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Linking Housing and Long-Term Supports and Services

Older adults with disabilities living in the community often need long-term services and supports delivered to their homes. But for older renters in particular, even the least expensive care options may quickly deplete assets. Meanwhile, the limited supply of affordable, accessible, and service-enriched housing leaves many older adults with low incomes at risk of premature institutionalization. While the federal government is making efforts to better coordinate housing and services for this vulnerable population, and local governments and nonprofits are developing some innovative approaches to housing and health care integration, the need is currently greater than can be met and expected to grow.

COMMUNITY-BASED CARE FOR OLDER ADULTS WITH DISABILITIES

Most older adults with disabilities live in the community. In fact, more than 90 percent of individuals aged 65 and over who have disabilities live in private homes. While most of these adults live with a spouse, partner, or other family member, the share living alone increases with age, rising from 22 percent of those aged 50–64 to 35 percent of those aged 80 and over (**Figure 23**).

Meanwhile, only 9 percent of people aged 50 and over with disabilities live in group quarters such as nursing homes or other congregate settings. Even as the older population has grown in recent years, the number of adults living in group quarters has shrunk, with the share of the 65-and-over population in nursing homes falling by 20 percent between 2000 and 2010. Some of this decline reflects wider availability of other care options such as supportive housing and assisted living, where older adults receive services but maintain private units, as well as an increasing emphasis on long-term care in private homes. Indeed, the 2013 National Study of Long-Term Care Providers reported that home health agencies served approximately 4.7 million of the 8.4 million recipients of long-term services and supports (Harris-Kojetin et al. 2013).

The costs of providing long-term care in the home are generally much less than in institutions. The Senate, in its deliberations on the Patient Protection and Affordable Care Act, noted that the costs to Medicaid of supporting three older adults with home and community-based services are roughly the same as those for nursing home care for one individual.

Nevertheless, residential care facilities such as nursing homes and assisted living are still important providers of long-term care. Indeed, the share of the older population living in group quarters rises sharply at age 85. The CDC reports that 1.4 million people (not necessarily all over the age of 50) were residents of nursing homes at any given time in 2012, and that these institutions serve more than 3 million people annually. Many nursing home stays follow a hospitalization and are brief, with a typical duration for older adults of just 15 days. At the same time, nursing homes continue to provide end-of-life care, with a typical stay of five months (Kelly et al. 2010).

Given the growing older population, more and more adults will need long-term services and supports. The CDC projects that the number of people receiving this care in the home, and in nursing, assisted living, and similar facilities will increase from 15 million in 2000 to 27 million in 2050 (Harris-Kojetin et al. 2013).

Those in need of long-term care are a particularly vulnerable group. They are at risk of financial fraud as well as physical and emotional abuse from caregivers. Those with dementia may be at even higher risk of ill treatment. Attention to this issue will become increasingly necessary as the aging population grows and more businesses and organizations become involved in assisting frail adults.

PAYING FOR LONG-TERM CARE

In-home care costs can be substantial. Licensed homemaker services (help with cooking and errands), licensed home health aides (assistance with personal care), and adult day care services are the least expensive forms of paid care and their costs have remained essentially flat for the past five years. Even so, the 2014 Genworth Cost of Care Survey reports that the median monthly cost for 30 hours of weekly service is about \$2,500 for homemaker services and \$2,600 for care by a home health aide. Meanwhile, the median daily rate for adult day services is \$65, bringing typical monthly expenses (for weekday use) to \$1,400. These costs come on top of monthly outlays for housing (rent or mortgage, insurance, taxes, and utilities), which averaged \$865 in 2012 for all

households aged 65 and over. By comparison, assisted living typically costs \$3,500 per month, while nursing homes run from about \$6,500 for a semi-private room to \$7,300 for a private room, with costs varying widely by state.

Older adults have only a limited number of options to cover long-term care expenses: out of pocket, through private insurance, or through Medicaid. According to the 2004 National Long Term Care Survey, more than half (53 percent) of older households with chronic disabilities living in the community and receiving any paid home care had to cover the cost themselves (HHS 2012). Households that have financial resources typically pay for independent and assisted living out of income from Social Security, pensions and annuities, and income from investments (Coe and Wu 2012).

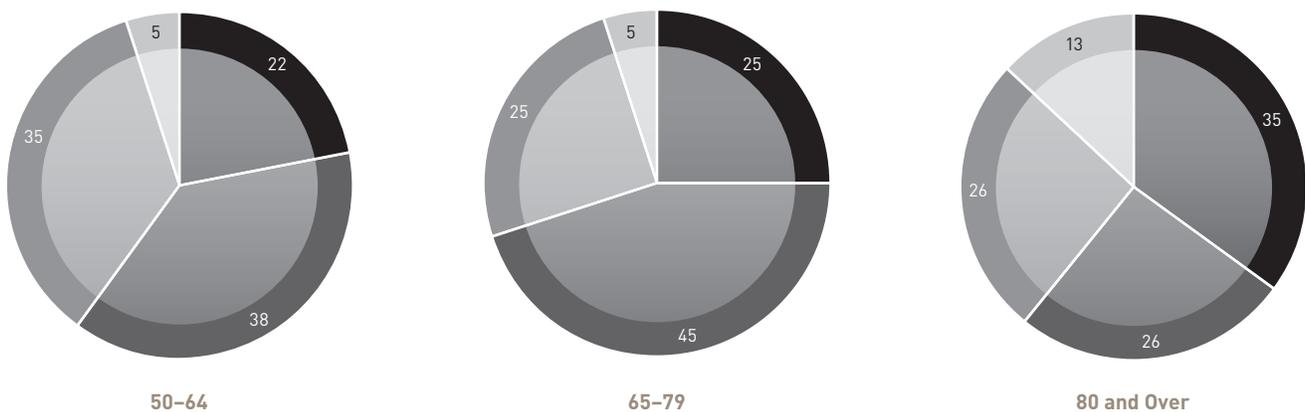
Homeowners can also tap their home equity to cover long-term care expenses, either through a variety of mortgage products or by selling their homes. In theory, the median homeowner aged 65 and over has enough assets—including home equity—to pay for 42 months in nursing care. In practice, however, it is unknown what role home equity plays in financing long-term supports and services or how homeowners divest their assets in older age.

Nevertheless, older renters are clearly less prepared than owners to pay for care later in life (Figure 24). While the typical older owner would have enough wealth to pay for three-and-a-half years in a nursing home, a stay in that type of residential facility

FIGURE 23

Most Older Adults with Disabilities Live in the Community, Many on Their Own

Share of Population with Disabilities by Age Group (Percent)



Housing Situation

- Live Alone
- Live with Spouse/Partner Only
- Live with Others
- Live in Group Quarters

Notes: Disabilities include hearing, vision, cognitive, mobility, self-care, and independent living difficulties. Other household members may be anyone other than, or in addition to, a spouse or partner. Group quarters include institutional and non-institutional settings.

Source: JCHS tabulations of US Census Bureau, 2012 American Community Survey.

would exhaust the wealth of the typical renter aged 65 and over in a matter of weeks. Even the cost of less expensive options, such as having a home health aide or attending adult day care, would deplete the assets of the typical older renter within four months.

Private insurance is used for only a modest share of long-term care costs, covering less than 12 percent of total expenses (O’Shaughnessy 2014). Indeed, the Congressional Budget Office reports that just 11 percent of households aged 65 and over had private long-term care insurance in 2010. Long-term care policies are expensive and the premiums are beyond the reach of many older adults. On average, policyholders aged 65–69 in 2010 paid \$3,800 annually for long-term care insurance while those aged 75 and over paid \$4,100 (AHIP 2012). In addition to its high costs, this insurance does not necessarily cover all care expenses. According to a HHS analysis, private insurance benefits subsidize only 60–75 percent of long-term care costs (O’Shaughnessy 2014).

For those without financial assets or long-term care insurance, Medicaid is the default option. Medicaid plays a critical role in financing the care of low-income households in institutional settings, including two-thirds of nursing home residents aged 65 and over (CBO 2013). To qualify for this support, individuals must spend down or otherwise dispose of their assets. Home equity may be excluded for a time, but Medicaid eligibility criteria include home equity limits and most states will try to recover expenses from beneficiaries’ estates.

Medicaid may also cover long-term care in the home through Home- and Community-Based Services (HCBS) waiver programs. Coverage and eligibility requirements vary by state, and states may limit the number of people who can receive the benefits. Moreover, the share

of Medicaid spending that states use for HCBS ranges widely from 15 percent to 65 percent (Reinhard et al. 2014).

Depending on the state, HCBS waivers also cover some types of home modifications for Medicaid-eligible adults with disabilities living at home. By one estimate, HCBS waiver programs paid for modifications to the homes of 36,400 recipients, with expenditures totaling \$106 million in 2009 (Ng 2014). With the recent increase in the number of state waiver programs, the use of waivers for home modifications has no doubt risen since then.

Medicare is the federal health insurance program for people aged 65 and over, as well as for certain younger persons with disabilities. With few exceptions this program does not pay for long-term care in any location or for home modifications. Medicare does, however, cover limited short-term care for those who are home-bound and need skilled assistance or rehabilitative care after a hospital stay, along with some costs for care in an institution after hospitalization. It may also pay for medically necessary services for residents of assisted living and adult day care. Medicare recipients can purchase Medigap insurance to add coverage for skilled nursing care, with options varying by state.

FAMILY CAREGIVING

With the high cost of long-term care, many older adults with functional or cognitive impairments rely on family or friends for care. Two out of three older adults with disabilities who receive long-term care services at home get their care exclusively from family members—primarily wives and adult daughters. Another quarter receive some combination of family care and paid help, with only 9 percent relying on paid help alone (Doty 2010).

FIGURE 24

The Typical Older Renter Paying for Long-Term Care Would Deplete All Assets Within Just a Few Months

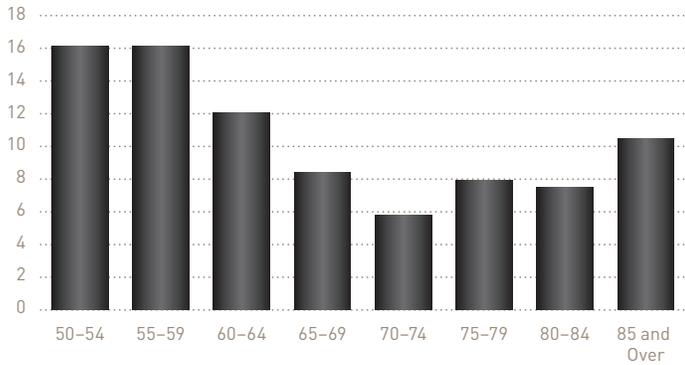
Care Category	Median Monthly Cost (Dollars)	Median Annual Cost (Dollars)	Number of Months Before Median 65-and-Over Households Spend Down Wealth		
			Owners		Renters
			Including Home Equity	Excluding Home Equity	
Adult Day Care	1,408	16,900	194	70	4
Homemaker	2,470	29,640	110	40	2
Home Health Aide	2,568	30,810	106	38	2
Assisted Living	3,500	42,000	78	28	2
Nursing Home	6,448	77,380	42	15	<1

Notes: Excluding housing wealth, the median net wealth of owners aged 65 and over was \$98,700 in 2010, while the median net wealth of same-aged renters was \$5,150. Homemaker and home health aide costs assume 30 hours of care per week. Sources: JCHS tabulations of Federal Reserve Board, 2010 Survey of Consumer Finances; 2014 Genworth Cost of Care Survey.

FIGURE 25

Householders in Their 50s Are More Apt to Be Childless

Share of Householders Who Do Not Have Children by Age Group (Percent)



Source: JCHS tabulations of University of Michigan, 2010 Health and Retirement Study.

Given the growth of the older adult population and the certainty that disabilities increase with age, the question arises whether family caregivers will be available to meet future needs. A significant share of the youngest baby boomers, now aged 50–59, do not have children who might take care of them as they age (Figure 25). Partly as a result of demographic shifts, AARP estimates that the ratio of potential family caregivers to those over 80 will fall from 7-to-1 today to 4-to-1 by 2030, and to less than 3-to-1 by 2050 (Redfoot et al. 2013). And as noted earlier, how families care for their aging relatives varies by race and ethnicity. Older Hispanic and Asian adults are more likely to live with family members, while older white and black adults are more likely to live in institutional settings.

Many of today’s family caregivers are themselves at least 50 years old and looking after both their children and their parents. Members of this “sandwich generation” may face their own housing, financial, and emotional challenges from serving these dual roles. For example, in addition to bearing the cost of care, they may have to move to be near a parent, travel long distances to coordinate care, or even forego their paid employment.

Housing options that allow family members to live in close proximity can make it easier to care for older loved ones. For example, in-law apartments and accessory dwelling units located on the property support intergenerational living situations. Multifamily rental housing development in low-density suburbs also provides options for older households that sell their homes but want to remain in the community.

INTEGRATING HOUSING AND HEALTH SUPPORTS

Many low- and moderate-income older adults with chronic conditions and disabilities cannot afford care in their homes or in

assisted living facilities. An alternative for these households is affordable, age-restricted housing with services. Under this type of model, residents live independently but care coordinators help manage their health and other needs with the goal of reducing hospitalizations and moves to nursing homes, prolonging independence and achieving significant cost savings to the Medicaid program. Such housing may provide meals; fitness, recreation, education, and cultural opportunities; and laundry, transportation, and other services. Some offer direct health care as well.

Expanding the limited supply of affordable housing with services faces a variety of challenges, however. Building and maintaining such housing requires funding for upfront capital costs, operating subsidies, and on-site services. HUD’s Section 202 program formerly provided capital grants to reduce development costs and funding to bridge gaps between the costs of production and the amounts tenants can pay, but Congress recently halted funding of the capital grant program. The new State Housing Project Rental Assistance Demonstration Program did, however, receive \$20 million in fiscal 2014 to test housing plus services models.

Another obstacle is the lack of interagency collaboration. A 2014 report prepared for the Department of Health and Human Services notes that the disconnects among Medicare, Medicaid, acute and chronic health care providers, affordable housing programs, aging programs, and long-term care services may lead to lower-quality care, premature institutionalization, and higher costs to insurance programs (HHS 2014).

The federal government is making some efforts to support the housing with services model. Under the Section 811 Project Rental Assistance Demonstration Program, HHS and HUD have funded 13 state housing agencies to provide rental subsidies to extremely low-income persons with disabilities (with no age requirement), including those seeking to transition out of institutional care (HUD 2014).

Several local government and nonprofit models also attempt to bridge housing and long-term care. Mercy Housing’s Mission Creek Senior Community in San Francisco serves very low-income adults aged 62 and over. Jointly funded by the City of San Francisco and California’s Medi-Cal program, the community provides skilled nursing services, occupational and physical therapy, a meals program, and coordination of care for residents. Over a third of the 140 units at Mission Creek are set aside for older adults referred by the San Francisco Department of Public Health from skilled nursing facilities, hospitals, and shelters. This approach provides significant cost savings for Medicare and Medicaid, while also minimizing operating costs through housing subsidies from the San Francisco Housing Authority and the San Francisco Department of Public Health.

In the Boston area, Jewish Community Housing for the Elderly (JCHE) provides affordable, independent housing with supportive programming for 1,500 residents of all backgrounds. While most units were funded by low income housing tax credits and the

Continuum of Housing and Care

Long-term services and supports can be provided in a range of living environments. In conventional housing and “lifestyle” housing for active older adults, supports can be brought into the home through homemaker services and home health aides. Independent living communities for older adults may offer a variety of services such as shuttles, recreation, laundry service, and at least some meals (although residents still have their own private kitchens), but typically stop short of providing assistance with either ADLs (such as eating, bathing, dressing, and walking) or IADLs (such as cooking, driving, and managing medications). Assisted living facilities generally offer these same

types of services but also provide help with ADLs and IADLs. Board and care facilities are generally smaller than assisted living and offer room, meals, and help with daily activities, but may not be licensed or monitored in the same way as assisted living. Nursing homes and rehabilitation centers deliver skilled nursing care. Continuing care retirement communities generally combine all or most of these options, with residents moving from independent living to assisted living and to nursing care as their needs change. Finally, hospices provide palliative care in a number of settings. The CDC estimates that hospices served 1.2 million patients in 2011.

Given the range of options and lack of standard definitions, estimating the size of the market for residential care facilities is challenging. The best counts available are for beds or units in larger care facilities since major surveys often exclude board and care homes. In its 2012 survey of facilities with 25 or more beds or units, the National Investment Center for the Seniors Housing and Care Industry (NIC) identified 2.9 million care units in over 22,000 properties—1.5 million in nursing care, 550,000 in assisted living, 130,000 in memory care, and 710,000 in independent living facilities.

Section 202 program and are therefore income-restricted, some units in the community rent at market rates. To make this work, in addition to federal and state funding, JCHE raises significant philanthropic dollars every year to support on-site services.

SUPPORTING AT-RISK ADULTS IN COMMUNITY SETTINGS

Other state and federal programs are attempting to help some current nursing home residents supported by Medicaid return to their homes or to community care settings. If available, Medicaid waivers providing funds for long-term services could support these transitions. However, having been institutionalized for a length of time, many of these older adults have given up their apartments, lost connections to the community, and lack the resources to set up new households (Reinhard 2010).

Medicaid’s Money Follows the Person Rebalancing Demonstration Program seeks to overcome these hurdles by covering some of the costs of establishing new homes, ensuring their safety, providing education in independent living skills, and funding services to assist with ADLs. Coverage varies by state, however, and the scale of the program is modest, serving roughly 35,000 individuals through June 2013, according to Medicaid.

The lack of affordable, accessible housing integrated with long-term care can leave some older adults either homeless or at risk

of homelessness. Boston’s Hearth provides 188 housing units for this population, integrating mental health care, health services, and social services to promote independence and a sense of community. Medicaid’s Group Adult Foster Care Program pays for the cost of services for residents needing help with ADLs.

NEW OPTIONS FOR NURSING CARE

As noted, despite trends toward shorter stays, nursing homes provide a critical component of long-term care. Yet according to the National Investment Center for the Seniors Housing and Care Industry (NIC), the median age of skilled nursing facilities is 36 years. The trend toward home- and community-based care suggests that these may not all be replaced in their current form, but rather that newer models may take their place.

One example of a newer model is the Green House Project, which provides care in small communities specifically designed with a home-like feel. Each of the 10–12 occupants of a property has a private room and bath, with a kitchen and dining room located in common areas. Direct-care providers at the Green House Project work in self-managed teams and are cross-trained to provide a wide range of support and care. As of May 2012, the Green House Project was active in 32 states, with 144 homes in operation and 120 in development. The homes are regulated and reimbursed like other skilled nursing facilities, and cost about the same to operate.