HOUSING ALTERNATIVES FOR THE ELDERLY
2015 UPDATE

by

Neil T. Rimsky, Esq.
Cuddy & Feder LLP
White Plains

NEW YORK STATE BAR ASSOCIATION
ELDER LAW SECTION

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Neil T. Rimsky

I. THE ECONOMY IN NEW YORK STATE

Despite some recent volatility, the economy continues to experience a steady but modest growth in 2015. The situation for seniors remains precarious as the "recovery" has not been shared by all seniors. The recovery in the market produces results only where the assets were not utilized during the downturn. Among seniors who relied on income of their investments, the results were far more severe. They could no longer rely on income and had to invade principal of their diminished resource. The recovery did not benefit those who used their principal.

Government programs remain strained. There have been significant cuts to Medicaid reimbursement since Governor Cuomo took office. More critically, Medicaid home care, on which many seniors rely for basic services, has been converted to Managed Long Term Care as a means to cut costs.

This writer ventures a guess that seniors will consider different and lower cost solutions involving some governmental resources. More consumers will try to remain in the community where the cost is far lower than in an institution. Yet, many of these same consumers will look to government assistance to help them make ends meet.

Financial Factors

Retirement Funds – Although retirement funds, both in qualified plans (such as IRA's, 401(k)'s,) and non-qualified plans, are reduced, these will continue to play a role. Rule changes promulgated several years ago by the IRS for qualified plans have expanded the available planning options wherein retirement funds can be used to fund the unified credit. The Internal Revenue Code provides that retirement funds can continue to grow tax free for generations. What is also important is that qualified plans, in pay status, are not deemed an available resource when applying for Medicaid provided that minimum distributions are in regularly monthly amounts. Although the income is budgeted, the asset is exempt.

Long Term Care Insurance - More persons above fifty years of age have purchased long term care insurance policies. However, by and large, long term care insurance is not the solution to long term care needs. More employers offer long term care insurance policies as a benefit. The modern indemnity policies offer more flexibility than the prior generation of reimbursement policies. Funds may be available for

different types of caregivers and care options. Underwriters now offer modified plans which combine life insurance with long term care insurance.

Government Assistance

Medicare provides no funding for purely custodial care, including assisted living, even where medically necessary. The Medicare supplement policies are similarly limited.

Medicaid has become the major payor of custodial care for middle-income and low-income persons. Even before the financial downturn, Congress attempted to limit this reliance on Medicaid by making Medicaid eligibility more difficult.

The Deficit Reduction Act of 2005

With the DRA, Congress enacted the most exhaustive cutbacks and reversal of prior trends in the Medicaid funding of custodial care. The look-back period was extended to five years for all transfers of resources on or after February 8, 2006. The most dramatic change is the method of calculation of the penalty period. In addition, the DRA imposed restrictions on home equity and on the forms of annuities and promissory notes.

The DRA continues to have a dramatic impact on elder care planning for many of our clients.

The Patient Protection and Affordability Act (PPACA)

The first two years of the Obama Administration saw the enactment of the Patient Protection and Affordability Care Act (PPACA). PPACA remains the law of the land despite multiple challenges addressed to the U.S. Supreme Court.

The Community First Option, one of the primary programs put forth by PPACA is critical to the understanding of community alternatives,

PPACA encourages community based care with the Community First Option, found in §2401 of the Act. A State may provide for Medical Assistance for home and community based attendant services and supports for 1) individuals who are eligible for medical assistance; 2) for an individual who has been determined to require institutional level of care; and 3) individuals as to whom there has been a determination, that absent such services, the individual would be in a facility, but only if the individual chooses to receive such home and community based attendant services and supports.

PPACA provides that States shall make available home and community based attendant services and supports to eligible individuals to assist in accomplishing activities of daily living, ADL's. Such services shall be under a person centered plan, agreed to by individuals in writing as appropriate.

These services shall be in a home or community setting (not a nursing home, mental hospital or intermediate care facility for mentally retarded) and under agency provider model or other model, the furnishing of which is selected, managed and dismissed by the individual (or the individual's representative); controlled to the maximum extent possible by the individual and provided by an individual who is qualified to provide such services, including family (defined by Secretary).

Services to be provided under PPACA shall include acquisition, maintenance and enhancement of skills necessary for the individual to accomplish ADL's in addition to back up systems or mechanisms (beepers or electronic devices) to ensure continuity of services and supports and voluntary training on how to select, manage and dismiss attendants.

Excluded from such services are room and board, assistive technologies, other than those above, medical supplies or equipment and home modification. However, permissible home and community based services and supports may include:

> expenditures for transition costs, such as rent and utility deposits, first month's rent and utilities, bedding, basic kitchen supplies and other necessities required for an individual to transition from nursing facility.
>
> expenditures relating to a need identified in an individual's person-centered plan of services that increase independence or substitute for human assistance, to the extent that expenditures would otherwise be made for human assistance.

There have been demonstration programs such as the Program of All-Inclusive Care for the Elderly (PACE). The Center for Medicare and Medicaid Services (CMS) has recently shown renewed interest in Managed Long Term Care Services and Supports (MLTCSS) beyond PACE. Regulations enacted in January 2014 encourage states to combine various home and community based waivers to serve multiple populations under Sections 1915 (a), (b) and (c) and Section 1115 of the Social Security Act.

For a more thorough discussion of these programs, please see the attached "Where Do we Go From Here? Long Term Care in the Age of the Baby Boomers", Shana Siegel and Neil Rimsky, NAELA Journal Vol 11, No 1.

Personal Issues – While Medicaid may have been essential in many cases, there was a price to be paid. Medicaid is a form of welfare. It was often a terrible embarrassment for persons who had worked hard and were so proud of their accomplishments, to be relegated to a welfare program to pay for basic care needs. There are many who, understandably, were not anxious to transfer resources or who considered it difficult to execute a spousal refusal.

II. LIVING IN THE COMMUNITY

There are a multitude of options to remain in the community.

Home Modification

The simplest way to stay out of a nursing home may be to remain at home. Although our homes were not designed for elder care, modest changes can make the home far more appropriate for and appealing to seniors who need some level of assistance.

For example, the owner can replace door knobs with larger knobs or handles which are easier to manipulate by hands having limited flexibility. The same can be said with respect to kitchen utensils. Many companies now manufacture utensils that are much easier to use.

Scatter rugs are easy to trip over, so it may make sense to remove the rugs and replace them with wall-to-wall carpeting. If there are wood floors, the occupant can wear rubber-soled shoes or socks with a rubberized bottom.

Illumination is another problem that can easily be addressed. It is possible to increase luminescence without increasing wattage. For those who are somewhat visually impaired, many appliances have large dials. A phone can have oversized buttons. For the hearing impaired, phones can be purchased with amplifiers.

The bathroom always presents some unique dangers. However, these too can be reduced. Installing a shower without a high lip which is easy to step into, plastic chairs and grab bars all reduce the possibility of injury in a shower.

Using the Home as a Financial Resource - Reverse Mortgages

Often, the home is the primary financial resource, which means that equity is not available. That does not help when care needs far outstrip social security, pension and other monthly income.

The reverse mortgage is designed to convert the illiquid home into a source of monthly income. In a typical reverse mortgage, the lender offers a monthly payment to supplement income. The owner does not owe the money back until the home is sold. There are many variations, including loans where, in addition to the monthly payment, the lender provides money up front to pay old bills or possibly to make household repairs.

The reverse mortgage has another advantage for those who are considering Medicaid home care. Since the **monthly payments** are in the form of a loan, the payments **are not deemed income and not budgeted**. However, if money is not spent

at the end of the month, such excess will be deemed a resource and possibly cause ineligibility by reason of excess resources.

Reverse mortgages, however, present significant **financial issues**. These loans compound interest on the principal balance, which means that the balance owing may far exceed the cash actually received. The equity in the home may quickly be reduced or, in some cases, exhausted.

It is for this reason that New York law insists on protections. Persons may not apply for a reverse mortgage unless they have received counseling from a not-for-profit organization which advises them of the long term financial risks.

Although several large financial institutions no longer offer reverse mortgages, reverse mortgages remain available, despite the recent economic downturn. For additional information on reverse mortgages, look at files.consumerfinance.gov/f/201409_cfpb_guide_reverse_mortgage.pdf and http://www.reverse.org .

Using Medicaid to Stay at Home

There are several factors which encourage the use of Medicaid to provide care so as to enable many of the elderly with some need for custodial care to remain home.

No Transfer of Assets for Community Care or Long Term Home Health Care - The transfer of asset provisions do not apply to Community Medicaid in New York. And, as of September 2007, the transfer of asset provisions no longer apply to the Long Term Home Health Care Program, also known as the Lombardi Program. More and more clients are considering transfers, either outright or in trust, to access these home-based Medicaid programs. There is no question that these same transfers will cause a substantial period of ineligibility should the individual require institutional care. However, the draconian changes in calculating the period of ineligibility have encouraged more persons to risk ineligibility for institutional Medicaid in order to remain at home with community Medicaid.

The 2015 Budget did not adopt provisions which would significantly reduce the availability of home based care.

Income Protection with the Pooled Community Trust - Income limits have severely restricted an individual's ability to remain at home and often pushed persons who did not belong there into a nursing home. Under current regulations, income in the community is limited to $825 a month plus the cost of health insurance. However, current rules permit the assignment of excess income to a community pooled income trust operated by a not-for-profit organization. The pooled income trusts, which were originally created in response to OBRA 1993, now enable individuals to remain at home.

Excess income is assigned to the pooled trust. Since the transfer of asset rules do not apply to community Medicaid or to the long term home health care program, there are no periods of ineligibility. Assets in the trust, although designed for the benefit of a particular individual, are not deemed to be an available resource and are not subject to a monthly spend-down. The assignment of income similarly converts income into unavailable income. The not for profit entity, for a modest fee, manages the money and acts upon instructions to pay ordinary household bills and expenses. This preservation of income permits needy individuals to stay at home with a sense of dignity.

Monthly transfers to the pooled trust will not be aggregated into a substantial period of ineligibility should the individual require institutional care.

Consumer Directed Personal Assistance Program (CDPAP) - Many persons are not well served by traditional community based Medicaid through an agency. Clients may be unhappy with the aides available through an agency; alternatively, aides may not be available at all due to lack of public transportation in many parts of the state. In addition, aides are limited in services they could perform. (For example, aides cannot suction a feeding tube, nor can they give medicines or injections to the patient).

The CDPAP program offers a way to provide care for these families while using Medicaid funds. The individual is responsible for hiring and training the aides and for the care, including the provision of substitute aides in the event that the primary aides are not available. The aides do not have to be certified; they can be family members or friends. But, the aides must be lawful residents.

Once financially approved, the case is directed to a Managed Long Term Care provider which manages one of several CDPAP programs around the state. These entities serve as the financial middle man, taking the Medicaid dollars and paying for the care, as well as providing the necessary government reporting requirements.

Recent Changes in the Law which Impact Medicaid for Community Care

Home Equity Cap - Applicants for home care must be cognizant of the cap on home equity.

The traditional "homestead" exemption is found at 18 NYCRR §360-4.7(a). Prior to the DRA, the homestead was an exempt resource for persons 65 years of age or older, certified blind or disabled. The homestead loses its exempt status if the owner moves out without the intent to return home AND, no spouse, child under 21, certified blind or certified disabled child or other dependent relative is living in the home.

18 NYCRR §360-1.4(f) defines "homestead" as the primary residence occupied by Medical Assistance (MA) Applicant/Recipient (A/R) and/or members of his/her family. Family members may include the A/R's spouse, minor children, certified blind or certified disabled children and other dependent relatives. Homestead includes the

home, land and integral parts such as garages and outbuildings. Homestead may be a condominium, coop, or mobile home, but may not be a vacation home, summer home or cabin.

Deficit Reduction Act - Section 6014 of the DRA - "Disqualification for Long Term Care Assistance for Individuals with Substantial Home Equity"

> "…in determining eligibility of an individual for medical assistance with respect to nursing facility services or other long term care services, the individual shall not be eligible for such assistance if the individual's equity interest in the individual's home exceeds $500,000…"

Each state has the option to increase the cap above $500,000, but not in excess of $750,000. New York State has exercised the option and set the home equity cap at $750,000. In 2015, the home equity cap is $828,000.

The home equity cap does not apply if applicant's spouse or child under 21, blind child or disabled child is residing in the home.

According to the Center for Medicare and Medicaid Services (CMS), the home equity cap applies to nursing home care, home and community based waiver services, certified home health care (CHHA), personal care services (home attendant) and alternate level of care in a hospital. New York, according to the 06 ADM 05, has a broader application of the cap. New York also includes medical model adult day care, private duty nursing, the consumer directed personal assistance program (CDPAP), hospice (in-patient or home hospice), personal emergency response systems and the managed long term care program.

Home Equity is fair market value less mortgage indebtedness. If the home is held in a form of shared ownership, e.g. joint tenancy, tenancy-in-common, or other similar arrangement, only the fractional interest of the A/R should be considered.

The Centers for Medicare and Medicaid Services (CMS) is required to establish a process to request a waiver for demonstrated hardship. 06 ADM 05 provides that hardship exists where denial would deprive the A/R of medical care such that the individual's health or life would be endangered; OR deprive the A/R of food, clothing, shelter, or other necessities of life AND there is a legal impediment that prevents the A/R from being able to access the A/R's equity interest in the property.

A legal impediment exists when an applicant is legally prohibited from, or lacks the authority to liquidate the resource; e.g., a legal impediment exists when an A/R needs the consent of a co-owner of a jointly-owned resource in order to sell the resource and the co-owner refuses to give consent.

III. HOUSING ALTERNATIVES – There are some exciting opportunities for housing options. We will begin with a historical review.

Naturally Occurring Retirement Communities

Naturally occurring retirement communities, or NORC's, are "communities" where residents age in place. These facilities were not designed as retirement communities; they may be apartment buildings, attached housing communities, condominium complexes, or other designed communities. While these communities were not intended as retirement communities, the nature of the community lends itself to planning for seniors. As these were naturally occurring, the inclusion of staff and services requires commitment and organization.

These communities have recreation areas and other common areas which could be adapted as residents age. The fact that so many seniors live in reasonably close quarters allows residents to share resources, including personal assistance. For example, two residents with light needs can share one aide. Or possibly, a resident with limited needs can share an aide with one or more residents with limited needs. Since most agencies insist on a four-hour minimum before sending an aide, the sharing offers the ability to reduce costs while providing safety.

NORC's offer a variety of social and recreational activities, including transportation for shopping and medical appointments, as well as theater and recreational outings.

NORCs may also be favored to provide Medicaid services to a larger number of persons at a lower cost without compromising safety.

This writer looks at NORC's, or community based variations of NORC's as a part of a long term solution.

Home Sharing

Maintaining a house and performing all the necessary chores can be exhausting. Many seniors who desire to remain at home have opted for home sharing. They barter some use of their home in exchange for companionship and assistance with home maintenance. Sometimes a local college student will take a room. The student may, for example, be responsible for caring for the yard, cooking, shopping, household cleaning, or similar light chores. Home sharing is often promoted by faith based groups who help students and seniors find each other. Home sharing is not likely to serve as a housing solution for many seniors.

Accessory Apartments

An accessory apartment is a practical way to remain safely in the community and close to family. The senior resides in an independent unit, usually in the home of an adult child. The family enjoys the senior's company, yet both remain independent and

separate. Several municipalities have sanctioned accessory apartments by inclusion in the zoning code.

Day Care Programs for Seniors

Day care programs provide a source of enrichment and stimulation for the senior and respite for the caregiver, both of which supplement a senior's life in the home. The Social Model Day Care can be funded under a Medicaid program.

IV. ASSISTED LIVING FACILITIES

"Assisted living" refers to a housing option for older adults which includes a residential unit, meals, on-site activities, links to health care providers and assistance with the activities of daily living.

The popularity of assisted living facilities is fueled by the following factors:

a. People often fear nursing homes; an assisted living facility is viewed as a more humane alternative.

b. Assisted living facilities promise a more active and satisfying life style for those able to enjoy them.

c. The cost of assisted living facilities is significantly lower than nursing care. Nursing homes in the New York Metropolitan region charge approximately $550 a day or $16,500 a month. Assisted living facilities in the same region charge a basic monthly rate between $5,000 and $7,500. Add-ons, including necessary individualized assistance, can drive the cost of assisted living much closer to the cost of nursing home care.

New York Law

Prior to 2004, New York legislation, as in most other jurisdictions, was grossly inadequate to protect the consumer. (Assisted Living Program Legislation was found at §461-L of the New York Social Services Law). Historically, facilities which were "licensed" assisted living facilities consisted of a few "adult homes" or "enriched housing programs."

The larger well-known facilities that we commonly associate with assisted living facilities were not subject to license requirements. The absence of regulation created problems for the industry, including poor oversight. In addition, the facilities typically operated as two separate entities, a rental unit and home care unit, resulting in confusion and lack of communication.

On August 12, 2004, the New York Legislature passed assisted living legislation, which added a new Article 46-B to the Public Health Law.

The 2004 legislation recognizes the importance of "congregate, residential housing with supportive services in a home-like setting" (§4650). The statute recognizes the basic philosophy of assisted living which "emphasizes *aging 'in-place'* (emphasis added), personal dignity, autonomy, independence, privacy and freedom of choice." (id).

The statute **defined an assisted living facility** as "an entity which provides or arranges for housing, on-site monitoring and personal care services, and/or home care services (either directly or indirectly), in a home-like setting of five or more adult residents unrelated to the assisted living provider." (§4651(1)).

This legislation imports many concepts from federal legislation. For example, the facility must provide an ISP, or ***Individualized Service Plan***, for every resident and must update the ISP on a regular basis. The ISP is developed with the resident, the resident's representative and the operator, in consultation with the resident's physician.

The legislation specifies that the **needs of the resident must be met** and that, if necessary, the resident's home health agency and physician must certify that such needs can be met. It is in this circumstance that the gray areas appear. The statute says that a resident who requires 24-hour nursing care must be discharged. However, such discharge need not take place and the resident may remain if: a) the resident hires appropriate nursing, medical, or hospice care; b) the resident's physician and home care services agency both determine and document that with the provision of such additional care, the resident can be cared for safely; c) the facility operator agrees to retain the resident and to coordinate the care; and d) the resident is otherwise eligible to remain at the residence.

The statute also provides that an operator can apply for an ***enhanced assisted living*** **certificate** (§4654). The operator who qualifies as "enhanced" is permitted to keep a resident beyond ordinary discharge. The operator has to make a showing of how the operator will meet these needs, including a written description of services, staffing levels, staff education and training, work experience and environmental modifications that will be made to protect the safety, health and welfare of the resident.

Many facilities hold themselves out as being able to deal with the special needs of persons with dementia or cognitive impairment. Facilities that hold themselves out as providing *special services* or *serving individuals with special needs* must submit a plan setting forth how such needs will be met.

Every resident is entitled to a **clear admissions agreement** that must contain certain minimum provisions. In addition, all residents must be given a statement of residents' rights when presented with advertising brochures or an admissions agreement.

Regulations were issued in 2008. However, the regulations were soon challenged in Court. [Empire State Association of Assisted Living, Inc. v. Daines, 26 Misc 3rd 340; 887 NYS 2d 452, (2009) and companion case, New York Coalition for Quality Assisted Living v. Daines, 24 Misc 3rd 1250, 901 NYS 2d 900 (2009)] found that several of the regulations were invalid as the Commissioner of the New York State Department of Health exceeded the statutory authority. What were struck down were regulations which imposed excessive costs on facilities. The legislation was not attacked.

You can find more information on assisted living options at http://www.assisted-living411.org/ and http://www.ltccc.org/news/documents/alguidepotresfinal.pdf .

Medicaid for Assisted Living

The Medicaid Funded Assisted Living Program (ALP) has provided funding for assisted living facilities. However, these facilities tend to be enriched housing arrangements. Recently, we're starting to see some beds available in some of the finer facilities. A list is available on the website cited above. The beds are still relatively few. However, there are far more than in the recent past, so the trend is toward opening up the assisted living program.

This change is critical and positive. Medicaid funding is under the community Medicaid program, for which there are no periods of ineligibility. The availability of some beds helps families who are considering Medicaid home care, but are frightened of the five-year look-back for institutional care. The ALP program offers a possible hedge.

V. CONTINUING CARE RETIREMENT COMMUNITIES (CCRC's)

Essential Components of CCRC's

Continuing Care Retirement Communities (CCRC's) offer shelter, care and services for a person's lifetime. There are three basic stages of care: independent living, assisted living and nursing home care. In the traditional life care arrangement, a resident may be admitted at the independent living level. As the resident becomes unable to perform certain activities of daily living, he/she moves to the assisted living facility. Should a resident's physical and/or psychological needs further increase, the facility, in consultation with the resident and the resident's health care provider, may move the resident to the nursing center. As new types of arrangements and financing (other than life care) are available, residents may enter at the assisted living level or, in some cases, the nursing home level.

Payment Arrangements

The traditional life care or extensive long term contract offers unlimited long term care at little or no substantial increase in monthly cost. The modified contract often provides independent living and assisted living at a substantially similar monthly rate.

However, the modified contract offers only a limited amount of nursing care at the modest monthly rate, after which the resident is responsible for substantially higher payments. The fee-for-service contract provides for the payment of a daily rate for all personal services according to the resident's level of care. Fee-for-service arrangements in New York State were first authorized at CCRC's in 2005.

The choice of contract affects who may apply. The extensive contract offers long term care at a level monthly cost. These CCRC's seek healthy and mentally competent applicants, since well residents, in effect, subsidize the more frail residents, thereby reducing the facility's average cost per resident over the long term. A fee-for-service arrangement, on the other hand, will manage its costs differently. These facilities are far less restrictive, admitting applicants with a significant level of physical or mental disability since each resident, in effect, pays for him/herself.

The extensive and modified contracts sometimes require a substantial up-front fee. However, in the case of the extensive contract, the facilities offer a continuum of care for a constant rate. That is, the resident pays the same fee whether in the assisted living unit or the nursing home.

Continuing Care Retirement Communities may require the residents to have long term care insurance; otherwise the CCRC itself applies a portion of the resident's payment to procure insurance on behalf of the resident.

A New York State Historical Overview

Most New Yorkers know so little about continuing care retirement communities. In fact, the number of CCRC's in New York State is far below those of our neighboring states. Why?

Early models elsewhere in the country showed potential, but generated problems and possible abuses. People paid large sums of money for the promise of lifetime care; however, in many cases, the facilities could not follow through on their promises for lifetime care, because their limited financial reserves could not keep up with the healthcare demand of the resident mix. Likewise, in many such cases, the value of the resident's investment was severely compromised, and on occasion, totally lost. New York lawmakers took note of these failures and drafted legislation with significant consumer safeguards that have resulted in a barrier to entry to potential operators.

New York law sets the bar high in terms of a facility's financial requirements. For example, the CCRC's liquid assets must be maintained in reserve to cover principal and interest payments for a year, operating costs for six months, repairs and replacements for a year and cash flow conditions as determined by regulation. There are additional restraints on CCRC's funded with Industrial Development Agency (or IDA) bonds.

Add to this the high cost of land in New York, particularly in the New York metropolitan area, and the result is a limited number of communities.

Resources For Further Information

Over the last decade, we have seen an explosive growth of these communities in the United States. Two entities, both of which have extensive websites, have organized in response to the spread of these communities. The first is the American Association of Homes and Services for the Aging (AAHSA), which offers advice on these communities, including definitions, a discussion of services provided and contract issues, as well as reference to other resources (See aahsa.org). The second organization is the Continuing Care Accreditation Commission (CCAC), which was acquired by the Commission on Accreditation of Rehabilitation Facilities (CARF) in 2003 to form CARF. CARF provides accreditation and reviews the credentials of continuing care retirement communities, aging services networks and other types of providers. Their web site (carf.org) discusses standards and lists currently accredited facilities.

The DRA - Treatment of Entrance Fees in CCRC's

The DRA provides that a Medicaid applicant is not eligible by reason of available resources if (1) the individual is a resident of a CCRC or life care community; (2) the contract provides that the facility may use the entrance fee to pay for the care where the resident has insufficient funds; (3) the individual or the individual's estate is eligible for a refund of a portion of the remaining entrance fee when the contract terminates; and (4) the entrance fee does not confer an ownership interest in the life care community.

As a practical matter, contractual provisions consistent with the new law are common. That is, all of the extensive or modified agreements which this author has reviewed have similar provisions permitting the facility to invade the refundable portion of the entrance fee.

In the case of a life care or extensive long term contract, this result is neither surprising nor significant. The life care arrangement usually requires a substantial up-front payment and the monthly costs are modest. Therefore, the issue addressed is not likely to arise in the extensive or life care arrangement.

The resident with a modified contract is more likely to be impacted by the subject provision of the DRA. Residents with a modified contract, where the monthly costs are likely to be much higher for nursing care than in a life care agreement, could possibly have used Medicaid to pay for their care. However, the DRA eliminates such a possibility, as the resident would be deemed to have an available resource, namely the residency deposit.

The DRA also provides that contracts for admission to a State licensed, continuing care retirement community or life care community, may require residents to spend down their care resources declared for the purposes of admission before applying for medical assistance. This provision, which is a direct violation of the

Nursing Home Reform Act of 1987, gives additional light to the political climate which motivated the DRA.

PPACA and CCRC's

Advantages of CCRC's

One-stop shopping
Peace of mind
Life style
Socialization

Disadvantages of CCRC's

High cost
Potential financial risk
Potential risk of inadequate services
Limited choice

VI. New Approaches to housing models.

VILLAGES - This writer remains excited about new approaches, the most prominent being the Villages. The primordial example is the Beacon Hill Village. The Beacon Hill Village, a not-for-profit organization, was formed in 2001 Members can join for an annual fee under $1,000 (less for individuals). There are reduced rates for persons with limited income. The Village offers members social activities, referrals for services at a discount, including home health care services, and some free services.

The Villages is a senior oriented living model. As of this writing, there are 28 Villages in New York State at various stages of development. Information about Villages can be found at the Village to Village website, vtvnetwork.org.

COOPERATIVE HOUSING – Cooperative housing, or co-housing, is a new model which offers opportunities for seniors. Co-housing communities are designed and developed with the co-housing idea in mind. However, that may not be realistic in many urban communities, so some co-housing communities retrofit existing housing.

Co-housing communities all have some common facilities, such as a common kitchen and dining area, a common sitting area, laundry and children's play area. These communities can also have common libraries, workshops and exercise rooms.

The residents manage their communities in a horizontal structure. Co-housing advocates refer to their communities as intentional neighborhoods, which distinguishes them from intentional communities which evolve around a particular ideology, such as ecology, or religion.

Co-housing communities emphasize persons of all ages, including seniors. More recently, some senior co-housing communities have emerged. Additional information can be found at cohousing.org.

For a more thorough discussion of NORC's and alternative housing arrangements, see the attached, "Residential Models for Today's and Tomorrow's Older Adults", Shana Siegel and Neil Rimsky, NAELA Journal Vol.9, No. 2.

VII. Appendix - ADVISING THE CLIENT – Factors To Consider When Looking At Assisted Living Facilities And CCRC's

Style of Living

Private bedroom, private bath
Independent kitchen available, if desired
Condition and repair
Comfort and amenities – television-computers-music-outdoor facilities, such as garden or walkway
Air conditioning
Pets – allowed?
Meals – dietary issues and restrictions; variety; flexibility in schedule
Neighborhood - safe, close to shopping, religious facilities or social contacts or family
Can residents have their own cars?
Is there alternative transportation available?
Storage area

Quality of Care

How do residents appear? Clean? Content?
Do residents interact well with Staff – Does staff listen – Are there clear lines of communication? Ratio staff/residents
Quality assurance program? Are residents' rights clearly posted?
Is there an on-site Ombudsman?

Services and Activities

Are lounge areas comfortable and well arranged to encourage socialization?
Opportunities to participate in activities with the surrounding community?
Shopping?
Religious activities and practices – Are these available on-site or locally?
Is there an exercise room or facility?

Policies

Restrictions on drinking/smoking/offensive behavior
Formal visiting hours

Procedures for short term removal, such as long weekends with family or a month in Florida
Are discharge criteria clearly set forth?
Safety regulations
    Sprinkler/fire extinguisher/exit lights
    Door bars
    Physician/nurse available
    Handling of medications
    Arrangements with off-site physicians/hospital
    Intercom or other emergency device

Business Practices

Licensure
Complaints/Violations
Financial disclosure
Reference

Contract Issues

The possibility of negotiating a contract is limited, particularly in the case of CCRC's insofar as these facilities are developed and approved with filed plans. In New York, the plans are filed with the Attorney General/Department of Law. The contract is part of the filing so that negotiation of significant terms is limited. The real issue is the ability to evaluate and choose between competing facilities.

A knowledge of local law is important, but not critical. What is significant is an understanding of the issues. The analysis should focus on four major issues:

Financial risk
Fee/payment obligations
Care/services provided
Residents' rights

Financial Risk

Our clients may be selling their largest asset, their home, and investing in the CCRC for their retirement, care, etc. These facilities offer no guarantees and there is no governmental backstop, as is the case with insured bank accounts. The analysis/review should investigate:

The developer
The provider of services, if different
    Financial projections
    Actual statements for functioning facilities including available reserves
Accreditation/licensure

Fees and Charges

There are a variety of contractual obligations. Those facilities with a small entrance fee may have high operational costs. A high entrance fee will probably signal moderate and stable costs.

A typical CCRC agreement where there is a substantial payment for the right to reside at the facility divides the purchase price into two components: a residential component and a life care component. The residential component can be viewed as the cost of housing; the life care component can be viewed as the cost of health related care.

The residential component is often the lion's share of the up-front cost, possibly 80-90% of the price. The residential component will often amortize at a modest rate. However, in many cases, the amortization is limited so that the residential component never drops below 80% or 90% of the original price.

The health care component usually amortizes at a higher rate. This portion of the cost may disappear in a relatively modest period of time.

The consequence of the amortization is that when the resident dies or moves out of the facility, the sum returned may be less than the original price paid.

The cost of increased care is often managed by means of long term care insurance. In some instances, the facility may require the applicant to have a certain minimal level of insurance. In other instances, the up front and monthly installments may be used to purchase long term care insurance.

The financial factors to consider are:

- Purchase price/Entrance fee
    - Residential component
    - Life care component
- Escrow
- Rescission/cancellation
- Refunds
- Monthly fees – What is covered and what is not
- Caps on fees/increases in fees
- Change in status (married-single)

Services Provided

Our clients are relying on these facilities for life care. What basic needs are provided in terms of housing, food, utilities, transportation, socialization, physician services, nursing assistance, drugs?

Charge for the services provided
Cost at different levels of service
Pre-existing conditions
Quality of care

Residents' Rights

Continuum of care implies transfer from one level of care to another. In the assisted living context, there is often a disposition on the part of the resident and the family against change. Residents want to remain in the more pleasant surrounding of an assisted living facility and avoid the more hospital-like environment of nursing home care. However, there may be situations where the medical staff suggests a change. What rights does the resident/family have for review and challenge of these decisions?

Appeal of medical decisions – Who is the final arbiter?
Participation in governance
Grounds for termination of contract

We suggest, for general information on housing options, a review of http://www.aging.ny.gov/HousingResources/index.cfm .

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Residential Models for Today's and Tomorrow's Older Adults

By Shana Siegel, CELA, and Neil T. Rimsky, CELA, CAP

Growing up, many of us heard stories about places like the Grand Concourse in the Bronx or Flatbush in Brooklyn where our grandparents lived with their parents and their grandparents. It was not unusual for three generations to live under the same roof or within walking distance. In 1900, 57 percent of adults 65 or older lived in multi-generational households.[1] At that time, only 6 percent of seniors lived alone.[2] Of course, much has changed since that time. Families are spread out across the country and seniors are living longer and healthier.[3] By 1980, the number of seniors living in multi-generational households had plummeted to 17 percent and nearly 30 percent of older adults were living alone.[4]

These demographic changes generated new housing and health care options. By the turn of the 21st century, seniors had their choice of over-55 communities, assisted living, and significantly expanded home care options and continuing care retirement communities. In particular, the latter showed great promise as one-stop shopping offering lifetime

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Shana Siegel, CELA, is a member of WanderPolo Law LLC, Upper Montclair, N.J. She is Vice President of the New Jersey Chapter of NAELA and is active in the New Jersey State Bar Elder and Disability Law section.

Neil T. Rimsky, CELA, CAP, is a member of the firm of Cuddy & Feder, LLP, in White Plains, New York. He received his undergraduate degree from the University of Rochester, Magna Cum Laude, and his law degree from Duke University. Mr. Rimsky serves on the Executive Committee of the New York State Bar Association Elder Law Section and as co-chair of the real estate and housing committee.

1 Pew Research Ctr., *The Return of the Multi-Generational Household* (Mar. 18, 2010), www.pewsocialtrends.org/files/2010/10/752-multi-generational-families.pdf.

2 *Id.*

3 Kathryn Lawler, *Aging in Place: Coordinating Housing and Health Care Provision for America's Growing Elderly Population* 6, Jt. Ctr. for Hous. Stud. of Harv. U. & Neighborhood Reinvestment Corp. (Oct. 2001), http://www.nw.org/network/pubs/studies/documents/agingInPlace2001.pdf (accessed June 20, 2013).

4 Pew Research Ctr., *supra* n. 1. The Pew study found a small resurgence of multi-generational households in recent years. It remains to be seen whether this will last beyond the economic difficulties that brought it on.

care for an up-front sum and a relatively modest monthly payment that never changed as levels of care increased.

Each of these trends in senior housing and long-term care has its benefits, offering care for persons in need of some supervision without placement in a skilled nursing facility. Still, these options have a number of drawbacks. First, they often result in an inappropriate level of assistance; either under- or over-care, due to the limited options available.[5] Expense is also a major issue. These options are often costly and thus available only to middle and upper income persons.[6] Lower income individuals tend to suffer the most from inappropriate levels of care, receiving either no assistance at home or being relegated to the most expensive form of senior care, nursing home care, which is available under the Medicaid program.[7] The costs to the Medicaid program are overwhelming many state budgets.[8]

The greatest problem with the options available has been that, often, these models are not what people want. Seniors want to age in place. An AARP report found that 83 percent of those 55 to 64 want to remain in their home as long as possible. This percentage rose to 92 percent for those 65 to 74 and 95 percent for those 75 and over.[9]

Over the next several decades, the number of seniors is projected to more than double to over 81 million by 2040.[10] We need better housing alternatives for older adults, as well as long-term care options that provide a home-like environment while ensuring quality care. Offering diverse housing and health care options allows individuals to customize their needs and remain as independent as possible. Aging in place is also more cost-efficient than unnecessary placement in a long-term care facility.

This article will focus on the residential trends that have emerged to facilitate aging in place. The health and social needs of seniors cannot be separated from their housing needs. This piece will focus on residential models.[11] All of the housing models described below share the planned integration of at least some health, long-term care and social services in or near an individual's home.

We will look at a number of residential options that have developed to address the needs of seniors. Our review is not meant to suggest that these models are panaceas or will solve all of the issues raised by aging in place. Other approaches exist. We are introducing these models as a way of furthering the developing discussion of aging-in-place options.

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5 Lawler, *supra* n. 3, at 5.

6 As a result, we are seeing a slowdown in assisted living and other high-end options, with continued growth concentrated in a few markets. Natl. Inv. Ctr. for the Seniors Hous. & Care Indus., *5 Markets Dominate Sluggish Assisted Living Construction,* Long-Term Living (Apr. 10, 2012), http://www.ltlmagazine.com/article/5-markets-dominate-sluggish-assisted-living-construction.

7 *Id.*

8 Elizabeth P. Allen, Wendy Cappelletto & Shana Siegel, *The Impact of State Medicaid Reform on Vulnerable Populations Needing Long-Term Care Services and Supports*, 8 NAELA J. 125 (2012).

9 Lawler, *supra* n. 3, at 15.

10 U.S. Census Bureau, *Statistical Abstract of the United States: 2012* 12 (2012), www.census.gov/compendia/statab/2012/tables/12s0009.pdf.

11 A follow-up article will address innovations in the provision of long-term care services.

I. Accessory Dwelling Units or Cottages

One classic approach to aging in place is the so-called "accessory dwelling unit," more traditionally known as an in-law suite. This separate living space is either connected to a family member's house or a separate dwelling on the property.[12] This option provides many of the benefits of multi-generational households but with additional privacy sought by modern families. The senior is provided with a sense of independence and dignity, while having someone close by.

Local zoning laws often prohibit the use of accessory units in areas zoned for single-family homes, but this prohibition is beginning to ease.[13] Generally, individual localities have addressed this issue, but Virginia is one of several states that has modified its zoning laws statewide to permit such units or "family health care structures" for individuals with either mental or physical impairment.[14]

Builders are increasingly incorporating technology and universal design[15] into these units as a means of forestalling the need for additional care. Railings, soft flooring, medication reminders, medical monitoring, and alert systems are increasingly common features in accessory dwelling units.[16] However, these units cannot adequately address the demographic and health care challenges facing many seniors, at least not without being combined with some of the community-based concepts outlined below.

II. Naturally Occurring Retirement Communities

The solution to housing problems sometimes just develops "naturally." The emergence of naturally occurring retirement communities, affectionately termed "NORCs" is a perfect example of an organic solution to aging in place. NORCs, by definition, were not designed as senior communities. They just evolved.[17]

One of the best-known and earliest NORC is Penn South. Members of the International Ladies Garment Workers Union (ILGWU) initially developed Penn South as cooperative housing.[18] Located in Chelsea in lower Manhattan, this co-op development encompasses 2,820 apartments in 10 high-rises.[19] Founded by a major union, Penn South

12 Sage Computing, Inc., *Accessory Dwelling Units: Case Study*, prepared for U.S. Dept. of Hous. & Urb. Dev. Off. of Policy Dev. & Research (June 2008), http://www.huduser.org/portal/publications/adu.pdf (accessed June 20, 2013).

13 *Id. See also* Rodney L. Cobb & Scott Dvorak, *Accessory Dwelling Units: Model State Act and Local Ordinance*, AARP Pub. Policy Inst. (2000), http://assets.aarp.org/rgcenter/consume/d17158_dwell.pdf (accessed June 20, 2013).

14 Nicholas Farber & Douglas Shinkle, *Aging in Place: A State Survey of Livability Policies and Practices*, Natl. Conf. of St. Legis. & AARP Pub. Policy Inst. (Dec. 2011), http://www.ncsl.org/documents/transportation/Aging-in-Place-2011.pdf.

15 Universal design is defined by the National Association of Home Builders as "design of products and environments to be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design." It commonly includes no-step entry, wide doorways, and one-story living. *See* Natl. Assn. of Home Builders, *What is Universal Design?* http://www.nahb.org/generic.aspx?genericContentID=89934 (accessed June 20, 2013).

16 Frederick Kunkle, *Pioneering the Granny Pod*, Wash. Post (Nov. 25, 2012).

17 *See* Farber & Shinkle, *supra* n. 14.

18 Lawler, *supra* n. 3, at 42.

19 *Id.*

embraces a number of collective endeavors, from its own electricity-generating facility to senior programming. Although the ILGWU remains only to provide pension services, union members joined together to form the Penn South Program for Seniors (PSPS) to bring social services, health services, and recreational services to Penn South residents. PSPS then formed its own nonprofit to contract with agencies, such as the Jewish Home and Hospital for the Aged, and seek outside funding.[20] To this day, a combination of municipal and state agencies as well as nonprofit and private entities supports the senior population at Penn South.[21]

Similar naturally occurring communities have developed throughout the country.[22] However, the infusion of supportive services is the key to success for these communities. New York first passed legislation to fund NORC Supportive Services Programs in 1994 (with encouragement from PSPS).[23] In New York, its supportive service programs (N-SSPs) are joint ventures between the State, the housing corporation, and the service providers.[24] In 2002, Congress began to support the development and testing of N-SSPs and since that time just one agency, the Jewish Federations of North America, has secured federal demonstration grants in 45 communities in 26 states.[25]

NORCs that include supportive services promote aging in place. They can also provide a means for convenient, efficient and cost-effective provisions for care and services. Therefore, the public policy implications of the NORC model are enormous.[26]

By definition, the NORC cannot be a planned community.[27] However, the NORC model of aging in place with shared services and community support has spawned other initiatives.[28]

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20 *Id.* at 43.

21 For a full history of Penn South, *see* Penn South, http://www.pennsouth.coop (accessed June 20, 2013). This site offers a rich explanation of the development of Penn South into a NORC, the services provided, and the challenges faced.

22 *See* NORCs: An Aging in Place Initiative, *NORC Public Policy, Promoting Healthy Aging: Aging in Place, NORC Supportive Service Programs, and the "Community Innovations for Aging in Place" Program*, http://www.norcs.org/page.aspx?id=160634 (accessed June 21, 2013).

23 Lawler, *supra* n. 3, at 43.

24 *Id. See also* NYC Dept. for the Aging, *NORC Concept Paper,* http://www.nyc.gov/html/dfta/downloads/pdf/norc_concept_paper.pdf (accessed June 21, 2013), in which the department announced it was seeking proposals from qualified vendors to provide NORC Supportive Service Programs.

25 NORCs: An Aging in Place Initiative, http://www.norcs.org (accessed June 21, 2013).

26 *See* NORCs: An Aging in Place Initiative, *supra* n. 22. The study notes that the status quo cannot continue because the elder population will reach close to 90 million by 2050. *See also* Lawler, *supra* n. 3, at 43, which notes that private investment in the model in New York dwarfs government funding and that state coffers have realized substantial savings in forestalling the need for more expensive care.

27 *See* Barbara A. Ormond et al., *Supportive Services Programs in Naturally Occurring Retirement Communities*, U.S. Dept. of Health & Human Servs. (Nov 2004), http://aspe.hhs.gov/daltcp/reports/norcssp.htm (accessed June 21, 2013).

28 *Id.* The NORC model fits well with the policy shift away from institutional care and toward community-based care. The NORC model also gives policy makers the opportunity to learn important lessons about what does work, what does not work, and why. This report reviews the history of NORCs and analyzes how NORCs serve the needs of communities. It also explores some of the challenges endemic to NORCs, including adequate communication, transportation, provision of services to all residents, and fundiug.

III. VILLAGES

Just as Penn South is the primordial NORC, Beacon Hill Village, a nonprofit organization formed in 2001, is the earliest example of the Village concept.[29] Beacon Hill Village is a member organization designed to assist and encourage persons to remain in the community. It promotes itself as "a member-driven organization for Boston residents 50 and over, [which] provides programs and services so members can lead vibrant, active and healthy lives, while living in their own homes and neighborhoods."[30] Beacon Hill recognizes that a key component of living at home is enjoying the vibrancy of life. The Beacon Hill Village website explodes with activities and ways to improve the lives of its members.[31]

Members can join for an annual fee under $1,000 — less for individuals and those with limited incomes.[32] Beacon Hill Village offers members social activities, referrals for services at a discount, including home health care services, as well as some services at no cost. Similar to NORCs, the program is built around the existing community and is a grass roots, member-driven organization.[33]

Unlike NORCs, Beacon Hill Village does not contract directly with governmental or private agencies to provide services to its members. Instead, it makes referrals to private providers they have vetted, often at a negotiated discount. As the Village encourages aging in place, these providers include handymen, caterers, computer technicians, companions, money managers, home health care providers, and geriatric care managers. To encourage a healthier lifestyle, Beacon Hill Village offers discounted gym memberships and personal trainers as well. Transportation is also available at a reduced cost to assist members with their daily activities, such as grocery shopping. Beacon Hill Village members also get free escorts to doctors and medical appointments.

Beacon Hill Village provides social and cultural programming as well. It sponsors trips to local cultural venues such as the Boston Pops, the Peabody Museum, and the Boston Ballet. It also brings in outside speakers on health and wellness, as well as academic, cultural and political topics. The success of Beacon Hill Village has spawned a movement of Villages nationwide.[34] Each Village is a nonprofit entity funded through membership fees. Relationships seem to be a key benefit of Villages. Because there is not generally the same agency collaboration as is seen with many NORCs, the role of volunteers, from both inside and outside the community, is very important.[35]

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29 *See* Beacon Hill Village, http://www.beaconhillvillage.org (accessed June 21, 2013).

30 *Id.*

31 *Id.*

32 Emily A. Greenfield et al., *A National Overview of Villages: Results from a 2012 Organizational Survey*, Rutgers Sch. of Soc. Work (Dec. 1, 2012), http://documents.clubexpress.com/documents.ashx?key=kYA6bFCyEAFYT percent2bTW4xG7fw0RCfsL0 percent2f4H percent2fFAmAbqcKGaecmWW44ASIg percent3d percent3d. This survey indicates that approximately two-thirds of Villages offer discounted membership for members in financial need.

33 Jane Gross, *Aging at Home: For a Lucky Few, a Wish Come True*, N.Y. Times (Feb. 9, 2006), http://www.nytimes.com/2006/02/09/garden/09care.html?pagewanted=all&_r=0 (accessed June 21, 2013).

34 Information on existing Villages as well as instructions for starting a Village community are available at Village to Village Network, http://www.vtvnetwork.org (accessed June 21, 2013).

35 Greenfield et al., *supra* n. 32, at 3.

As of this writing, somewhere in excess of 85 Villages exist across the United States, with 120 more in various states of development.[36] A map on the Village to Village Network website indicates that Villages have emerged in all but a handful of states.[37]

The Rutgers School of Social Work issued a study in December 2012 with a detailed survey of Villages nationwide, including budgets, membership fees, and services as well as demographic information on membership.[38] This study indicated that the communities were successful at serving lower-income individuals; more than 12 percent of members were described as impoverished.[39] It also found that fewer than 25 percent of members needed assistance with daily chores.[40] Therefore, it remains to be seen how effective Villages will be at allowing members to remain at home as their care needs increase.[41]

IV. Cohousing

Cohousing (also known as collaborative housing) is generally defined as a small clustered community of either attached units or single family homes with some common facilities and outdoor space.[42] Resident management and participation is a central aspect. Residents may be expected to participate in maintaining the common space and join in regular community meals and other events.[43] Although each residence is a fully functional and independent unit, cohousing communities all have some common facilities, usually a common house with kitchen and dining area, a common lounge or sitting area, laundry and children's play area.[44] These communities can also have common libraries, workshops, and exercise rooms. Ideally, cohousing communities are designed and developed with the communal aspect in mind, as the neighborhood layout can be a key factor in the model. However, cohousing proponents can also retrofit existing housing.[45]

The residents manage their communities in a horizontal, collaborative structure. Cohousing advocates refer to their communities as intentional neighborhoods, which distinguishes them from intentional communities that evolve around a particular ideology, such as ecology, or religion.[46] Cohousing draws from earlier concepts of planned com-

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36 *Id.* at 2.

37 *See* Village to Village Network, http://www.vtvnetwork.org/content.aspx?page_id=0&club_id=691012.

38 Greenfield et al., *supra* n. 32.

39 *Id.*

40 *Id.*

41 Some Villages are beginning to address these issues directly. Capitol Hill Village, in Washington, D.C., formed a partnership with Washington Hospital Center's Medical House Call Program. In Pennsylvania, Crozer-Keystone Village is affiliated with and overseen by a health care institution. *See* Martha Thomas, *Villages: Helping People Age in Place*, AARP Mag. (May/June 2011), http://www.aarp.org/home-garden/livable-communities/info-04-2011/villages-real-social-network.html.

42 Keith Wardrip, *Cohousing for Older Adults*, AARP Pub. Policy Inst. (Mar. 2010).

43 *See* Cohousing Assn. of the U.S. website, cohousing, http://www.cohousing.org (accessed June 21, 2013).

44 *See* cohousing, *Tell me about common meals,* http://www.cohousing.org/node/27 (accessed June 21, 2013). Cohousing units have their own full kitchens. Residents usually share two or three meals a week at the community house.

45 *Id.*

46 This is just one aspect that distinguishes cohousing communities from communes. *See* cohousing, Cohousing Basics, http://www.cohousing.org/node/531 (accessed June 21, 2013), for a discussion of the

munities, such as Garden Cities and New Towns, but shrinks the model to facilitate even greater social interaction.[47]

Cohousing communities were designed to embrace persons of all ages, including seniors. These communities encourage active neighborliness, promoting not just self-reliance, but interdependence. In some respects, cohousing is reminiscent of the multigenerational house. Only, in this case, community is the "family." While there are no formal support services incorporated into these communities, informal supports may allow seniors to remain in the community longer than they otherwise could.[48]

The Cohousing Association lists over 200 communities across the country ranging between 7 and 67 households.[49] The vast majority of these communities are intergenerational. However, more recently, a small number of senior cohousing communities have emerged.[50] As these communities mature, they may evolve to encompass some of the supports seen with Villages and NORCs, although their size may limit the ability to do so as efficiently.

V. Livable Communities

The concept of a livable community (also known as a lifetime community) has emerged in recent years, envisioning a community intentionally designed to include affordable, accessible and diverse housing options combined with nearby amenities, services and transportation.[51] Like NORCs, livable communities promote public-private partnerships to improve amenities and services for seniors, as well as other community members. Such an initiative might involve grants from the state, demonstration programs, technical assistance, review of land use and zoning laws, and development of accessibility standards.[52]

Livable communities do not necessarily involve new housing options, but intentional planning and collaboration to provide supports within close proximity to facilitate aging in place.[53] Florida has undertaken a statewide initiative with 160 communities bring-

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basic characteristics of cohousing.

47 *See e.g.* Dennis Hardy, *From Garden Cities to New Towns* (Routledge 1991).

48 Wardrip, *supra* n. 42, at 2.

49 Cohousing Association of the United States, *Cohousing Directory*, http://www.cohousing.org/directory (accessed June 21, 2013). As noted above, there are larger, planned communities built on the garden city model that incorporate many of the same features as cohousing. These include Radburn, New Jersey, and Forest Hills Gardens, Queens.

50 *See* Wardrip, *supra* u. 42, at 2. *See also supra* n. 43 for a brief discussion of aging and senior cohousing at Cohousing, http://www.cohousing.org/node/16 (accessed Aug. 7, 2013).

51 *See e.g.* Keith Wardrip, *Strategies to Meet the Housing Needs of Older Adults*, AARP Pub. Policy Inst. (Mar. 2010).

52 *See e.g.* Fla. Dept. of Elder Affairs, *Blueprint Communities for a Lifetime* (2007), http://www.communitiesforalifetime.org/docs/blueprint2007web.pdf (accessed June 21, 2013); Wardrip, *supra* n. 51; Farber & Shinkle, *supra* n. 14.

53 In 2006, the County of Westchester in New York launched the Livable Communities Initiative, which provides information and links to county wide programs that encourage seniors to age in place. Westchestergov.com, Livable Communities Initiative, http://seniorcitizens.westchestergov.com/livable-communities (updated June 11, 2013).

ing together local agencies, community organizations and nonprofits for collaboration.[54] While state funding has been very limited, the Florida program has resulted in a number of productive partnerships and pilot programs. These public-private initiatives include health self-management training, home modification programs, transportation services, new housing complexes, and intergenerational programming.[55]

Transit is a key factor in whether many seniors can remain in the community. About one in five older adults do not drive.[56] Nearly half of all seniors do not currently have access to public transportation.[57] Adequate transit and affordable housing stock near transit are essential components to developing livable communities and promoting aging in place.

Affordable housing options are an important part of livable community planning. The federal Department of Housing and Urban Development (HUD) provides about 300,000 subsidized housing units under Section 202 for seniors nationally.[58] Subsidized housing is a small subset of the affordable housing units available to seniors. Approximately 1.4 million individuals over age 50 live in subsidized or public housing and over half of all subsidized units are occupied by older adults.[59]

Diverse housing options within one community is also a key element of livable community planning, allowing seniors to downsize or find the residential option that fits them while remaining local. Universal design is an important element of planning for livable communities because of its emphasis on building to allow for aging in place. Simple design specifications like lever handles and faucets, roll-under counters and sinks, and barrier-free showers can be incorporated in new building initiatives and regulatory schemes.[60]

In addition to transportation and housing, seniors need access to other services in close proximity. Shopping, recreation, health care, and senior services all need to be available within walkable distances.[61] Walkable neighborhoods have become very desirable real estate. In recent years, the highest housing values per square foot have shifted from suburban communities to walkable urban neighborhoods in many metropolitan areas, reversing housing cost trends that have favored suburban settings since the 1960s.[62]

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54 Fla. Dept. of Elder Affairs, *supra* n. 52.

55 *Id.*

56 Wardrip, *supra* n. 51.

57 *Id.*

58 Elinor Ginzler, *From Home to Hospice: The Range of Housing Alternatives, in Independent for Life: Homes and Neighborhoods for an Aging America* 53 (Henry Cisneros, Margaret Dyer-Chamberlain & Jane Hickie eds., U. of Tex. Press 2012).

59 Wardrip, *supra* n. 51.

60 Farber & Shinkle, *supra* n. 14.

61 Elizabeth Plater-Zyberk & Scott Ball, *Longevity and Urbanism, in Independent for Life: Homes and Neighborhoods for an Aging America, supra* n. 58, at 197.

62 Christopher B. Leinberger & Michael Glynn, *Neighborhood Development, in Independent for Life: Homes and Neighborhoods for an Aging America, supra* n. 58, at 209.

VI. Lessons From These Trends

The residential models discussed are all in their relative infancy. It is too early to draw conclusions and declare successes. It is notable, however, that these concepts all share several qualities.

A. Stakeholder Involvement

Many seniors have embraced Villages, cohousing, and livable communities because they are built on input and involvement by community members. Older adults do not want to be told what to do by a social worker half their age; they want to design their own solutions.[63] As policymakers, developers, and nonprofits continue to explore how to bring services to seniors, it is important not to lose sight of the fact that older adults are in the best position to define what services and supports they need and want. Community outreach will be a key to expanding these models beyond their current limited scope. Senior centers, and religious and civic organizations are just a few places that can provide forums for introducing aging-in-place models to the greater public and solicit support and involvement at the grass roots level.

One of the goals of these models is to bring back the ideal of interdependence and communal responsibility that we associate with the neighborhoods of our past. This is a central tenet of cohousing.[64] Livable communities, NORCs, and Villages also rely heavily on volunteers to provide needed support to older adults in the community.[65] They also allow opportunities for seniors to share their skills, time, and wisdom with younger community members. The intergenerational nature of many of these initiatives has been a major factor in their appeal, as well as their success.[66]

B. Integrated Planning

Flexibility and choice are important features in most of these models. Many seniors reject the cookie-cutter approach that traditional over-55 communities offer.[67] However, these models prove that staying in large, multi-level homes in sprawling suburban communities is not the only option. Policymakers and developers would be wise to focus more on offering diverse housing options within close proximity to services and venues that seniors need or desire.

Although the focus of this article is on the residential component, it is clear that one of the most significant measures of the success of any model for aging in place is the ability to provide home and community-based services and supports in a cost-effective manner. As programs such as NORCs, Villages, livable communities, and cohousing mature, they promise to allow for delivery of services at a fraction of the cost of providing the

63 Gross, *supra* n. 33.

64 Wardrip, *supra* n. 42.

65 *See e.g.* Lawler, *supra* n. 3, at 43 and 46. Volunteer organizations that focus on supporting seniors in their homes have begun to spread. In White Plains, a membership organization has emerged that provides various services including transportation, meal assistance, home repair and maintenance, professional, and technology services. *See* Aging in Place in White Plains, www.aipwhiteplains.org (accessed June 21, 2013).

66 *See* Thomas, *supra* n. 41.

67 Gross, *supra* n. 33. *See also* Thomas, *supra* n. 41.

same services to individuals in traditional, suburban neighborhoods.

The ability to bring services to where people reside, as well as the ability to take advantage of economies of scale, is essential. Aging in place does not happen by chance — it comes about by focused and coordinated efforts. Whether through members, volunteers, and private service providers as in the Village model or through a formal collaboration of public, private, and nonprofits in livable communities and NORC SSPs, an intentional campaign to facilitate aging in place is needed.

C. Private-Public Collaboration

New York already has found that public and private collaboration can provide substantial return on its investment. The state legislation requires NORC Supportive Services Program grant applicants to match state dollars with private funds from the housing entity as well as private donations. The program has resulted in private investment far beyond the required levels, reaching nearly four times the initial state investment. New York has also estimated that the programs saved the state approximately $11 million in reduced health care expenses.[68]

Federal, state, and local governments must do more to promote aging in place. Despite the long-term savings potential, this may seem a difficult sell at a time when budgets are already facing deficits. Funding demonstration programs are important but Florida, for example, found that it can have an impact while spending relatively small amounts of public dollars by focusing on providing technical support and educational materials for local initiatives throughout the state.[69] Another potential for modest government investment is through the use of tax incentives. By offering tax incentives to private developers or other businesses, governments can encourage private enterprises to undertake aging-in-place initiatives. Tax incentives for private enterprises or joint public-private ventures may be an effective way to promote the costly infrastructure changes that are needed.

Securing funding poses a core challenge for comprehensive aging initiatives. Although the health, social service, and housing needs of seniors are closely entwined, government regulation and funding streams are generally separate.[70] Funding needs to be addressed in order to facilitate comprehensive aging-in-place initiatives.

The Affordable Care Act expands funding for preventive care and home and community-based care.[71] These initiatives would be most effective if they were incorporated as one piece of a global approach to aging in place that could maximize the efficiencies in service delivery.

Likewise, private insurers would be wise to consider flexibility in reimbursing health-related and non-traditional services (such as accessibility renovations, transportation, medical monitoring, and Village fees), which might stave off the need for more

68 Lawler, *supra* n. 3, at 43.

69 *See e.g.* Fla. Dept. of Elder Affairs, *supra* n. 52. Likewise, the County of Westchester in New York launched its Livable Communities Initiative, which focuses primarily on providing information to seniors about services that are available to them. *See* Westchestergov.com, *supra* n. 53.

70 Lawler, *supra* n. 3, at 17, 28.

71 Shana Siegel, *The Affordable Care Act, in Health Care Law: A Practical Guide*, Chap. 1A-1 (Scott Becker, Ronald Lundeen Jr. & Alison Vratil Mikula eds., Matthew Bender & Co. 2012).

costly long-term care. This flexibility might increase the attractiveness of these policies for consumers and save money for insurers.[72]

Even without governmental funding or widespread collaboration between public and private entities, nonprofits can still better facilitate aging in place by adopting a more global approach to the provision of services. Many charitable organizations focus on providing certain limited services to a needy population. In this time of shrinking resources, however, serving a more economically diverse population and providing a broader array of services may serve the community better and bring in needed revenue.[73] By reaching beyond traditional social services into ancillary services (such as geriatric care management, check writing, transportation, and shopping), some nonprofits may be able to better serve their constituents, while at the same time providing additional revenue to other struggling agency programs.

VII. Conclusion

As we prepare for the ranks of older adults to swell over the next generation, there is little doubt that the existing housing and service delivery models are not sufficient to meet the needs or desires of baby boomers. As a society we must develop coordinated efforts to better address the housing, health, and service needs of seniors. Successful aging in place requires involvement from the senior, the family, the community, local and state government, the private sector, and nonprofits. With public-private collaboration, integrated planning, and stakeholder involvement, we can realize cost savings while maximizing independence and choice, thereby allowing more older adults to remain in their homes and communities.

72 In an article in The Wall Street Journal, *Should You Purchase Long-Term-Care Insurance?* (May 14, 2012), http://online.wsj.com/article/SB10001424052702303425504577352031401783756.html,Prescott Cole, a senior staff attorney at California Advocates for Nursing Home Reform, argues that long-term-care insurance does not compare favorably with other insurance products on a cost-benefit basis.

73 Aging-in-place services are coordinated by Westchester Jewish Community Services (http://www.wjcs.com), a nonprofit agency based in White Plains, N.Y. Among the coordinated services are aging-in-place organizations and partnerships, adult group homes for the disabled, geriatric care management, senior center programs and meals, volunteer opportunities, geriatric outreach services, elder abuse counseling, home care, respite care, home delivered meals, home technology assistance, family caregiver networks, legal services, and geriatric think tank and planning strategies. Other agencies such as Jewish Family Service of North Jersey (http://www.jfsnorthjersey.org) also expanded its services to better serve seniors.

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Where Do We Go From Here? Long-Term Care in the Age of the Baby Boomers[1]

By Shana Siegel, CELA, and Neil T. Rimsky, CELA, CAP

I. Introduction

We have yet to meet a client who wants to spend his or her final years in a nursing home. Instead, aging in place has become the new meme of senior living. In a previous article in *NAELA Journal*,[2] we explored this concept, highlighting residential models that promise to allow seniors to remain in the community. We described housing trends that incorporate amenities and services that seniors need in a more efficient and economical manner than traditional suburban neighborhoods. We also noted the proverbial elephant in the room: Aging in place cannot become a reality without integrating affordable long-term care services.[3]

The type of coordinated and focused effort being brought to bear to promote aging in place has not yet emerged for revamping the long-term care system. Although there is much discussion about the difficulties in financing long-term care, there is less focus on service delivery.[4] We began to wonder, why has there been so little reform in the provision of long-

Shana Siegel, CELA, is the principal of WanderPolo & Siegel, in Montclair, Ne.J. She is president of the New Jersey Chapter of NAELA and is active in the New Jersey State Bar Elder and Disability Law section.
Neil T. Rimsky, CELA, CAP, is a member of the firm of Cuddy & Feder, LLP, in White Plains, New York. He received his undergraduate degree from the University of Rochester, Magna Cum Laude, and his law degree from Duke University. Mr. Rimsky serves on the Executive Committee of the New York State Bar Association Elder Law Section and as co-chair of the real estate and housing committee.

1 In this article, we define baby boomers as those born between 1946 and 1964, which seems to be the most common definition

2 Shana Siegel & Neil T. Rimsky, *Residential Models for Today's and Tomorrow's Older Adults*, 9 NAELA J. 225 (2013).

3 "Although the focus of this article is on the residential component, it is clear that one of the most significant measures of the success of any model for aging in place is the ability to provide home and community-based services and supports in a cost-effective manner." *Id.* at 233.

4 *See* Howard Gleckman, *Policy Experts Agree: The U.S. System for Financing Long-Term Care is Crumbling,*

term care services?

The number of individuals in nursing homes has stayed essentially constant during the past 30 years.[5] During this period, the need for long-term care services has grown substantially. Nearly one-half of older adults, or 18 million people, have difficulty with or receive help with their daily activities.[6] Over the past 15 years, we have seen major growth in the population over 80, the majority of whom need long-term care services; however, this has not resulted in the proliferation of new models of long-term care. Interestingly, the same population anomaly that has preserved the status quo now is likely to be the impetus for change: baby boomers.

During the past 20 years, large numbers of baby boomers have provided care to family members, thus mitigating the need for formal care.[7] Approximately 90 to 95 percent of seniors rely on family members for some or all of their care needs.[8] Nearly 3 million individuals who need assistance with three or more activities of daily living (i.e., who require nursing home level of care) do not live in nursing homes. Most of these individuals have at least one family caregiver.[9] Unfortunately, this trend will not continue.

As boomers shift from caregivers to those in need of care over the next several decades, the strain on an already stressed long-term care system will be overwhelming. The demographic projections are stunning. Between 2010 and 2030, the population over age 80 will increase by 79 percent, while the population 45 to 64 will remain roughly the same.[10] Between 2030 and 2040, the over-80 age group will continue to grow, increasing by an additional 44 percent.[11]

The care needs of this population cannot be supported by a shrinking pool of informal caregivers, and our current paid care models are vastly insufficient. The cost of traditional long-term care is simply too expensive. A study by AARP found that long-term care services and supports are unaffordable for middle-class families in every state. Even home care costs consume approximately 84 percent of median income.[12] Medicaid budgets are already overwhelmed with nearly half of Medicaid spending (more than $120 billion in fiscal year 2012)

Forbes (Mar. 27, 2013), http://www.forbes.com/sites/howardgleckman/ 2013/03/27/policy-experts-agree-the-u-s-system-for-financing-long-term-care-is-crumbling (accessed Oct. 20, 2014).

5 Ari Houser, *Nursing Homes*, AARP Pub. Policy Inst. Fact Sheet (Oct. 2007), http://assets.aarp.org/rgcenter/il/fs10r_homes.pdf (accessed Oct. 20, 2014).

6 Vicki Freedman & Brenda Spillman, *Disability and Care Needs among Older Americans*, 92 Milbank Q. 509 (Sept. 2014).

7 Donald Redfoot et al., *The Aging of the Baby Boom and the Growing Care Gap: A Look at Future Declines in the Availability of Family Caregivers* 3, AARP Pub. Policy Inst. Insight on the Issues (Aug. 2013).

8 Estimates vary slightly. *See* James R. Knickman & Emily K. Snell, *The 2030 Problem: Caring for Aging Baby Boomers*, 37(4) Health Servs. Research 849 (Aug. 2002); Susan C. Reinhard et al., *Raising Expectations, 2014: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers* 41 n. 34, AARP, The Commw. Fund & The SCAN Found. (June 19, 2014), http://www.longtermscorecard.org/~/media/Microsite/Files/2014/Reinhard_LTSS_Scorecard_web_619v2.pdf (accessed Oct. 20, 2014).

9 Freedman & Spillman, *supra* n. 6, at 509.

10 Redfoot et al., *supra* n. 7, at 5.

11 *Id.* at 6.

12 Robert Mollica & Leslie Hendrickson, *AARP State Long-Term Services and Supports Scorecard: What Distinguishes High- from Low-Ranking States? Case Study: Minnesota* 12 (May 2012).

being consumed by long-term care.[13]

These demographic and financial realities demand a policy response. There has been much discussion about the challenges the above-described demographics will create for funding long-term care for the baby boomer generation. A number of studies have explored public and private long-term care financing models.[14] Even though public policy must address and expand financing options, it is just as essential to analyze how we provide long-term care services and supports. Our current national approach to long-term care, which relies heavily on unpaid family caregivers and Medicaid coverage for nursing home care, cannot meet the needs of aging baby boomers.

Some progress has been made in recent years in developing better models for the provision of long-term care services and supports, overcoming the stereotypical model of the sterile and uncaring nursing home. The Medicaid program has served as a laboratory for testing and developing systems of providing a more diverse and appropriate range of long-term care services to seniors in a cost-efficient manner. There have been some promising results, but they have not led to widespread market reform. While federal law, including the Affordable Care Act,[15] is slowly moving toward the goal of keeping seniors our of nursing homes, federal efforts are centered on the means-tested Medicaid program, leaving it unable to spur the private-sector changes that are necessary to address the long-term care needs of the middle class.[16]

This article discnsses recent efforts in providing long-term care services and supports and how they might be broadened and replicated.[17] We highlight examples of public-private partnerships that maximize government services in conjunction with not-for-profit and private supports as a way to provide comprehensive long-term care services in a cost-effective manner. We also touch on how technology can play a role in the continuing care of seniors at a significantly reduced cost.

By reviewing some of the limited successes in the current delivery of long-term care, we begin to formulate a vision of a long-term care system that combines government and private resources to serve the anticipated long-term care needs of baby boomers. We also offer some first steps state and federal government and other stakeholders might take to move this vision forward.

13 Kaiser Fam. Found., *Distribution of Medicaid Spending on Long Term Care*, http://kff.org/medicaid/state-indicator/spending-on-long-term-care (accessed Oct. 20, 2014)

14 Two such studies were published by The SCAN Foundation: Eileen J. Tell, *Overview of Current Long-Term Care Financing Options*, http://www.thescanfoundation.org/sites/thescanfoundation.org/files/tsf_ltc-financing_current-financing-options_tell_3-20-13_2.pdf (Mar. 2013); Richard G. Frank et al., *Making Progress: Expanding Risk Protection for Long-Term Services and Supports through Private Long-Term Care Insurance* (Mar. 2013), http://www.thescanfoundation.org/sites/thescanfoundation.org/files/tsf_ltc-financing_private-options_frank_3-20-13.pdf. Minnesota has also studied this issue extensively. For further reading, *see Financing Options to Help Minnesotans Pay for Long-Term Care: Report and Recommendations — Own Your Future Advisory Panel* (Feb. 2014), https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6911-ENG (accessed Oct. 20, 2014).

15 Patient Protection and Affordable Care Act, Pub. L. 111-148 (2010) as amended by the Health Care and Education Reconciliation Act, Pub. L. 111-152 (2010). These two laws are collectively referred to as the Affordable Care Act or ACA.

16 Ironically, the cost of these programs has exploded and is not sustainable, because many in the middle class, who cannot afford the costs of long-term care, actively plan to access the Medicaid system.

17 We have provided references wherever possible, but note that the paucity of data and research on these issues (beyond basic hand-wringing about how broken our long-term care system is) is one of our major points.

II. Family Caregivers Remain an Important Resource, but They Need Support

As highlighted above, informal care by family caregivers has always been an integral part of the long-term care system. The economic value of unpaid care was approximately $450 billion in 2009 — nearly four times the amount the Medicaid program spent on long-term care that year ($119 billion).[18] Most Americans plan on relying on their families if and when they need long-term care.[19] Unfortunately for most baby boomers, this may be an unrealistic assumption, because the number of potential caregivers for each older adult will plummet from seven today to less than three by 2050.[20]

We are starting to see greater recognition of the need for supporting family caregivers. This is perhaps the easiest and most cost-efficient action government can take to address the long-term care crisis. The recently published Centers for Medicare & Medicaid Services (CMS) rule on home and community-based services (discussed in detail below) requires Medicaid home and community-based services programs to conduct an assessment of caregivers' needs when their assistance is part of the care plan for a person with a disability.[21] This, it is hoped, will lead states to develop systems for providing caregivers with appropriate information, training, respite, and other services tailored to their individual needs and preferences.

One example of an evolving caregiver support system is nurse delegation. Family caregivers are increasingly finding themselves engaging in more complex nursing tasks.[22] This is because most states allow nurses to train family members to perform many medical tasks, such as medication administration and tube feeding. However, nurses are generally prohibited from training paid direct care workers. This prevents families from relying on home health aides to provide services while they work or take respite time. Many states are beginning to address this issue by modifying their rules on nurse delegation to allow training of home health aides while incorporating guidelines for patient safety.

III. Home and Community-Based Care Is Preferable

Even when family care is not an option, policymakers and consumers agree that allowing seniors to age in place is preferable to placing them in nursing homes. Most older adults strongly prefer home and community-based care to nursing home care.[23] Policymakers note that even when no informal caregivers are providing support, the average cost of care is substantially lower in a home setting than in a nursing home.[24] Astonishingly, however, Medicaid has been slow to provide comprehensive home and community-based services. The majority of Medicaid dollars spent on long-term services and supports still go to nursing home care.

18 Lynn Feinberg et al., *Valuing the Invaluable: 2011 Update — The Growing Contributions and Costs of Family Caregiving* 1, AARP Pub. Policy Inst. Insight on the Issues (June 2011).

19 *See* Redfoot et al., *supra* n. 7, at 7.

20 *Id.* at 1.

21 42 C.F.R. §§ 430, 431, et seq. (2014).

22 Redfoot et al., *supra* n. 7, at 2.

23 Kathryn Lawler, *Aging in Place: Coordinating Housing and Health Care Provision for America's Growing Elderly Population* 15, Jt. Ctr. Hous. Stud. Harv. U. & Neighborhood Reinvestment Corp. (Oct. 2001), http://www.jchs.harvard.edu/sites/jchs.harvard.edu/files/lawler_w01-13.pdf (accessed Oct. 20, 2014).

24 *See Genworth 2014 Cost of Care Survey*, Genworth Financial, Inc. (Mar. 25, 2014), https://www.genworth.com/dam/Americas/US/PDFs/Consumer/corporate/130568_032514_CostofCare_FINAL_nonsecure.pdf (accessed Oct. 20, 2014).

This is particularly true for older adults, with an average of less than 30 percent of long-term services and supports expenditures going to home and community-based services.[25] This is slowly changing as states try to stem Medicaid budget woes by shifting to more home and community-based services. Progress in this area is mixed. In the top three stares, nearly 80 percent of Medicaid beneficiaries receive long-term care services and supports in rhe home and community compared with around 25 percent in the worst performing states.[26]

Traditional single-family suburban housing can be a major barrier to seniors remaining in the community. As discussed in our previous article, residential models can be designed to encourage independence and facilitate aging in place.[27] For instance, naturally occurring retirement communities (NORCs) and villages provide services to members of the community based on some basic concepts. These concepts include economies of scale, public-private partnerships, personal commitments, community and neighborhood commitments, in-kind contributions, philanthropic contributions, and resident fees.

Many NORCs contract with nonprofits or private agencies to provide health and social services to their residents.[28] Villages provide their members with referrals to vetted providers who in turn offer discounted rates to those members. They also commonly offer limited support services such as transportation, companionship, housekeeping, home repair, yard care, and health care advocacy through volunteers and staff.[29]

The provision of support services within senior or communal housing provides a number of efficiencies. It minimizes the need for offsite transportation and allows services to be delivered less expensively through economies of scale. A number of studies have found that these models of providing services can forestall the need for long-term care as well as increase social interaction and improve emotional well-being.[30] However, these models do not currently provide sufficient services (nor are they widespread enough) to meet the needs of seniors most at risk for institutionalization (i.e., those with substantial long-term care needs).[31]

If we really want seniors to be able to age in place, we must offer easy access to the services they need at affordable rates. Many seniors are forced to leave their homes when they need multiple types of services. Some senior housing programs offer service coordinators who provide information on the options, cost, and availability of needed support and health care services. Service coordinators in a federally subsidized housing program for seniors are also tasked with coordinating service delivery to maximize independent living and with monitoring the quality and quantity of services to fit needs of residents. This program has expanded

25 Reinhard et al., *supra* n. 8, at 33.

26 *Id.*

27 Siegel & Rimsky, *supra* n. 2.

28 N.Y.C. Dept. for the Aging, *NORC Concept Paper 2*, www.nyc.gov/html/dfta/downloads/pdf/norc_concept_paper.pdf (accessed Oct. 20, 2014). In this paper, the department announced it was seeking proposals from qualified vendors to provide naturally occurring retirement community (NORC) supportive service programs.

29 Carrie L. Graham et al., *The Impact of the "Village" Model on Health, Well-Being, Service Access, and Social Engagement of Older Adults*, 41 Health Educ. Behavior 91S (Oct. 2014), http://heb.sagepub.com/content/41/1_suppl/91S.full.pdf+html (accessed Oct. 24, 2014).

30 *Id.; see also* Lawler, *supra* n. 23, at 43 n. 18 (noting that state coffers have realized substantial savings in forestalling the need for more expensive care).

31 *See* Graham et al., *supra* n. 29, at 96S.

since the 1990s, and now there are service coordinators at approximately half of the Section 202 communities across the country.[32]

However, most baby boomers cannor or will not consider government-subsidized housing. Services need to be integrated into a variety of market-rate housing options in order to provide opportunities for sustainable long-term care.[33] Again, we find the NORC serving as a model.

Although the earliest NORCs were in large buildings, a future goal is to apply the concept to community-based care while expanding the range of services offered. In 2005, the New York legislature dedicated funds to a new iteration, the Neighborhood NORC (NNORC). The NNORC applies the concepts that made the NORC successful to serve seniors in neighborhoods instead of only those in large housing developments.[34] It also substantially expands the services provided to facilitate aging in place with supportive services, such as service coordination, case assistance, case management, counseling, health assessment and monitoring, home-delivered meals, transportation, socialization activities, home care facilitation, and monitoring. The services are provided through an interfaith partnership that includes public, private, and nonprofit organizations.[35] Unfortunately, New York has invested only $2 million in the program; therefore, it is likely to remain limited in scope for the foreseeable future.[36]

IV. Care Coordination Is a Necessity

For those not living in senior (or other congregate) housing, the provision of information about the numerous services available across the community is insufficient and services are provided in isolation. Any successful home and community-based long-term care model must include the provision of coordinated services. Although there have been demonstration programs such as the Programs of All-Inclusive Care for the Elderly (PACE) for many years, only recently are states and CMS moving toward a truly coordinated approach to home and community-based services.[37]

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32 U.S. Dept. of Hous. & Urban Dev., *Section 202 Supportive Housing for the Elderly: Program Status and Performance Measurement* 55 (June 2008), http://www.huduser.org/Publications/pdf/sec_202_1.pdf (accessed Oct. 20, 2014).

33 LeadingAge has demonstrated the progress made: LeadingAge, *Senior Housing in New York State* (Feb. 2013), http://www.leadingageny.org/?LinkServID=1E3B04BD-C423-8037-8A4B9D3C0B783623 (accessed Oct. 20, 2014). In New Jersey, several nonprofits have banded together to provide "portable assisted living services" to residents in senior housing buildings. Colleen Diskin, *Assisted Living at Your Doorstep: On-Site Senior Services in Westwood,* NewJersey.com (updated Oct. 14, 2014), http://www.northjersey.com/news/assisted-living-at-your-doorstep-on-site-senior-services-in-westwood-1.1108652?page=all (accessed Nov. 14, 2014).

34 Leading Age, supra n. 33, at 11.

35 *See* Jewish Fedn. of N.E. N.Y., *Corporate Sponsorship Proposal – Neighborhood Naturally Occurring Retirement Community (NNORC),* https://www.jewishfedny.org/give/corporate-sponsorship/nnorc (accessed Oct. 20, 2014).

36 LeadingAge, *supra* n. 33, at 11. Additional funding includes in-kind contributions, private housing partners, philanthropies, corporate sponsors, and community stakeholders.

37 The U.S. Department of Housing and Urban Development also is moving beyond offering service coordinators toward integrating health services with the Service Enriched Housing (SEH) program, which provides services to elderly residents who need assistance with activities of daily living in order to live independently.

In 1990, the first PACE received Medicare and Medicaid waivers to operate. As of 2011, more than 80 programs existed in 30 states.[38] PACEs provide a continuum of care and services to seniors with long-term care needs with the goals of controlling costs, delivering quality care, and allowing individuals to remain at home for as long as possible. PACE providers receive capitated fees for each participant, which rewards cost savings and encourages the efficient provision of services.[39] Generally, the results have been positive. A number of studies have found that PACE participants have substantially lower rates of nursing home use and hospitalization and improved health outcomes.[40] Studies have also shown that PACEs can result in cost savings to states compared with traditional Medicaid home and community-based services.[41]

States and CMS have begun showing increased interest in managed long-term care services and supports (MLTSS) beyond PACE.[42] Increasing numbers of states are turning to MLTSS — the number of states with MLTSS programs increased from 8 in 2004 to 26 in 2014.[43] Medicaid MLTSS programs can be operated under multiple federal Medicaid managed care authorities at the discretion of the states and as approved by CMS, including sections 1915(a), 1915(b), and 1115.[44] Section 1915(a) allows states to offer voluntary enrollment into capitated managed care otherwise unavailable to states providing home and community-based services on a fee -for-service basis. Section 1915(b) waivers allow services to be delivered through managed care organizations. These waivers can be combined with 1915(c) waivers, which allow states to provide long-term care services in home and community settings rather than in institutional settings. Section 1115 authorizes research and demonstration projects, allowing a state to apply for program flexibility to test approaches to financing and delivering services to Medicaid beneficiaries.

Recently, CMS took a major step in simplifying this piecemeal approach. It issued a rule in January 2014 that facilitates streamlined administration of home and community-based services waivers.[45] The regulation also provides states with the option to combine coverage for multiple populations into one waiver under section 1915(c). In addition, it imposes a 5-year waiver approval and renewal cycle to simplify administration and allow states to align

38 U.S. Dept. of Health & Human Servs., CMS, *CMS Manual System Pub. 100-11 Programs of All-Inclusive Care for the Elderly (PACE) Manual* 2 (June 3, 2011), http://www.cms.gov/Medicare/Health-Plans/pace/downloads/r1so.pdf (accessed Oct. 20, 2014).

39 *Id.*

40 *See* Jody Beauchamp et al., *The Effect of the Program of All-Inclusive Care for the Elderly (PACE) on Quality: Final Report*, Mathematica Policy Research (Feb. 12, 2008); L.A. Meret-Hanke, *Effects of the Program of All-Inclusive Care for the Elderly on Hospital Use*, 51(6) Gerontologist 774 (2011).

41 D. Wieland et al., *Does Medicaid Pay More to a Program of All-Inclusive Care for the Elderly (PACE) than for Fee-for-Service Long-Term Care?* 68(1) Js. Gerontology: Series A, Biological Sci. Med. Sci. 47 (Jan. 2013).

42 Interestingly, Minnesota, which is the top-ranked state for long-term care services and supports, has enrolled its senior Medicaid beneficiaries in managed care since 1983 and incorporated long-term care services in 2005.

43 Paul Saucier et al., *The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update* 1, Truven Health Analytics (July 2012), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/MLTSSP_White_paper_combined.pdf (accessed Oct. 20, 2014).

44 Social Security Act, 42 U.S.C., 1396n and 1315.

45 42 C.F.R. §§ 430, 431, et seq.

concurrent waivers with state plan amendments.

This is significant, because the lack of a large-scale unified approach has undoubtedly limited the impact on the private marketplace up until now. Of course, as long-term care services largely remain uncovered by insurance, there has been little incentive for private providers to undergo systemic change.

V. Seniors Who Cannot Remain at Home Can Receive Patient-Centered Care in a Home-Like Environment

Some private providers have chosen to innovate and incorporate the principles of home-like environments and patient-centered care into their long-term care models. A growing number of facilities are promoting the Eden Alternative as the next best option for individuals who cannot remain at home. The Eden Alternative is a model that emerged in the 1990s, which focuses on providing holistic, patient-centered care in a pleasant, active setting. This approach aims to create an environment that fosters independence, actively engages seniors, and promotes strong interpersonal relationships. Hundreds of facilities and providers have embraced the Eden Alternative philosophy to varying degrees. Countless others promote patient-centered care and home-like environments without any affiliation with the Eden Alternative movement. Several studies have found that this approach can significantly impact patient well-being, resulting in a reduction in boredom, helplessness, and depression.[46]

Another model stemming from the Eden Alternative that is gaining in popularity is the Green House Project. This paradigm incorporates the Eden Alternative principles into building design, resulting in small communities of homes for 6 to ten seniors who require skilled nursing care. Green House facilities offer communal living in a home-like environment with direct caregivers who integrate personal care and management of the homes. The staffing of direct caregivers allows for more individual engagement and increased direct care time. Again, we see that residents living in Green House settings experience better quality of care and report better quality of life than traditional nursing home residents. Staff and families also reported higher rates of satisfaction.[47]

As the Green House model starts to reach some market saturation,[48] consumers are starting to respond. A majority of consumers favor this model over other long-term care options. One survey found that 90 percent of consumers wish there were more Green House facilities available; 60 percent indicated that they would pay more for this type of offering.[49]

46 Brenda Bergman-Evans, *Beyond the Basics: Effects of the Eden Alternative Model on Quality of Life Issues*, 30(6) J. Gerontological Nursing 27 (June 2004); Sherry B. Robinson & Richard B. Rosher, *Tangling with the Barriers to Culture Change: Creating a Resident-Centered Nursing Home Environment*, 32(10) J. Gerontological Nursing 19 (Oct. 2006).

47 R.A. Kane et al., *Resident Outcomes in Small-House Nursing Homes: A Longitudinal Evaluation of the Initial Green House Program*, 55(6) J. Am. Geriatric Socy. 832 (June 2007).

48 Jewish Home Lifecare, *Research Shows Life Flourishes in a Green House*, http://www.jewishhome.org/the-changing-face-of-aging/a-new-model-of-nursing-home/research-shows-life-flourishes-in-a-green-house (accessed Oct. 20, 2014). As of 2012, there were more than 130 Green House communities across the country and almost as many in development.

49 The Green House Project, *What Informal Caregivers Think about the Green House Project: Results from Interviews, Focus Groups and Survey*, http://thegreenhouseproject.org/doc/28/consumer-research.pdf (accessed Oct. 20, 2014).

This is important, because ultimately the market will be a key driver of culture changes for long-term care.

VI. Technology Will Play a More Important Role

Technology will undoubtedly play an important role in the provision of long-term care services in the future. It may reduce professional caregiver workloads; increase caregiver efficiency; provide coordination of care and longitudinal data; and provide peace of mind for family caregivers and reduce their burden.[50] Technology can be used to provide access to resources and health information and reduce social isolation.[51]

Remote sensor technology can be used to monitor the daily activities of vulnerable seniors.[52] Sensors are placed unobtrusively around the home. Computer software learns to recognize daily routines. In the event of a change in routine, information is transferred to the call center, which can notify family members and social workers. Similar technology is being used at various NORCs.[53]

To combat isolation, one nonprofit developed software in collaboration with Microsoft, the New York City Department of Aging, and the New York City Department of Technology and Telecommunications.[54] The Virtual Senior Center allows homebound seniors to engage in activities such as discussion groups, video-based classes, face-to-face communication with peers, and wellness classes. Surveys show significant reduction in anxiety, depression, and loneliness.[55] Other social connectedness technologies include senior-friendly social networking websites, easy-to-use email systems, email-to-paper communications systems, easy-to-use videophones, and video conferencing systems.[56]

Telehealth promises to stretch limited resources, thus allowing providers to remain in contact with seniors in their homes.[57] Devices that can use this technology include blood pressure cuffs, glucose meters, medication reminders, and weight scales. Another option is to locate telehealth kiosks in community centers or other buildings.[58] Participants can activate

50 LeadingAge Ctr. for Aging Servs. Techs., *Health and Wellness Technologies*, LeadingAge (May 3, 2011), www.leadingage.org/Health_and_Wellness_Technologies.aspx (accessed Oct. 20, 2014).

51 *See* LeadingAge, *supra* n. 33, at 35. Innovations have been used by Selfhelp Community Servs., Inc., a not-for-profit organization dedicated to maintaining the independence and dignity of seniors and at-risk populations.

52 *See* Selfhelp Community Servs., Inc., *Remote Sensor Technology*, www.selfhelp.net/technology/remote-sensor-technology (accessed Oct. 20, 2014).

53 *See* LeadingAge, *supra* n. 33, at 35.

54 Microsoft News Ctr., *Virtual Senior Center Enhances Lives of Homebound Seniors* (Mar. 10, 2010), http://news.microsoft.com/2010/03/10/virtual-senior-center-enhances-lives-of-homebound-seniors (accessed Oct. 20, 2014).

55 *See* Selfhelp Community Servs., Inc., *Virtual Senior Center — Selfhelp's Virtual Senior Center Program: Changing Lives ... Every Day*, http://selfhelp.net/virtual-senior-center (accessed Oct. 20, 2014). The Virtual Senior Center is supported by the UJA-Federation of New York, Consumer Electronics Association Foundation, AARP Foundation, Harry and Jeanette Weinberg Foundation, and Harriet and Robert H. Heilbrunn Fund.

56 *See* LeadingAge, *Social-Connectedness Technologies* (updated May 19, 2014), http://www.leadingage.org/Social_Connectedness_Technologies.aspx (accessed Oct. 20, 2014).

57 *See* Selfhelp Community Servs., Inc., *Telehealth*, http://selfhelp.net/technology/telehealth (accessed Oct. 20, 2014).

58 *See* LeadingAge, *supra* n. 33, at 36. Selfhelp has partnered with Jewish Home Lifecare; partial funding for the kiosks comes from Enterprise Community Partners.

a touch screen by swiping a card, which records and monitors vital statistics such as blood pressure and weight. Health care providers can then track the information.

Electronic documentation technologies are primarily aimed at health care professionals and professional caregivers. Technologies such as electronic health records, poinr-of-service systems, electronic prescribing, medication administration records, electronic charting, and electronic workflow and documentation systems can improve health care efficiency, ensure communication among providers, and allow for better performance and results measurement.[59]

VII. The Federal Government Must Play a More Proactive Role

With the looming demographic changes, none of the limited initiatives that are available now will be sufficient to address the tidal wave of baby boomers needing long-term care. Unfortunately, the federal government is only now studying new approaches. In 2013, the U.S. Senate Commission on Long-Term Care issued a report to Congress with detailed recommendations on rebalancing services, integrating care, performing uniform assessments, and improving access to care as well as recommendations on workforce and financing reforms.[60]

CMS recently took a major step forward in encouraging innovation and expansion of coordinated home and community-based services with the publishing of a new federal regulation.[61] The rule implements the section 1915(i) home and community-based services state plan option,[62] including new provisions under the Affordable Care Act that offer states the option to provide expanded home and commnnity-based services. Under the new rule, CMS imposes new definitions of home and community-based settings to emphasize the importance of an individual's independence and integration with the greater commnnity.[63] For instance, home and community-based settings must be integrated into and provide full access to the greater community and optimize an individual's autonomy and independence in making life choices. Settings that are provider owned or controlled must allow for tenant protections, provide private units with lockable doors, provide access to food at any time, and have no limitations on visitor hours.[64]

The regulation includes provisions aimed at facilitating streamlined administration of home and community-based services waivers and provides states with the option to combine coverage for multiple populations into one waiver under section 1915(c).[65]

The new regulation also includes important provisions for person-centered planning, which require that a customized plan be developed to provide the health care and long-term services and snpports an individual needs.[66] The regulation requires the plan to incorporate

59 *See* LeadingAge Ctr. for Aging Servs. Techs., *Electronic Documentation Technologies*, LeadingAge (May 3, 2011), http://www.leadingage.org/Electronic_Documentation_Technologies.aspx (accessed Oct. 20, 2014).

60 *United States Senate Commission on Long-Term Care: Report to the Congress* (Sept. 30, 2013), http://www.gpo.gov/fdsys/pkg/GPO-LTCCOMMISSION/pdf/GPO-LTCCOMMISSION.pdf (accessed Oct. 20, 2014).

61 79 Fed. Reg. 2948 (Jan. 16, 2014) (amending 42 C.F.R. §§ 430, 431, et seq.).

62 Social Security Act, 42 U.S.C., 1396n § 1915(i).

63 42 C.F.R. § 441.301(c)(4).

64 *See* 79 Fed. Reg. 2948, 3030–3031 (amending 42 C.F.R. § 441.301).

65 *See* 79 Fed. Reg. 2948, 3022 (amending 42 C.F.R. § 441.302).

66 *See* 42 C.F.R. §§ 441.301, 441.530, 441.725.

an individual's goals and preferences, including those related to community participation, employment, income and savings, health care and wellness, and education.[67]

Although it is too early to have gained any practical experience with these changes, they hold real promise as they normalize the concept of patient-centered care and coordination of services to meet the needs of individuals. The administrative provisions also are important, because they allow states to adopt a more comprehensive approach to long-term care instead of having to rely on a number of small, separate waivers.

VIII. States Need to Take the Lead in Engaging Private Providers and Nonprofit Agencies and Fostering Collaboration

Fortunately, some states have taken a more proactive approach by analyzing these long-term care issues and preparing for the upcoming demographic changes for some time. Minnesota's Aging 2030 project was designed to help state agencies develop policy options to prepare for the demographic shifts that will peak in 2030 when baby boomers turn 85.[68] Minnesota also evidenced a longstanding commitment to home and community-based services and managed care, innovative housing models, strong public-private collaboration, and a focus on quality improvement.[69] Minnesota ranked first in its ability to serve new users of long-term care services and supports in home and community-based settings. At 83.3 percent, Minnesota's effectiveness on this indicator is far above the national median of 49.9 percent. Minnesota also ranked first on the availability of assisted living and residential care alternatives.[70] The AARP scorecard concludes that "a willingness to experiment, innovate, and challenge the status quo are the hallmarks of successful states."[71]

Other states have actively engaged in developing public-private collaboration to provide long-term care services in the community. A common theme emerging from these programs is the importance of working together with existing community service providers, such as home care agencies, area agencies on aging, mental health providers, and adult day health centers.

New York has been active in promoting the integration of services in communities where seniors reside by collaborating with nonprofits and private providers. Besides the NORC and NNORC models, the Weinberg Campus, in Buffalo,[72] combines market-rate independent housing with long-term care services. The Weinberg Campus is a not-for-profit community of modern buildings that offer an array of services for independent seniors.[73] It also offers the Total Aging in Place Program, which is a managed long-term care health plan for those who need long-term care. Services covered by the program are provided by a coordinated team of nurses, rehabilitation specialists, and social workers who work with their clients' physicians to develop a plan intended to meet the needs of each client.[74] Services include day programs,

67 42 C.F.R. § 441.725.
68 Mollica & Hendrickson, *supra* n. 12, at 4, fn. 7.
69 *Id.* at 4.
70 *Id.* at 7.
71 Reinhard et al., *supra* n. 8, at 56.
72 *See* Weinberg Campus, http://www.weinbergcampus.org (accessed Oct. 20, 2014).
73 *Id.*
74 *See* Weinberg Campus, *MLTC Total*, http://www.weinbergcampus.org/MLTCTotal/tabid/ 278/Default.aspx, *click on* MLTC Total tab (accessed Oct. 20, 2014).

care management, medical transportation, and home care and is available to persons who can pay privately as well as those covered through Medicaid.

Flushing House, in Queens County, is another example of a public-private partnership.[75] Built in 1974 by the United Presbyterian and Reformed Adult Ministries, Flushing House provides independent housing and support services at more affordable middle-class rents.[76] Practically nonexistent a few decades ago, retirement residences similar to Flushing House now number in the thousands across the United States. However, most of these independent living facilities are real estate developments owned by large, for-profit corporate chains, and many require large upfront buy-ins. The challenge is to capitalize on government and nonprofit involvement to allow this model to be more available and affordable for older Americans.

IX. Conclusion

Although we have highlighted many hopeful signs that long-term care reform can occur, progress remains uneven across the country. The majority of individuals needing long-term care do not have access to the options highlighted here. Moreover, most of the innovation in the provision of integrated, patient-centered services has been directed at Medicaid recipients. Community-based long-term care options for the wealthy and the poor are beginning to expand, but for most middle-class Americans, the services they need to remain at home continue to be unaffordable and piecemeal. Unfortunately, the financing structure for long-term care has limited the impetus for private providers to innovate and collaborate. It is hoped that this will change as market demand increases.

We have approximately 20 years before large numbers of baby boomers need long-term care. Policymakers must engage now in systemic change to prepare. We are practicing Elder Law attorneys, not policy wonks. We do not claim to have all the answers and are not presumptuous enough to think we have the perfect model.[77] However, our research has led us to reach certain conclusions that can form the basis for further study.

Coordinated, patient-centered long-term care services and supports must be integrated into communities to facilitate aging in place. We believe that communal living is necessary for cost-efficient service delivery. Although private companies may develop communal housing, not-for-profit agencies that serve seniors and people with disabilities may be the most well suited to provide these services. Models such as NNORCS, the Weinberg Campus, and Green Houses should be studied, because they hold promise for wider application.

Public financial support is also essential to the ultimate success of any program of long-term care. Government support should include direct financing, tax incentives, public grants, and knowledge sharing. States must also take the lead in supporting the most cost-effective means of providing care, such as providing additional support to family caregivers. This, along with maximizing technology, is key to reducing the cost of long-term care. Active engagement and collaboration among private providers, community agencies, and federal and state government is essential to bringing innovative patient-centered care to middle-class Americans.

75 Owned and operated by the United Presbyterian and Reformed Adult Ministries.

76 *See Flushing House*, http://www.flushinghouse.com/aboutus.html (accessed Oct. 20, 2014).

77 Of course, we realize that there is no one model that will solve our nation's long-term care woes and therefore can only offer a series of recommendations for reform.