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Promising Practices

Affordable Housing as a Key Piece of Older Adults' Long-Term Services and Supports: Solutions that Consider the Whole Equation

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Introduction

To live successfully in the community and mitigate the risk of needing to move to an institutional setting, low-income older adults and younger people with disabilities who require long-term services and supports (LTSS) need both affordable, stable housing and appropriate services. Thus, while past versions of the LTSS State Scorecard have focused on states' performance in the area of home- and community-based services, the 2020 edition highlights another key driver in creating more choices for individuals with care needs: affordable housing.[1]

Some states have, in fact, developed solutions in this area. This report highlights how such states have addressed both housing and service concerns for Medicaid and state-funded LTSS beneficiaries by linking affordable housing properties with LTSS and other supportive services.[2] While most states and their managed care plan vendors primarily view affordable housing merely as an alternative source of shelter for individuals who are transitioning from nursing homes to the community, the state programs presented in this report take a more proactive approach to linking housing with services. For these states, housing with services is a platform for helping low-income LTSS beneficiaries to successfully remain in their own apartments and communities—reducing the likelihood of a move into a higher care, higher cost living environment like a nursing home or other licensed residential care setting.

Further, such solutions may address other impending challenges. The home care workforce is projected to add nearly 1.1 million new jobs—more than any other occupation—over the period of 2018 to 2028. In addition, an estimated 3.7 million home care workers will change occupation or retire, leaving their positions to be filled.[3] One analysis predicts a shortage of approximately 446,000 home health aides by 2025.[4] The economies of scale created by clustered service delivery in a congregate setting can help address worker shortages and potentially reduce state home care costs. Under that approach, people with LTSS needs may live in the same community, in close proximity to one another, allowing for services to "cluster" nearby and service delivery to be cost effective and efficient.

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1 Susan Reinhard et al., *Advancing Action: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers* (Washington, DC: AARP, September 2020), https://www.longtermscorecard.org/2020-scorecard/preface.

2 The term *affordable housing*, also called *subsidized housing*, refers to apartment communities that receive some form of public subsidy to make the rents affordable to individuals with incomes below a certain eligibility level (e.g., public housing or Section 202 Supportive Housing for the Elderly).

3 PHI, *Direct Care Workers in the United States: Key Facts* (Bronx, NY: PHI, September 2020), https://phinational.org/resource/direct-care-workers-in-the-united-states-key-facts/.

4 Mercer, *Demand for Healthcare Workers Will Outpace Supply by 2025: An Analysis of the U.S. Healthcare Labor Market* (Washington, DC: Mercer, LLC, 2018), https://www.mercer.us/our-thinking/career/demand-for-healthcare-workers-will-outpace-supply-by-2025.html.

Background

LTSS trends in recent years have further highlighted the key link between affordable housing and LTSS. Spurred by rebalancing initiatives—that is, efforts to more equitably balance LTSS spending between services delivered in home and community-based settings and nursing homes (traditionally the larger recipient of funds)—many states have sought ways to expand community living opportunities for people with LTSS needs. Studies have repeatedly shown that older adults and people with disabilities want to live in their homes or communities if possible and, in many cases, enabling such options prove to be more cost-effective.[5] Moreover, some people find themselves at risk of institutionalization due to inappropriate housing. A key challenge states face in providing community-based choices for individuals with care needs is an inadequate supply of affordable and accessible housing.

A historic driver of the imbalance toward nursing-facility care is that Medicaid pays for individuals to live in nursing homes, while funding does not cover room and board for people receiving home- and community-based services (HCBS) who have the same level of need. In recent years, however, the Center for Medicare & Medicaid Services has clarified that Medicaid can pay for "housing-related" services and activities.[6] These reimbursable benefits focus on helping Medicaid beneficiaries secure and keep housing and on supporting systemic actions to facilitate housing access. They take the following forms:

- ***Housing transition services*** help individuals transition from institutional settings to the community (e.g., screening for housing barriers and developing a support plan; assisting with the housing search and application process; identifying resources for move-in needs such as security deposit, furnishings, and environmental modifications; arranging for move).
- ***Housing and tenancy sustaining services*** help individuals keep their housing after it is secured (e.g., training on the responsibilities of tenancy; intervening in behaviors that might jeopardize tenancy; assisting in disputes with landlords and neighbors; linking with community resources to prevent eviction).
- ***State-level collaborative activities*** support collaboration efforts across public and private entities to assist in identifying and securing housing resources (e.g., developing formal/informal agreements with housing agencies and organizations; participating in planning efforts; creating housing locator systems).

States can use a variety of Medicaid waiver[7] and demonstration authorities to cover these services and activities, which means that populations eligible for—and the reach of—the services can vary according to the authority(s) used.[8]

In line with these allowed services and activities, several states have created housing specialist roles within their Medicaid agencies to help build capacity and resources to expand housing opportunities. To support the goal of transitioning people from institutional to community settings,

5 The AP-NORC Center for Public Affairs Research "Long-Term Care in America: Americans Want to Age at Home," (May, 2021), https://apnorc.org/projects/long-term-care-in-america-americans-want-to-age-at-home.

6 US Centers for Medicare & Medicaid Services, Center for Medicaid & Chip Services, *Coverage of Housing-Related Activities and Services for Individuals with Disabilities*, Informational Bulletin (Baltimore, MD: Department of Health and Human Services – Centers for Medicare & Medicaid Services, June 26, 2015), https://www.medicaid.gov/federal-policy-guidance/downloads/cib-06-26-2015.pdf.

7 Section 1115 demonstrations and waiver authorities in section 1915 of the Social Security Act are vehicles states can use to test new or existing ways to deliver and pay for health care services in Medicaid and the Children's Health Insurance Program .(CHIP). https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html.

8 Medicaid and CHIP Payment and Access Commission (MACPAC), *Issue Brief: Medicaid's Role in Housing* (Washington, DC: MACPAC, October 2018), https://www.macpac.gov/wp-content/uploads/2018/10/Medicaid%E2%80%99s-Role-in-Housing.pdf.

for example, many states used Money Follows the Person[9] rebalancing funds to pay for this position.[10] Housing specialists often focus on building relationships and collaborations with state and local housing agencies and organizations to identify or develop options for expanding Medicaid recipients' access to affordable and accessible housing. In states that have adopted Medicaid managed care, housing specialists also help educate managed care organizations (MCOs) on housing resources and building partnerships at the local level. Several MCOs have also created housing specialist roles. These staff members often foster relationships with housing entities, educate MCO care coordinators and family caregivers about housing resources and programs for which clients could qualify, and help clients secure and maintain housing.

In addition to housing-related services and activities that focus on housing transitions, many states also use Medicaid to fund environmental modifications that increase a home's accessibility for persons with physical and mobility limitations. Such adaptations can enable people with LTSS needs to continue living in their homes, as well as help create an accessible option for individuals transitioning into a community setting. The types of modifications covered varies by state but could include such actions as installing ramps, stair lifts, bathroom grip bars, or wheelchair accessible bathtubs and showers, or widening doorways to accommodate wheelchairs.

This range of approaches has helped expand housing access, providing opportunities and support for some Medicaid-eligible individuals to transition to a place that maximizes their independence or to remain at home.

In addition to providing affordable and accessible shelter, subsidized housing communities can offer a platform for addressing other concerns states face in delivering HCBS. The increasing shifts toward providing LTSS in the community—combined with an older adult population that is both expanding and aging—has led to higher demand for HCBS.[11] Simultaneously, states are experiencing strains on their Medicaid budgets and shortages in direct care workers who provide the HCBS. Strategies that purposefully link LTSS programs with subsidized housing communities present a promising option for efficiently delivering HCBS with fewer financial and human capital resources.

A sizable proportion of residents living in subsidized housing communities for older adults are likely to need and be eligible to receive Medicaid or state-funded LTSS. Due to their low incomes, approximately two-thirds of older adults receiving housing assistance from the US Department of Housing and Urban Development (HUD) are eligible for both Medicare and Medicaid.[12] People who meet the criteria for eligibility for both Medicare and Medicaid often have complex medical conditions, and 40 percent of them also need LTSS to address care needs.[13] Over half of these individuals are living with

9 "Money Follows the Person (MFP) is a Medicaid demonstration program that supports state efforts for rebalancing their long-term services and supports system so that individuals have a choice of where they live and receive services. From the start of the program in 2008 through 2019, states have transitioned 101,540 people to community living under MFP." https://www.medicaid.gov/medicaid/long-term-services-supports/money-follows-person/index.html.

10 Mathematica, *Money Follows the Person Demonstration: Overview of State Grantee Progress, January to December 2016* (Washington, DC: Mathematica, September 2017), https://mathematica.org/publications/money-follows-the-person-demonstration-overview-of-state-grantee-progress-january-to-december-2016.

11 RTI International, *An Overview of Long-Term Services and Supports and Medicaid: Final Report* (Research Triangle Park, NC: RTI International, May 2018), https://aspe.hhs.gov/basic-report/overview-long-term-services-and-supports-and-medicaid-final-report.

12 The Lewin Group, *Picture of Housing and Health: Medicare and Medicaid Use among Older Adults in HUD-Assisted Housing* (Falls Church, VA: The Lewin Group, 2014), http://aspe.hhs.gov/daltcp/reports/2014/HUDpic.shtml.

13 Medicaid and CHIP Payment and Access Commission and Medicare Payment Advisory Commission (MACPAC and MedPAC), *Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid* (Washington, DC: MACPAC and MedPAC, January 2018), https://www.macpac.gov/wp-content/uploads/2020/07/Data-Book-Beneficiaries-Dually-Eligible-for-Medicare-and-Medicaid-January-2018.pdf.

five or more chronic conditions.[14] An analysis of the National Health Interview Survey found that 72 percent of older adults ages 62 and older who receive housing assistance report having mobility limitations, 33 percent say they need help with routine activities, and 23 percent need help with personal care.[15]

Anecdotal evidence from housing providers indicates that many residents already participate in Medicaid HCBS programs. Housing staff report that multiple home care aides are in and out of their communities throughout the day. This clustering of residents using LTSS presents an opportunity to organize the delivery of the services in a way that could be more efficient and effective—and beneficial for residents and housing communities.

While increasing housing opportunities and addressing worker shortages across the board is vital, states should also consider various residential settings that can benefit those individuals who need LTSS. More specifically, states should explore ways in which affordable housing arrangements can facilitate delivery of LTSS and how Medicaid and state-funded LTSS can help keep people, with increasing levels of disabilities, living independently in community-integrated settings.

Delivering LTSS in Affordable Housing Communities: Two Approaches

Three states, Connecticut, New Jersey and Massachusetts, offer insights into how they have tapped subsidized housing to more effectively deliver LTSS. The states have developed strategies or formal programs that provide alternative mechanisms for delivering Medicaid or state-funded HCBS services to residents in subsidized housing.

Connecticut and New Jersey have created programs through their state's assisted living framework. Given the similarities of the two states' approaches, this report will first examine this common element before providing further detail on each of all three states' efforts. Massachusetts meanwhile, encourages assigning dedicated vendors to subsidized housing properties that have a concentration of residents (older adults and people with disabilities) using home care services.

CONNECTICUT AND NEW JERSEY'S ASSISTED LIVING TIE-IN

Connecticut and New Jersey's programs do not turn participating housing properties into licensed facilities; rather, they create a mechanism for delivering services to residents in participating housing properties who need a higher level of support and are participating in Medicaid HCBS and 1115 waiver programs. The states adapt their assisted living regulations to allow the housing properties to remain "independent"(not licensed by the state) and accommodate certain aspects of the housing setting.

Under this approach taken in Connecticut and New Jersey, properties retain resident eligibility criteria established by the housing subsidy program under which they operate; such criteria are generally based on age and income but do not consider health or functional characteristics. This means residents have varying levels of care needs; some individuals are functionally eligible

14 Lewin Group, *Picture of Housing and Health*.

15 Public and Affordable Housing Research Corporation (PAHRC), *The Security of Home: How Rental Assistance Provides Low-income Seniors with a Healthier Future* (Cheshire, CT: PAHRC, 2020), http://www.pahrc.org/wp-content/uploads/2020/07/Senior-Spotlight-Summer-2020.pdf.

for HCBS services and others are not. The number of residents utilizing HCBS services can also vary over time. Participation in the HCBS services or onsite assisted living programs is voluntary and not a condition of tenancy.

Housing properties typically do not have dedicated sections or units in the building where assisted living services are delivered, allowing residents who need services to live amid the broader group of residents. Further, with services tied to residents and not apartment units, residents do not have to move to a new unit if they begin utilizing assisted living services. Some housing properties may have a group of apartments with expanded accessibility features (e.g., roll-in showers) in the building, and residents utilizing assisted living services and in need of such features may sometimes choose to move to such a unit, if one becomes available.

Agencies must meet state-required standards to deliver HCBS and/or assisted living services. The agencies place LTSS staff onsite on the housing property, and those staff assist the cluster of residents within the building who utilize HCBS services through the assisted living program. The housing properties give the service provider their own secure office space to store supplies and materials. Aside from contracting with the agency that will provide the onsite services, housing providers remain primarily independent from coordination and delivery of the HCBS services. The quantity and range of services a participating resident receives is determined by the state's established service allocation formulas and/or service planning process for HCBS/assisted living services.

Because the number of residents participating in the onsite assisted living programs—and their service needs—can vary, programs allow some flexibility in staffing levels. Generally, specific ratios or minimum onsite hours are not established, but service agencies are required to staff at levels that can appropriately address the needs of the group of residents participating in the program.

Following is a closer look at how the three states have tapped the LTSS via subsidized housing approach.

Connecticut

In 2000, Connecticut expanded its assisted living program to make it available in a set of independent affordable senior housing communities, including the state's 24 Congregate Housing for the Elderly Program properties as well as (initially) up to four federally funded senior housing properties.[16]

Spurring the expansion in part was the state's experience with its congregate housing program. In that program, providers were finding that the needs of some residents would grow beyond the supports the program could offer. Aware of the issue, the state responded by adding in the assisted living services to support those residents with greater needs. The result is that today 13 congregate properties and seven federally assisted properties offer the assisted living program; in Fiscal Year 2018, 243 residents received assisted living services across the properties.[17]

Licensed Assisted Living Services Agencies (ALSAs) perform the services. They place staff onsite at the housing property for a certain number of hours per day and have an on-call nurse always available. Regulations establish neither a minimum hourly presence nor staffing levels, but require that adequate staffing be provided to meet participants' needs. ALSA

16 Helga Niesz, "Assisted Living Demonstration Programs and Federal Elderly Housing," OLR Research Report 2004-R-0469 (Hartford, CT: Connecticut Office of Legislative Research, June 16, 2004), https://www.cga.ct.gov/2004/rpt/2004-R-0469.htm; General Statutes of Connecticut, § 8-206e.

17 The number of residents receiving assisted living services is not necessarily the same as the number of residents eligible for state-funded or Medicaid-waiver HCBS, as residents choose to receive services through the assisted living program. CT Department of Social Services, *Connecticut Home Care Program for Elders Annual Report to the State Legislature SFY 18, July 2017–July 2018* (Hartford, CT: CT Department of Social Services, November 2019), https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Reports/Annual-Reports/CHCPE-Annual-Report-for-SFY-2018.pdf?la=en.

Connecticut Congregate Housing for the Elderly Program

Connecticut created the Congregate Housing for the Elderly Program in 1985 after identifying a growing population of lower-income older adults with a specific level of needs: they had some difficulties performing household or personal tasks associated with independent living, but did not need the level of care or supervision provided in a nursing home.

To address the issue, the state provided loans or grants that supported the development of 24 rental properties. Each congregate property offers a set of services that includes resident service coordination, one daily meal, weekly light housekeeping, wellness and prevention programs, emergency transportation, and 24-hour emergency response. The state provides ongoing subsidies for both rents and services. (See the appendix for additional details.)

services include personal care, such as hands-on assistance with daily activities (e.g., dressing, grooming, bathing, using the toilet, transferring, walking, eating, and nursing care).

The Connecticut Home Care Program for the Elderly (CHCPE) pays for assisted living services. CHCPE includes a Medicaid waiver-funded component and, for those residents who do not meet Medicaid functional income/asset eligibility criteria, a state-funded component. Because the asset level and minimum age requirements to move into a congregate or federally assisted housing property differ from those of CHCPE, the Department of Economic and Community Development—one of two sponsoring agencies for the congregate program—may provide a subsidy for up to a certain level of care, depending on the individual's income and assets (see the appendix for additional details).

New Jersey

When creating its assisted living program in 1993, New Jersey wanted to make services available in a range of settings, including subsidized housing properties for older adults. This thinking was inspired by the state's Congregate Housing Services Program, which offers a set of services in affordable senior housing communities to residents as their needs change and they require assistance with life tasks.

The state's assisted living licensure requirements, however, were incompatible with the regulations for housing properties subsidized by HUD.[18] HUD considered facilities requiring a license to be a medical facility; such category would be ineligible to receive HUD rental assistance. In addition, the housing properties could not necessarily meet the building standards required for assisted living facilities without expensive retrofitting.

In 1994, the state received a demonstration grant from the Administration on Aging to develop an assisted living model that would be compatible with subsidized housing settings.[19] After the pilot period and an evaluation study, the state amended its regulations to create an assisted living program, which continues today, that is delivered in subsidized housing communities.[20] The program may be offered in any type of subsidized housing community. Currently, it is available in about 15 properties across the state.

Housing-communities partner with a licensed assisted living program provider to deliver services. Service providers must staff each site

18 Robert Mollica, *Assisted Living Policy and Regulation: State Survey* (Washington, DC: National Academy for State Health Policy, April 1995), https://aspe.hhs.gov/basic-report/assisted-living-policy-and-regulation-state-survey#NJ.

19 Robert Mollica et al., *Guide to Assisted Living and State Policy* (Washington, DC: National Academy for State Health Policy, May 1995), https://aspe.hhs.gov/basic-report/guide-assisted-living-and-state-policy.

20 N.J. Admin. Code § 8:36-23.

with a minimum number of aides and nursing personnel to address the needs of the residents participating in the program. Properties generally have onsite staff available 12 to 16 hours per day and available on call 24/7. One person—an employee of the assisted living program or the housing staff—must be onsite 24 hours a day, available to contact appropriate authorities in an emergency. Assisted living program staff deliver the same services available in licensed assisted living residences and must provide or arrange for assistance with personal care, nursing, medications, and dietary and social work services.

Services are paid for through the state's Medicaid Family Care Comprehensive Demonstration Waiver. Residents who are financially ineligible for the waiver may pay privately if they would like to participate in the program.

Massachusetts

Whereas Connecticut and New Jersey housing with services model involves assisted living programs, Massachusetts takes a different approach. The state supports a cluster care strategy through its state-funded Supportive Housing Program and encourages the strategy to be utilized in other affordable senior housing communities.

The Supportive Housing Program is a joint program of the Executive Office of Elder Affairs (EOEA) and the Department of Housing and Community Development. The program creates a supportive living environment in state-funded public housing properties serving older adults and people with disabilities, by funding coordination and linkages to services, 24/7 emergency response, congregate meals, and social activities, among other needs.[21]

EOEA contracts with Area Services Access Points (ASAPs) to provide the services in 41 participating housing properties. ASAPs are state-designated entities responsible for coordinating and delivering community-based LTSS to individuals who meet the requirements for state or federally funded programs.

ASAPs staff an onsite service coordinator at each Supportive Housing property who assists all residents in the building with accessing needed benefits and resources. In some cases, the ASAP may establish the onsite service coordinator to also be the case manager for all residents in the building who receive case management services from the ASAP or it may assign a single case manager separate from the service coordinator to work with all residents receiving case management services.

In addition, ASAPs may also contract or enter into a memorandum of understanding (MOU) with a primary HCBS provider to place staff onsite at the housing properties for a certain number of hours per day to assist all residents in the building receiving publicly funded HCBS. The priority is to have the designated provider agency offer HCBS to ASAP clients in the buildings; the program is mindful of protecting resident choice. An ASAP may select an alternative provider if the resident has a justified reason to request another provider, an alternative provider is needed to better address a resident's cultural needs, or the designated agency has difficulty meeting staffing requirements due to workforce shortages or related challenges.

EOEA encourages ASAPs' use of a cluster care model in subsidized housing properties serving older adults beyond the Supportive Housing Program sites. Approximately 20 years ago, EOEA drafted language that ASAPs could use in their contracts or MOUs with homecare agencies to define and support these arrangements.

21 The program is also available in a few federally funded public housing communities.

Overall State Program Observations

These state-level solutions and the experiences coming out of them suggest that as states work to strengthen and expand LTSS opportunities in the community, subsidized housing properties for older adults offer a strategic platform for efficiently reaching concentrations of older adults needing HCBS. Clustering care delivery in the housing settings could stretch limited workforce and funding resources, enhance the quality of care delivery, and allow more people with increasing LTSS needs to remain in their homes and communities and avoid moving into more costly settings, including nursing homes. Following are some observations gleaned from the state programs examined.

ENHANCED EFFICIENCY AND EFFECTIVENESS. In traditional home care programs, aides visit participants on certain days for blocks of time, generally a minimum of two or four hours. For example, an aide might visit a resident's home Monday, Wednesday, and Friday from 8:00 to 10:00 a.m. By contrast, through the clustered approach, a select number of aides are stationed at the housing property and provide support to multiple residents throughout the day.

Such dynamics seem to be playing out successfully in the everyday community-housing setting. The clustering created by the Connecticut and New Jersey programs allows onsite aides to assist many residents simultaneously, thus reducing the number of aides needed to serve the same number of people—which could be advantageous given the previously mentioned exploding demand for home care aides and worker shortages.

Clustering may also help with workforce stability and retention, as it minimizes some challenges with the traditional HCBS model. Many direct care workers rely on public transportation, so eliminating travel between clients' homes allows them to be more efficient and productive while seeing residents and carrying out other care related duties. Additionally, under the more standard home-care model, if a client does not need care for the day or must cut the scheduled time short (e.g., for a doctor's appointment), the worker may not get paid for the lost hours because they are not delivering services. In a cluster model, these variations turn to efficiencies and paid hours, with the worker able to see other clients in the building—stabilizing the worker's shift and preserving pay.

Placing direct care workers onsite also allows them to see participating residents more flexibly and responsively throughout the day. One worker can stop by one apartment to help with preparing breakfast, go on to help other residents throughout the morning, and return later in the day to the first apartment for a medication reminder or assistance with another meal. This flexibility allows workers to maximize their work hours by reducing downtime spent with any one resident and instead assist residents at their preferred schedules. Workers can also respond to unscheduled or unexpected events, such as a resident returning home from a hospital stay or having an emergency need.

Onsite placement also allows service provider staff to see participating residents more regularly, providing the opportunity to notice potential changes in condition. By spotting concerns earlier, staff may help avoid urgent health issues or accidents that could result in emergency room visits or hospital stays and lead to further declines. Research has found that cluster care models can lower Medicaid home care costs.[22]

HOUSING AND SERVICE PROVIDER STAFF COLLABORATION. Examination of the programs revealed that a purposeful connection between the LTSS provider and housing property allows staff from

22 Penny Hollander Feldman, Eric Latimer, and Harriet Davidson, "Medicaid-Funded Home Care for Frail Elderly and Disabled: Evaluating the Cost Savings and Outcomes of a Service Delivery Reform," *Health Services Research* 31, no. 4 (October 1996): 489–508.

both entities to share information, when resident permission is granted, and potentially coordinate around resident needs. Housing staff may be able to supplement insight about residents, helping the service provider understand how they can better assist them. Service staff may be able to help address issues with residents causing disruptions to the property. In one New Jersey property offering the assisted living program, for example, the service provider and housing staff collaborated to enroll a resident who was in danger of being evicted for not taking prescribed psychiatric medications. The housing staff found that assisted living program staff were able to stabilize the resident, monitor the administration of the medications, and address other care needs, which minimized the disruptions the resident caused to the community and eliminated potential eviction.

Service providers are also able to leverage other services or resources available at the property. This approach can vary depending on the housing property, but it could include a service coordinator who assists residents in applying for and maintaining public benefits, such as nutritional, transportation, and energy assistance benefits that address social determinant of health needs. Properties also often bring wellness and social programming onsite, which can also help support clients' physical and mental health.

Intentional collaboration can also lead to expanded supports for those residents who may be ineligible for Medicaid waiver services because they do not meet the functional eligibility criteria, but could still benefit from some assistance. With the Massachusetts Supportive Housing Program, some participating housing authorities have committed supplemental funds to expand services and allow onsite direct care workers to assist home care-ineligible clients with intermittent or emergency needs. For example, workers might temporarily assist residents after they return from the hospital or during an illness. Moreover, some ASAPs are able to fund additional services through their operating grants.

AGING IN PLACE.

Putting these types of supports in residential settings helps facilitate aging in place. When residents move into a housing community, they may be fully able to manage their daily activities on their own. As they age and their needs begin to change, residents can access needed supports. As residents' needs continue to progress, the more continual and flexible presence of onsite staff may allow for supporting more extensive assistance or monitoring, precluding or delaying the need to move to a higher level of care.

A NEED FOR LICENSING/REGULATORY FLEXIBILITY.

The examination of state programs highlighted a potential need for creativity in working through matters arising from regulations currently on the books. New Jersey and Connecticut had to be willing to adapt their assisted living regulations to fit the realities of existing physical property designs, housing regulations, and the potential volume of individuals who could participate within one housing property.

In Connecticut, assisted living services are provided in the state's "managed residential communities" (MRCs) by ALSAs. The state licenses the service provider (the ALSA), not the property (the MRC). The ALSA, which receives a license from the Department of Social Services to provide services in a specific MRC, certifies that the MRC is meeting all requirements established by the Department of Public Health. Most MRCs in Connecticut are private-pay assisted living facilities.

Introducing Connecticut's assisted living program into the congregate housing properties presented a challenge: The properties and the ALSAs working with them could not meet all the MRC and ALSA requirements. For example, the ALSA regulations require a minimum of 20 hours per week of onsite nursing supervision. If a housing property had only four participants utilizing assisted living services, however, it would not make financial sense to have a nurse available for so many hours. The state responded by granting permission to the Department of Public Health,

which oversees ALSAs, to waive provisions of the ALSA regulations as they pertain to operation in the congregate housing properties.[23] The state also excluded the congregate housing properties from the MRC requirements because the communities were already being monitored by the Department of Housing, which oversees the congregate housing program.[24]

New Jersey, meanwhile, created within its assisted living regulations, a new category for delivering assisted living in subsidized housing communities called the assisted living program. An assisted living program "[refers to] the provision of or arrangement for meals and assisted living services, when needed, to the tenants (also known as residents) of publicly subsidized housing which because of any Federal, State, or local housing laws, rules, regulations or requirements cannot become licensed as an assisted living residence."[25] The assisted living program providers are licensed; the subsidized housing communities are not.

FINANCIAL SUSTAINABILITY.

Volume of resident participation is a key factor in financial sustainability for service providers in Connecticut and New Jersey. Some residents in affordable housing properties are not functionally eligible to receive assisted living services. In both states, services are funded through Medicaid waivers, which require participants to be eligible for nursing-home levels of care.[26]

In addition to this constrained pool of eligible participants within a housing property, both states allow eligible residents to receive services through the onsite assisted living program or through a Medicaid waiver program in which services are arranged individually and delivered one-on-one. Though supportive of resident choice, this approach can further limit the pool of participants in the onsite assisted living program.

In both states, the subsidized housing-based assisted living programs are granted some flexibility in staffing levels to account for the varying participation numbers. Service providers must maintain a minimal level of staffing onsite to appropriately address resident needs. In general, providers in both states maintain direct care workers onsite for at least 12 hours a day and nurses for varying hours, in addition to having nursing staff available on-call 24 hours a day. If enough residents do not participate in the assisted living programs, however, the providers can have difficulty covering their staffing and other costs and maintaining financial viability. This situation can lead to providers discontinuing programs or feeling reluctant to initiate new ones.

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23 State of Connecticut, *An Act Concerning Programs and Modifications Necessary to Implement the Budget Relative to the Department of Social Services*, House Bill No. 6002, June Special Session, Public Act No. 00-2, https://www.cga.ct.gov/2000/sum/2000sum00002-R00-HB-06002-sum.htm.

24 General Statutes of Connecticut, § 19a-6c, https://law.justia.com/codes/connecticut/2019/title-19a/chapter-368a/section-19a-6c/.

25 New Jersey Administrative Code, § 8:36-1.3, https://www.nj.gov/health/healthfacilities/documents/rfpappendixes/appendix_a.pdf.

26 Connecticut's Home Care Program for the Elderly, which funds assisted living services in congregate and HUD-assisted properties, also has a component that is state funded. The state-funded component serves individuals who would not qualify for the Medicaid waiver, including those who are at risk of nursing home placement and need assistance with one or two critical needs(the Medicaid waiver requires needing assistance with three or more critical needs), or who are above the Medicaid eligibility asset levels.

Conclusion

The many states seeking to expand or strengthen their community-based LTSS services face the closely connected challenge of shortages in available HCBS workers and affordable and accessible housing. Creating a better system with expanded options for people with LTSS needs requires strategies that address both challenges.

The strategies discussed above do not produce new housing units, and yet they offer a promising LTSS delivery approach that can provide more flexible and responsive supports to residents than can the traditional one-to-one home care model, while streamlining the number of staff needed to support the same number of residents. The ability to leverage the affordable housing platform to offer integrated, community-based care options for people needing LTSS could strengthen the rationale for expanded public and private investment in new affordable housing stock.

Although the New Jersey and Connecticut models tap their assisted living programs, Massachusetts' approach shows that such a formal regulatory and licensing structure may not always be needed, and that the strategy could be applicable in any state. With a goal of creating a more efficient delivery model, the Massachusetts model does not introduce additional service requirements, regulatory oversight, or administration costs that may accompany an assisted living program; it simply rearranges the delivery of programs that are already in place.

States operating managed LTSS programs may need to consider how they could implement a clustered care strategy given the number of participating MCOs. A key consideration for the success of a clustered strategy is adequate volume to financially support onsite staff. With residents receiving LTSS split across multiple entities, individual MCOs may not have a large enough volume to warrant onsite staff. Additionally, having multiple provider agencies staffed onsite may be difficult for the housing properties to accommodate and confusing to residents. Managed LTSS states may need to consider how they can encourage or direct collaboration across MCOs.

Nevertheless, approaching home- and community-based LTSS in the context of affordable housing offers great promise, for the very issues themselves are inextricably intertwined. As some states have shown, solutions arise from the same place as the challenges they solve: in the details of implementation.

Appendix. Massachusetts, Connecticut, and New Jersey Program Descriptions

PROGRAM	ADMINISTERING AGENCY	LOCATIONS	PROGRAM ELIGIBILITY	SERVICES AVAILABLE	SERVICE PROVIDER AND STAFFING	PAYMENT MECHANISM
Massachusetts Supportive Housing Program	Jointly administered by the Executive Office of Elder Affairs (EOEA) and the Department of Housing and Community Development	41 state and federally funded public housing communities for adults and persons with disabilities	Open to all residents who live in a housing property that operates the program Eligibility to move into participating housing properties varies depending on type of property (state or federally funded public housing) and location, but will be based on age and income	• Service coordination • 24/7 on-call emergency response • One daily meal, including congregate meal Monday through Friday, if needed • Social activities Residents apply for home- and community-based services (HCBS) independent of the Supportive Housing Program	Aging Services Access Points (ASAPs) staff an onsite service coordinator ASAPs may also select a dedicated home care vendor to provide services to residents in a Supportive Housing Program site who are using state-funded or Medicaid waiver HCBS; onsite staffing is determined by the ASAP and home care vendor according to the needs of the group of residents These HCBS services are not funded under the Supportive Housing Program	EOEA provides each participating housing resident with an annual contact; sites bill EOEA monthly No charges to residents for any services provided by the Supportive Housing program

PROGRAM	ADMINISTERING AGENCY	LOCATIONS	PROGRAM ELIGIBILITY	SERVICES AVAILABLE	SERVICE PROVIDER AND STAFFING	PAYMENT MECHANISM
New Jersey Assisted Living Program	Department of Health	Publicly subsidized housing properties (any housing property where the construction has been financed by funds from any local, state, or federal entity for the purpose of making the housing affordable to persons with incomes below the median income)	Eligible for NJ Family Care Medicaid Managed Long-Term Services and Supports (LTSS) program: • 65 years or older, or under 65 and determined to be blind or disabled by the Social Security Administration or the State of New Jersey • Meets clinical eligibility for nursing-facility level of care (needs hands-on assistance with three or more activities of daily living, such as bathing, dressing, toileting, locomotion, transfers, eating, and bed mobility, or has cognitive deficits and requires supervision and cueing with three or more activities of daily living) • Income limit: $2,349/month (single person) • Asset limit: $2,000/month	Provide or arrange for: • Assistance with personal care (including but not limited to activities of daily living) • Nursing • Pharmaceutical • Dietary (dining services and/or meal preparation) • Social work services	Licensed Assisted Living Program (ALP) provider ALP provider must ensure that adequate staffing (number and ability and training) is available to address assessed needs of participants Staff are generally onsite 12 to 16 hours/day, 7 days/week; a nurse is available on-call 24/7 There must be onsite 24 hours/day at least one ALP provider or publicly subsidized housing staff member who can be responsible for contacting appropriate authorities, including the ALP provider, in the event of an emergency	Participants pay rent to housing property; may receive subsidy so rent is no more than 30 percent of income, depending on type of housing property Services paid for by NJ Managed LTSS Medicaid waiver or private pay

PROGRAM	ADMINISTERING AGENCY	LOCATIONS	PROGRAM ELIGIBILITY	SERVICES AVAILABLE	SERVICE PROVIDER AND STAFFING	PAYMENT MECHANISM
Connecticut Assisted Living	Department of Social Services and Department of Public Health	• 24 Congregate Housing for the Elderly properties (see details on this program in the following table) • 7 elderly properties funded by the US Department of Housing and Urban Development (HUD) • 5 Assisted Living Demonstration Communities	Meet qualifications of Connecticut Home Care Program for Elders (CHCPE): • 65 years old or older • Connecticut resident • At risk of nursing-home placement (requires assistance with critical needs such as bathing, dressing, eating, taking medications, and toileting) • Medicaid waiver income limit: $2,349/month • State-funded income limit: no limit • Medicaid waiver asset limit: $1,600/month (individual), $3,200/month(couple, both receiving services), $27,328/year (couple, one receiving services) • State-funded income limit: $38,592 (individual), $51,456 (couple)	• Core services: housekeeping, personal laundry, and meal preparation • Personal services: assistance with daily activities including but not limited to dressing, grooming, bathing, toileting, transferring, walking, and eating • Onsite nurse: available hours depend on needs and number of participants • On-call nurse: available 24 hours/day	Core services are provided or arranged for by the managed residential communities, which is the property in which the assisted living services are delivered (i.e., congregate housing or HUD-funded properties) Personal and nursing services are provided by Assisted Living Services Agencies No required staffing ratio; onsite staffing must be adequate to meet participant needs and an on-call nurse must be available at all times	In congregate housing and HUD-funded properties, participants pay rent to property; may receive rent subsidy so rent is no more than 30 percent of income Services are paid for through CHCPE; residents eligible for state-funded categories (do not need nursing-home level of care or assets are over Medicaid level) are required to pay 9 percent of cost of services In Congregate Housing for the Elderly properties, Department of Housing administers a subsidy program for residents who are under age 65 and/or income/asset ineligible for CHCPE

PROGRAM	ADMINISTERING AGENCY	LOCATIONS	PROGRAM ELIGIBILITY	SERVICES AVAILABLE	SERVICE PROVIDER AND STAFFING	PAYMENT MECHANISM
Connecticut Congregate Housing for the Elderly *This program is not a focus of this report. This description is being provided, however, because it is a type of property in which the state's assisted living program is delivered.	Jointly administered by the Department of Housing (DOH) and the Connecticut Housing Finance Authority (CHFA) Funds ongoing rent and congregate service subsidies; CHFA provided loans/grants to build/rehab the 24 congregate housing properties	24 properties	• 62 years old or older • Annual income less than 80 percent of area median income • Temporary or periodic difficulties with one or more activities of daily living • Meet established criteria of a local selection committee, which include but are not limited to a physical and functional assessment of frailty, an evaluation of housing conditions and living arrangements, and an assessment of daily living needs State does not have a standardized tool to determine functional eligibility for program; each property develops its own assessment mechanism	• Resident service coordinator • One daily meal • Weekly light housekeeping • Wellness and prevention programs • Emergency transportation • 24-hour emergency coverage (onsite security)	Congregate housing property No minimum staffing requirements	Residents pay: • Monthly base rent; some may receive rent subsidy, so they pay no more than 30 percent of rent • Monthly congregate service fee, based on adjusted income, up to a maximum amount Rent and congregate service fee vary by property

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