct HUD to develop such a database and make it available on its website, to include senior housing developed and/or financed through the following programs:

HUD Section 202
HUD Section 236
HUD Section 221(d)(3) BMIR
HUD Section 221(d)(3)
HUD Section 221(d)(4)
HUD Section 231
HUD Public Housing
HUD Section 8 New Construction, Substantial, and Moderate Rehabilitation
Low-Income Housing Tax Credits
Freddie Mac
Fannie Mae
Federal Home Loan Bank
Mortgage Revenue Bonds
501(c)(3) Bonds
RHS Section 515
RHS Section 538

At a minimum, the information needs to include project name, address, phone number, number of units, date of construction, occupancy rate, and type of financing.

RECOMMENDATION 5.3: CONGRESS SHOULD ENCOURAGE AND, AS NEEDED, AUTHORIZE THE SECONDARY MARKET GSES TO DEVELOP MODEL SENIOR HOUSING DEMONSTRATION PROGRAMS THAT LEAD TO PERMANENT AND MEANINGFUL CHANGE IN THE DELIVERY OF SERVICE-ENRICHED HOUSING.

The Commission recognizes that loan products supporting service enriched housing for seniors present different underwriting challenges from the GSEs' mainstream products on the market today. Financing of service-enriched housing requires the involvement of different sets of private and public sector partners than is customary. In order for these new partnerships to establish a strong footing, Congress should encourage the GSEs to develop innovative demonstration programs that forge public/private partnerships among various agencies of government lenders, developers, housing providers, and service providers.

For purposes of these demonstration programs, any barriers presented by existing GSE statutory authorities should be waived. In addition, where necessary, the FHA Section 232 and 242 programs should be employed to provide lenders and the secondary market with reasonable risk mitigation. It is the intent of the Commission that these demonstration programs result in the formulation of permanent programs that work for all of the GSEs' stakeholders: senior residents, developers, financial institutions, and investors.

RECOMMENDATION 5.4: FANNIE MAE AND FREDDIE MAC SHOULD DEVELOP EFFECTIVE RURAL PROGRAMS. FURTHER, HUD'S ENFORCEMENT OF THE GSES' RURAL LENDING GOALS SHOULD TAKE INTO CONSIDERATION THEIR EFFECTIVENESS IN PROVIDING FINANCING TO SMALL, DIFFICULT-TO-SERVE RURAL COMMUNITIES.

GSE loan standard and program guidelines should not carry an implicit bias against rural areas. A complete offering of financial products and services should be equally available in rural areas and urban areas. A good rural program should acknowledge and accommodate differences between rural and urban properties and borrowers.

Lenders in rural areas face difficult and unique challenges when working with the secondary market GSEs. The GSEs should develop comprehensive guidelines, programs, and operating procedures designed specifically to meet the needs and conditions of rural lenders. Secondary market purchase standards and services should recognize that low-asset financial institutions do not have the resources or the volume of loans to sell to Fannie Mae and Freddie Mac or to meet standards that are designed for larger metropolitan markets. The secondary market GSEs should also relieve small financial institutions from excessive loan guarantee costs and onerous default liability requirements that are beyond the ability of small lenders to carry.

Further, the GSEs, particularly Fannie Mae, play an important role as investors in the Low-Income Housing Tax Credit. GSE standards for purchase of tax credits may exclude some small communities entirely, however, or make it very difficult for developers to build tax credit projects up to GSE standards. (For example, Fannie Mae requires that tax credit project rents be 10 percent below market. This standard is difficult to achieve, given the absence of comparable properties and the difficulty of determining market rents in rural areas.) The Commission strongly recommends that the GSEs establish investment standards appropriate to rural areas.

RECOMMENDATION 5.5: THE FEDERAL HOME LOAN BANKS AND THE FEDERAL HOUSING FINANCE BOARD SHOULD IDENTIFY, AND THE BANK SYSTEM SHOULD PROMOTE, WAYS IN WHICH FEDERAL HOME LOAN BANK SYSTEM PRODUCTS AND AUTHORITIES CAN BE USED TO SERVE THE HOUSING AND HEALTH FACILITY NEEDS OF SENIORS.

The Federal Home Loan Bank System has several financial instruments to support lending and investments for the new types of housing and service facilities that will be needed to accommodate the growing number of 21st Century seniors. Among these financing instruments and programs are the Affordable Housing Program, Community

Investment Program, Community Investment Cash Advance Program, Bank letters of credit, and the individually tailored community support programs and products under each Bank's community lending plan.

In addition to the well-established community development programs, the Federal Home Loan Banks have newly enacted legislative authority to purchase loans and make targeted investments. Because this legal authority has been recently enacted, however, its full potential is yet to be explored. The Finance Board, as the Banks' mission regulator, in keeping with its primary role as an arm's-length safety and soundness regulator, could disseminate information on Bank System authorities and products and identify ways by which the Bank System might assist in the production of senior housing. Actions that the Finance Board could take are:

- Holding hearings or sponsoring forums to identify ways in which the Banks can meet the growing demand for financing of community projects for seniors, and formulating ways in which Bank System authorities and products might be employed to finance senior housing and community facilities; and

- Serving as a clearinghouse to describe Bank initiatives, products, underwriting challenges and solutions, best practices, and model programs that will support housing and services for seniors.

RECOMMENDATION 5.6: THE FEDERAL HOME LOAN BANK SYSTEM'S PROGRAMS SHOULD BE FULLY UTILIZED IN RURAL AREAS.

The Federal Home Loan Bank System has many member financial institutions that are located in rural areas. As a result, the Banks generally tend to be responsive to their rural markets and several Banks have undertaken specialized lending products to assist rural lenders. However, the reach into rural areas in those Bank districts where urban areas predominate needs to be expanded.

An example of an innovative program brought to the Commission's attention that assists small lenders is the Federal Home Loan Bank of Atlanta's Affordable Multifamily Purchase Program, in which the Bank purchases loans from affordable housing lender consortia. The Commission encourages other Banks to develop similar innovative multifamily finance products to address the need for housing for low- to moderate-income seniors. Additionally, under new authority available to it, the Bank System is encouraged to invest in tax credit projects in rural areas and to develop specialized rural programs that will support both independent and service-enriched rental housing for seniors.

RECOMMENDATION 5.7: CONGRESS SHOULD ADDRESS THE NEED FOR A PRESCRIPTION DRUG BENEFIT FOR SENIORS.

An examination of housing costs alone does not tell the full story of affordable senior housing. Other factors, in particular the high cost of prescription drugs, weigh heavily on many senior's budgets. Medicare's lack of a prescription drug benefit leaves substantial gaps in coverage for seniors. The overwhelming cost of prescription drugs can squeeze

the budgets of seniors, leaving them with inadequate income to pay for other necessities. This very real and urgent problem often requires seniors to choose between the medications and health care they need, the quality of housing they also need, and the other necessities of life, such as food. One consequence can be premature institutionalization.

The enactment of appropriate pharmaceutical interventions can prevent deterioration of health conditions and help individuals to maintain their quality of life. Relief from the weight of the prescription drug financial burden will go a long way toward ensuring that seniors can afford necessary medical care and services as well as the housing and supportive services they need.

RECOMMENDATION 5.8: HHS SHOULD ACCELERATE THE TRANSITION TO PERMANENT PROGRAMS OF THOSE HCBS DEMONSTRATIONS THAT HAVE BEEN SHOWN TO BE EFFECTIVE, AND ENCOURAGE THE BROADER IMPLEMENTATION OF THE PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) MODEL BY IDENTIFYING AND ELIMINATING BARRIERS TO ITS EXPANSION.

People who are eligible for both Medicare and Medicaid generally have more intensive health needs than other Medicare beneficiaries. It is a challenge to coordinate adequately the delivery of services to this vulnerable population, and those who attempt to do so must navigate complex and conflicting program rules. According to a report by the National Chronic Care Consortium, more than $100 billion — 28 percent of Medicare expenditures and more than 35 percent of Medicaid expenditures — address the needs of the dually eligible.[140] A renewed focus is needed on how to integrate funding for acute, primary, and long-term care, particularly for people with chronic illnesses.

The Program of All-Inclusive Care for the Elderly (PACE) is one innovative Federal program that combines Medicare and Medicaid (or private pay) funding to deliver a comprehensive array of medical and long-term care services. Started as a demonstration program in 1990, PACE now has expanded and has permanent authorization by Congress. Each State may choose, however, whether to participate in the program. The PACE financing model uses a flat-rate, capitated payment to pay for a full range of services designed to facilitate the ability of seniors to remain in their communities. A key element of the PACE model is adult day care, which is often located in senior housing properties or in senior centers. The average PACE participant is 80 years old, needs assistance with three activities of daily living, and has about eight medical conditions.[141] Despite the proven ability of PACE to maintain these severely disabled seniors in the community, participation in PACE is limited.

Research is needed to examine barriers to the expansion of PACE and to improve on the PACE model. For example, the Elderly Housing Coalition has suggested increasing collaboration between federally assisted housing providers and PACE programs. In recommendations to the Commission, the Elderly Housing Coalition addressed the challenges that PACE sponsors face in financing adult day centers. They recommended the development of a HUD financing program for property retrofitting or creating PACE program day centers within federally assisted housing facilities. Other barriers to the

expansion of PACE are rooted in States' concerns about the growth of their Medicaid budgets.

Expansion of cost-effective programs that coordinate and integrate services can improve the health and functional status of seniors with disabilities. Participants are able to go to one source for all their health and supportive service needs, and care providers can integrate services, thus preventing gaps in coverage. Continuing research is necessary to help inform the debate on issues such as the effectiveness of PACE and other capitated programs in preventing premature and unnecessary institutionalization, in meeting the expectations of participants, and enhancing the effectiveness of links among services and senior housing. The roles and responsibilities of the States as they pertain to PACE should be evaluated along with the feasibility of implementing new forms of capitated payment models that integrate acute and long-term care financing and services for the dually eligible.

RECOMMENDATION 5.9: CONGRESS SHOULD CONSIDER ENACTING A REFUNDABLE TAX CREDIT AVAILABLE TO INDIVIDUALS WITH DISABILITIES OR BY FAMILIES THAT CARE FOR A SENIOR WITH DISABILITIES.

Almost all seniors with disabilities (95 percent) receive at least some assistance from informal (unpaid) caregivers such as relatives, friends, and neighbors. Two-thirds (67 percent) rely *exclusively* on unpaid help.[142] Although this informal care fills a critical gap in the Nation's service delivery system, it often takes a heavy toll on caregivers — most of whom are wives and daughters. These caregivers need both support and opportunities for respite from their responsibilities.

The availability of informal caregivers is a key factor in preventing premature institutionalization. Half of seniors with long-term care needs who lack a family network live in nursing facilities, compared with only 7 percent of those who have family caregivers.[143] Providing financial support to informal caregivers can minimize, delay, or prevent the use of public long-term care programs, especially nursing facilities. A tax credit would provide additional income to offset the costs of providing such services.

RECOMMENDATION 5.10: SUPPORT PRIVATE SECTOR DEVELOPMENT OF HOUSING WITH SERVICES.

With a small amount of government support and without government expenditure, the private sector can meet the housing and service needs of the majority of this and the next generation of America's seniors. Making this modest investment will free federal, state and local monies to fund other programs for seniors. These monies will be available because the private sector can reduce both Medicare and Medicaid expenditures.

The private sector has demonstrated that it can meet the needs of seniors who:

1. Own their home. According to the 2000 Census: 81.3% of the 65 –74 year olds; 77.3% of the 75 – 84 year olds; and 66.1% of the 85 and over cohort own their home; and

2. Have a low to moderate income. The Federal Interagency forum on Aging-Related Statistics reported in *Older Americans 2000: Key Indicators of Well-Being* that in 1998, 62% of seniors had low to moderate income (an additional 27% had high incomes).

A private sector model, which has demonstrated efficacy in meeting the needs of low to moderate-income seniors, is the continuing care retirement community (CCRC). These communities provide independent living, home health care, assisted living and nursing care, along with a comprehensive array of health-related and social services. In addition, to address seniors' evolving and long-range medical needs, many CCRCs offer an onsite physician group and hospice program.

By providing these services on campus, acute care utilization can be dramatically reduced, creating significant savings for Medicare. In *Older Americans 2000: Key Indicators of Well-Being*, it was reported that in 1996, 29% of the health care expenditures incurred by Americans 65+ were consumed by acute care. Even marginal reductions in utilization can provide significant resources to fund other programs.

In addition, residents of CCRCs are less likely to require long-term stays in nursing homes because:

1. The environment reduces the risk of falling.
2. Meal programs ensure good nutrition.
3. Preventive and primary care are convenient and readily available.
4. Social interaction is extensive.
5. Assisted living is available.

By reducing the number and length of stays in nursing homes, CCRCs prevent seniors from requiring the support of the Medicaid program, a substantial fiscal drain on Government resources.

CCRCs enable seniors to maintain active, connected lifestyles while having access to health care services and facilities, as they need them. Flexibility also exists in the type of contract that can be secured – ranging from full life care (which ensures complete care and service coverage for life) to modified life care (which covers a limited scope of care and service) to fee-for-service models (which offer *a la carte* service adaptability). More than 350,000 American seniors have already availed themselves of this option and the number is increasing rapidly.

In order to make these campuses affordable for low- to moderate-income seniors, economies of scale must be realized. While the average size of a CCRC is about 300 units, developers in large metropolitan areas and their surrounding suburbs have designed very successful, affordable CCRCs with 1,000 to 2,000 independent living units and 200 to 400 health care beds. At this size, a metropolitan CCRC can realize the necessary economies of scale to provide the full range of services at a cost that is accessible to low- and moderate-income seniors who previously owned a home.

It is challenging to identify, acquire, and obtain zoning approvals for sites large enough and suitably located to be appropriate for affordable senior housing communities. To achieve the necessary economies of scale for metropolitan area CCRCs, a site of approximately 50 to 100 acres is required. It is rare to find large, undeveloped sites in the communities in which seniors have lived most of their lives; therefore, redevelopment opportunities are particularly attractive.

Another impediment of development is State-imposed limitations on the ability to construct and license health care facilities under certificate of need regulations. Many States exempt CCRCs from certificate of need; others do not. In every case, the rules are different and nearly always result in barriers to development.

In order to promote the development of the CCRC model of service-enriched housing, the Commission recommends that the Federal Government:

1. Provide access to government-controlled/owned property in major metropolitan areas by acknowledging service-enriched seniors housing developments as a preferred use in redevelopment plans.

2. Provide financing for the purchase price of the land by subordinating payment to a senior construction lender or make the property available under a senior housing development conveyance, similar to economic development conveyances; and

3. Enact Federal legislation that permits CCRCs to license a full continuum of health care services that is adequate to serve their residents. This continuum should include nursing care, assisted living, home health care, and hospice services. This range of services should be available to anyone who has signed a continuing care contract and has paid the required entrance fee.

Taking these inexpensive steps will enable the private sector to meet the housing and services needs of low- and moderate-income seniors. By meeting the needs of this population, both Medicare and Medicaid expenditures will be reduced freeing monies to fund other programs needed to care for America's seniors.

RECOMMENDATION 5.11: CONGRESS SHOULD CONSIDER THE CREATION OF A TAX INCENTIVE FOR INDIVIDUALS PURCHASING LONG-TERM CARE INSURANCE.

A promising source of private, long-term care service funding is long-term care insurance. At the current time, insurance accounts for a small fraction of long-term care spending; however, there has been a noteworthy growth pattern in insurance purchases.

Of particular interest are those plans sold through employer-sponsored or life insurance markets. The Commission believes that long-term care insurance can be a valuable means to fill gaps in long-term care service coverage. More flexible and affordable products are

needed. In addition, consumers must have an ease of comparison among available insurance products.

An "above the line" tax deduction can provide an incentive for individuals to obtain personal long-term care insurance and will, thereby, reduce future seniors' reliance on public assistance programs such as Medicaid.

PART VI. CONCLUSION: A MANDATE FOR CHANGE

In the fall of 1999, Congress created this bipartisan Commission to provide insight into the future housing, health, and supportive services needs of seniors in America. Congress asked the Commission to undertake a broad examination of the future needs of seniors and the actions necessary to meet those needs. Congress mandated a review of Federal policy and programs, as well as policies that affect the private sector and individuals.

The senior population in this country is growing at rates even beyond those anticipated. In 2020, one in six Americans will be age 65 and above; in 2030, it will be one in five. This is a dramatic increase from the start of the 20th Century, when the senior population constituted less than 5 percent of the U.S. population.[144]

Such a profound change in the composition of the population creates a new challenge for our national policymakers and resources. As a Commission, we struggled time and again with the fact that we are a Federal commission and our recommendations need to be targeted to a Federal audience. But this "aging of America" requires actions and solutions far beyond what the Federal Government can provide. Although policy may be made at the Federal level, the implementation of solutions will be primarily at the local level. Effective solutions rest with private businesses and local governments, with volunteers and advocates, with charitable and faith-based organizations, and with social-minded investors.

We see this as a community crisis, a State problem, and a national concern — without a simple answer, without a single solution. We call for the Federal Government to lead, to act as the catalyst for change, to make it easier for local governments and the private sector to serve, and to provide the necessary support. Our Commission may be Federal in scope, but this quiet crisis affecting seniors cuts across all levels of government, all communities, all races, creeds, and cultures, and all economic strata.

The Federal role in meeting the needs of seniors is extensive. Federal health and housing programs, as well as other Federal policies, directly affect millions of seniors. Current policies already have significant shortcomings that affect the welfare of a large segment of this Nation’s senior population, however, and an even greater segment will be adversely affected in the future unless changes are made.

Existing Federal policy is fragmented — not just as it relates to programs directed at low-income seniors, but for the broader population of seniors as well. Inconsistency leads to a lack of clarity and coordination that can add needless expense, and undermines the effectiveness of well-intended efforts. For example, seniors in federally assisted housing often do not receive the health and supportive services they need and for which they are eligible. Low-income seniors living in the community often have unmet housing needs as well as inadequate or non-existent community-based services. Seniors in rural areas frequently have extremely limited housing, services, or health care options in their communities. Some low-income seniors find themselves eligible for housing assistance but ineligible for health-related assistance, because qualification standards differ among

programs that were all designed to help the same people in need. Finally, seniors who do not qualify for need-based assistance often find themselves without services because gaps in programmatic coverage sometimes lead to overwhelming health-related costs. Policies must be synchronized and modernized to meet the evolving needs and demands of a new generation of seniors, and to address the crisis.

A Call To Action

Federal policy must be more responsive to the needs and desires of the next generation of seniors. The Nation must embrace consumer choice and tailor programs to fit individual needs. Americans must think residential, not institutional.

The existing senior housing stock needs to be preserved. The supply of service-enriched, affordable housing must be increased substantially to meet the growing demand. Shortages already exist, and data indicate that they will only worsen. Housing policy should also foster aging in place for homeowners and renters, by helping to ensure that housing quality is maintained and is adaptable to the needs of seniors.

The majority of today's seniors are homeowners. Programs such as Medicare and Medicaid should build on that, and look toward expanding access to community-based services to better serve all seniors, so that they can age in place to the fullest extent practicable.

Federal agencies must collaborate more closely to address the needs of future seniors in America, and address them in the least restrictive environment. Legislative and administrative action must streamline the interrelationships among agencies as they affect policies targeted to seniors. Often, even when programs theoretically match well with the needs of elders, the lack of connection at the agency level leads to ineffective implementation and inadequate utilization.

Housing is usually built without regard to service provision. Health services are usually provided without regard to housing environment. Medicare and Medicaid do not work in concert to ensure efficient, quality health care. Too much policy is developed in a vacuum rather than in an open forum; too much policy is developed to serve narrow rather than broad interests.

Comprehensive needs deserve comprehensive attention. Cross-cutting needs require cross-cutting thinking and solutions. It is, therefore, vital that the comprehensive needs of seniors be addressed in a coordinated fashion by all government agencies whose mandate includes aiding older persons.

We call on the States to meet the needs of seniors. In the case of housing, homestead exemptions, wise use of HOME funds, and Community Development Block Grants (CDBG) can ensure that seniors living in the community can remain in the community. Helping to make dollars dedicated to seniors go farther, or giving seniors a hand in maintaining or adapting their homes, is being responsive to both consumer need and choice. The creation of goals for senior housing within Low-Income Housing Tax Credits, HOME, and other State-based programs should be developed so that these

financing tools can be used to develop affordable housing to meet this urgent demand. Effective use of transportation funds can help seniors remain independent in their communities by providing the necessary transportation infrastructure.

States need to avail themselves fully of Medicaid waivers to provide home and community-based services that prevent premature institutionalization and allow more seniors to remain in the place they call "home," whether that be a single-family residence, a subsidized rental apartment, or with a family member. Congress should provide the financial incentives to make this happen. While skilled nursing care will always be needed, nursing facilities should no longer be the default choice for placement of seniors with health and service needs. Steps need to be taken to ensure that a quality workforce exists to provide those services in communities and facilities.

Local government can take action by establishing senior-friendly communities that are safe and provide adequate transportation, services, housing, and supports. It can provide property tax exemptions or abatements, and use tax increment financing mechanisms as incentives to the development of affordable senior housing. Localities should endeavor to coordinate the resources already available to seniors and, working with local agencies, non-profits, and providers, establish clearinghouses of information that are both accessible and understandable to seniors. They should examine their senior population and consider their needs when developing community planning documents and tools. Larger communities, which receive allocations of HOME and CDBG funding, should target portions of these resources to promote senior housing and health services.

Government is a major partner in ensuring that the future needs of seniors are met through its policies and actions, but it is only one partner. The private sector and individuals have leading roles as well. The Government Sponsored Enterprises, such as Fannie Mae and Freddie Mac, and the financial sector must endeavor to provide the capital needed to ensure that affordable senior housing and health facilities are constructed. Doors must be open to the provision of services and the creativity of various delivery models. Financial products must be available to address the needs of seniors, including affordable long-term care insurance, secure reverse mortgages, and other financial tools and incentives to help retirees take responsibility for their own future. There is also a need for reasonably priced, quality housing constructed by the private sector that includes the option of affordable services' packages.

Community and faith-based organizations should increase their focus on senior constituents and endeavor to fill gaps for those in need. Organizations should work to educate themselves so that they can provide improved, comprehensive, and more accessible services and information to seniors and their families. Existing senior housing providers need to open their doors to the community, not just their residents.

Finally, individuals must take action. This is not a crisis where the solution rests solely with government and business. Solutions must also start at the grassroots level — with volunteers in the community and local advocates. Non-profit, voluntary, and faith-based organizations have long been the mainstay of services to seniors, particularly those with limited incomes. They need continuing support.

The Baby Boomers begin to retire in less than a decade; there is limited time to plan for the future. Smart planning will help to ensure the maximum number of choices for tomorrow's seniors. Whether it involves investing in long-term care insurance or simply setting aside savings for uncertainty, individuals can and should plan for their own futures so that when the time comes, the Nation can marshal and maximize the resources needed to ensure that America's seniors can enjoy the best quality of life.

Congress created this Commission believing that the Nation faces a surge in the seniors population far beyond expectations. This Commission has reviewed the need, consulted with experts, and honored the seven Mandates given to us by Congress. We advise the Congress that, indeed, a crisis is on the horizon. We have identified the problem, we have shared our vision, and we have stated our recommendations. This is our Mandate for Change. To be effective, we must work together as a Nation, at all levels of government, as private and public partners, embracing the challenges set forth.

Part VII. – BEST PRACTICES

Philosophies of Care

The Eden Alternative
Independent Choices

Affordability

Coming Home Program for Affordable Assisted Living
ElderChoice
Public Housing and Assisted Living: Two Success Stories
Sarah's Circle: Intergenerational Supportive Housing

Coordinating Health and Housing Services

Friends Life Care at Home
CareConnections
Nursing Home Without Walls Program

Community Wide Approach to Care

Naturally Occurring Retirement Communities
East Boston - A Health and Housing Partnership
SAFE HOME

Additional Supportive Services

Umbrella Senior Services, Ltd.
Jewish Home and Hospital Transportation Department
Customized Health care: Meeting the Individual at the Point of Need
Home Repair: Insuring the Safety and Independence of Seniors

The Eden Alternative

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The Eden Alternative is a radically different approach to long-term care. Although Eden Alternative programs focus on changing the culture of nursing facilities, the Eden ideology extends to all methods of long-term care service delivery. Founder Bill Thomas based the development of the Eden Alternative on his observation that individuals do not want to go to nursing facilities, primarily because many nursing facilities are undesirable places to both live and work. Nursing facilities are often *institutional* environments in which patients are *treated*. The Eden Alternative seeks to create a *living* environment in which care is *exchanged*, with residents and staff both giving and receiving.

After completing his training at the Harvard Medical School, and residency at the University of Rochester, Dr. Bill Thomas served as a physician in a nursing facility. That experience changed his life. Dr. Thomas came to believe that even the best nursing facilities were flawed; the patients were deteriorating despite the careful attention of doctors and staff. Dr. Thomas concluded that the fundamental problem with nursing facilities was that they were devoid of *life*. To improve the quality of *life* of the residents and as a result, the health of residents, Dr. Thomas felt the nursing facility should be infused with *life*. He and his wife Judy developed The Eden Alternative to address what they identified as the three plagues of the long-term care institution — loneliness, helplessness, and boredom; radically re-imagining the delivery of long-term care.

The Eden Alternative seeks to cure loneliness, not with medication, but by providing residents with companionship and surrounding them with life. A core philosophy of The Eden Alternative is that life creates life; the opportunity to care for other living things in a spontaneous environment, rather than the prescription of pills, can restore and maintain a individual's life no matter their age or physical impairment. Nursing facilities that adopt The Eden Alternative commit to changing the culture of their nursing facility, moving away from an institutional model to a team based model. The staff gets to know the residents, and provides the services and assistance that suit the individual's specific needs.

By emphasizing a culture change, The Eden Alternative addresses the major problems affecting nursing facility care today: staff turnover, low staff retention and quality of care. Thomas has found that when the staff is treated well, the elderly are treated well, increasing the quality of life for employees and residents alike. The intimate atmosphere creates a homelike environment, invigorating both the staff and the residents. Eden disbands the hierarchical management structure of the typical nursing facility. The certified nursing assistants, a major part of the nursing facility staff, have control over their schedules and help to decide how tasks and responsibilities should be divided.

In the over 300 nursing facilities that have adopted The Eden Alternative model, the most visible change is the presence of plants, animals and children. One of the ten principles of The Eden Alternative, "Loving companionship is the antidote to loneliness" encourages nursing facility staff, residents and administrators to fill the facility with

plants, animals and children - all of which involve the planning and organization of residents and focus residents on giving care, not just receiving it.

Thomas sums up the philosophy of The Eden Alternative by stating:" In long-term care, love matters. And the heart of the problem is, institutions can't love. When we rethink our mass institutionalization of elders, when we do these things, we're not just making a better life for the elderly, we're making life better for everybody in every part of society."

Write-up is based on:
www.edenalt.com
Willging, Paul, "The Eden Alternative to Nursing Home Care More than Just Birds" *Aging Today.*
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PBS Newshour Interview with Susan Dentzer February 27, 2002

Independent Choices

Cash and Counseling Demonstration in Arkansas

IndependentChoices is a demonstration project funded by the Robert Wood Johnson Foundation and the US Department of Health and Human Services. The project is designed to measure the role of choice and flexibility in the quality of personal care services and to maximize the independence of Medicaid beneficiaries with chronic illness. The primary goal is to increase consumers' control over their personal care and assistance, enhance their satisfaction with that care, and meet their needs more fully without increasing costs.

Eligible Arkansas Medicaid beneficiaries, who are willing and selected, exchange their agency personal care services for a cash allowance. Participants use the cash allowance to purchase their own personal assistance services. Empowering consumers to make their own choices about their own care is expected to improve consumer's independence and quality of life. Consumers can hire family members, friends, or acquaintances to provide care or use their cash allowance to buy equipment and devices that increase their independence.

The state provides participants with a monthly cash allowance based on the number of hours of personal care that they require each week, as determined by a medical professional. The average monthly allowance is $350. Counselors help participants develop a spending plan. These counselors check in with participants on a monthly basis, and are always available to them by phone. Participants become employers when they hire a personal care aide. Bookkeepers are available to help participants with the paperwork required to pay an employee's wages and withhold taxes. Participants who cannot or do not want to make the decisions regarding how to spend their allowance can rely on a representative decision maker, a relative or a friend, to help.

Most enrollees are highly pleased with the care arrangements they've made; many have contracted with friends and family. The highly personal nature of the care provided, and

the vulnerability of the recipients, underscores the importance of giving consumers the option of hiring familiar caregivers who treat them with dignity and respect. By hiring someone who knows and cares for them, the quality and consistency of care improves. The program has allowed some individuals to purchase equipment needed to help them remain independent (e.g., a microwave for an elderly woman, a washing machine for a blind man).

One Personal Story:
Lillie B. is 88 and never leaves her home, except to go to the doctor or the hospital. The woman who, at one time or another in her life, worked as a cotton picker, a woodchopper, a peach grader, and a nanny, now has a difficult time getting around on her own. She can't cook her own meals, can't bathe herself, or get herself into or out of bed. She spends her days in an easy chair in her living room and her nights in bed, assuming she has help moving from one to the other at the beginning and end of each day.

But Lillie knows how to take care of herself, even if she can't manage it physically. This is why she was one of the first people to enroll in IndependentChoices. She likes to tell people: "I've been in four nursing homes, and I've escaped every one of them."

Lillie uses her $662 monthly allowance from IndependentChoices to pay Barbara W., a former aide who's become "like a daughter," to visit her daily and help her with getting out of bed, bathing, dressing, preparing meals, and some housekeeping. "Barbara will come any time I call," says Lillie. Barbara averages about six hours a week working for Lillie, but she can only help out in the day time during the week, so Lillie is currently training another personal care aide to assist her around Barbara's schedule. Lillie also pays a family friend to do her grocery shopping once a week and plans to hire her 67-year-old son, David, to help her out a few times a week. And she uses part of her allowance to buy personal care items like facial tissue, bath tissue, and over-the-counter medications. "I like being able to have a say in who comes here and cares for me," says Lillie. "It's important to get someone who's on the ball and can do the job."

Write up is based on:
http://www.independentchoices.com/ICHome.htm
Stone, Robyn "Providing Long-Term Care Benefits In Cash: Moving to a Disability Model" *Health Affairs* Volume 20(6).
Brown, Randall and Foster, Leslie, "Cash and Counseling: Early Experiences in Arkansas" *Issues in Brief* Mathematica Policy Research December 2000.
University of Maryland Center on Aging www.inform.um.edu/aging

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Coming Home Program for Affordable Assisted Living

National Cooperative Bank Development Corporation and
Robert Wood Johnson Foundation

The National Cooperative Bank Development Corporation partnered with the Robert Wood Johnson Foundation to address the overwhelming need for affordable long-term care services, which could meet the needs of the frail elderly, and in1992, the Coming Home Program was established.

The Coming Home Program is designed to bring the benefits of assisted living to low-income, frail seniors living in rural areas. The rural elderly make up 25 percent of the population in some areas and often need services that are not available in their communities. As a result, many are forced to relocate or are unnecessarily institutionalized in nursing facilities. Assisted living can provide frail seniors with an alternative to such institutions as well as offer a “missing piece” in the continuum of care.

The Coming Home program focuses on smaller communities where there are fewer options for frail seniors, particularly those with modest incomes. In order for the Coming Home program to be successful, it must reach Medicaid-eligible seniors, for they are the most "at risk" for premature institutionalization. Individual states determine the financial criteria for Medicaid eligibility.

The Coming Home Program has taken on the challenge of creating housing that offers varying levels of service to meet the different needs of seniors, while remaining affordable to the very low-income elderly. The purpose of each project is to develop affordable assisted living facilities that integrate housing with services for frail or chronically ill seniors, and to assist them in living as independently as possible. This requires understanding both the intricacies of affordable housing development and the various funding sources, social and medical criteria that shape the delivery of services to the elderly with long-term care needs.

As a result, the Coming Home Program partners with area non-profits to combine the local knowledge of the market needs with the technical expertise of national researchers and developers, to overcome the obstacles that arise when trying to combine a range of subsidies and loans. The project's units are 100% affordable to seniors living at 60% of the area median income, and 50% of the units must be reserved for individuals whose income is at 50% or below area median income.

Success in Oregon: Rock Cove Assisted Living, a 30-unit facility located in The Dalles, Oregon, was created in response to an unmet need for decent housing and services for elderly of all income levels who were unable to live alone, but who did not need continuous skilled nursing care. Half of the units are targeted to low- to moderate-income seniors. Working in a collaborative effort with Columbia Cascade Housing Corporation (CCHC), they overcame challenges posed by the site and hostile community members, and obtained the financing needed to make the facility affordable to low-income elderly. A growing number of elderly who have lived and worked in the area all their lives can stay and live in dignity at an affordable rate. Parents of residents can live close to their children. Best of all, elderly of all income levels can enjoy the breathtaking setting in the scenic Columbia River Gorge, as well as receive the personalized services they need to remain as independent as possible and to age in place with self-respect.

Private pay residents comprise an estimated 50% of the occupants of the facility. These residents pay rates starting at $1,400 per month for a studio apartment. Rates include all utilities except for phone and cable TV, three meals a day and all services provided by facility staff. The rates are much lower than the rates for a nursing facility. Medicaid eligible residents occupy the remainder of the units. The amount these residents pay is

based on their income. It is difficult to segregate the housing costs, but it is estimated that the housing costs of the 15 units targeted to low- income households is $285 per month, much lower than market rate rents in the area.

Write up is based on
www.ncbdc.org
www.rwjf.org
Interview with Matthew Haas Illinois Initiative
Interview with Robert Jenkens Vice President National Cooperative Development Bank Community Development Corporation
Testimony of Robert Jenkens of National Cooperative Bank Development Corporation, Columbus, Ohio September 24, 2001.
Glashen, Leah "Assisted Living Creates Haves in Rural Areas: Coming Home Offers More Choice" *AARP Bulletin* July-August 2001.

ElderChoice

Massachusetts Housing Finance Agency
1 Beacon Street
Boston, MA 02108
(305) 547-0418

ElderChoice is a program operated by the Massachusetts Housing Finance Agency (MHFA) that assists developers who are building and operating housing for seniors who need assistance to continue to live independently. The MHFA tackled the difficult challenge of building affordable housing with supportive services for low-income individuals by combining the lower interest rates provided through their tax exempt and taxable bond financing program with the subsidy of Medicaid waivers.

Developers interested in providing affordable assisted living need not navigate the financing and Medicaid services separately. The funding streams are coordinated by the MHFA and the developer need only apply to the MHFA, a one-stop shop. In the MHFA program, the affordable assisted living model requires that 20% of the units remain affordable to low-income residents, while the other 80% are market rate units.

The MHFA worked with the Massachusetts Medicaid office to qualify these developments for Group Adult Foster Care waivers. The waivers provide $34/day to fund the supportive services provided to the low-income residents of the assisted living facility. The guarantee of this waiver has allowed developers to move forward with their projects knowing that the funds for service delivery can be worked into the operating pro forma. By streamlining the funding process, the MHFA has been able to build 14 developments to date, producing over 1,200 assisted living units through the Elder CHOICE program.

Impetus for the program came from state health and human services professionals who recognized that assisted-living housing could help rein in Massachusetts' rising Medicaid costs and, in the process, provide a more satisfying living environment than nursing facilities for many frail elderly.

The agency had tried to develop new housing with services for the elderly in the mid-1980s, but cutbacks in state housing subsidies prevented progress until other funding

sources could be found. In 1992 the agency accepted, on a pilot basis, an application from a developer proposing to build assisted-living units, a portion of which would be reserved for low-income elders. The mix of housing and services made the application particularly complex. To speed its review, the agency assembled a working group of specialists in such areas as design, housing management, service delivery, and loan underwriting. This interdisciplinary group developed a comprehensive, streamlined method that has proven to facilitate loan approvals.

Financing for assisted living requires a creative mix of funds from multiple sources. Funding for the state's assisted-living units comes from the sale of bonds to private investors, equity from private developers, proceeds from the sale of Federal Low-Income Housing Tax Credits, and other Federal sources.

Operating costs for Elder CHOICE developments come primarily from tenants' rents, Supplemental Security Income, and Group Adult Foster Care, a Medicaid program for low-income elderly. The Massachusetts' Division of Medical Assistance estimates that Elder CHOICE will save about $5,000 per year for every low-income elder residing in assisted living rather than in a nursing facility.

Write up is based on:
www.mhfa.org
Testimony of Tom Gleason, Executive Director, Massachusetts Housing Finance Authority, Cambridge, Massachusetts, March 1, 2002.
Interview with Frank Creeden, Massachusetts Housing Finance Authority
1995 Innovations in Government Award, Kennedy School of Government

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Public Housing and Assisted Living:

Two Success Stories

Helen Sawyer Plaza
Miami, Florida

Neville Place
Cambridge, Massachusetts

Helen Sawyer Plaza: The first public housing assisted living facility in the Nation, Helen Sawyer Plaza is a 104 unit facility operated by the Miami-Dade Housing Agency (MDHA). Originally built in 1976 as a center to house the frail elderly and handicapped, the changing needs of its residents forced the MDHA to rethink the traditional delivery of public housing. After a major conversion and remodeling, it re-opened in 1998 as an assisted living facility with 21 one-bedroom and 83 efficiency apartments. The Helen Sawyer Plaza provides a range of services to its residents, who are all Medicaid eligible and over the age of 60, to keep them in their apartments and out of institutions. Services include: attendant care, behavior management, companion services homemaking, intermittent nursing, medical administration, occupational therapy, personal care, physical therapy, access to specialized equipment and supplies, speech therapy and social and recreational activities.

The Helen Sawyer Plaza offers affordable housing to some of Miami's lowest income seniors, while insuring that they have the supportive services they need to remain independent as long as possible. The median income of residents in the Helen Sawyer Plaza is $7,451- just 35% of the area median income. Without an affordable assisted living option, most residents would be forced to move into nursing facilities. The project has received numerous awards and the support of the community, elected officials and funding partners. Helen Sawyer Plaza has been so successful that the Miami-Dade Housing Agency has plans to convert another one of its facilities, Ward Towers, into an assisted living facility.

Neville Place: Neville Place is a development of Neville Community Partners, a joint venture led by the Cambridge Housing Authority (CHA). CHA formed Neville Community Partners, a consortium of Cambridge-based housing and health organizations, to redevelop the existing Neville Manor Building into affordable assisted living. This is the first phase of a planned senior living campus providing a continuum of care for local seniors in need of health care services and housing. The second phase of the development is the construction of a skilled nursing facility, scheduled to open in 2003.

Neville Place is a mixed income, 71-unit assisted living facility, operated by the Cambridge Housing Authority. It was designed to address the growing needs of the Housing Authority and the Cambridge community's elderly populations. The facility has expansive grounds, mature woodlands, community gardens and a public walking path that follows the perimeter of Fresh Pond.

Through the creativity of the Cambridge Housing Authority, the development partnership was able to find a way to combine Section 8 vouchers with the Massachusetts Medicaid Waiver program (i.e., the Group Adult Foster Care Waiver), to provide both housing and services to the lowest income seniors.

Participation in the Group Adult Foster Care program also provides an important safety net for low-income residents who spend down their assets paying for assisted living at Neville Place. The state program offers assurance that any low-income resident who needs help with activities of daily living will not have to move from Neville Place due to depletion of savings and/or inability to continue to pay privately.

Services provided at Neville Place include daily meals, a wellness program, activities, scheduled transportation, laundry services, housekeeping, residence security, dementia care, personal care, medication monitoring, and computer/internet access.

Write up is based on:
Testimony of Dan Weunschel, Executive Director, Cambridge Housing Authority, Cambridge, Massachusetts March 1, 2002.
Interview with Jenn Faigan Cambridge Housing Authority
Testimony of Rene Rodriguez Miami-Dade Housing Authority Miami, Florida January 14, 2002

Sarah's Circle: Intergenerational Supportive Housing

2551 17th Street, NW, Suite 103
Washington, DC 20009
(202) 332-1400
www.sarahscircle.org

Sarah's Circle Inc., an award-winning example of supportive housing for the elderly in Washington, D.C., is an exemplary project that provides intergenerational programs for residents. In addition to the facility's 38 residents, Sarah's Circle serves over 250 seniors of the nearby community. Sarah's Circle offers free lunch services five days a week, health maintenance programs, transportation, social services assistance and housekeeping.

It also offers intellectually stimulating programs, including an intergenerational program in which children from a nearby elementary school participate in weekly events organized by the Sarah's Circle Senior Center. The executive director of Sarah's Circle, Ruth Sachs, credits the services and residents' meaningful involvement in the community with keeping these elderly out of nursing facilities.

Typically, Sarah's Circle residents have incomes at or below 30 percent of the area median income and many are below the poverty level. The existing 34-unit project was started in 1983 with a $375,000 mortgage from CDBG funds. Rents are kept low by rent abatements raised through capital campaigns and donations. Yearly, Sarah's Circle raises $100,000 for abatements. Rents range from $215 for an efficiency to $530 for a two bedroom, which is often shared by two persons. Of the yearly $540,000 budget, $190,000 is spent on the facility's programs.

A pillar in its community, Sarah's Circle Inc. is an example of an organization that has demonstrated ability to self-fund through government and charitable contributions in order to meet debt service and maintain operations. Yet, Sarah's Circle is also an example of an organization that will require access to mainstream financing if it is to expand its services to benefit other residents.

The board of directors of Sarah's Circle Inc. is currently seeking to purchase another building. However, this time around, it seeks a public/private partnership to include financing from a conventional lender. Sarah's Circle and similar organizations across the country are facing a major challenge: underwriting standards for service-enriched projects are still under development. Credit enhancement, lender support by the Government Sponsored Enterprises and Federal Housing Administration, supportive Federal policies, and identification of best practice models for development and financing of service enriched housing will be required in order for the need to be met.

Friends Life Care at Home

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Friends Life Care at Home began through the partnership of two non-profit Quaker organizations, a Philadelphia area hospital and a retirement community. They came together to address the needs of the increasing number of elderly individuals in the community who desired to live in their homes as they aged. In 1985, the Robert Wood Johnson Foundation and the Pew Foundation funded a research project to explore how these two organizations could develop a program to provide long-term care services which would keep individuals in their homes as long as possible. After the research and demonstration project ended, Friends Life Care at Home began to enroll members. Presently 1,500 individuals are members, receiving a range of long-term care services that include everything from assistance with grocery shopping to 24 hour, 7 days a week home health care.

Friends Life Care at Home is a "hybrid" of long-term care insurance. An individual must be in good health and independent to join. All members are over the age of 50, but there is no upper limit on the age of applicants. Individuals pay a one- time entrance fee, followed by monthly fees to maintain their membership. The program is designed to provide care coordination that allows individuals to remain in their homes as long as possible, with adequate access to health care and supportive services to maximize their quality of life. There are six plans from which members can choose, all of which provide different packages of direct service. Those services include: proactive wellness and care coordination, home health care, homemaker services, emergency response system, home inspection, nutritional support, and adult day care. Additionally, some plans provide care in an assisted living or nursing facility.

Friends Life Care at Home measures its success on its ability to provide individuals with choice, flexible service options and the supports they need to remain in their homes as long as possible. The Friends Life Care at Home program has begun to expand outside its original service area in Pennsylvania, offering services in Maryland, Virginia, Washington, DC and Delaware.

Write up is based on:
Interview with Joe Lukach
www.friendslifecareathome.org
Testimony of Peter Kaprielyan Friends Life Care at Home, Columbus, Ohio September 24, 2002

CareConnections

Boston region

CareConnections is a program operated by West Suburban Elder Services, the Area Agency on Aging serving the towns west of Boston, Massachusetts. Funded by the Older Americans Act and the Massachusetts Home Care Program, CareConnections makes the critical link between housing and services by providing service coordination and extended services to any housing agency within the West Suburban network, particularly senior public housing. While the services are tailored to the specific needs of each housing facility, services are available to those with subsidy as well as those who pay privately. They are affordable and flexible to provide individuals with the maximum benefit.

The program's primary goal is to support individuals as they age in place and prevent them from entering nursing facilities. Coordinators assess individuals to both determine their service needs and their eligibility for state and federally supported programs. Individuals are involved in their care, helping to subcontract services and insure quality and consistency of care. There is a 24-hour live-in aide in each facility or a combination of home health aides and personal care assistance, to provide continual access to care, no matter when the need arises.

The CareConnections program leverages the density in Boston area housing facilities to provide flexible and affordable care. Often, individuals only need 15-20 minute intervals of assistance (getting out of bed in the morning, assistance with lunch preparations, medication monitoring and preparing for bed at night). Normally these services are delivered in 1-2 hour blocks, more than an individual might need or could afford. CareConnections can coordinate services in a housing facility to deliver assistance in shorter service blocks, insuring that individuals receive the assistance they need, at a price they can afford. Additional services are provided as needed and include: meals-on-wheels, home health aides, personal care services, homemaker services, and medication distribution. Services are both regularly scheduled and available on an as needed basis.

As a result of CareConnections, elderly housing facilities in the Boston area have seen a decrease in the number of individuals who must leave their apartments and enter nursing facilities.

Write up is based on:
Testimony of Roberta Rosenberg of the Jewish Community Housing for the Elderly, Cambridge, Massachusetts March 1, 2002
Testimony of Sue Temper of West Suburban Elder Services, in Cambridge, Massachusetts March 1, 2002
Massachusetts Department of Elder Affairs
West Suburban Elder Services www.wses.org

Nursing Home Without Walls Program

New York and Hawaii

New York began the Nursing Home Without Walls program (also known as the Lombardi program, in recognition of its legislative sponsor) in the late seventies in an effort to reduce state expenditures on nursing facility care and provide individuals with the option they most desired- the option to stay at home rather than enter an institutional setting.

The program is designed to reduce Medicaid state expenditures by providing individuals whose physical or cognitive impairments require nursing level services, services in their homes. As long as the necessary health and housing programs can be provided in an individual's home at 75% of the cost of a nursing facility in the individual's community, the state will fund the required combination of home-based services.

Individuals must be Medicaid eligible and require nursing facility level of care. Services can include a range of health and personal care services, including housekeeping and chore services, home health aides, and medical equipment. Because the program is designed to allow individuals to remain in their homes rather than enter an institution, the program addresses the individual's health *and* housing concerns. Should an individual's home require repair (e.g., furnace replacement, plumbing or roof repair) or the individual's changing health require home modifications (e.g., grab bar installation, ramp construction, door way widening), the program can fund the necessary work. Individuals participate in the organization and supervision of their care plans as much as possible.

After New York's success, Hawaii developed a program based on the New York model. Hawaii employed the Nursing Home Without Walls model to address the challenges of the delivering long-term care across non-contiguous land areas. Hawaii has an extremely tight supply of nursing facility beds and a limited ability to construct new facilities. The Nursing Home Without Walls program allows individuals to combine a range of services, employ professionals and friends to provide the support needed to age in place as long as possible.

Write up is based on
Interview with Dora Bluth- NY Long-term care
Interview with Fran Galdera Hawaii Nursing Home Without Walls
Testimony of Cullen Hayashida, Assisted Living Options Hawaii, Miami, Florida January 14, 2002

Naturally Occurring Retirement Communities

Penn-South and the Beginning of the NY State NORC Program

Penn South is a cooperative housing development of 2,820 units and 6,200 residents in the Chelsea area of Manhattan in New York City. It is a moderate-income, non-profit,

limited-equity housing cooperative composed of ten high-rise apartment buildings. By 1985, more than 75 percent of Penn South's population was over 60, and the co-op board began to investigate possible ventures to support the senior residents. As part of these investigations, the board came across the research of Michael Hunt and Gail Gunther-Hunt in which the term "Naturally Occurring Retirement Community," or NORC, was coined. NORCs have generally been understood as buildings, apartment complexes, or neighborhoods, not originally planned for older people but where, over time, the majority of the residents have become elderly. The researchers recognized in a 1985 study that NORCs differ from the stereotypical retirement community, and "yet are the most common form of retirement community in the USA."

Once the Penn South Co-op had begun to call itself a NORC, the co-op board set up a special committee, the Penn South Program for Seniors (PSPS), charged with developing programs to forestall nursing facility placement and encourage the elderly to remain in their own homes among family, friends and caring neighbors. PSPS selected three primary agencies to provide the programs and services to the NORC: Self-help Community Services, Inc., Jewish Home & Hospital for the Aged, Inc., and the Educational Alliances, Inc./UJA-Federation of New York, a major private philanthropic organization that contributed funds to assist the program. Many other social and health agencies in the community also agreed to bring their services to the co-op.

Within a few years of operation, PSPS had achieved a firm level of organizational integrity, acceptance within the co-op community, and recognition within the field. A new non-profit corporation had been organized called Penn South Social Services, Inc. (PSSS) to assume the fiscal responsibility for and policy determination over PSPS. PSSS enabled the NORC to formally contract with social and health agencies and to receive direct government and foundation grants. PSPS was now mobilized, sheltered within its own 501(c)(3) organization, and gaining momentum. Soon, both the acronyms "NORC" and "N-SSP" (NORC Supportive Service Program) would be written into state legislation.

In 1994, New York State passed legislation providing support for NORC Supportive Service Programs. The N-SSP legislation established a channel to fund housing and social services in a coordinated manner. The program sought to prevent costly housing problems common to senior residents, and strengthen intergenerational ties in the housing complex. It was endorsed by both political parties in the legislature and was approved by two governors of opposing political parties. As the result of the program's early successes, New York City also took an interest in NORC programs, and their highly organized blocks of voting constituents, and created its own local N-SSP legislation to supplement the state program.

Fourteen N-SSPs now operate in New York State under the N-SSP legislation and funding. These programs represent more than the individual demands of a senior population: they save public dollars by requiring each housing entity that requests state funds to match the grant with its own funds, as well as to attract philanthropic dollars. Each N-SSP is designed as a collaborative venture between New York State, a housing company, and social service and health agencies. The N-SSPs often receive collateral benefits by providing attractive sites for private medical providers, home-care agencies,

and other service providers. These private providers take advantage of the efficient service delivery produced by concentrated populations of seniors. As a result of partnerships with private providers, New York state dollars have leveraged almost four times as many dollars in private investment, above and beyond the required philanthropic match. According to the New York state legislature, N-SSPs have saved the state an estimated $11 million over three years by forestalling 460 hospital stays and 317 nursing facility placements.

Village Care, New York: Recent Developments in the NORC Model

Village Care of New York is designed to confront the problems of an aging community through an "Urban Village" model, a model that provides an array of residential and community services seeking to provide the most appropriate service in settings that offer choice, safety and independence. Village Care first conducted a series of focus groups to better understand the needs of the elderly in the immediate community. They found that the need for adequate housing generally included a desire for personal care, housekeeping, meal preparation in a way that can be affordable to middle income households and low-income households, with the application of entitlements. When constructing this enriched housing environment, Village Care invented its own balance of appropriate rents, service delivery pricing and marketing that responded to the community's specific needs, yet could remain financially feasible.

Write up is based on:
Testimony of Arthur Webb of Village Care, New York in Syracuse, NY July 30, 2002.
Testimony of Freda Vladeck of Aging in Place Initiative in Miami, Florida January 14, 2002.
Interview with David Smith, Penn South Co-op
Interview with Nat Yalowitz, Penn South Co-op.
Interview with Cheryl Kliger, Strickers Bay Building NORC
Bassuk, Karen and Nat Yalowitz. “Innovative Social Policies: The NORC Programs.” Presentation to the Asia-Pacific Regional Conference for the International Year of Older Persons, Hong Kong; April, 1999

East Boston- A Health and Housing Partnership

10 Grove Street
East Boston MA, 02128

In response to the lack of appropriate elderly housing and facilities, the East Boston Neighborhood Health Center and the East Boston Community Development Corporation combined expertise and resources to construct a series of community adult day centers, community health centers and elderly housing in the East Boston community. This partnership represents the necessary links between health and housing services to promote the choice and flexibility American seniors desire.

The East Boston Neighborhood Health Center had been operating the East Boston Home Care program since 1973. The Health Center provided the health and personal care services seniors needed to remain in their homes and in the East Boston community. In 1982, the program administrators began to hear of the success of On Lok, the San

Francisco demonstration using capitated Medicaid and Medicare services to deliver comprehensive community based care to the frail elderly. The East Boston community became one of the first PACE (Program for the All Inclusive Care of the Elderly) sites, bringing the success of San Francisco to Boston.

It became apparent that, while the East Boston Neighborhood Health Center could now more adequately address the health needs of individuals in the community, housing needs also had to be addressed or individuals would be forced to leave in order to find appropriate housing. At the same time, the East Boston Community Development Corporation began to notice that its residents had grown more frail. The building management was spending more and more time addressing the service needs of the tenants. Just providing a roof over their head was not enough. Elderly residents needed some supportive services to remain in their apartments safely.

The partnership between the East Boston Neighborhood Health Center and the East Boston Community Development Corporation formed to increase the available affordable senior housing in the community and insure that the proper level of services could be provided to support individuals in their housing. Over the last two decades, these two East Boston groups have created a series of affordable housing developments with adult day care centers and supportive services.

Now, even as the residents of East Boston are growing older and more frail, those who age in the community can stay in the community and receive the care they need.

Write up is based on
Testimony of John Cradock of East Boston Neighborhood Health Center, Cambridge, Massachusetts March 1, 2002
Testimony of Al Caldarelli of East Boston Community Development Corporation Cambridge, Massachusetts March 1, 2002
www.npaonline.org

SAFE HOME

South East Senior Housing Initiative
10 South Wolfe Street
Baltimore, MD 21231

In late 1989, discussions among several organizations that serve Southeast Baltimore City centered on the growing aging population in the community. Of constant concern were the increasing physical obstacles impeding the ability of older residents living in Baltimore row homes to remain independent, the problems these older residents faced trying to maintain their homes, the neighborhood deterioration that results when homes are not maintained, and the lack of affordable housing options within the community for older residents. The community in general and the elderly residents, more specifically, were at risk as these problems continued to grow.

From these shared concerns, the South East Senior Housing Initiative (SESHI) was developed. Safe Home is a program of SESHI, which allows aging individuals to remain

in their homes and continue to play a vital role in the community. A unique partnership, this program combines the resources and expertise of the Baltimore Medical System- a neighborhood- based health care system, Johns Hopkins School of Public Health, Banner Neighborhoods, Neighborhood Housing Services of Baltimore and the Baltimore City Commission on Aging and the South East Senior Housing Initiative to prevent falls and keep seniors in their homes.

The project attempts to address some of the particular challenges of individuals aging in Baltimore row houses--townhouses with 2-3 stories and the bathroom located on the second floor. The partnership promotes independent living for low to moderate-income seniors in their own homes through a program of integrated environmental modification, intervention and support. They maintain community health and stabilization by keeping independent older adults in their homes as long as possible.

The Safe at Home program coordinates the services of health providers, local non-profits and community organizations to facilitate the supportive services, home modifications, and health care that the elderly residents need. Doctors, nurses, senior center staff, social workers or family members, refer clients to the program. The City Commission on Aging performs a complete assessment on the home evaluation of both the health and housing needs of the individual. A plan for home modifications and other services may be developed and then shared with client, caregivers and physician.

The program connects individuals to the necessary health and supportive services and can provide home repair and home modification services. The program also has a community loan closet to distribute free durable medical goods, a volunteer program to assist individuals with chores and shopping, and an emergency loan fund that provides interest free loans for more extensive home repairs. Service coordinators maintain on-going supportive relationships with clients, and provide periodic contact and revisits to assess changing needs and conditions.

Write up is based on:
Interview with Peter Merels of South East Senior Housing Initiative
www.seshi.org

Umbrella Senior Services, Ltd.

108 Erie Boulevard
Schenectady, New York 12306
(518) 346-5249

Founded in 1988 on Long Island, NY, Umbrella Senior Services now serves seniors in New York, Florida and Montana. Umbrella is designed to respond to the basic needs of aging seniors who wish to remain in their homes, but find that many of the ordinary chores and tasks involved in maintaining a home are more than they can handle.

The basic membership is $200/year for a single-story house and $250/year for a two-story house, after which services are charged on an hourly basis. Services include 24-hour emergency response, 7 days a week, annual home maintenance inspection, smoke alarm battery replacement, gutter cleaning, handyman services ($8.00/hr), domestic chores and shopping ($5.00/hr), parts and materials discounts, fixed rates for licensed plumbers and warranties on handyman services.

The handyman service is the center of Umbrella operations. When a problem arises, the handyman goes to the member's home to perform an on-site inspection. In an emergency, the handyman is at the home within the hour. The handyman assesses the problem and, at the owner's discretion, either repairs the problem directly or makes the appropriate referral. The handymen are most often seniors themselves. The goal of the Umbrella Services is to prevent deferred maintenance by addressing a minor repair problem when it occurs, rather than waiting until a major repair is required.

Umbrella Senior Services also conducts a home audit, identifying potential problems and assessing the need for a range of home modifications including grab bars, higher wattage bulbs, and a simple yet critical reorganization of the kitchen, moving all the essential items within reach.

At the most basic level, Umbrella Senior Services, Ltd. provides home repair services to seniors, helping them to maintain and preserve the value of their home. On a much broader level, Umbrella Senior Services provides seniors with the security of knowing that they will receive high quality repair and modification services, by individuals they can trust.

Based on:
www.non-profits.org
www.theumbrella.org

Jewish Home and Hospital Transportation Department

New York (Bronx, Manhattan and Westchester)
Frank Lipari
(718) 579-0241

The Jewish Home and Hospital in New York solves the challenge of decreasing mobility through its transportation department. For over 20 years, the Transportation Department has insured that the region's seniors can access the recreational, health and social services they need. The department primarily serves the clients of the Jewish Home's Adult Day Health Center; however, the recent restructuring of Medicaid reimbursement will allow the department to respond to the frequent requests to expand their services. Currently the department's 24 para-transit vans run 77,000 trips annually.

Quality Makes a Difference. The Transportation Department of the Jewish Home and Hospital seeks to provide quality transportation for those it carries. All drivers are certified and CPR-trained, and receive extensive training in serving the aging and disabled populations. Drivers get to know their clients and work to provide special assistance to those with dementia, Alzheimer's disease and those needing physical assistance. Pick-up and drop-off routes are specially arranged to minimize waiting and trip time. Jewish Home drivers wear uniforms and vehicles are clearly marked to insure services are delivered with professionalism, trust and respect.

As Director Frank Lipari explained, the focus of the work at the Transportation Department is not on moving bodies from one place to another, it is about helping someone's grandmother or someone else's father to continue to live independently. "We know their name, before we know their apartment number. It's not about picking up the lady in apartment 3B, it's about taking Ms. Jones to the doctor, seeing her through the appointment and returning her home safely. It's about reminding Mr. Smith that he shouldn't eat chocolate on the bus because he is a diabetic, while making sure he enjoys that afternoon's recreation." The training and dedication of their drivers reflect this commitment to the individual, delivering quality service from door to door.

Write-up based on:
LINK Newsletter of the Jewish Home and Hospital Winter 2001
www.jewishhomes.org
Interview with Frank Lipari

Customized Health Care: Meeting the Individual at the Point of Need

House Call
Washington Hospital Center
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Washington, DC 20010-2975
(202) 877-0218

The Washington Hospital Center House Call Program began in 1999 as a response to the needs of the frail elderly. Dr. George Taler and Dr. Eric DeJonge along with the support of Washington Hospital CEO, Ken Samet, set out to establish a patient centered system of care, and to support the needs of the frail elderly aging in place. Rather than place the office as the focus of outpatient care, the House Call program puts the individual, where they live, as the focus of care. Using portable technology, the House Call program provides personalized care, including diagnostic tests and treatment, in an individual's home.

The primary objective of the program is to change a person's lifestyle. "Understanding where a patient lives allows me to make better recommendations regarding their treatment and care", says Dr. DeJonge. The House Call program allows doctors and

other medical professionals to monitor home compliance with treatment and identify illness before it becomes an expensive emergency. Dr. Taler explains, "Our program has a built-in early warning system, allowing us to prevent illness and hospitalization." In fact when comparing the year prior to enrollment in the House Call program and the year after enrollment, individual Emergency Room visits dropped 45% and hospitalization rates dropped 20%.

At present, 480 individuals are enrolled in the House Call program. Clients are frail elderly, ranging in age from 75 to 100. They are the individuals at risk for the greatest medical needs and the greatest medical expense. A majority of enrollees, though not all, are house bound. At a minimum, individuals receive monthly in-home visits. Should an individual require hospitalization, he or she is admitted to the geriatrics wing at the Washington Hospital Center. This continuity of service allows the same doctors to provide both outpatient and inpatient care, saving time, expense and improving the overall quality of care. Doctors do not have an office practice, in addition to their House Calls. The sole mission of the program is to provide compassionate and high quality care at the home.

The House Call team not only cares for the individual patient but works closely with the individual's family, providing support and reassurance. House Call visits are part medical treatment, part counseling, and part education/training. The social worker on staff provides community resources for the support of the caregiver and family. The House Call program is available to a family 24 hours a day, 7 days a week. The personalized approach to health care and the delivery of services in an individual's home fosters a strong and personal relationship between the House Call team, the patient and the patient's family. This relationship can ease the transition to terminal care at home.

House Call provides a national model, demonstrating a new way to deliver health care services to an aging population. The program is based on four principles: providing medical care for elderly persons that meets the needs of the patient and their family, reestablishing a humanistic approach to care of the elderly, providing state of the art diagnostic tests and treatment in the home, and coordinating all home and hospital services to promote communication and continuity of care. The current model of health care is one that requires the patient to go *to* the doctor, and does not meet the needs of the frail elderly. Instead, House Call brings the doctor to the patient, customizing care to fit an individual's particular need. This radical approach to health care not only recognizes the transportation challenges of an aging person, but the House Call model is a flexible model of care, understanding an individual's specific health care needs within the context of the of how an individual lives, particularly, the place they call home.

Write-up based on:
Transcript from ABC Nightly News May 12, 2002
Interview with Dr. Eric DeJonge
Interview with Dr. George Taler
Materials furnished by the House Call Program

Home Repair: Insuring the Safety and Independence of Seniors

RESTORE
Emergency Home Repair Program for the Elderly
New York State

The New York State Legislature appropriates funds annually for the repair of owner occupied elderly homes. Each year, not-for-profit programs submit proposals detailing how they will administer the funds including the selection of eligible recipients, construction managements(?), and program compliance. Those programs that are awarded funding serve individuals over the age of 60, with incomes at or below 80% of the area median income.

Repairs concentrate on the remediation of hazardous conditions that may threaten the health and safety of the elderly owners. Total repair costs cannot exceed $5,000. To date the program has completed more than 3,500 repairs throughout 58 counties in the state of New York.

Community Housing Resource Center
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The Community Housing Resource Center (CHRC) serves the home repair needs of elderly and disabled individuals inside the City of Atlanta. Designed to address the health and safety hazards in a home, the CHRC's Home Repair Program focuses on critical repairs often too expensive to complete on a fixed income. Services include roof repair, plumbing repair, furnace repair or installation, and electrical system replacement. The CHRC also provides minor home modification and constructs wheelchair ramps. Since the repair program began in 1999, the CHRC has completed over 750 home repairs.

To qualify, individuals must be either disabled or over age 62 and have an income below 50% of the area median income. Priority is given to individuals with an annual income below 30% of the area median. Community Development Block Grant funding from the City of Atlanta and private philanthropic sources fund the repair program.

Recently, the CHRC has formed a number of alliances to address the comprehensive needs of their clients, the majority of which are frail, elderly women struggling to age in place. The CHRC has partnered with the Visiting Nurses Association to coordinate the health and housing services of the lowest income seniors. The VNA administers the state Medicaid Waiver program (Community Care Services Program), providing home health and personal care services to low-income, frail seniors. While caseworkers assess the social service and health needs of an individual, the CHRC inspects the home, completing any needed repairs, particularly those that could affect an individual's health concerns. For example, if an elderly individual is suffering from a respiratory illness and receiving in home health care, the CHRC can inspect the heating system and replace the

furnace or supply weatherization services to insure that a home repair problem is not exacerbating their health problem. If an individual is having difficulty with balance, the CHRC can insure that there are no floorboards or doorways that present a potential hazard. In a similar relationship, the CHRC has partnered with the local Adopt-a-Grandparent program to repair the homes of "adopted" elderly individuals. Residents receive the social supports they need to remain in the community while the CHRC insures that their home remains a safe and adequate place to live.