Housing and Home and Community-Based Services: What it Takes to Age in Place

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Patti Prunhuber, Senior Housing Staff Attorney, Justice in Aging

Claire Ramsey, Senior Health Staff Attorney, Justice in Aging

Introduction

Older adults overwhelmingly state that they want to stay in their homes as they age, getting the services they need and remaining connected to their family, friends, and community.[1] Yet many are forced to give up that ideal and instead receive their care in a nursing facility. There are many contributing factors that result in the unnecessary institutionalization of older adults, including the lack of affordable and accessible housing, health care and/or social supports, and transportation assistance. These contributing factors can even result in homelessness. Further, there are racial and wealth inequities that shape who is able to age in the community, and who cannot.

This issue brief explores the relationship between housing and health for aging adults, and describes some promising programs that link safe, permanent, and affordable housing with a varied set of Medicaid-reimbursable health care and supportive services to assist older adults, persons with disabilities, and people at risk of, or experiencing homelessness, to remain in their communities. As the federal Medicaid program and health care programs throughout the United States increasingly recognize the importance of social determinants of health, there are increased opportunities to build bridges between health care and a range of housing-related supports and housing options.

Housing is Health Care

Securing safe, affordable, and stable housing produces beneficial health outcomes for anyone, and especially for older adults and people experiencing homelessness.[2] This has become even more crucial in the context of the COVID-19 pandemic. People 65 years of age and older and those with underlying medical conditions are at greatest risk for serious health consequences or death if they become infected with the virus. For older adults, becoming homeless or being confined to a nursing facility due to lack of housing in the community can have life-threatening consequences.

Many older, low-income adults face unaffordable rents, putting them at increased risk of housing instability and homelessness. A recent study found that adults whose housing became unaffordable had an increased risk of unmet medical needs.[3] When households struggle to pay their rent, they not only face financial and housing instability, they also are at heightened risk for a host of negative health outcomes. Because homelessness and poor health are inextricably linked, some of the least healthy and most costly Medicaid enrollees are homeless or precariously housed.[4] Conversely, among those experiencing long-term homelessness, getting into supportive housing has led to better overall health and reduced emergency room visits. A recent initiative to move people experiencing homelessness out of shelters and into hotel rooms in King County, Washington showed slowed rates of transmission of the COVID-19 virus, but also improved physical and mental health, and increased overall stability.[5]

Olmstead v. L.C.—The Right to Community Living

The federal Americans with Disabilities Act (ADA) requires state and local governments to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities."[6] In *Olmstead v. L.C.*, the U.S. Supreme Court decided that states are required to provide long-term services and supports to qualified individuals in the community in certain instances. This is known as the integration mandate.[7] This mandate requires that persons with disabilities be served in the community when: (1) the state's treatment professionals have determined that community placement is appropriate; (2) community placement is not opposed by the individual; and (3) "the placement can be reasonably accommodated, taking into account the resources available" and the needs of others with disabilities. The Department of Justice and several Circuit Courts expanded the *Olmstead* decision to apply to individuals who are at risk of being institutionalized, but are not currently living in nursing facilities.[8] These rules apply to older adults with disabilities as well.

Defining Home- and Community-Based Services (HCBS)

Home and Community Based Services (HCBS) is an umbrella term that describes a wide variety of long-term services and supports that assist people who need help with daily needs. HCBS are administered in people's homes and communities, rather than in nursing facilities and other institutions. HCBS enable many people with disabilities of all ages to live independently and to fully participate in their communities as they choose. HCBS includes health services to address an individual's medical needs, social services to assist with Activities of Daily Living (ADLs), and Instrumental Activities of Daily Living (IADLs), and community integration supports.

The suite of HCBS services is broad and includes:

- Home health care (such as skilled nursing care; physical, occupational, and speech therapy; pharmacy services);
- Personal care (assistance with ADLs such as bathing, dressing, eating, transferring, toileting, and IADLs such as laundry, shopping, running errands, and housekeeping);
- Durable medical equipment;
- Transportation;
- Meal delivery;
- Home modifications; and
- Caregiver training and respite.

What Types of HCBS do States Offer?

While state Medicaid programs must cover care provided in nursing facilities,[9] almost all HCBS provided outside of a nursing home are an optional state Medicaid benefit. This means that it is easier to access institutional care than it is to access HCBS. Today, all 50 states and DC provide HCBS to adults age 65 and older and certain other populations through combinations of state plan benefits and waivers. However, the specifics—what those supports and services are, who is eligible, and how many people are served varies from state to state.

ADVOCACY TIP

The American Rescue Plan of 2021 included a temporary ten percent increase in the federal Medicaid reimbursement rate provided to states to increase access to HCBS for Medicaid beneficiaries. This temporary increase in the federal share of HCBS funding gives states a unique opportunity to expand the services they cover, or the people they cover, allowing them to receive health services in their homes and communities, rather than in nursing homes or other institutions.[10] Stakeholders and advocates are encouraged to engage with their states to ensure states utilize this funding opportunity to expand access to HCBS.

1. Mandatory HCBS: Home Health Services

All states must provide "home health" services under their state Medicaid plan; this has been a mandatory Medicaid benefit since 1970.[11] Unlike the federal *Medicare* Home Health benefit, the *Medicaid* Home Health benefit does not require that a person be home-bound, and states are prohibited from requiring eligibility for nursing or therapy services as a condition of home health.[12] In fact, states may not limit Medicaid home health services to individuals who require skilled services as defined by Medicare (i.e., skilled nursing and therapy services).[13] For a more detailed description of Medicaid HCBS eligibility and scope of potential services, see Medicaid Home and Community Based Services for Older Adults with Disabilities: A Primer.

2. Medicaid Optional HCBS Services

States can also elect to offer additional HCBS as an optional state plan benefit. In 2018, 1.2 million people received HCBS through optional personal care state plan services across 34 states.[14] In addition, approximately 400,000 people received services through the Community First Choice Option (Section 1915(k)) in eight states and about 81,000 in eleven states under section 1915(i) authority.[15] It should be noted that when states adopt Medicaid optional services, the state can cut these benefits during times of budget shortfall or make the optional benefit less comprehensive without running afoul of federal Medicaid rules.

3. Medicaid Waivers that Support HCBS

All fifty states and D.C. have chosen to provide some HCBS through at least one federal Medicaid waiver.[16] A waiver allows a state to operate a program that doesn't follow all the Medicaid program rules. For example, waivers allow states to set an overall limit on the number of people and the specific population(s) served, or can limit operation to only certain parts of the state.[17] As a result, there are great variations between the states in the HCBS eligibility requirements, scope of services, and wait time. In 2018, over 2.5 million individuals nationwide received HCBS through state waivers, and about 820,000 eligible individuals were on a waiting list for HCBS.

One of the major benefits of Medicaid waivers is that they allow states to innovate and to provide services that Medicaid normally doesn't cover. This is especially important when states are trying to think about health more expansively and to provide services that address the social determinants of health.

EXAMPLE 1:

North Carolina's Healthy Opportunities Pilot will allow managed care organizations to purchase services related to housing, transportation, food, interpersonal violence, and toxic stress under an approved 1115 waiver. Eligible individuals must live in one of the covered regions and have one qualifying physical or behavioral health condition and one qualifying social risk factor. Homelessness and housing are considered social risk factors under the pilot. The goal of the pilot is to evaluate the effectiveness of evidence-based, non-medical interventions, which include the following housing services: housing navigation, support, and

sustaining services, inspection for housing safety and quality, housing move-in support, essential utility set-up, home mediation services, home accessibility and safety modifications, healthy home goods, one-time payment for security deposit and first month's rent, and short-term post hospitalization housing. The state recently selected three organizations to serve three different regions of the state and the pilot is set to begin in the spring of 2022.[18]

Types of Community-Based Housing That Allow For Aging in Place

The types of housing that are available to support aging in the community fall on a continuum of care beginning with an **affordable, accessible home that is owned or rented** by an older adult to **subsidized affordable housing** to **permanent supportive housing, to integrated, enriched service supportive housing** to A**ssisted Living Facilities** (licensed residential facilities also called board and care, RCFE's). Having an adequate supply of assisted living and residential care units, and subsidized, accessible housing options is the necessary infrastructure so that more people can be served in home and community settings as they age.

Private Homes and Rental Units

Individuals can receive Medicaid-funded HCBS in their private homes or rental units, and programs can also offer case management and stabilization services, and help the resident put needed HCBS in place. Medicaid can potentially pay for additional housing-related supports, such as home modifications to increase accessibility, and housing-related services to support individual tenancies, such as landlord mediation or dispute resolution, or referral for legal representation in an eviction. There is also homesharing, where an older resident lives with another person who may help with rent or act as their caregiver.

EXAMPLE 2

The SASH (Support and Services at Home) Program integrates social service, community health, and housing resources to support Vermonters who choose to live independently at home, helping them age healthily, while reducing medical costs and delaying or preventing institutional care.[19] A wellness nurse and a SASH care coordinator provide care on-site at existing affordable and public housing units, and also support those who live in mobile homes or single apartments. The care team works with each resident to develop a plan tailored to their health needs, including preventative care and their desire for community. Payment for the care team is made through CMS All-Payer Accountable Care Organization (ACO) Model, meaning that they are using a mixed payer model – Medicare, Medicaid, and private health care organizations.

Subsidized or Affordable Housing

Older adults are at the center of our nation's housing affordability and homelessness crisis as our nation's population is aging and income inequality continues to grow, especially for older adults of color. Older adult renters are more likely to spend a larger share of their income on rent than the population as a whole, and these rental cost burdens place them at increased risk of housing instability and homelessness. Getting access to affordable housing is key to preserving older adults' ability to remain in their home or in a community-based setting.

Subsidized housing can be project-based, where the rent subsidy is attached to a particular unit in a complex or building, or the subsidy can be through a voucher. A rental subsidy or voucher, such as a federally funded housing choice voucher (Section 8), can be used to contract with a private landlord, and can be taken to a new unit where the landlord accepts the voucher.

Project-based housing ties the rental subsidy to the project complex and cannot be transferred to a new location. The Section 202 program is project-based subsidized housing that specifically serves low-income seniors (age 62+). Some Section 202-funded projects have service coordinators to assist with accessing health and necessary support services.

Most subsidies guarantee that your rent and utility costs will not exceed 30% of household income, which is considered the benchmark for "affordable" rent. However, the Low-Income Housing Tax Credit Program provides a shallow subsidy that provides a below market rent, but it is not capped at 30% of income.

Although live-in aides are allowed in subsidized units, there are requirements in order to qualify. Specifically, the person (1) must be determined essential for the care and well-being of the person; (2) should not be obligated to support the person; and (3) would not be living in the unit except to provide the necessary supportive services.[20] Additionally, local public housing authorities have some discretion to adopt local policies regarding live-in aides and must approve a live-in aide.[21] While family members can be approved as live-in aides, they do not gain succession rights to the unit if the person they are assisting must move into a higher level of care or dies.[22]

EXAMPLE 3:

Integrated Wellness in Supportive Housing (IWISH) is a U.S. Housing and Urban Development (HUD) demonstration project where HUD-assisted properties provide site-based coordination and delivery of services to address the interdependent health and supportive service needs of older residents. IWISH funds a full-time Resident Wellness Director and a part-time nurse in HUD properties exclusively or predominantly serving older resident households. More information is available at: Supporting Aging in Place through IWISH: 1st Interim Report.

Permanent Supportive Housing

Permanent Supportive Housing (PSH) combines a housing subsidy with intensive, integrated supportive services, but generally does not support residents who need assistance with ADL's, or have medical needs they cannot self-manage. PSH can address the changing needs of aging tenants by offering layered aging and health services to help people remain in their homes. PSH can integrate HCBS to allow an aging tenant to remain housed with additional supports, sometimes called enriched services PSH. PSH is often used to support and house people experiencing homelessness. As these individuals age, they may require additional specialized services and modifications to their housing units in order to maintain housing stability and prevent them from unnecessarily going to long-term care.

Assisted Living Facilities

The term assisted living facilities describes a range of community-based housing in licensed residential facilities. These licensed facilities are also called board and care, Adult Residential Facilities (ARF) and Residential Care for the Elderly (RCFE). The facility provides room and board (meals) and 24-hour care and supervision. It is considered appropriate for residents who need a non-medical level of care, such as help with bathing, dressing, and medication management. Although, most residents private pay for this care, and Medicaid typically does not pay for non-medical care, CMS has approved assisted living waivers in several states, six of which are still in operation.[23]

Integrating Housing and HCBS

Recognizing that housing is one of the key components of the Social Determinants of Health (SDOH), Medicaid allows states to pay for housing-related support services such as housing location services, eviction prevention, and one-time housing payments to help people obtain housing and pay for move-in costs. For Medicaid beneficiaries experiencing homelessness, getting and staying housed is essential for being able to access meaningful health care, and Medicaid can support coordinated health care and social services related to obtaining and keeping housing.

While Medicaid funds cannot be used to pay for *ongoing* housing costs, state Medicaid programs and managed care organizations can pay for:

- *Housing transition services,* such as helping an individual with assessing their preferences and barriers to a successful tenancy, securing required documentation (e.g., Social Security card, birth certificate, prior rental history), locating housing, assisting with the application processes and paperwork, and clearing credit or criminal record impediments to obtaining housing;
- *One-time housing payments* for things like security deposits, utility arrearages, moving costs, home accessibility modifications, or necessary furnishings to facilitate occupancy. This direct payment is only for persons transitioning out of Medicaid-funded institutions or other provider-operated living arrangements; and
- *Tenancy sustaining services* that support an individual in being a successful tenant. This could include helping tenants understand their rights and responsibilities under the lease, including taking care of their homes and connecting to needed treatment, help with the recertification process, eviction prevention (negotiating with landlords and assistance with personal budgeting), and other activities to help prevent a loss of housing or assist individuals in finding more suitable housing quickly.[24]

HCBS waivers, health homes, section 1115 waivers, and other options provide further flexibility to help address health-related needs, and can lead to better health outcomes by bridging the gap between health care and other related services.[25] In addition to covering certain housing-related services, states have the option, through their state plan or through waivers, of including in their Medicaid plan non-medical services to address other Social Determinants of Health, such as:

- *Non-medical Transportation* for individuals who need Medicaid-funded home and community-based services (HCBS) and who may lack transportation to access community activities and resources, such as grocery stores.
- *Home-Delivered Meals* for older adults and individuals who need HCBS may need additional help meeting their nutritional needs.[26]

EXAMPLE 4

California's Whole Person Care pilot (waiver) provides housing-based care management and tenancy supports, including help finding and securing housing, coverage for some move-in costs and minor home modifications targeted to people who are experiencing homeless, or could exit institutions with available supportive housing. A key feature is coordination with the managed care organization, housing authority, and CBO's to deliver comprehensive services, and connect people to permanent housing.

Conclusion

When Medicaid funding prioritizes supporting the housing-related needs of persons at risk of institutionalization, as well as those transitioning out of institutions, it promotes community integration of individuals needing Long-Term Services and Supports (LTSS). This is especially urgent during the COVID-19 pandemic, given the high risk of virus transmission in congregate settings. And, according to a recent report commissioned by the Centers for Medicare and Medicaid Services, serving an individual with community-based services is generally more cost-effective than serving that same person in an institutional setting.[27]

States are currently experimenting with additional ways to link social supports, Medicaid-reimbursable health care services, and affordable housing to promote healthy living at home as we age. There is increased interest in how to bring these comprehensive services to aging adults, individuals with disabilities, homeless or formerly homeless adults, and individuals re-entering the community from prisons, jails, or other institutions. These efforts have been bolstered by the recent guidance on how states may implement the temporary 10% increase in Medicaid funding to enhance HCBS and prevent unnecessary institutionalization.[28]

By integrating affordable, accessible housing with home and community-based health and social supports, we can ensure that older adults can continue to age in their homes and in their communities, close to neighbors, friends, and family.

Additional Resources

- Justice in Aging: Medicaid Home and Community Based Services for Older Adults with Disabilities: A Primer

Case consultation assistance is available for attorneys and professionals seeking more information to help older adults. Contact NCLER at ConsultNCLER@acl.hhs.gov.

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Endnotes

1 Joanne Binette and Kerri Vasold, "2018 Home and Community Preferences: A National Survey of Adults Ages 18-Plus," AARP Research, Washington, DC, July 2019, https://www.aarp.org/research/topics/community/info-2018/2018-home-communitypreference.html.

2 Peggy Bailey, Center on Budget and Policy Priorities, "Housing and Health Partners Can Work Together to Close the Housing Affordability Gap," 2020, available at: https://www.cbpp.org/research/housing/housing-and-health-partners-can-work-together-to-close-the-housing-affordability.

3 Katherine L. Chen, MD, et al, "Unmet Medical Needs Among Adults Who Move due to Unaffordable Housing: California Health Interview Survey," 2011–2017, available at: https://pubmed.ncbi.nlm.nih.gov/33372238/.

4 See, for example, Katherine A. Koh, Melanie Racine, Jessie M. Gaeta, et. al. "Health Care Spending And Use Among People Experiencing Unstable Housing in the Era of Accountable Care Organizations." Health Affairs. Vol. 39, No. 2. Feb. 2020. Joel

C. Cantor, Sujoy Chakravatry, Jose Nova, et. al. "Medicaid Utilization and Spending Among Homeless Adults in New Jersey: Implications for a Medicaid-Funded Tenancy Support Services." Milibank Q. Vol. 98, No. 1. Mar. 2020.

5 Eckart, Kim, "Turning hotels into Emergency Shelter as part of COVID-19 response limited spread of Coronavirus, improved health and stability.", University of Washington News, October 7, 2020.

6 28 C.F.R. § 35.130(d); see also, 28 C.F.R. § 41.51(d).

7 Olmstead v. L.C. ex rel. Zimring, 527 U.S. 581, 587 (1999), holding that a state must allow a person to receive long-term care services in the community if the person does not oppose living in the community, a professional has deemed community living to be appropriate, and provision of such services can be reasonably accommodated by the state.

8 Id.; U.S. Dep't of Justice, Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C. (2011); e.g. Fisher v. Oklahoma Health Care Authority, 335 F.3d 1175 (2003).

9 42 C.F.R. Sec. 438.2.

10 American Rescue Plan (ARP) of 2021, Section 9817. Section 9817 of the ARP temporarily increases the FMAP by 10 percentage points for certain Medicaid1 HCBS expenditures beginning April 1, 2021, and ending March 31, 2022. Centers for Medicaid and Medicare Services (CMS) have issued a State Medicaid Director Letter, available at: https://www.medicaid.gov/federal-policy-guidance/downloads/smd21003.pdf.

11 42 USC 1396a(10)(D); 1396d(a)(7); see 42 C.F.R. § 440.210(a)(1).

12 For more information about the Medicare Home Health benefit, see Stein and Holt, "Understanding Medicare Home Health Coverage," Feb. 2020.

13 CMS, State Medicaid Director Letter, Olmstead Update No: 3, July 25, 2000, Attachment 3-g. "The "homebound" requirement

is a Medicare requirement that does not apply to the Medicaid program. Imposing a homebound requirement on receipt of Medicaid home health benefits as explained below violates Medicaid regulations related to "amount, duration, and scope of services" at 42 CFR 440.230 and "comparability of services" at 42 CFR 440.240."

14 Kaiser Family Foundation, Medicaid Home and Community-Based Services Enrollment and Spending, Feb. 4, 2020 at https://www.kff.org/medicaid/issue-brief/medicaid-home-and-community-based-services-enrollment-and-spending/.

15 Id.

16 Forty-seven of these states provide them through the 1915(c) of the Social Security Act and twelve states provide HCBS programs through the 1115 waiver authority, which allows states to create experimental, pilot, or demonstration projects.

17 Social Security Act §§1915(c), 1115; For information about specific state waivers, see https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html.

18 For more information, see North Carolina Department of Health and Human Services, Healthy Opportunities Pilots at https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/healthy-opportunities-pilots.

19 Vermont is operating under a section 1115(a) Medicaid demonstration. https://innovation.cms.gov/innovation-models/vermont-all-payer-aco-model

20 24 C.F.R. §5.403; see also HUD Occupancy Handbook 4350.3: Occupancy Requirements of Subsidized Multifamily Housing Programs, Chapter 3: Eligibility for Assistance and Occupancy, Section 1(E)(3)(a)(2)-(4), November 2013.

21 24 C.F.R. § 982.551(h)(4).

22 For example, Section 202 and Section 8 housing allow adult children to be added to the household after the initial lease is signed if that child is needed for essential care of a family member, also justifying an additional bedroom-sized unit. This may afford the adult child with more housing stability; however, they are treated as live-in aides and are explicitly required to relinquish any future rights to the unit once the elder/disabled person no longer resides in the unit. See HUD Occupancy Handbook 4350.3: Occupancy Requirements of Subsidized Multifamily Housing Programs, Chapter 7: Recertification, Unit Transfers, and Gross Rent Changes, Section 7-4D, June 2007, available at https://www.hud.gov/sites/documents/43503c7HSGH.PDF.

23 The six states with current approved 1915(c) assisted living waivers are Arkansas, California, Mississippi, Ohio, Virginia, and Wyoming.

24 For a more detailed description of what housing-related activities and services states may receive Medicaid reimbursement for, with the goal of promoting community integration for individuals with disabilities, older adults needing long-term services and supports (LTSS), and those experiencing chronic homelessness, see, SHO#21-001, Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH), Dept. of Health & Human Services, Centers for Medicaid and Medicare Services at pp. 5-7, Jan. 7, 2021, available at: Social Determinants of Health (SDOH) State Health Official (SHO) Letter (medicaid.gov).

25 Center on Budget & Policy Priorities, updated January 2020. "Medicaid can Partner with Housing Providers to Address Social Needs," available at https://www.cbpp.org/research/health/medicaid-can-partner-with-housing-providers-and-others-to-address-enrollees-social.

26 Id.

27 Debra J. Lipson, "Measures of State Long-Term Services and Supports Rebalancing," HCBS Quality Measures Issue Brief (Nov. 2019) at 2, https://www.medicaid.gov/medicaid/quality-of-care/downloads/hcbs-quality-measures-brief-3-rebalancing.pdf.