

***Affordable Assisted Living Facilities:
Government-Sponsored Benefits for Reimbursing
Assisted Living Services, Room, and Board***

Conducted For:

Department of Elder Affairs
Committee on Affordable Assisted Living Facilities

By

Jennifer R. Salmon, Ph.D., Principal Investigator
Stefanie Thompson, Research Assistant
Vicki Sims

Florida Policy Exchange Center on Aging
Tampa, FL

April 2003

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Florida Policy Exchange Center on Aging
University of South Florida
4202 E. Fowler Ave. USF#30437
Tampa, FL 33620
www.fpeca.usf.edu
(813) 974-3468

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¹ Florida Policy Exchange Center on Aging, University of South Florida, Tampa, FL

² Agency for Health Care Administration, Tallahassee, FL

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EXECUTIVE SUMMARY

Florida's low-income frail elder population has few financial and caregiving resources available for long-term care needs. The default option for long-term care for this population is the Medicaid nursing home program. Affordable options to nursing home placement are critical to meeting the expressed needs and preferences of these elders, as well as to controlling costs. There is variation across the state in what people earn (Area Median Income varies \$912/year) and what they pay for a basic need like rent (Fair Market Values vary \$2,748/year) depending on region and rurality and yet the reimbursement for assisted living services is at the same rate statewide.

We proposed the following three requirements for a state to consider its publicly-funded assisted living program to be affordable: 1) the resident can pay for care with current income and eligible benefits (e.g. Medicaid Waiver, Section 8 voucher) and retain sufficient funds to pay for health insurance premiums, unreimbursed medical expenses, and a small personal needs allowance (currently \$54/month in Florida) or 5% of their income (whichever is higher), 2) the facility can provide a private room and at least one personal care service for at least 50% of its residents who earn no more than 300% of Supplemental Security Income (SSI), currently \$1,635/month, or provide these services at a rate that is affordable to the resident as described above, and operate at a profit; and 3) the state and federal government does not pay more than half of the current Medicaid nursing home rate for assisted living services (e.g., approximately \$1,903/month). There are many ways to reduce the costs of building and operating an ALF and other ways for paying for the services, room, and board costs.

Assisted Living Services

There are four main ways that states reimburse assisted living facilities for services: Medicaid Waivers, 2) State Plan, 3) Waiver and State Plan, and 4) General Revenue. Medicaid Waivers have become the predominant option adopted by most states (27 in 2000). Within these reimbursement methods, four states provide tiered rates. Tiered rates reduce the incentive for cherry-picking higher functioning (lower need) residents and receiving a flat rate payment, regardless of level of need. Tiered rates reflect the assessed level of need and cost of care. It is critical to have cost data from ALFs in order to set realistic rates, but accurate cost data is labor-intensive to obtain and analyze. It is also important to have a valid, independently administered client assessment instrument to assign the appropriate level to each client. Geographic tiered rates adjust for regional variations in cost of living but then use flat rates within each region. This would be most similar to Medicaid reimbursement of nursing homes for long-term care. In fact, states could use the regional Medicaid reimbursement rates as a standard and then calculate the ALF rate as a percentage of that rate. Cost of living adjustments are important to keeping the reimbursement rate at a level that enables a facility to provide high quality care and a reasonable rate of return to its owners.

Florida has two reimbursement options for assisted living services: a 1915(c) Medicaid Waiver, the Assisted Living for the Elderly program; and a state plan program, the Assistive Care Services for disabled individuals who receive Supplemental Security Income and need 24-hour unscheduled assistance. The ALE Waiver pays for additional support and supervision to

eligible recipients living in ALFs licensed for extended congregate care or limited nursing services. ALE waiver recipients must be age 60+, Medicaid eligible, and meet one or more functional requirements and have income up to 300% of SSI or \$1,635/month (\$19,620/year) and assets of less than \$2,000.

ACS is a Medicaid State Plan program that provides all eligible adults access to services in ALFs, adult foster care homes, and residential treatment facilities. ACS recipients must be 18 years and older, Medicaid eligible, have a current health assessment that indicates medical necessity for ACS, need assistance with two services, reside in an ACS-enrolled facility. Income is limited to \$685/month for OSS/SSI recipients and \$651/month for MEDS-AD recipients. The maximum ALE daily waiver rate is \$28/day or \$851 for an average month. Using resident income and Medicaid reimbursement, the overall payment to a facility that accepts ALE waiver recipients is \$1,570 for a 30-day month. There were 3,179 ALE recipients in 2001 receiving an average annual ALE reimbursement of \$9,937.08. The maximum reimbursement to ALFs for ACS recipients is \$9.28/day or \$278.40 for a 30-day month (\$847.80 with OSS room and board). ALFs report 13,338 potential OSS beds as of June 2002; not all of these are currently filled with individuals who qualify for OSS and receive ACS.

There is variation in the number of OSS beds and ALE Waiver slots by county. About half of the rural counties (N=16) and two-thirds of the urban counties (N=23) are considered underserved by low cost ALFs. Although urban counties are overall underserved and are home to 95% of frail elders in the state, Dade and Hillsborough counties are both over-served. For example, Dade County has 11% of the state's disabled elders age 70 and older and 42% of the state's OSS beds. On the other hand, Highlands, a rural county, has 1% of the state's frail elder population but .54% of the OSS beds. The distribution of low-cost beds in the state is not equitable.

The U.S. Department of Veterans Affairs has two monetary or income-based programs that are based on service and non-service-connected disability or age. The Aid and Attendance benefit requires that the recipient: need assistance with at least three ADLs, be determined nearly blind, or currently receive care in a nursing home. To be eligible for Housebound benefits, the veteran or widowed spouse must need assistance with two ADLs, be determined nearly blind, or receive care in a nursing home. Pensions are based on income less medical expenses in excess of 5% of the maximum benefit (the Basic Pension). Medical expenses include the cost of living at an ALF if it is for medical reasons (e.g., supervision of medications), and for out-of-pocket medical expenses. As of December 1, 2001, the maximum Housebound benefit is \$11,679 for a veteran and \$14,639 with one dependent. The maximum for Aid and Attendance is \$15,945 annually for a veteran and \$18,902 for a veteran with one dependent. The maximum benefit for widowed spouses for Housebound is \$7,832 and \$9,810 with one dependent; and for Aid and Attendance, it is \$10,243 and \$12,221 with one dependent.

Room and Board

The Optional State Supplementation (OSS) Program is a state supplement to individuals receiving Supplemental Security Income provided through the Social Security Administration and for other low-income elders and disabled adults as defined by rule. Currently the maximum

SSI/OSS payment for ALF residents is \$623.40 per month (\$78.40 from OSS). The recipient is entitled to keep \$54 of his/her income for personal needs. Thus the facility gets \$569.40 per month for room and board.

Section 8 voucher assistance is a Federal HUD program that provides rental assistance in private apartments for low-income elders. It cannot be used to pay for meals or services and cannot be used when tenants need continual medical or nursing care. Assisted Living Facilities that receive Section 8 vouchers must be inspected annually and the Fair Market Rental Value is adjusted at that time. Fair Market Rates can be as high as 120% of the Fair Market Value for a tenant with a disability in a particular geographic area. The tenant pays 30% of their adjusted monthly income toward rent (including utilities) and the housing authority pays the difference. There is no federal policy for set asides for either elders or for those in assisted living facilities but housing authorities can set priorities for different types of households based on identified local needs. In addition project-based Section 8 vouchers are an option in some circumstances.

Individuals are eligible for Section 8 vouchers if their income is at or below 80% of the Area Median Income. This ranges from a low of \$2,095/month in the northern part of the state to a high of 2,378/month in the southern region. A large majority of Section 8 recipients do not exceed 50% of AMI and many Housing Authorities set their eligibility level at 50% of AMI. The fair market rental values are established for each county and vary by region. In northern counties the average for an efficiency is \$419 and for a one bedroom, it is \$462/month. In the southern region it is \$457 for an efficiency and \$535 for a one bedroom.

Fair Share Vouchers are awarded competitively by HUD to public housing authorities through its Super Notice of Funding Availability (Super NOFA). The last deadline was March 25, 2002 and was for a total of 16,460 fair share vouchers. Public Housing Authorities (PHAs) agree to allocate at least 15% of their fair share vouchers for households with disabilities. Their applications receive additional points if they use 3% of the vouchers for people with disabilities who are on Medicaid HCBS Waivers. Only seven of these PHAs designated 3% of their set aside for disabled individuals who are on the HCBS Waiver (n=64).

Based on a survey of Housing Authorities that represent 54 regions of the state, there are very few “unused” vouchers (total N=3,201, average 87 per county). On average, responding Authorities have 2,231 individuals on their waiting list (total statewide=93,715) and they report that it will be 8 to 23 months (average 12 months) before they can take new applications. some Housing Authorities will allow Section 8 vouchers to be used for assisted living facilities and some Authorities are considering conversion of public housing to vouchers, which would put vouchers in the hands of more beneficiaries

Combining Section 8 vouchers with either the Assistive Care Services or the Assisted Living for the Elderly waivers that are available to frail elders in Florida (described earlier in this report), it is possible to meet the definition of affordable from the three perspectives listed earlier: the resident, the facility, and government. If the elder lives in an efficiency apartment and pays all but a \$54 personal needs allowance (PNA) for room, board, and assisted living services, the ALF could receive a monthly reimbursement of \$918 to \$1,443 for elders using the ACS Waiver and \$1,672 to \$1,888 for elders using the ALE Waiver depending on the region of

the state. The lower reimbursement would be for those who were at 30% of AMI and the higher reimbursement would be for those at 50% AMI. Those who are the poorest--who receive SSI--receive more assistance than those at 30% of AMI and so the total reimbursement for them is in the middle.

In addition to reimbursement for room costs, ALFs can decrease the overall operating expenses through housing and food programs:

- The Assisted Living Conversion Program (ALCP) helps qualified nonprofit owners convert independent senior apartments into assisted living units.
- Section 202 housing is the primary way that HUD finances construction of rental housing for low-income elders. Qualified housing is owned by non-profit organizations and are available to elders 62+ who are under 50% of AMI.
- Section 232 insures mortgages that cover the construction and rehabilitation of health care facilities for people who need long-term care or medical attention.
- Section 811 housing provides interest free capital advances to non-profit organizations to construct or rehabilitate rental housing with supportive services (24-hour staffing, in-unit call buttons, and planned activities) for low-income persons age 18-62 with disabilities in order to allow the tenants to live independently.
- Multifamily housing service coordinators, funded through HUD, assist elderly residents and residents with disabilities to obtain needed supportive services from the community; to prevent premature and unnecessary institutionalization; and to assess individual service needs, determine eligibility for public services, and make resource allocation decisions which enable residents to stay in the community longer.
- Elderly Nutritional Program is the largest community based nutritional program for elders and is funded by the Older Americans Act. Funds provide for congregate meals and home-delivered meals. Eligible programs are those that serve elderly 60+ regardless of income as well as a spouse of any age; disabled persons under age 60 who reside in housing facilities occupied primarily by the elderly where congregate meals are served.
- The Food Recovery Program (or Gleaning) is coordinated by Florida farmers, community action agencies and other food relief agencies as well as volunteers
- The Federal Food Stamp Program is an individual income-based program to “promote the general welfare and to safeguard the health and well being of the Nation’s population by raising the levels of nutrition among low-income households.” In a single-person household, elders age 60+ or disabled persons with less than \$716 net monthly income are eligible. Residents of federally subsidized housing for the elderly and disabled or blind individuals who are residents of group living arrangements are treated as a one-person household for food stamp purposes. The benefit is on average \$44/month for elders living alone and on SSI (\$528/year). For 10 qualifying residents, the facility would receive \$5,280 for food costs annually which could justify an initial one-time expenditure of \$800 for the required EBT equipment.

Policy Recommendations

The following policy recommendations are suggested based on the analysis of data and previous research that is presented in this report:

- 1) Adopt the following designation of affordable assisted living: “Affordable assisted living is based on a licensed facility providing a private room and at least one personal care service to at least 50% of its residents who earn no more than 300% of Supplemental Security Income (SSI) at a rate that allows the resident to retain a monthly personal needs allowance (currently \$54) or 5% of their income (whichever is higher).”
- 2) Investigate the feasibility of calculating regional ALE waiver rates within the State that represent a percentage of the Medicaid nursing home rate. This system should be used to establish new rates for the ALE Waiver, which would be adjusted annually based on changes in the nursing home rate. This method is supported by the fact that there are regional differences in housing and labor costs. Four scenarios are provided:
 - 100% of the current Medicaid nursing home rate in each county would cost the state \$105,901,408 a year based on current ALE case months (5 times the current \$21,764,690 spent on ALE Waiver) and the cost to the state of these individuals were forced to enter a nursing home because alternatives did not exist. The state of Maryland currently sets its cost neutrality threshold at 100% of the Medicaid nursing home rate. This would amount to \$3,636-\$3,970/month depending on region of the state.
 - The definition for affordable used earlier set the rate at 50% of the nursing home rate which would amount to a two and a half-fold increase over the current cost (\$52,950,704) or \$1,818-\$1,985/month depending on region.
 - 25% of the local nursing home rate represents a modest 22% increase in expenditures (\$26,475,408) for the same number of client months. The rate for assisted living would be \$909-\$993 depending on the region, slightly higher than the current \$851/month.
 - A two-tiered rate could combine scenarios 2 and 3. Tier 1 would be set at 25% of the local nursing home rate and Tier 2 would be set at 50% of the local nursing home rate. We assume that two-thirds of the ALE waiver clients would qualify for the higher rate and one-third would qualify for the lower rate. The total cost is about 62% more than the current expenditure (\$35,212,527). If the State chooses to implement a tiered rate, it would be necessary to make the lowest tier no less than the current rate. In addition, clients would need to be re-evaluated by an independent agency (e.g. CARES) to prevent “gaming” of the tiered rates (i.e., classifying a resident at the higher level of need than is appropriate).
- 3) In addition to considering adjusting the current ALE reimbursement rates based on the above scenarios, expand and make more equitable the distribution of ALE waiver dollars to rural and urban counties. There should be a better match between the potential need and the availability of OSS/ACS funds or ALE waivers. Frail elders should have equal access to these affordable options, regardless of where they live in the state.

- 4) Request additional Section 8 vouchers from the U.S. Housing and Urban Development and require them to be set aside specifically for elders with incomes up to 50% of the area median income and who require supportive services in an assisted living facility or HUD facility. The State should work with eligible Public Housing Authorities (those with 97% of their vouchers leased) to set aside at least 3% of their fair share section 8 vouchers for disabled individuals who qualify for HCBS Medicaid Waiver assistance.
- 5) Request from the Administration on Aging additional congregate meal sites located in affordable assisted living facilities.
- 6) Work with the federal USDA to amend the eligibility requirements to participate in the Food Stamp program for communal dining facilities so that any licensed assisted living facility (including for-profit facilities) may be authorized to accept these payments on behalf of the eligible residents. Smaller, independent but for-profit ALFs represent the backbone of assisted living in the state and many run their facilities at very low cost to residents. If they will accept a low income individual, then they should be allowed to accept food stamp payments for that individual. There is no cost to the state for this change.
- 7) Educate ALF developers, operators and residents about the public reimbursement and financing options available to them to make assisted living an affordable option.

INTRODUCTION AND OVERVIEW

In the state of Florida, there are 616,557 elders age 70 and older who need assistance with at least one activity of daily living. This represents 4% of the total population or 29% of the age 70+ population (Table 1 and Appendix A). Half of the 70+ population earns less than \$16,000 income annually and one-fourth has an average income of just \$6,410. Elders who are among the lowest 25% for income are twice as likely to need assistance with activities of daily living compared to those who are in the top 25% of income. They are also 75% less likely to be living with a spouse than those at the top income level (4.8% vs. 18%).¹ In essence, Florida's low-income frail elder population has few financial and caregiving resources available for long-term care needs. The default option for long-term care for this population is the Medicaid nursing home program. Affordable options to nursing home placement are critical to meeting the expressed needs and preferences of these elders, as well as to controlling costs.

There are also differences by region of the state and in rural and urban areas. Not surprisingly, among urban counties, the northern region has a smaller proportion (3.7%) of elders who are 70+ and disabled than in the south (5.3%). The southern region has the highest average number per county. These elders represent 29% of the over 70 population in every region. On the other hand, among rural counties, the central region has the highest average number of disabled elders 70+ and they represent the highest percentage of the overall population (5%). The fact that the percentage of the 70+ population that is disabled is 28-29% of the 70+ population, regardless of region of the state or rural or urban county, suggests that the need for services for this population is just as great, regardless of where one lives in Florida. The fact that

¹ Reynolds-Scanlon, S., Reynolds, S.L., Peek, M.K., Polivka, L. and Peek, C. (1999). *Profile of Older Floridians*. Tampa, FL: Florida Policy Exchange Center on Aging.

this population represents just 4% of the overall population, suggests that providing affordable assisted living should be within the reach of government budgets.

Table 1
Average Need by Region of the State

	North	Central	South	All	Sig.
All Counties	41	11	15	67	
Total 70+ with one ADL	138,502	187,145	290,910	616,557	
Avg. 70+ with one ADL	3,378	17,013	19,394	9,202	***
Percent of 70+ population	29%	29%	29%	29%	
Percent of total population	3%	4%	4.5%	3.6%	**
Urban Counties	15	9	10	34	
Avg. 70+ with one ADL	7,803	20,018	28,522	17,130	**
Percent of 70+ population	29%	30%	29%	29%	
Percent of total population	3.7%	3.8%	5.3%	4.2%	*
Rural Counties	26	2	5	33	
Avg. 70+ with one ADL	825	3,490	1,132	1,034	**
Percent of 70+ population	29%	28%	28%	29%	*
Percent of total population	2.9%	5.0%	3.0%	3.0%	*

There are differences by region and rurality in terms of income and rental values (Table 2). Although the average area median income (AMI) for one-person households of any age in all counties is \$2,758 it can range from as low as \$2,438/month in rural central counties to \$3,200/month in urban southern counties. Poor individuals (30% of AMI) have \$731/month to \$960/month in income. The fair market value (FMV) for efficiencies is \$434 statewide but ranges from \$399 in rural central counties to \$475 in urban central counties. Counties with higher median income also have higher average rent. There is variation across the state in what people earn (AMI varies \$912/year) and what they pay for a basic need like rent (FMV varies \$2,748/year) depending on region and rurality and yet the reimbursement for assisted living services is at the same rate statewide. This report will describe how Florida pays for assisted living services, room, and board and how these costs can be made more affordable, especially given the variability in costs in the state.

Table 2
Average Income and Rental Values by Region and Rural vs. Urban

	North	Central	South	All	Sig.
All Counties	41	11	15	67	
Monthly Individual Area Median Income	\$2,634	\$2,929	\$2,973	\$2,758	**
30% AMI	\$790	\$879	\$892	\$827	**
50% AMI	\$1,310	\$1,468	\$1,487	\$1,375	**
80% AMI	\$2,095	\$2,349	\$2,378	\$2,200	**
Fair Market Value for efficiency	\$419	\$461	\$457	\$434	**
FMV for 1 bedroom	\$462	\$533	\$535	\$490	***
Urban Counties	15	9	10	34	
Monthly Individual Area Median Income	\$2,878	\$3,039	\$3,200	\$3,015	
30% AMI	\$863	\$912	\$960	\$905	
50% AMI	\$1,419	\$1,524	\$1,600	\$1,500	*
80% AMI	\$2,270	\$2,438	\$2,560	\$2,400	*
Fair Market Value for efficiency	\$445	\$475	\$469	\$460	
FMV for 1 bedroom	\$498	\$554	\$563	\$532	*
Rural Counties	26	2	5	33	
Monthly Individual Area Median Income	\$2,493	\$2,438	\$2,519	\$2,494	
30% AMI	\$748	\$731	\$756	\$748	
50% AMI	\$1,247	\$1,219	\$1,259	\$1,247	
80% AMI	\$1,994	\$1,950	\$2,015	\$1,995	
Fair Market Value for efficiency	\$404	\$399	\$433	\$408	
FMV for 1 bedroom	\$442	\$436	\$478	\$447	

N=67 Counties

Affordable assisted living facilities can be understood three ways: the affordability to the low to moderate income resident, the adequacy of the reimbursement to the facility, and the cost to the state and federal government. We propose the following set of requirements for a state to consider its publicly-financed assisted living program to be affordable:

- The resident should be able to pay for care in an assisted living facility with current income and eligible benefits (e.g. Medicaid Waiver, Section 8 voucher) and retain sufficient funds to pay for health insurance premiums, unreimbursed medical expenses, and a small personal needs allowance (currently \$54/month in Florida) or 5% of their income (whichever is higher). For example, for calculating an affordable room rate for assisted living facilities, the Florida Statutes (420.602) define affordable housing as total monthly rental or mortgage payments not exceeding 50% of the adjusted Area Median Income for very low-income

persons or not exceeding 80% of adjusted AMI for low-income persons. For section 8, a rental assistance program described later in this report, the resident contribution is 30% of their income and the remainder is paid by section 8 vouchers. This is the standard for affordable room costs being used here for all elders.

- The facility should be able to provide a private room and at least one personal care service for at least 50% of its residents who earn no more than 300% of Supplemental Security Income (SSI), currently \$1,635/month, or provide these services at a rate that is affordable to the resident as described above (e.g., no more than current income and eligible benefits plus a personal needs allowance). Facilities should be able to serve this clientele and operate at or near market rate, which according to one analysis for facilities that have less than 70 beds, is \$1,668/month and for 70 beds or more it is \$2,628/month assuming a very low percentage of residents who qualify for Medicaid.¹ From the facility owner's perspective, affordability is to operate at a profit.
- The state and federal government should not pay more than two-thirds of the current Medicaid nursing home rate for assisted living services, using all available public reimbursements (e.g., approximately \$1,903/month), including Medicaid waiver funding.

The Florida Department of Elder Affairs, on behalf of the Committee on Affordable Assisted Living Facilities (CAALF), contracted with the Florida Policy Exchange Center on Aging to conduct a review of the literature and government-sponsored programs to identify options for paying for assisted living services, room, and board for low-income frail elders, in order to increase the affordability to residents, facilities, and state and federal government.

¹ Province Valuation Group (2001). *New Data Reveals Insights Into Senior Housing/Assisted Living Rates and Rations—an Industry Analysis: 1999-2000*. Atlanta, GA: Province Valuation Group.

Research Questions

This report addresses four research questions:

1. What is the full array of government-sponsored benefits that can be used to pay for assisted living services, room, and board?
2. How do other states use these options?
3. How does Florida make use of these options?
4. What changes to federal, state, or local laws would be necessary to make full use of these options?

Research Methods

Staff conducted a review of the research and policy literature on financing assisted living facilities and low-income housing with services. Staff also identified and conducted secondary data analyses using existing data from U.S. Housing and Urban Development (HUD), U.S. Census, the Asset and Health Dynamics of the Oldest Old Survey, and the National Academy for State Health Policy.

Staff conducted original data collection in four specific areas--Section 8 vouchers, Food Stamps, Veterans Benefits, and the use of Tiered Reimbursement Rates. These areas received special attention because of interest expressed by DOEA staff and the CAALF.

The Section 8 Survey (Appendix B) was e-mailed or faxed by FPECA to 104 identified Housing Authorities. The survey was developed by staff and reviewed by members of the Policy Committee for the Committee for Affordable Assisted Living Facilities. It consists of 18 questions which address: the makeup of the Section 8 voucher and Public Housing population, the availability of new vouchers, and the use of Section 8 vouchers for assisted living facilities.

To understand how to best use Food Stamps and other publicly-funded meals programs for assisted living, staff conducted an exhaustive internet search of Federal and State agency

websites including HUD, U.S. Department of Agriculture (USDA), Administration on Aging (AoA), Social Security Administration (SSA), the Florida Department of Children and Families and the Florida Department of Agriculture and Consumer Services in addition to national food organizations such as Food Research and Action Center (FRAC), and World Hunger Year (WHY). Key informant interviews with staff from federal and state agencies were conducted via telephone. Information was collected regarding statutes, definitions, benefits, program eligibility, resources, grant application requirements, and other details of each program. Veterans benefits data were collected with key informants in state and federal veterans programs.

State reimbursement of assisted living services was identified through a review of the National Academy for State Health Policy's *State Assisted Living Policy: 2000*.¹ There are six states that currently use tiered rates to reimburse assisted living facilities. Of these, state agency staff were contacted in four states with large programs: Arizona, Maryland, Oregon, and Washington. The remaining states were Alaska and Delaware. Staff were asked about the history of the development of their tiered rates, the acuity levels and reimbursement rate associated with each tier, and the pros and cons of using a tiered reimbursement system. Although the focus of this report is on how to cover some of the costs of assisted living services, room, and board, we have also addressed the many ways to build the capacity of assisted living facilities to reduce their costs (e.g. reduced interest on construction loans to sources of food supplies for low income residents).

¹ Mollica, R. (2000). *State Assisted Living Policy: 2000*. Portland, ME: National Academy for State Health Policy.

ASSISTED LIVING SERVICES

State Comparisons

There are four main ways that states reimburse assisted living facilities for services (Table 3; Appendix C and D)¹: 1) Medicaid Waivers, 2) State Plan, 3) Waiver and State Plan, and 4) General Revenue. Medicaid Waivers have become the predominant option adopted by most states (27 in 2000). Most states have a 1915(c) waiver to pay for assisted living services. Arizona has a 1115 research and demonstration waiver. These will be described below. In addition, states reimburse facilities under the State Plan or combine a Waiver and State Plan. One state pays for assisted living services through its General Revenue funds.

There are five ways that Medicaid Waiver programs are different from State Plan programs. State Plan services must be provided to all beneficiaries for whom the service is medically necessary and who qualify financially (in Florida, income not exceeding 90% of poverty or \$685/month as of 4/1/02), and provide the service in the same amount and scope statewide. Medicaid Waiver plans may only serve those who meet the state's nursing home level of care criteria and income eligibility may be set up to 300% of SSI (currently \$1,635/month). Waivers may limit coverage to certain groups, geographic areas, or numbers of beneficiaries based on spending limits and may not duplicate State Plan services.² Nearly all states with income and asset cut-offs for eligibility for reimbursement for assisted living waiver services use 300% of SSI and \$2,000 in assets.

¹ Mollica (2000).

² Ibid.

Table 3
State Financing Options

	N States
Financing Plan	
Medicaid Waiver	27
State Plan	5
Waiver & State Plan	3
General Revenue	1
TOTAL	36
Income Cut-Off	
300%	19
250%	1
200%	2
TOTAL	22
Rates	
Flat Rate	12
Care Plan Rate	10
Case Mix Rate	3
Setting-Specific Rate	2
Tiered Rate	6
TOTAL	33

1915(c) Waiver

Medicaid home and community-based waivers permit states to waive three basic rules that apply to Medicaid State Plan programs as described above: statewideness, comparability of services, and income and assets eligibility tests. The 1915(c) waiver permits seven services to be provided: case management, homemaker, home health aide services, personal care, adult day health, habilitation, and respite care. Other services can be provided subject to approval. The goal of the program is to create innovative alternatives to placing Medicaid-eligible persons in hospitals or nursing homes. The cost of providing the waiver services must be cost neutral compared to maintaining the beneficiaries in a nursing home. For more information: <http://cms.hhs.gov/medicaid/1915c/default.asp>. Florida uses its 1915(c) Waiver, in part, to support its Assisted Living for the Elderly Waiver which is described later in this section.

1915(b) and 1915(c) Combined Waiver

The 1915(b) waiver is used for managed acute care programs and is only permitted for beneficiaries who meet the State Plan requirements for services but it can be used to waive the usual requirement for statewideness or for specialty care. By combining it with the 1915(c) Waiver, States can create coordinated or integrated long-term and acute care programs. This was achieved by Texas for their Star+Plus program but was not successful in Florida with its Diversion program which was re-written as a 1915(c) waiver. Florida's Diversion program uses the same capitated rate to cover assisted living facility services when warranted. For more information: <http://cms.hhs.gov/medicaid/1915b/1915bc.asp>.

1115 Waiver

The 1115 Waiver is for research and demonstration projects and allows states to experiment with new ideas as long as they are budget neutral over a five year period. Arizona is the one state that covers assisted living services under this waiver which combines all long-term care programs, including long-term Medicaid nursing home care, under one capitated rate and is managed by a managed care organization. For more information:

<http://cms.hhs.gov/medicaid/1115/default.asp>.

State Plan

Five states provide for assisted living services through their State Plan. For example, Massachusetts provides adult foster care for all Medicaid eligible beneficiaries who need assistance with one ADL and are at risk of being institutionalized. The daily services rate in 2000 was \$34.09.¹

¹ Mollica (2000).

Waiver and State Plan

Three states combine the 1915(c) waiver with their State Plan by leveraging their optional state supplement for SSI beneficiaries to gain more Medicaid resources for a package of “assistive community care services.” Florida is one of these states and currently offers this option for frail elders and disabled adults who need personal services in a 24-hour supportive residential setting (see Florida Programs later in this section).

Tiered-Rates

As part of a Medicaid waiver or State Plan program for reimbursing assisted living facilities, six states have established a system of tiered rates which take into account acuity levels, geographic differences in the cost of living, or differences in assisted living setting (e.g. ALF, residential care, foster care, etc.). Florida’s two programs—the ALE and ACS—represent two rates but they are not set up as a tiered system. That is, both rates are the same without regard to geographic differences in the cost of housing and services. Although the ACS rate can be used for individuals who are not at a nursing home level of care, in reality, approximately half do meet this level of acuity but because of assets or lack of ALE waivers available, ACS clients get the lower rate. Four states with full-fledged tiered rates will be described below followed by analysis of the pros and cons of this option.

The Arizona Long-Term Care Systems (ALTCS) is a 1115 Waiver program. In 1989 it added adult foster care (under 5 residents) to its capitated rate managed long-term care program. This was followed by new licensing categories: assisted living homes (under 11 residents), assisted living centers (over 10 residents), and supportive residential living centers (which require private rooms). The state negotiates its capitated rates with Managed Care Organizations which then negotiate rates with assisted living providers. The current capitated rate is

\$2,446/month (for Medicaid and Long-Term Care). As in other states, private market rate ALFs are overbuilt in Arizona and therefore providers are interested in participating in Medicaid program. Five of the MCOs are county run, one is for profit, and one is a non-profit. The State reviews capitated rates annually. The state initiated a 10-15% increase in the assisted living rate because of a concern for getting the best care for clients. The program has 14,000 clients across the continuum: 48% are in nursing facilities, 39% in HCBS, and 13% in one of the assisted living options. MCOs are allowed to keep 80% of their savings from placing clients in HCBS or ALF programs.

Maryland started with a demonstration project for Medicaid Waivers for assisted living facilities and used a single rate for both adult foster care and assisted living facilities. The regulations for ALFs changed in 1999 and all facilities had to be licensed as ALFs. To support higher acuity residents, a two-tiered rate plus a supplement for special services was developed for room and board and waiver services (\$1,950 and \$2,350 including a maximum of \$420/month for room and board). A supplement on top of the annual cost of the monthly rates up to a total annual cost of \$47,750 could be used for ramps, chairlifts, roll-in showers, assistive devices, behavioral modification therapy, additional home health, transportation, physical and occupational therapy. The total is adjusted based on the nursing home rate. As such, Maryland's assisted living waiver uses the full nursing home Medicaid reimbursement level as its barometer of cost neutrality (other states set their assisted living rates quite a bit lower).

Oregon received the first Medicaid Waiver in 1990 for reimbursing assisted living facilities, adult foster homes (AFH), and residential care facilities (RCF). Residents are entitled to receive Medicaid LTC services in any setting with a preference given to non-institutional care. The state began with tiered rates for all non-institutional settings. Clients are assessed for

nursing home eligibility by an AAA or Senior and Disabled Services Division (SDSD) case manager (depending on region of the state). AFH and RCF rates have recently been changed to flat rates with three \$225/month add-ons for specialized care (e.g. daily nursing). Tiered rates for ALFs were increased annually until 2002 when they remained the same.

Washington implemented a three tiered reimbursement for assisted living facilities in 1995 when there were very few ALFs in the state and they served about 500 residents. The program has grown to 4,000 residents. Their tiered rates are based on nursing, operations, and capital costs. They recently instituted a capital add-on for new construction that ranges from \$4.33-\$4.77/day.

Table 4 provides a comparison of rates and acuity levels for these three programs. The tiers have been expanded in this table to incorporate the full range of options used in each state including: acuity level, geographic differences, and setting differences.

Table 4
Tiered Rate Comparisons

	Arizona	Maryland	Oregon	Washington
Participating Facilities	1,242	280 Group Home Subsidy (GHS) 429 Medicaid Waiver	138 ALF 187 RCF 2,000 AFH	192
Participants	1,757	GHS: 500 Waiver: 1,276	ALF: 3,960 (mostly private rooms) RCF: 6,805 (shared rooms) AFH: 8,000	4,000
Level 1	Needs minimal assistance with 3+ categories (bathing, feeding, mobility, transferring, continence, orientation, medical condition, medical/nursing treatment)	Occasional monitoring of medical, cognitive, or psychiatric conditions; minor assistance with treatment; setup assistance with medication; minimal support for some ADLs; occasional assistance with falls, pressure ulcers and other risk factors; uncomplicated management of disruptive behaviors.	ALF: needs assistance with 2 critical ADLs; or any 3 ADLs; or 1 critical ADL and 1 other ADL. RCF: needs assistance with any 2 ADLs and night assistance.	Needs substantial or total assistance with 0-3 ADLs and no sensory or cognitive status problems
Level 2	Needs moderate assistance with 4+ categories (bathing, feeding, mobility, transferring, continence, orientation, medical condition, medical/nursing treatment)	Medicaid Waiver Level II: Nursing home level of care; frequent monitoring of minor medical, cognitive, or psychiatric conditions; frequent but not daily administration of treatment; administration of medications; frequent support for some ADLs; minimal support of any number of ADLs; frequent management of falls, pressure ulcers and other risk factors; frequent management of disruptive behaviors.	ALF: assistance with behavior and eating; or assistance with toileting. RCF: needs assistance with 2 of 3 critical needs; or with any 3 ADLs.	Needs substantial or total assistance with 0-3 ADLs and has some sensory or cognitive status problems; OR needs substantial or total assistance with 3+ ADLs and no sensory or cognitive status problems.
Level 3	Needs maximum assistance with 5+ categories (bathing, feeding, mobility, transferring, continence, orientation, medical condition, medical/nursing treatment)	Medicaid Waiver Level III: Nursing home level of care; frequent monitoring of major medical conditions that interfere with ADLs; substantial ongoing monitoring of cognitive and behavioral conditions; daily administration of treatment and medications; as much support as needed for any number of ADLs; substantial management of falls, pressure ulcers and other risk factors; substantial management of disruptive behaviors.	ALF: needs assistance with 4-6 ADLs; or assistance with toileting, eating, and behavior. RCF: Dependent in 1 ADL.	Needs substantial or total assistance with 0-3 ADLs and has some sensory or cognitive status problems; OR needs substantial or total assistance with 3+ ADLs and has sensory or cognitive status problems.

Source: Interviews with State Agency Staff; Mollica (2000)

Table 4 (Continued)
Tiered Rate Comparisons

Arizona		Maryland		Oregon		Washington	
Level 4				ALF: Dependent in 1-2 ADLs; or needs assistance in 4-6 ADLs plus behavior. RCF: Dependent in 2 of the 3 critical needs (behavior, continence, mobility); or dependent in 1 of 3 critical needs and needs assistance at night.			
Level 5				ALF: Dependent in 3-6 ADLs; or dependent in behavior and 1-2 other ADLs. RCF: Dependent in behavior, continence, and mobility.			
N of Tiers	Nine (3 levels for each of three types of AL settings; based on weighted averages)	Three (one non-Medicaid rate for group home subsidy and two Medicaid rates).		Thirteen (4-5 levels for three setting types)		Nine (3 levels for three geographic areas)	
1	AFC1 \$1,232	Group Home Subsidy (will increase to \$650 November 2002) \$550		ALF 1	\$652	Non-Metro County 1	\$1,630
2	ACH/AL Home 1 \$1,321	Level II Medicaid Waiver (includes \$420/room and board) \$1,950		AFH 1	\$700	Metro County 1	\$1,675
3	AFC 2 \$1,413	Level III Medicaid Waiver (includes \$420/room and board) \$2,350		ALF 2	\$862	Non-Metro County 2	\$1,811
4	ACH/AL Home 2 \$1,546			RCF/AFH 1	\$917	King County 1	\$1,815
5	ALC 1 \$1,552			AFH 2	\$925	Metro County 2	\$1,864
6	AFC 3 \$1,643			ALF 3	\$1,140	Non-Metro County 3	\$1,999
7	ALC 2 \$1,916			RCF/AFH 2	\$1,142	King County 2	\$2,032
8	ACH/AL Home 3 \$2,054			AFH 3	\$1,150	Metro County 3	\$2,070
9	ALC 3 \$2,324			RCF/AFH 3	\$1,367	King County 3	\$2,266
10				AFH 4	\$1,375		
11				ALF 4	\$1,491		
12				RCF/AFH 4	\$1,592		
13				ALF 5	\$1,840		

Pros and Cons of Tiered Rates

The main reason states choose to provide tiered rates is to reduce the incentive for cherry-picking higher functioning (lower need) residents and receiving a flat rate payment, regardless of level of need. Some states report that facilities will choose to provide more specialized care (dementia, head injury, ventilator-dependent) because they will be reimbursed for it. Tiered rates reflect the assessed level of need and cost of care. It is critical to have cost data from ALFs in order to set realistic rates, but accurate cost data is labor-intensive to obtain and analyze. It is also important to have a valid, independently administered client assessment instrument to assign the appropriate level to each client.

The main reason that states do not use a tiered system is that without an independent means of assessment and reassessing residents, clients can enter a facility and be assessed at a higher level of care than is actually justified. That is, just as facilities can cherry pick the highest functioning clients with a flat rate, there may be incentives to select the lowest functioning clients in a tiered rate system and have them begin at the highest payment level. In states where the reassessment is done independently, the ALF could be penalized if a resident improves and the rate is then decreased. But, if this is not done consistently, the reimbursement may be artificially high. Oregon is running out of funds for its ALF waiver since it is an entitlement and not capped at a certain number of slots. As a result, Oregon has instituted a moratorium on licensing new ALFs until June 2003. At the same time, in Maryland, the former Adult Foster Care operators have expressed concern that in order to take the higher rate, they must be monitored more often and their often quite frail elders, would be forced to move to a nursing

home because of their level of frailty. In the past, they could take care of these individuals and allow them to live out their remaining years in a familiar environment.¹

In Oregon, some facilities have asked for a flat rate in order to better cover all residents. The state considered a flat rate based on licensed level of care for the setting but the resident would be forced to move if they became too frail at a facility licensed for a lower level of care. Another option is to allocate a limited number of slots but keep the tiered rates reasonable for the ALFs.

Another way to look at tiered rates is to create geographic tiers to adjust for regional variations in cost of living but then use flat rates within each region. This would be most similar to Medicaid reimbursement of nursing homes for long-term care. In fact, states could use the regional Medicaid reimbursement rates as a standard and then calculate the ALF rate as a percentage of that rate.

Finally, cost of living adjustments are important to keeping the reimbursement rate at a level that enables a facility to provide high quality care and a reasonable rate of return to its owners. Arizona initiated a 15% increase in ALF rates, that was not requested by the managed care organizations in order to increase the quality of care in the facilities. Washington bases its rates on nursing, operations, and capital costs and provides a capital add on for new construction. All four states adjust their rates annually, although Oregon, due to its fiscal crisis, did not do so for 2002.

Florida Programs

Florida has two reimbursement options for assisted living services: a 1915(c) Medicaid Waiver, the Assisted Living for the Elderly program, and a state plan program, the Assistive

¹ Morgan, L.A., Eckert, J.K., & Lyon, S.M. (1995). *Small Board-and-Care Homes: Residential Care in Transition*. Baltimore: Johns Hopkins University Press.

Care Services for disabled individuals who receive Supplemental Security Income and need 24-hour unscheduled assistance. For more information on both programs, consult the manual available from the Florida Agency for Health Care Administration at:

<http://floridamedicaid.consultec-inc.com/> and click on Provider Support and then Handbooks.

Assisted Living for the Elderly Waiver

The ALE Waiver is part of a 1915(c) Home and Community-Based Services Waiver held by the state. The program pays for additional support and supervision to eligible recipients living in ALFs licensed for extended congregate care or limited nursing services. ALE waiver recipients must be age 60+, Medicaid eligible, and meet one or more functional requirements:

- assistance with 4+ ADLs,
- total help with 1+ ADLs,
- Alzheimer's Disease diagnosis and need assistance with 2+ ADLs,
- have a degenerative medical condition, or
- be awaiting discharge from a nursing home but needing supervision or personal care.

Financial eligibility is limited to those with incomes up to 300% of SSI or \$1,635/month (\$19,620/year) and assets of less than \$2,000. Waiver recipients with incomes up to \$716/month may also get reimbursed under Assistive Care Services (see below).

The maximum ALE daily waiver rate is \$28/day or \$851 for an average month and the ACS rate is \$9.28/day or \$282 for an average month. Using resident income and Medicaid reimbursement, the overall payment to a facility that accepts ALE waiver recipients is \$1,570 for a 30-day month. In addition, ALFs may bill \$125/month for incontinence supplies for ALE recipients whose care plan states they are needed. The facility may not bill for days when the recipient is not at the facility for a 24-hour period. There is a \$100/month case management fee

paid to the AAA's case management agency (called the lead agency in Florida). There were 3,179 ALE recipients in 2001 receiving an average annual ALE reimbursement of \$9,937.08 (E. Nue, personal communication).

Assistive Care Services

ACS is a Medicaid State Plan program that provides all eligible adults access to services in ALFs, adult foster care homes, and residential treatment facilities. ACS recipients must be 18 years and older, Medicaid eligible, have a current health assessment that indicates medical necessity for ACS, need assistance with two services, reside in an ACS-enrolled facility, and not participate in any of the Medicaid waiver managed care plans. Income is limited to \$685/month for OSS/SSI recipients and \$651/month for MEDS-AD recipients. Individuals with incomes above \$685 would need to apply for the ALE waiver (see above).

The maximum reimbursement to ALFs for ACS recipients is \$9.28/day or \$278.40 for a 30-day month (\$847.80 with OSS room and board described later) and may not be billed if the resident has left the facility for a 24-hours or more. ALFs report 13,338 potential OSS beds as of June 2002; not all of these are currently filled with individuals who qualify for OSS and receive ACS.

Availability of Affordable ALF Beds

There is variation in the number of OSS beds and ALE Waiver slots by county (Table 5). About half of the rural counties (N=16) and two-thirds of the urban counties (N=23) are considered underserved by low cost ALFs.¹ Table 5 provides an estimate of the need for assisted living services (number of persons who are 70 and older and needing assistance with 1 or more

¹Golant, S.M. (2001). Responding to the low-income and vulnerable seniors in Florida's rent-subsidized rental facilities. In: Polivka, L. and Salmon, J.R. (Eds). *Informational Report of the Task Force on Availability and Affordability of Long-Term Care for the Florida Legislature in Response to House Bill 1993*. Tampa, FL: Florida Policy Exchange Center on Aging. pp 339-375.

ADLs; 70+ dis.), the number of ALFs, Total beds, total OSS beds, and total individuals receiving ALE waiver assistance (ALE). For each of these demand and supply variables, the percentage of the total demand and supply for the state is computed (% of Total). A designation of “fair share” was computed in other research by Golant (2001) based on the proportion of the state’s frail and poor elders in each county compared to the proportion of the state’s affordable assisted living beds (defined as an estimate of elder-occupied OSS beds). If public financing of assisted living was distributed fairly across the state, counties would have the same ratio of need to supply. For example, one county may be occupied by 5% of the state’s poor and frail elder population but has only 1% of the state’s total supply of affordable ALF units. These would be designated as counties with “less than their fair share” (Golant, 2001). Another county has 10% of the state’s poor and frail population but 20% of the state’s total supply of affordable ALF units. These counties are considered to have “more than their fair share.”

Although urban counties are overall underserved and are home to 95% of frail elders in the state, Dade and Hillsborough counties are both over-served. For example, Dade County has 11% of the state’s disabled elders age 70 and older and 42% of the state’s OSS beds. On the other hand, Highlands, a rural county, has 1% of the state’s frail elder population but .54% of the OSS beds. The distribution of affordable beds in the state is not equitable.

Table 5
Need and Availability of Affordable ALFs and Fair Share of OSS Beds

	Total 70+ Disabled³	% of Total	ALFs⁴	Total Beds⁴	% of Total	OSS⁴	% of Total	ALE⁵	% of Total	Fair Share⁶
North²	URBAN COUNTIES¹									
ALACHUA	4,591	0.74%	12	762	0.98%	11	0.08%	1	0.03%	Less
BAY	3,878	0.63%	13	526	0.68%	250	1.86%	42	1.31%	About Right
CITRUS	7,952	1.29%	14	650	0.84%	45	0.33%	53	1.65%	Less
CLAY	2,760	0.45%	7	187	0.24%	25	0.19%	30	0.94%	Less
DUVAL	17,616	2.86%	73	2,620	3.39%	736	5.46%	58	1.81%	More
ESCAMBIA	8,261	1.34%	24	1,258	1.63%	172	1.28%	25	0.78%	About Right
FLAGLER	2,695	0.44%	19	172	0.22%	3	0.02%	3	0.09%	Less
HERNANDO	8,486	1.38%	12	947	1.22%	101	0.75%	94	2.93%	About Right
LAKE	11,643	1.89%	27	1,329	1.72%	59	0.44%	50	1.56%	Less
LEON	4,365	0.71%	12	843	1.09%	25	0.19%	31	0.97%	Less
MARION	12,986	2.11%	27	1,291	1.67%	123	0.91%	6	0.19%	Less
OKALOOSA	3,785	0.61%	10	414	0.54%	50	0.37%	30	0.94%	More
SANTA ROSA	2,358	0.38%	8	394	0.51%	36	0.27%	40	1.25%	Less
ST. JOHNS	4,066	0.66%	14	490	0.63%	10	0.07%	21	0.65%	Less
VOLUSIA	21,599	3.50%	90	3,459	4.47%	275	2.04%	135	4.21%	Less
Central										
BREVARD	19,487	3.16%	40	1,392	1.80%	72	0.53%	78	2.43%	Less
HILLSBOROUGH	25,650	4.16%	122	4,788	6.19%	830	6.16%	187	5.83%	More
MANATEE	14,728	2.39%	45	2,088	2.70%	142	1.05%	75	2.34%	Less
ORANGE	18,872	3.06%	82	2,400	3.10%	282	2.09%	86	2.68%	About Right
OSCEOLA	3,993	0.65%	9	375	0.48%	77	0.57%	21	0.65%	More
PASCO	21,040	3.41%	53	2,462	3.18%	284	2.11%	105	3.27%	Less
PINELLAS	49,687	8.06%	256	8,520	11.01%	973	7.22%	290	9.04%	About Right
POLK	18,662	3.03%	36	2,248	2.91%	168	1.25%	80	2.49%	Less
SEMINOLE	8,046	1.30%	40	1,672	2.16%	77	0.57%	60	1.87%	Less
South										
BROWARD	64,216	10.42%	206	8,394	10.85%	1,299	9.64%	267	8.33%	About Right
CHARLOTTE	10,454	1.70%	20	1,148	1.48%	24	0.18%	15	0.47%	Less
COLLIER	12,271	1.99%	22	1,457	1.88%	0	0.00%	35	1.09%	Less
DADE	65,231	10.58%	620	8,710	11.26%	5,593	41.51%	527	16.43%	More
INDIAN RIVER	7,316	1.19%	20	808	1.04%	6	0.04%	100	3.12%	Less
LEE	23,500	3.81%	45	2,370	3.06%	26	0.19%	198	6.17%	Less
MARTIN	7,903	1.28%	8	399	0.52%	2	0.01%	3	0.09%	Less
PALM BEACH	61,611	9.99%	102	5,224	6.75%	395	2.93%	95	2.96%	Less
SARASOTA	23,614	3.83%	74	3,641	4.71%	98	0.73%	72	2.25%	Less
ST. LUCIE	9,106	1.48%	41	953	1.23%	46	0.34%	63	1.96%	Less
Total Urban	582,426	94.46%	2,203	74,391	96.15%	12,315	91.41%	2,976	92.80%	

Table 5 (continued)
Need and Availability of Affordable ALFs and Fair Share of OSS Beds

	Total 70+ Disabled³	% of Total	ALFs⁴	Total Beds⁴	% of Total	OSS⁴	% of Total	ALE⁵	% of Total	Fair Share⁶
North										
RURAL COUNTIES¹										
BAKER	383	0.06%	0	0	0.00%	0	0.00%	0	0.00%	Less
BRADFORD	710	0.12%	3	79	0.10%	51	0.38%	19	0.59%	About Right
CALHOUN	411	0.07%	2	31	0.04%	20	0.15%	0	0.00%	More
COLUMBIA	1,564	0.25%	12	357	0.46%	109	0.81%	20	0.62%	More
DIXIE	430	0.07%	1	25	0.03%	22	0.16%	0	0.00%	About Right
FRANKLIN	359	0.06%	1	22	0.03%	0	0.00%	5	0.16%	Less
GADSDEN	1,159	0.19%	4	117	0.15%	56	0.42%	13	0.41%	About Right
GILCHRIST	392	0.06%	0	0	0.00%	0	0.00%	0	0.00%	Less
GULF	420	0.07%	1	16	0.02%	0	0.00%	3	0.09%	Less
HAMILTON	301	0.05%	3	43	0.06%	33	0.24%	0	0.00%	More
HOLMES	599	0.10%	3	77	0.10%	41	0.30%	0	0.00%	More
JACKSON	1,486	0.24%	3	101	0.13%	38	0.28%	17	0.53%	About Right
JEFFERSON	402	0.07%	1	33	0.04%	33	0.24%	0	0.00%	More
LAFAYETTE	174	0.03%	1	50	0.06%	0	0.00%	2	0.06%	Less
LEVY	1,217	0.20%	2	118	0.15%	40	0.30%	17	0.53%	More
LIBERTY	135	0.02%	4	73	0.09%	59	0.44%	10	0.31%	More
MADISON	612	0.10%	1	16	0.02%	0	0.00%	0	0.00%	Less
NASSAU	1,333	0.22%	4	226	0.29%	91	0.68%	16	0.50%	More
PUTNAM	2,527	0.41%	7	280	0.36%	149	1.11%	23	0.72%	More
SUMTER	2,509	0.41%	4	46	0.06%	3	0.02%	12	0.37%	Less
SUWANNEE	1,255	0.20%	3	102	0.13%	22	0.16%	10	0.31%	Less
TAYLOR	538	0.09%	0	0	0.00%	0	0.00%	0	0.00%	Less
UNION	178	0.03%	0	0	0.00%	0	0.00%	0	0.00%	Less
WAKULLA	438	0.07%	1	24	0.03%	18	0.13%	0	0.00%	More
WALTON	1,225	0.20%	5	90	0.12%	41	0.30%	17	0.53%	Less
WASHINGTON	704	0.11%	8	135	0.17%	124	0.92%	0	0.00%	More
Central										
HARDEE	756	0.12%	5	137	0.18%	98	0.73%	0	0.00%	More
HIGHLANDS	6,225	1.01%	12	563	0.73%	73	0.54%	30	0.94%	Less
Southern										
DESOTO	1,223	0.20%	5	92	0.12%	32	0.24%	2	0.06%	About Right
GLADES	357	0.06%	0	0	0.00%	0	0.00%	0	0.00%	Less
HENDRY	706	0.11%	1	40	0.05%	0	0.00%	0	0.00%	Less
MONROE	2,256	0.37%	4	52	0.07%	5	0.04%	0	0.00%	Less
OKEECHOBEE	1,147	0.19%	3	33	0.04%	0	0.00%	15	0.47%	Less
Total Rural	34,131	5.54%	104	2,978	3.85%	1,158	8.59%	231	7.20%	
ALL COUNTIES	616,557	100%	2,307	77,369	100%	13,473	100%	3,207	100%	

¹Based on 381.0406 Florida Statutes (less than 100 individuals per square mile or designated by Census as rural). ²Medicaid Regions 1-4B=Northern; 5-7=Central; 8-11=Southern. ³Based on Florida AHEAD Oversample extrapolated to 2000 Census Data. ⁴From Florida AHCA, June 2002. ⁵From Florida DOEA, January-December 2001. ⁶Fair share of OSS beds, from Golant, S. (2001).

Veterans Programs

The U.S. Department of Veterans Affairs has two monetary or income-based programs that are based on service and non-service-connected disability or age: Aid and Attendance and Housebound.¹ In addition, there are federal and state-sponsored domiciliary care programs (Table 6).

Aid and Attendance and Housebound Programs

Eligibility is based on the requirements for the Basic Pension. To qualify for a pension, veterans or a widowed (and not remarried) spouse of a veteran must have either a disability or be at least 65 years of age and receiving SSI. Veterans must have 90 days or more of active military service, one day of which was during a period of war (one of the nine wars--Civil War, Indian Wars, Spanish-American War, Mexican border period, WWI, WWII, Korean conflict, Vietnam era, or Persian Gulf War), and be honorably discharged.² Surviving widows may not remarry and continue to receive the benefit.

The Aid and Attendance benefit requires that the recipient: need assistance with at least three ADLs, be determined nearly blind, or currently receive care in a nursing home. To be eligible for Housebound benefits, the veteran or widowed spouse must need assistance with two ADLs, be determined nearly blind, or receive care in a nursing home. Depending on the nature of the disability and on the medical examiner's diagnosis one ADL could qualify an applicant for Housebound Benefits.

¹ 38 Code of Federal Regulations 3.3

² 38 Code of Federal Regulations 3.2; 38 CFR 3.3

Table 6
Eligibility and Benefits for Veterans Programs to Support Care in an ALF

	Aid and Attendance	Housebound	Federal Domiciliary Home	State Domiciliary Home
Authorizing Entity	U.S. Veterans Affairs	U.S. Veterans Affairs	U.S. Veterans Affairs	Florida Veterans Affairs
Veteran Status	Veteran, spouse, or a dependent parent of a veteran that served in one of the nine wars: Civil War, Indian Wars, Spanish-American War, Mexican border period, WWI, WWII, Korean conflict, Vietnam era, or Persian Gulf War.	Veteran, spouse, or a dependent parent of a veteran that served in one of the nine wars, Civil War, Indian Wars, Spanish-American War, Mexican border period, WWI, WWII, Korean conflict, Vietnam era, or Persian Gulf War.	Honorably discharged Veteran only (no spouse or dependents). If the Domiciliary is filled to capacity, veterans who served in a war have priority.	Honorably discharged Veteran only (no spouse or dependents). Once full, those veterans who served in a war get top priority.
Residency Status	None	None	Generally an enrolled with VA. (Appendix E)	Resident of Florida for one year (from time of application)
Disability Status	Need assistance with 3+ ADLs, be determined nearly blind, or receiving care in a nursing home.	Need assistance with 2+ ADLs, be determined nearly blind, or receiving care in a nursing home.	Acute medical or psychological condition but can at least function and care for own needs in a wheel chair.	Need assistance with 1+ ADL but must not need nursing home, hospice or hospital at time of admittance.
Age or Worker Status	65 and marginal worker status (generally, 1 day a week at minimum wage).	65 and marginal worker status (generally, 1 day a week at minimum wage).	18 and expected to return to independent living.	18
Income Limitations	Veteran \$1,328 a month (less medical expenses) no dependents or \$12,516 annually (less medical expenses) with one dependent Spouse \$850 per month (less medical expenses).	Veteran \$973 a month (less medical expenses) with no dependents or \$12,516 annually (less medical expenses) with one dependent Spouse \$652 per month (less medical expenses)	\$1,200 a month or \$14,400 annually.	None.
Benefit	\$15,945 annually, no dependents. \$18,902 annually, one dependent. \$10,243 annually, widowed spouse.	\$11,679 annually, no dependents. \$14,639 annually, one dependent. \$7,832 annually, widowed spouse.	Total care paid for (no stipend).	For veterans whose total income is less than \$15,949 the Federal government pays \$24.40 per day to the facility. Veteran pays the difference less a personal needs allowance. OSS can be used as well.
Limitations	No limitations other than those listed above.	No limitations other than those listed above.	Must be enrolled in the VA Health Care System. Rehabilitation in Federal domiciliary home only.	Only for State domiciliary home.

Pensions are based on income less medical expenses in excess of 5% of the maximum benefit (the Basic Pension). Medical expenses include the cost of living at an ALF if it is for medical reasons (e.g., supervision of medications), and for out-of-pocket medical expenses. Although qualified veterans receive medical care at any VA health care facility (see Appendix E), they are not covered by the VA at non-VA facilities. Prescriptions are covered for veterans with a service-connected disability only, although under certain circumstances non-service connected disabled veterans can get prescriptions with a small co-payment. Out-of-pocket expenses such as supplemental insurance policies, medications, co-payments, and ALF care for medical necessity, are deducted from annual income in order to determine the basic pension (Table 7). Although these medical expenses are deducted from income to determine eligibility, the veteran may find that distance from a VA health care facility is a factor in deciding to use an ALF (e.g., if they are taken by ambulance to a non-VA health care facility and then are responsible for the cost of care).

As of December 1, 2001, the maximum Housebound benefit is \$11,679 for a veteran and \$14,639 with one dependent. The maximum for Aid and Attendance is \$15,945 annually for a veteran and \$18,902 for a veteran with one dependent. The maximum benefit for widowed spouses for Housebound is \$7,832 and \$9,810 with one dependent; and for Aid and Attendance, it is \$10,243 and \$12,221 with one dependent.

Payments to the veteran or spouse are retroactive. If a veteran is in a nursing home or hospital and needs assisted living care, then assisted living facilities can admit a veteran if he/she appears to qualify for aid and attendance or housebound benefits program. To apply for Housebound or Aid and Attendance benefits, the VA Form 21-526 needs to be completed and is available on-line at: (http://vabenefits.vba.va.gov/vonapp/about_vonapp.asp) or by phone (1-

800-827-1000). County Veteran Service Offices are listed on-line at:

(<http://www.floridavets.org/organization/cvso.asp>) or available by phone (1-800-827-1000).

Table 7
Guide to Determine if Pension Benefits are Possible for Your Circumstance:
Single Veteran Medically Qualified For Housebound Benefits¹

Source of Monthly Income	Amount
Social Security Disability	\$725
Other Pension	\$1,305
Total Monthly Income	\$2,030
Annualized income (12 x total income)	\$24,360
Monthly Medical Expenses (Example)	
Assisted Living Facility	\$1,400
Medicare Deduction	\$54
Supplemental Health Insurance	\$120
Total Monthly Medical Expenses	\$1,574
Annual Medical Expense Calculation	
Annualized Total (12 x total medical expenses)	\$18,888
Deductible Medical Expenses: 5% of Basic Pension (\$9,556)	-\$477
Adjusted Annual Medical Expense	\$18,411
Annual VA Countable Income	
Annualized Income	24,360
Less Adjusted Medical Expense	-18,411
Net VA Countable Income	\$5,959
Example: Maximum Pension	
Basic Pension w/ Housebound	\$11,679
Countable Income	-\$5,959
Net Annual Pension	\$5,720
Monthly Pension Award (Net Annual / 12)	\$477

¹Source: Hillsborough County Veterans Service Office. (March 8, 2002). Handbook and Guide for Obtaining Pension Benefits from U.S. Department of Veterans Affairs.

ALFs may contact local county VA offices on the behalf of the veteran. For both programs, the following documentation is required:

- DD Form 214, Discharge Certificate Required Documentation
- Latest Available Social Security award letter and all other sources of income
- Supporting medical assessment or medical statements (Appendix F)
- ALF Monthly Expense Explanation (Appendix G)

- Optional documents—marriage/birth/divorce certificates
- Death certificate of veteran if un-remarried spouse is claiming benefits.

Federal Veterans' Domiciliary Home

In October 1996, Congress passed Public Law 104-262, the Veterans' Health Care Eligibility Reform Act of 1996. This legislation was the building block for the creation of a Medical Benefits Package, which includes domiciliary benefits for enrolled veterans. The Medical Benefits Package emphasizes preventive and primary care, thus the federal domiciliary's function is for rehabilitation (see Table 6). Veterans with a medical or psychiatric care level that does not require nursing home or hospital care services but still needs further rehabilitation (e.g., occupational or physical therapy) are admitted until the veteran is functional for community release. Veterans who are not able to return home or to the community do not qualify. To qualify, veterans must be enrolled in the VA's health care system and completed a VA Form 10-10EZ form available on-line (<https://www.1010ez.med.va.gov/sec/vha/1010ez/>) or by calling the VA Enrollment Service Center (1-877-222-VETS). The completed Form 10-10EZ should be mailed to the medical center or clinic. The VHA Facilities Locator is available at <http://www.va.gov/sta/guide/home.asp>. State or County Veterans Service Offices are listed in the blue pages of the phone book under "United States Offices" and "Veterans Affairs" or online at <http://www.va.gov/VSO/>.¹

¹ Department of Veterans Affairs. On-line Form 10-10 EZ: Enrollment Alternatives. Available at <https://www.1010ez.med.va.gov/sec/vha/1010ez/#Enrollment>.

State Veterans Domiciliary Home Program

The State's Veterans Domiciliary Home Program is under auspices of the Veterans Home Program for Florida veterans in need of assisted living (see Table 6). For honorably discharged veterans to qualify they must have resided in Florida for at least one-year at the time of application and need assistance with activities of daily living (ADL). The purpose of the program is to provide care for those veterans who do not need the extent of care provided by hospice, hospital, or nursing home.

Eligibility is based on the following criteria:¹ 1) at least 18 years of age requiring assistance with ADLs; 2) an honorably discharged veteran as defined in Chapter 1.01 (14) Florida Statutes; 3) a resident of Florida for at least one year prior to admission; 4) free from communicable disease, chronic inebriation, dementia or active mental illness and/or violent behavior unless controllable by medication; 5) capable of self-preservation with assistance from staff in an emergency involving evacuation of the facility; and 6) represented by a legal guardian if determined to be incapacitated pursuant to Chapter 744, Florida Statutes.² Spouses of veterans are not eligible for this program.

There is one state domiciliary home, Robert H. Jenkins, Jr. Veterans Domiciliary Home of Florida in Lake City, with a capacity of 150 residents. The home generally has space available for veterans who qualify. For further information, call 386-758-0600 ext. 3104 or visit their website at <http://www.floridavets.org/organization/dom.html>. The \$1,387 monthly cost of care is paid based on the veteran's income less \$100 personal needs allowance. On average, veterans pay \$711 and as a medical expense, it is reimbursed annually.

¹Florida Department of Veterans' Affairs. Domiciliary Care. Available at <http://www.floridavets.org/organization/dom.html>

² Ibid.

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ROOM

U.S. Social Security Administration and Florida Social and Economic Assistance Programs

Supplemental Security Income/Optional State Supplement

The Optional State Supplementation (OSS) Program is a state supplement to individuals receiving Supplemental Security Income provided through the Social Security Administration and for other low-income elders and disabled adults who meet the criteria for an assisted living facility, adult foster care, family care home, or other specialized living arrangement. Currently the maximum SSI/OSS payment for ALF residents is \$623.40 per month (\$78.40/month from OSS). The recipient is entitled to keep \$54 of his/her income for personal needs. Thus the facility gets \$569.40 per month for room and board.

This program allows third party supplementation on top of the OSS payment made directly to the facility and for not more than twice the amount of the SSI/OSS combined payment for room and board (currently \$623.40). The third party payments such as rental vouchers are not to be considered as income for purposes of determining OSS eligibility.

Housing and Urban Development Programs

Section 8 and Fair Share Vouchers

Section 8 voucher assistance is a Federal HUD program that provides rental assistance in private apartments for low-income elders. It cannot be used to pay for meals or services and cannot be used when tenants need continual medical or nursing care. Assisted Living Facilities that receive Section 8 vouchers must be inspected annually and the Fair Market Rental Value is adjusted at that time. Fair Market Rates can be as high as 120% of the Fair Market Value for a tenant with a disability in a particular geographic area. The tenant pays 30% of their adjusted monthly income toward rent (including utilities) and the housing authority pays the difference.

The tenant may pay up to 40% of their adjusted income if necessary (e.g., if rental rates are higher than FMV). Health-care expenses that are not reimbursable from another source (such as Medicare or Medicaid) and that exceed 3% of income can be deducted from the resident's income when calculating the resident's rent, thus raising the Section 8 payment from HUD and potentially increasing the overall facility reimbursement. For example, if a resident is on the Medicaid waiver and has enough income to pay patient responsibility, this amount would be considered a deductible health-care expense.

There is no federal policy for set asides for either elders or for those in assisted living facilities but housing authorities can set priorities for different types of households based on identified local needs. In addition project-based Section 8 vouchers are an option in some circumstances.¹

Income and fair market rental value data available from the U.S. Housing and Urban Development (HUD) demonstrate the potential for using Section 8 rental vouchers to pay for the room rental portion of an assisted living facility. Individuals are eligible for Section 8 vouchers if their income is at or below 80% of the Area Median Income (Table 2, page 3; Appendix A). This ranges from a low of \$2,095/month in the northern part of the state to a high of 2,378/month in the southern region. A large majority of Section 8 recipients do not exceed 50% of AMI² and many Housing Authorities set their eligibility level at 50% of AMI. The fair market rental values are established for each county and vary by region. In northern counties the average for an efficiency is \$419 and for a one bedroom, it is \$462/month. In the southern region it is \$457 for an efficiency and \$535 for a one bedroom. County level data for AMI and FMV are provided in Appendix A.

¹ AAHSA Fact Sheet: HUD Rental Assistance in Assisted Living, 10/16/00

² Golant, S.M. (1999). *The Casera Project*. Gainesville, FL: University of Florida Department of Geography.

The eligible beneficiary pays 30% of actual income (less allowable deductions for medical and other expenses) for rent and utilities. The remaining amount up to 120% of FMV is paid for by the Section 8 voucher. For example, a beneficiary in north Florida may have \$790 net income (less deductions) and pay \$237 towards a one bedroom rented for \$462. The remaining \$225 would be paid for by the Section 8 voucher. Or the beneficiary in south Florida may earn \$1,427/month and would pay \$428 towards a one bedroom rented for \$550. The remaining \$122 would be paid by the Section 8 voucher.

Fair Share Vouchers are awarded competitively by HUD to public housing authorities through its Super Notice of Funding Availability (Super NOFA). The last deadline was March 25, 2002 and was for a total of 16,460 fair share vouchers. PHAs agree to allocate at least 15% of their fair share vouchers for households with disabilities. Their applications receive additional points if they use 3% of the vouchers for people with disabilities who are on Medicaid HCBS Waivers. PHAs must have leased 97% of their current Section 8 vouchers in order to apply. In 2001, there were 22 PHAs that received a total of 4,070 fair share vouchers with 15% set aside for the disabled (N=596; Table 8). Only seven of these PHAs designated 3% of their set aside for disabled individuals who are on the HCBS Waiver (n=64). For more information go to: <http://www.tacinc.org/hc/fairshare.htm>.

Table 8

Fair Share Vouchers Awarded in Florida, 2001

Public Housing Authority	Total Vouchers	15% Set Aside for Disabled	3% Set Aside for Disabled with HCBS Waiver
Broward County Housing Authority	500	75	15
City of Pensacola	50	8	2
Clearwater Housing Authority	125	19	0
Deland Housing Authority	110	17	0
Hialeah Housing Authority	745	112	22
Housing Authority of Boca Raton	50	8	2
Housing Authority of Brevard County	234	35	0
Housing Authority of Lee County	42	0	0
Housing Authority of Springfield	68	0	0
Housing Authority of the City of Dania	100	15	0
Housing Authority of the City of Deerfield Beach	81	12	0
Housing Authority of the City of Fort Lauderdale	354	53	0
Housing Authority of the City of Sarasota	144	22	0
Ormond Beach Housing Authority	38	6	0
Pahokee Housing Authority Pahokee	7	1	0
Palatka Housing Authority	59	9	0
Palm Beach County Housing Authority	500	75	0
Punta Gorda Housing Authority	20	3	0
Sarasota Board of CC	80	12	2
Tallahassee Housing Authority	367	55	11
Titusville Housing Authority	56	8	0
West Palm Beach Housing Authority	340	51	10
Total	4070	596	64

Source: Housing Center for People with Disabilities (2002). Fair Share Vouchers.
<http://www.tacinc.org/hc/fairshare.htm>

Section 8 Survey

We conducted a survey of 104 Housing Authorities in the State of Florida to understand the feasibility of using Section 8 vouchers as a source of rental assistance in assisted living facilities. Four-fifths (83%) of all Housing Authorities responded to the survey with equal representation from the three geographic regions of the state (Table 9).

Table 9

Section 8 Survey Response Rate

	Northern	Central	Southern	All
Counties	41	11	15	67
Total Housing Authorities	41	31	32	104
Total Responding Authorities	35	25	27	87
Response Rate	85%	81%	84%	84%

The responding Housing Authorities represent 54 regions. Four of these regions serve a total of 22 counties. The remaining are single counties or cities. HUD reports 88,451 vouchers in use in Florida. There are a total of 62,762 (71%) Section 8 vouchers in use by responding housing authorities (Table 10). There are 13,678 vouchers held by elders in these responding housing authorities. There are very few “unused” vouchers (total N=3,201, average 87 per county). On average, responding Authorities have 2,231 individuals on their waiting list (total statewide=93,715) and they report that it will be 8 to 23 months (average 12 months) before they can take new applications.

On average, just 11% of Authorities report that they have project-based vouchers set-aside for elders age 65+ (not displayed). Slightly fewer (8%) report that they are considering public housing projects to be converted to vouchers. Of the four Authorities who reported the number of projects with project-based vouchers, they reported 124 such projects statewide serving 3,918 elders age 65+. Fourteen Housing Authorities reported that they currently provide vouchers for assisted living and 23 more reported they would approve vouchers for assisted living facilities.

In summary, some Housing Authorities will allow Section 8 vouchers to be used for assisted living facilities and some Authorities are considering conversion of public housing to vouchers, which would put vouchers in the hands of more beneficiaries. Golant estimates that there are over 9,000 elder beneficiaries that currently occupy public housing developments.¹ Added to the 13,678 elder households reported by these Authorities who already receive Section 8 vouchers, there is a good potential to identify Section 8 voucher holders who could receive assistance in an assisted living facility (if adequate services were not available through their

current housing arrangement). At the same time, the high number of individuals who are on the waiting list suggests that ALFs that want residents to be able to use Section 8 vouchers to pay for rent will need to market their services to elders who currently hold these vouchers, since they can be transferred to another Section 8 property. This can be done by marketing to elders in independent Section 8 housing or by developing a relationship with the Housing Authority to accept referrals of elders in public housing who can no longer live independently. Appendix H provides a summary of section 8 vouchers by county as reported by the responding housing authorities.

Table 10
Total Section 8 Households, Vouchers, Waiting Lists by Region

	N	North	Central	South	All
Total Counties		41	13	13	67
HUD					
Counties with Section 8 vouchers	54	28	13	13	54 ¹
Sum of Vouchers ²	54	18,578	23,397	46,476	88,451
Average Number of Vouchers in County	54	664	1,800	3,575	1,638
Section 8 Survey Respondents³					
N Counties/Regions	43	24	8	11	43
Have Section 8 vouchers	43	22	8	11	41
Have policy to set aside vouchers for 65+	39	3	2	5	10
Have a waiting list	41	22	8	10	40
Have project based vouchers set aside for 65+	38	1	1	2	4
Have public housing projects under consideration for conversion to vouchers	38	1	0	2	3
Currently provide vouchers for ALF	40	8	3	3	14
Would approve vouchers for ALF	29	11	4	8	23
Households with Section 8	43	15,478	16,146	31,138	62,762
Households 65+ with Section 8	40	1,815	2,221	9,642	13,678
Unused Section 8 vouchers	37	582	81	2,538	3,201
Number on waiting list	42	9,586	9,196	74,933	93,715
Projects with project-based vouchers	4	5	5	114	124
65+ living in projects with project-based vouchers	5	70	NA	3,848	3,918

¹ Four housing authorities serve multiple counties. There are no housing authorities in Bay County (Northern region), Desoto and Hardee Counties (Central region) and Glades and Okeechobee Counties (Southern region).

² HUD reports that Crestview HA (Okaloosa County, Northern Region) had 40 certificates but the HA reports that these were converted in September 2001 and they have 197 vouchers; and that Titusville HA (Brevard County, Central Region) has low rent only but they report they have 280 Section 8 vouchers. Source: <https://pic.hud.gov/pic/haprofiles/haprofilelist.asp>

³ N= Number of Housing Authorities that responded to each question (out of 43 total responding); NA=not reported

¹ Golant (1999).

Affordable Assisted Living: Combining ALE, ACS, OSS, and Section 8

Combining Section 8 vouchers with either the Assistive Care Services or the Assisted Living for the Elderly waivers that are available to frail elders in Florida (described earlier in this report), it is possible to meet the definition of affordable from the three perspectives listed earlier: the resident, the facility, and government. Table 11 provides twelve scenarios for an elder who rents an efficiency (no bedroom) apartment in an ALF in the three regions of the state using the average fair market rental value for each region and who qualifies at 30% or at 50% of the area median income, and uses either the ACS or the ALE waiver. Table 12 does the same comparison for a one-bedroom apartment.

With this combination of public benefits, if the elder lives in an efficiency apartment and pays all but a \$54 personal needs allowance (PNA) for room, board, and assisted living services, the ALF could receive a monthly reimbursement of \$918 to \$1,443 for elders using the ACS Waiver and \$1,672 to \$1,888 for elders using the ALE Waiver depending on the region of the state. The lower reimbursement would be for those who were at 30% of AMI and the higher reimbursement would be for those at 50% AMI. Those who are the poorest--who receive SSI--receive more assistance than those at 30% of AMI and so the total reimbursement for them is in the middle. The reimbursement for a one-bedroom unit is in the same range as for the efficiency (Table 12).

As mentioned earlier, health-care expenses that are not reimbursable from another source (such as Medicare or Medicaid) and that exceed 3% of income can be deducted from the resident's income when calculating the resident's rent, thus raising the Section 8 payment from HUD and potentially increasing the overall facility reimbursement. This possibility is not considered in these scenarios since the amount would vary from individual to individual.

The resident expense would be at the limit of what was suggested in the definition of affordable, leaving only a \$54 PNA for their use. The highest facility reimbursement using these scenarios would be over the market rate for facilities with fewer than 70 beds (\$1,668). The total government portion of these options would be lower than the 67% of the nursing home reimbursement rate suggested earlier in this report (\$2,405). These scenarios show one way to meet the three-part definition of affordable. Providing a more livable PNA would reduce the facility reimbursement. The trade-off on affordability is between the resident and the facility.

Table 11
Section 8 Scenarios: Efficiencies

\$278.40 ACS = \$9.28 x 30 days				\$1,570.00 Maximum ALE Waiver
\$651.00 Meds AD income threshold				\$910.80 Patient Responsibility (single occupancy)
\$716.00 Other income threshold				\$555.40 Maximum OSS Room & Board
\$623.40 Maximum SSI/OSS Payment				\$54.00 PNA
<hr/>				
NORTH	\$419.00 FMR			
Voucher & ACS	SSI	30% AMI	50% AMI	
Resident Income	\$531.00	\$790.00	\$1,310.00	
SSI/OSS	\$623.40	\$92.40	\$0.00	\$0.00 SSI/OSS-Income
Rent	\$187.02	\$187.02	\$237.00	\$393.00 30% of income up to FMR
Section 8	\$231.98	\$231.98	\$182.00	\$26.00 FMR - tenant rent
Meals	\$200.00	\$200.00	\$200.00	\$200.00 Paid from SSI/OSS, Income
ACS Medicaid	\$278.40	\$278.40	\$0.00	\$0.00 If Medicaid-eligible
AL Services Private Pay	\$0.00	\$0.00	\$278.40	\$278.40 If not Medicaid-eligible
Facility Payment	\$897.40	\$897.40	\$897.40	\$897.40 Rent+Sec8+meals+ACS Medicaid/Private
PNA	\$236.38	\$236.38	\$74.60	\$438.60 Income + OSS - rent - meals - ACS private
<i>Max Facility Payment if \$54 PNA</i>	<i>\$1,079.78</i>	<i>\$1,079.78</i>	<i>\$918.00</i>	<i>\$1,282.00</i> Facility Payment+PNA-\$54
Voucher & ALE Waiver				
Resident Income	\$531.00	\$790.00	\$1,310.00	
SSI/OSS	\$623.40	\$92.40	\$0.00	\$0.00 OSS - income (if app)
Patient Responsibility	\$0.00	\$0.00	\$166.60	\$345.20 Income + OSS - OSS
Rent	\$187.02	\$159.30	\$237.00	\$393.00 30% of income up to FMR
Section 8	\$231.98	\$259.70	\$182.00	\$26.00 FMR - tenant rent
Board	\$200.00	\$200.00	\$200.00	\$200.00 Paid from SSI/OSS, Income
AL Services Private Pay	\$278.40	\$278.40	\$0.00	\$0.00 given if income less than 716
ALE Waiver	\$736.20	\$736.20	\$848.00	\$669.40 Max. waiver-pt respons-ACS-max R&B
Facility Payment	\$1,570.00	\$1,570.00	\$1,570.00	\$1,570.00 Max. waiver
PNA	\$236.38	\$264.10	\$186.40	\$371.80 Income+OSS-Pt resp-rent-board
<i>Max Facility Payment if \$54 PNA</i>	<i>\$1,752.38</i>	<i>\$1,780.10</i>	<i>\$1,702.40</i>	<i>\$1,887.80</i> Facility Payment+PNA-\$54

Table 11 (Continued)

CENTRAL		\$461.00 FMR		
Voucher & ACS		SSI	30% AMI	50% AMI
Resident Income		\$531.00	\$879.00	\$1,468.00
SSI/OSS	\$623.40	\$92.40	\$0.00	\$0.00 SSI/OSS-Income
Rent	\$187.02	\$187.02	\$263.70	\$440.40 30% of FMR up to FMR
Section 8	\$273.98	\$273.98	\$197.30	\$20.60 FMR - tenant rent
Meals	\$200.00	\$200.00	\$200.00	\$200.00 Paid from SSI/OSS, Income
ACS Medicaid	\$278.40	\$278.40	\$0.00	\$0.00 If Medicaid-eligible
ACS Private	\$0.00	\$0.00	\$278.40	\$278.40 If not Medicaid-eligible
Facility Payment	\$939.40	\$939.40	\$939.40	\$939.40 Rent+Sec8+meals+ACS Medicaid/Private
PNA	\$236.38	\$236.38	\$136.90	\$549.20 Income + OSS - rent - meals - ACS private
<i>Max Facility Payment if \$54 PNA</i>	<i>\$1,121.78</i>	<i>\$1,121.78</i>	<i>\$1,022.30</i>	<i>\$1,434.60 Facility Payment+PNA-\$54</i>
Voucher & ALE Waiver				
Resident Income		\$531.00	\$879.00	\$1,468.00
SSI/OSS	\$623.40	\$92.40	\$0.00	\$0.00 OSS - income (if app)
Patient Responsibility	\$0.00	\$0.00	\$255.60	\$503.20 Income + OSS - OSS
Rent	\$187.02	\$159.30	\$263.70	\$440.40 30% of FMR or FMR
Section 8	\$273.98	\$301.70	\$197.30	\$20.60 FMR - tenant rent
Board	\$200.00	\$200.00	\$200.00	\$200.00 Paid from SSI/OSS, Income
ACS Medicaid	\$278.40	\$278.40	\$0.00	\$0.00 given if income less than 716
ALE Waiver	\$736.20	\$736.20	\$759.00	\$511.40 Max. waiver-pt respons-ACS-max R&B
Facility Payment	\$1,570.00	\$1,570.00	\$1,570.00	\$1,570.00 Max. waiver
PNA	\$236.38	\$264.10	\$159.70	\$324.40 Income+OSS-Pt resp-rent-board
<i>Max Facility Payment if \$54 PNA</i>	<i>\$1,752.38</i>	<i>\$1,780.10</i>	<i>\$1,675.70</i>	<i>\$1,840.40 Facility Payment+PNA-\$54</i>
SOUTH		\$457.00 FMR		
Voucher & ACS		SSI	30% AMI	50% AMI
Resident Income		\$531.00	\$892.00	\$1,487.00
SSI/OSS	\$623.40	\$92.40	\$0.00	\$0.00 SSI/OSS-Income
Rent	\$187.02	\$187.02	\$267.60	\$446.10 30% of FMR up to FMR
Section 8	\$269.98	\$269.98	\$189.40	\$10.90 FMR - tenant rent
Meals	\$200.00	\$200.00	\$200.00	\$200.00 Paid from SSI/OSS, Income
ACS Medicaid	\$278.40	\$278.40	\$0.00	\$0.00 If Medicaid-eligible
ACS Private	\$0.00	\$0.00	\$278.40	\$278.40 If not Medicaid-eligible
Facility Payment	\$935.40	\$935.40	\$935.40	\$935.40 Rent+Sec8+meals+ACS Medicaid/Private
PNA	\$236.38	\$236.38	\$146.00	\$562.50 Income + OSS - rent - meals - ACS private
<i>Max Facility Payment if \$54 PNA</i>	<i>\$1,117.78</i>	<i>\$1,117.78</i>	<i>\$1,027.40</i>	<i>\$1,443.90 Facility Payment+PNA-\$54</i>
Voucher & ALE Waiver				
Resident Income		\$531.00	\$892.00	\$1,487.00
SSI/OSS	\$623.40	\$92.40	\$0.00	\$0.00 OSS - income (if app)
Patient Responsibility	\$0.00	\$0.00	\$268.60	\$522.20 Income + OSS - OSS
Rent	\$187.02	\$159.30	\$267.60	\$446.10 30% of FMR or FMR
Section 8	\$269.98	\$297.70	\$189.40	\$10.90 FMR - tenant rent
Board	\$200.00	\$200.00	\$200.00	\$200.00 Paid from SSI/OSS, Income
ACS Medicaid	\$278.40	\$278.40	\$0.00	\$0.00 given if income less than 716
ALE Waiver	\$736.20	\$736.20	\$746.00	\$492.40 Max. waiver-pt respons-ACS-max R&B
Facility Payment	\$1,570.00	\$1,570.00	\$1,570.00	\$1,570.00 Max. waiver
PNA	\$236.38	\$264.10	\$155.80	\$318.70 Income+OSS-Pt resp-rent-board
<i>Max Facility Payment if \$54 PNA</i>	<i>\$1,752.38</i>	<i>\$1,780.10</i>	<i>\$1,671.80</i>	<i>\$1,834.70 Facility Payment+PNA-\$54</i>

Table 12
Section 8 Scenarios: 1 Bedroom

\$278.40 ACS = \$9.28 x 30 days	\$1,570.00 Maximum ALE Waiver
\$651.00 Meds AD income threshold	\$910.80 Patient Responsibility (single occupancy)
\$716.00 Other income threshold	\$555.40 Maximum OSS Room & Board
\$623.40 Maximum SSI/OSS Payment	\$54.00 PNA

NORTH

\$462.00 FMR

Voucher & ACS

	SSI	30% AMI	50% AMI	
Resident Income	\$531.00	\$790.00	\$1,310.00	
SSI/OSS	\$623.40	\$92.40	\$0.00	\$0.00 SSI/OSS-Income
Rent	\$187.02	\$187.02	\$237.00	\$393.00 30% of income up to FMR
Section 8	\$274.98	\$274.98	\$225.00	\$69.00 FMR - tenant rent
Meals	\$200.00	\$200.00	\$200.00	\$200.00 Paid from SSI/OSS, Income
ACS Medicaid	\$278.40	\$278.40	\$0.00	\$0.00 If Medicaid-eligible
AL Services Private Pay	\$0.00	\$0.00	\$278.40	\$278.40 If not Medicaid-eligible
Facility Payment	\$940.40	\$940.40	\$940.40	\$940.40 Rent+Sec8+meals+ACS Medicaid/Private
PNA	\$236.38	\$236.38	\$74.60	\$438.60 Income + OSS - rent - meals - ACS private
<i>Max Facility Payment if \$54 PNA</i>	<i>\$1,122.78</i>	<i>\$1,122.78</i>	<i>\$961.00</i>	<i>\$1,325.00</i> Facility Payment+PNA-\$54

Voucher & ALE Waiver

Resident Income	\$531.00	\$790.00	\$1,310.00	
SSI/OSS	\$623.40	\$92.40	\$0.00	\$0.00 OSS - income (if app)
Patient Responsibility	\$0.00	\$0.00	\$166.60	\$345.20 Income + OSS - OSS
Rent	\$187.02	\$159.30	\$237.00	\$393.00 30% of income up to FMR
Section 8	\$274.98	\$302.70	\$225.00	\$69.00 FMR - tenant rent
Board	\$200.00	\$200.00	\$200.00	\$200.00 Paid from SSI/OSS, Income
AL Services Private Pay	\$278.40	\$278.40	\$0.00	\$0.00 given if income less than 716
ALE Waiver	\$736.20	\$736.20	\$848.00	\$669.40 Max. waiver-pt respons-ACS-max R&B
Facility Payment	\$1,570.00	\$1,570.00	\$1,570.00	\$1,570.00 Max. waiver
PNA	\$236.38	\$264.10	\$186.40	\$371.80 Income+OSS-Pt resp-rent-board
<i>Max Facility Payment if \$54 PNA</i>	<i>\$1,752.38</i>	<i>\$1,780.10</i>	<i>\$1,702.40</i>	<i>\$1,887.80</i> Facility Payment+PNA-\$54

Table 12 (Continued)

CENTRAL		\$533.00 FMR		
Voucher & ACS		SSI	30% AMI	50% AMI
Resident Income		\$531.00	\$879.00	\$1,468.00
SSI/OSS	\$623.40	\$92.40	\$0.00	\$0.00 SSI/OSS-Income
Rent	\$187.02	\$187.02	\$263.70	\$440.40 30% of FMR up to FMR
Section 8	\$345.98	\$345.98	\$269.30	\$92.60 FMR - tenant rent
Meals	\$200.00	\$200.00	\$200.00	\$200.00 Paid from SSI/OSS, Income
ACS Medicaid	\$278.40	\$278.40	\$0.00	\$0.00 If Medicaid-eligible
ACS Private	\$0.00	\$0.00	\$278.40	\$278.40 If not Medicaid-eligible
Facility Payment	\$1,011.40	\$1,011.40	\$1,011.40	\$1,011.40 Rent+Sec8+meals+ACS Medicaid/Private
PNA	\$236.38	\$236.38	\$136.90	\$549.20 Income + OSS - rent - meals - ACS private
<i>Max Facility Payment if \$54 PNA</i>	<i>\$1,193.78</i>	<i>\$1,193.78</i>	<i>\$1,094.30</i>	<i>\$1,506.60</i> Facility Payment+PNA-\$54
Voucher & ALE Waiver				
Resident Income		\$531.00	\$879.00	\$1,468.00
SSI/OSS	\$623.40	\$92.40	\$0.00	\$0.00 OSS - income (if app)
Patient Responsibility	\$0.00	\$0.00	\$255.60	\$503.20 Income + OSS - OSS
Rent	\$187.02	\$159.30	\$263.70	\$440.40 30% of FMR or FMR
Section 8	\$345.98	\$373.70	\$269.30	\$92.60 FMR - tenant rent
Board	\$200.00	\$200.00	\$200.00	\$200.00 Paid from SSI/OSS, Income
ACS Medicaid	\$278.40	\$278.40	\$0.00	\$0.00 given if income less than 716
ALE Waiver	\$736.20	\$736.20	\$759.00	\$511.40 Max. waiver-pt respons-ACS-max R&B
Facility Payment	\$1,570.00	\$1,570.00	\$1,570.00	\$1,570.00 Max. waiver
PNA	\$236.38	\$264.10	\$159.70	\$324.40 Income+OSS-Pt resp-rent-board
<i>Max Facility Payment if \$54 PNA</i>	<i>\$1,752.38</i>	<i>\$1,780.10</i>	<i>\$1,675.70</i>	<i>\$1,840.40</i> Facility Payment+PNA-\$54
SOUTH		\$535.00 FMR		
Voucher & ACS		SSI	30% AMI	50% AMI
Resident Income		\$531.00	\$892.00	\$1,487.00
SSI/OSS	\$623.40	\$92.40	\$0.00	\$0.00 SSI/OSS-Income
Rent	\$187.02	\$187.02	\$267.60	\$446.10 30% of FMR up to FMR
Section 8	\$347.98	\$347.98	\$267.40	\$88.90 FMR - tenant rent
Meals	\$200.00	\$200.00	\$200.00	\$200.00 Paid from SSI/OSS, Income
ACS Medicaid	\$278.40	\$278.40	\$0.00	\$0.00 If Medicaid-eligible
ACS Private	\$0.00	\$0.00	\$278.40	\$278.40 If not Medicaid-eligible
Facility Payment	\$1,013.40	\$1,013.40	\$1,013.40	\$1,013.40 Rent+Sec8+meals+ACS Medicaid/Private
PNA	\$236.38	\$236.38	\$146.00	\$562.50 Income + OSS - rent - meals - ACS private
<i>Max Facility Payment if \$54 PNA</i>	<i>\$1,195.78</i>	<i>\$1,195.78</i>	<i>\$1,105.40</i>	<i>\$1,521.90</i> Facility Payment+PNA-\$54
Voucher & ALE Waiver				
Resident Income		\$531.00	\$892.00	\$1,487.00
SSI/OSS	\$623.40	\$92.40	\$0.00	\$0.00 OSS - income (if app)
Patient Responsibility	\$0.00	\$0.00	\$268.60	\$522.20 Income + OSS - OSS
Rent	\$187.02	\$159.30	\$267.60	\$446.10 30% of FMR or FMR
Section 8	\$347.98	\$375.70	\$267.40	\$88.90 FMR - tenant rent
Board	\$200.00	\$200.00	\$200.00	\$200.00 Paid from SSI/OSS, Income
ACS Medicaid	\$278.40	\$278.40	\$0.00	\$0.00 given if income less than 716
ALE Waiver	\$736.20	\$736.20	\$746.00	\$492.40 Max. waiver-pt respons-ACS-max R&B
Facility Payment	\$1,570.00	\$1,570.00	\$1,570.00	\$1,570.00 Max. waiver
PNA	\$236.38	\$264.10	\$155.80	\$318.70 Income+OSS-Pt resp-rent-board
<i>Max Facility Payment if \$54 PNA</i>	<i>\$1,752.38</i>	<i>\$1,780.10</i>	<i>\$1,671.80</i>	<i>\$1,834.70</i> Facility Payment+PNA-\$54

In addition to reimbursement for room costs, ALFs can decrease the overall operating expenses through HUD programs that are described below.

Assisted Living Conversion Program (ALCP)

The Assisted Living Conversion Program (ALCP) is a conversion program that helps qualified nonprofit owners convert independent senior apartments into assisted living units to serve frail elderly people as defined in Section 232(B) (6) of the National Housing Act.

Authorization for this program is found in the HUD Reform Act of 1989, Public Law 101-235, 42 U.S.C. 3545. Eligibility and application requirements can be found on HUD's website,

<http://www.hud.gov/cfda/2001/14314.cfm>. Licensed ALFs must accommodate five or more individuals who need assistance with minimum but continuous care with ADLs. The ALF may be combined with other facilities such as nursing homes, intermediate care facilities and board and care homes.

Section 202, Supportive Housing for the Elderly Program

Section 202 housing was initiated by the Housing Act of 1959 and is the primary way that HUD finances construction of rental housing for low-income elders. Qualified housing is owned by non-profit organizations and are available to elders 62+ (at least one person) who are under 50% of AMI. Not all buildings have congregate dining rooms. Sponsors may provide personal care, meals, and health care services that are generally funded through Medicaid waivers or State General Revenue programs.¹ Within Section 202, there are two current grant initiatives. Capital advance funds are awarded to private non-profit organizations and non-profit consumer cooperatives for the construction or rehabilitation of a structure or acquisition of a structure held by FDIC (formerly Resolution Trust Corporation). Capital advance funds bear no

Golant (1999).

interest and if very low-income elderly persons use the building constructed with the grant money for at least 40 years, then no repayment is required.

Project Rental Assistance Contract (PRAC) funds are used to cover the difference between the tenants' contributions toward rent (30 percent of adjusted income) and the HUD-approved cost to operate the project or to provide supportive services and to hire a service coordinator in those projects serving frail elderly residents. The supportive services must be appropriate to the category or categories of frail elderly residents to be served.

Section 232 and 232/223(f) Housing

Section 232 insures lenders against the loss on mortgage defaults. Section 232 insures mortgages that cover the construction and rehabilitation of health care facilities for people who need long-term care or medical attention. The program allows for long-term, fixed rate financing (up to 40 years for new and rehabilitated properties and up to 35 years for existing properties without rehabilitation) that can be financed with Government National Mortgage Association (GNMA) Mortgage Backed Securities. The program refinances (with or without repairs) non-substantial rehabilitation projects and installs safety equipment including major movable equipment. The type of assistance is FHA mortgage insurance for HUD-approved lenders.

Section 811 Housing

Section 811 Housing provides interest free capital advances to non-profit organizations to construct or rehabilitate rental housing with supportive services (24-hour staffing, in-unit call buttons, and planned activities) for low-income persons age 18-62 with disabilities in order to allow the tenants to live independently. The types of housing that can be developed include small group homes, independent living projects and dwelling units in multifamily housing developments, condominium and cooperative housing. Project rental assistance contract (PRAC)

funds are used to cover the difference between the tenants' contributions toward rent (30 percent of adjusted income) and the HUD-approved cost to operate the project. Funds may not be used for: 1) Nursing homes, infirmaries and medical facilities; 2) Transitional housing facilities; 3) Manufactured housing facilities; 4) Intermediate care facilities; 5) Community centers, with or without special components for use by persons with disabilities; 6) Sheltered workshops and centers for persons with disabilities; 7) Headquarters for organizations for persons with disabilities; and 8) Refinancing of sponsor-owned facilities without rehabilitation. In 2001, Florida was awarded \$5,361,100, which covered six projects: in Cape Coral, Clearwater, Cocoa, Palm Bay, Springfield, and St. Petersburg.

Multifamily Housing Service Coordinators

HUD awarded 51 grants totaling \$5,000,000 in fiscal year 1999 for multifamily housing service coordinators to assist elderly residents and resident with disabilities to obtain needed supportive services from the community; to prevent premature and unnecessary institutionalization; and to assess individual service needs, determine eligibility for public services, and make resource allocation decisions which enable residents to stay in the community longer. The Service Coordinator Program provides funding for the employment and support of service coordinators in insured and assisted housing developments that are designed for the elderly and those with disabilities. Eligible applicants are owners of Sections 202 and Section 202/8, existing Section 8 projects with project-based assistance, and moderate rehabilitation developments including Rural Housing Service Section 515/8 and 221(d)(4) projects); Section 202 projects as defined under 24 CFR Sections 277 and 885, 221(d)(3) below-market interest rate and 236 projects.

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BOARD

There are several programs that address one or more aspects of food preparation and delivery for aged or disabled persons. In some cases, the programs build capacity within a HUD project. In other cases, the program reimburses or delivers meals onsite. These programs are described below and are organized by the Federal or State program that provides funding.

Administration on Aging

Elderly Nutritional Program (ENP)

The ENP is the largest community based nutritional program for elders. It is a Title III program under the Older Americans Act and provides states with pass through funding for Area Agencies on Aging for distribution. Funds are used to provide for congregate meals and home-delivered meals. Eligible programs are those that serve elderly 60+ regardless of income as well as a spouse of any age; disabled persons under age 60 who reside in housing facilities occupied primarily by the elderly where congregate meals are served; disabled persons who reside at home and accompany older persons to meals; nutrition service volunteers; and American Indians, Alaskan Natives and Native Hawaiians as established by tribal organizations. Other eligibility requirements are that programs must at least offer one-third of the daily recommend dietary allowance as established by the Food and Nutrition Board of the National Academy of Sciences-National Research Council in addition to nutrition screening, assessment, education and counseling. ENP covers approximately 45% of program costs. Additional funds must be matched through fund raising or other organizations such as the United Way. Nationally, 41% of nutritional services projects have waiting lists. For Assisted Living Facilities to qualify for funds they must open congregate meals to the community as Title III C sites. More information can be found on AoA website at <http://www.aoa.dhhs.gov/factsheets/enp.html>.

Florida Department of Agriculture, Consumer Services (FDACS)

The Food Recovery Program

The Food Recovery Program (or Gleaning) is coordinated by Florida farmers, community action agencies and other food relief agencies as well as volunteers. Information can be found at the Florida Department of Agriculture and Consumer Services, Division of Marketing and Development Bureau of Food Distribution's website: www.fl-ag.com. The USDA provides *A Citizen's Guide to Food Recovery* at: <http://www.usda.gov/news/pubs/gleaning/content.htm>.

U.S. Department of Agriculture

Food Stamps

The Federal Food Stamp Program (Title VII, Chapter 51) is an individual income-based program to “promote the general welfare and to safeguard the health and well being of the Nation’s population by raising the levels of nutrition among low-income households.”¹ In a single-person household, elders age 60+ or disabled persons with less than \$716 net monthly income (total gross income less certain allowable deductions) are eligible. For persons in institutions to meet eligibility requirements they must meet one of the following criteria:

Elderly or disabled member means a member of a household who:

- (1) is 60 years of age or older;
- (2) Receives supplemental security income benefits under title XVI of the Social Security Act or Disability or Blindness payments under titles I, II, X, XIV, XVI of the Social Security Act;
- (3) Receives federally or state-administered supplemental benefits under section 1616(a) of the Social Security Act provided that the eligibility to receive the benefits is based upon the disability or blindness criteria used under title XVI of the Social Security Act,
- (4) Receives federally or state-administered supplemental benefits under section 212(a) of Pub.L. 93-66;
- (5) Receives disability retirement benefits from a governmental agency because of a disability considered permanent under section 221(i) of the Social Security Act.²

¹ 7 CFR 271.2

² Ibid.

Generally, most people are not eligible for food stamps if they receive the majority of their meals (over 50 percent of three meals daily) at a facility like an assisted living facility or nursing home. The following individuals can receive food stamps and are treated as a one-person household for food stamp purposes¹:

- Residents of federally subsidized housing for the elderly; OR
- Narcotic addicts or alcoholics who reside at a facility or treatment center for the purpose of regular participation in a drug or alcohol treatment and rehabilitation program. This includes the children but not the spouses of such persons who live with them at the treatment center or facility; OR
- Disabled or blind individuals who residents of group living arrangements; OR
- Women or women with their children who are temporarily residing in a shelter for battered women and children; OR
- Residents of public or private nonprofit shelters for homeless persons.

If meals are prepared and served in a group living arrangement facility to residents who are blind or disabled, the following rules apply:

Eligible foods means:

(3) Meals prepared and delivered by an authorized meal delivery service to households eligible to use coupons to purchase delivered meals; or meals served by an authorized communal dining facility for the elderly, for SSI households or both, to households eligible to use coupons for communal dining;

(5) Meals prepared and served by a group living arrangement facility to residents who are blind or disabled as defined in paragraphs (2) through (11) of the definition of “elderly or disabled member” contained in this section.²

The procedure for transferring a food stamp benefit to an ALF is outlined in Table 13.

Only facilities that are licensed by AHCA, have 16 or fewer beds, and are non-profit, may accept food stamps. The total cost to the facility is a one-time purchase of the equipment used to process EBT cards (\$600-\$800). More information can be found in Appendices I and J.

The food stamp benefit is on average \$44/month for elders living alone and on SSI. This amounts to \$528 annually. For 10 qualifying residents, the facility would receive \$5,280 for

¹ 7 CFR 273.1(b)(7)(vii)(A).

² Ibid.

food costs annually which could justify an initial one-time expenditure of \$800 for the EBT equipment.

Table 13

Procedure for Transferring Food Stamp Benefit to Facility for Payment of Meals for Beneficiary

- | | |
|-----|---|
| 1. | Establish facility as a contractor with the Department of Children and Families (see Appendix J for application). Facilities must serve 16 or fewer individuals, be non-profit, and be licensed as an ALF (or other group home) by AHCA. Contact USDA Food and Nutrition Services Branch Office (850-942-8315 for application). |
| 2. | Purchase credit card equipment (EBT scanner, PIN pad, and printer) for transferring food stamp benefits to facility bank account (one-time \$600-\$800 purchase). |
| 3. | Develop accounting procedures to show the use of food stamp benefits for beneficiaries only. |
| 4. | For each beneficiary, complete the Request for Assistance form from (DCF; may already be completed for residents on Medicaid) and check "food stamps." |
| 5. | For each beneficiary, complete the "Application for Public Assistance" including form to make the Facility's representative an Authorized Representative for the beneficiary and Declaration of U.S. Citizenship form HRS ES 2058, stock number 5747-000-2058-5. |
| 6. | The Authorized Representative is responsible for supplying DCF with a list of current beneficiaries each month. |
| 7. | Two Food Stamps Electronic Benefit Transfer cards are mailed to the facility. One is in the name of the Authorized Representative with the beneficiary's name listed and one is for the beneficiary. If the beneficiary leaves the facility with more than 15 days left in the month, the beneficiary is entitled to 50% of the monthly benefit. |
| 8. | The Authorized Representative transmits the charge (the monthly benefit amount) using the EBT equipment. The equipment transfers the amount to the facility's bank account to pay for food costs associated with the beneficiary. The equipment prints a receipt as a record of the transaction. Note: if a resident is likely to be in the facility for less than 30 days, it is better to transfer half the amount on the 1 st of the month and the other half on the 15 th of the month. |
| 9. | Every other month residents must be recertified through the DCF representative by filling out identification information on front page, signing page 29 and having the resident's representative sign page 30 of the Application for Assistance Booklet, HRS ES form 2067, stock number 5747-000-2067-4. |
| 10. | When a beneficiary no longer meets the requirements for the food stamps program, the authorized representative is responsible for returning both cards to the Federal Office in Lockheed, VA. |
| 11. | Notify DCF representative upon resident's permanent transfer. |

POLICY RECOMMENDATIONS

The following policy recommendations are suggested based on the analysis of data and previous research that is presented in this report:

1. Adopt the following designation of affordable assisted living: “Affordable assisted living is based on a licensed facility providing a private room and at least one personal care service to at least 50% of its residents who earn no more than 300% of Supplemental Security Income (SSI) at a rate that allows the resident to retain a monthly personal needs allowance (currently \$54) or 5% of their income (whichever is higher).”
2. Investigate the feasibility of calculating regional ALE waiver rates within the State that represent a percentage of the Medicaid nursing home rate. This system should be used to establish new rates for the ALE Waiver, which would be adjusted annually based on changes in the nursing home rate. This method is supported by the fact that there are regional differences in housing and labor costs. For example, there are regional differences in average fair market values for apartments (see Section 8 analysis described earlier in this report). Table 14 provides an analysis of how this change would affect the ALE waiver rates in the state. Appendix K provides the weighted average nursing home rate by county.

From the perspective of cost neutrality, 100% of the current Medicaid nursing home rate in each county would cost the state \$105,901,408 a year (Scenario 1) based on current ALE case months. This is nearly five times the current expenditures for the program (\$21,764,690) and the cost to the state if these individuals were forced to enter a nursing home because alternatives did not exist. The state of Maryland currently sets its cost neutrality threshold at 100% of the Medicaid nursing home rate.

The definition for affordable presented earlier, suggested that the ALE waiver could be set at 50% of the nursing home rate and meet the requirement for cost neutrality (Scenario 3). This would amount to a 2.4 fold increase over the current cost (\$52,950,704). Two alternative approaches are also presented in Table 14. Scenario 2 uses 25% of the local nursing home rate and represents a modest 22% increase in expenditures for the same number of client months. Another option is to institute a two-tiered rate that is also based on the nursing home rate. Tier 1 would be set at 25% of the local nursing home rate and Tier 2 would be set at 50% of the local nursing home rate. Scenario 4 assumes that two-thirds of the ALE waiver clients would qualify for the higher rate and one-third would qualify for the lower rate. This 2:1 split is based on the fact that analysis of Medicaid long-stay nursing home and ALE waiver clients shows that, on average, ALE waiver clients need total assistance with .73 ADLs compared to 1.8 for NH¹. The total cost is about 1.6 times the current expenditure (\$35,212,527) but one-third of the cost for Scenario 1 (100% of the nursing home rate). If the State chooses to implement a tiered rate, it would be necessary to make the lowest tier no less than the current rate (\$851/month). For scenarios 2 and 4 the lowest rate (25% of the nursing home rate) would be \$909-\$993/month depending on region of the state (Appendix K). In addition, clients would need to be re-evaluated by an independent agency (e.g. CARES) to prevent “gaming” of the tiered rates (i.e., classifying a resident at the higher level of need than is appropriate).

¹ Mitchell, G.,E.; Anderson, S.; Chen, H.; Polivka, L.; Salmon, J.R.; Schonfeld, L. et al. (December 2001). *Florida's Medicaid Long-Term Care Population: A Preliminary Profile*. (Agency for Health Care Administration Contract #M0207). Tampa, FL: Florida Policy Exchange Center on Aging.

Table 14

Scenarios for Increasing ALE Reimbursement Based on Nursing Home Rate and Tiers¹

	N Clients	N Case Months	Total Actual ALE Cost 2001	Scenario 1	Scenario 2	Scenario 3	Scenario 4 ²
				NH Rate Applied to ALF Waiver Clients ³	25% of NH Rate	50% of NH Rate	1/3 at 25% NH Rate; 2/3 at 50% NH Rate ²
URBAN COUNTIES			Monthly:	<i>\$3,970</i>	<i>\$993</i>	<i>\$1,985</i>	
North	619	4,538	\$8,301,981	\$17,574,011	\$4,393,503	\$8,787,005	\$5,843,359
Central	982	8,067	\$672,254	\$32,605,254	\$8,151,314	\$16,302,627	\$10,841,247
South	1,375	11,800	\$2,933,278	\$48,858,735	\$12,214,684	\$24,429,368	\$16,245,530
RURAL COUNTIES			Monthly:	<i>\$3,636</i>	<i>\$909</i>	<i>\$1,818</i>	<i>\$1,518</i>
North	184	1,539	\$8,921,484	\$5,465,011	\$1,366,253	\$2,732,506	\$1,817,116
Central	30	235	\$44,298	\$838,665	\$209,666	\$419,333	\$278,856
South	17	133	\$891,395	\$556,095	\$139,024	\$278,047	\$184,901
Total	3,207	26,312	\$21,764,690	\$105,901,408	\$26,475,352	\$52,950,704	\$35,212,527
Increase⁴				4.87	1.22	2.43	1.62

¹Assisted living services only; room and board paid by client or OSS reimbursement.

²Based on one-third of current case months at 25% of NH rate and two-thirds at 50% of NH rate.

³Based on monthly cost X total case months

⁴Increase over the current expenditures for ALE waiver.

- In addition to considering adjusting the current ALE reimbursement rates based on the above scenarios, the State needs to expand and make more equitable the distribution of ALE waiver dollars to rural and urban counties. Earlier in this report, the concept of “fair share” (Golant, 2001) was raised. There should be a better match between the potential need (here, we used the number and percentage of elders age 70 and older who need assistance with at least one ADL) and the availability of OSS or ALE waivers. Rural counties are home to just 5.5% of the state’s frail elder population and have 8.6% of the OSS beds and 7.2% of the ALE waivers. Still, some urban counties such as Dade and Hillsborough have more than their fair share of both OSS and ALE waivers whereas Duval has more than its share of OSS beds but is limited in ALE Waivers. Frail elders should have equal access to these affordable options, regardless of where they live in the state.
- Request additional Section 8 vouchers from the U.S. Housing and Urban Development and require them to be set aside specifically for elders with incomes up to 50% of the area median income and who require supportive services in an assisted living facility or HUD

facility. The State should work with eligible Public Housing Authorities (those with 97% of their vouchers leased) to set aside at least 3% of their fair share section 8 vouchers for disabled individuals who qualify for HCBS Medicaid Waiver assistance.

5. Request from the Administration on Aging additional congregate meal sites located in affordable assisted living facilities.
6. Work with the federal USDA to amend the eligibility requirements to participate in the Food Stamp program for communal dining facilities so that any licensed assisted living facility (including for-profit facilities) may be authorized to accept these payments on behalf of the eligible residents. Smaller, independent but for-profit ALFs represent the backbone of assisted living in the state and many run their facilities at very low cost to residents. If they will accept a low income individual, then they should be allowed to accept food stamp payments for that individual. There is no cost to the state for this change.
7. Educate ALF developers, operators and residents about the public reimbursement and financing options available to them to make assisted living an affordable option.

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