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Affordable Assisted Living: Creative Ways To Make It Work

A two-part series explains how Medicaid and tax credits help solve some of the challenges of housing the elderly.

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There are serious housing problems facing our aging population. What can be done as people age and become more frail, and unable to fully take care of themselves? This is an economic problem as well as a social one. If continual or frequent nursing, medical, or psychiatric services are not yet necessary, it is not appropriate to place people in nursing homes. For the wealthiest members of our community, assisted living facilities may be an option. In such facilities, meals, security, transportation, assistance with daily living and other amenities are provided in an apartment setting. But the costs to live in such a facility are significant, totaling thousands of dollars a month. Placement in assisted living facilities may require a six-figure income or seven figures in assets.

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So, how can we speak of "affordable assisted living?" The term seems to be an oxymoron. This series will demonstrate that "affordable assisted living" facilities can be developed in many places throughout the country. Others have discussed ways to move in the direction of affordable assisted living. Jim Moore's article, "Pathway to Affordability," published in the May 2003 issue of *Assisted Living Today*, outlines nine helpful suggestions to help make affordable assisted living feasible. Many of my clients have found that even if they were to utilize all nine of the suggestions, many facilities are still not feasible. These developers have found that the key to affordable assisted living, just as the key to affordable nursing homes and affordable housing, is governmental subsidies. Governmental aid comes in the form of operational subsidies or subsidies that provide capital for construction. The subsidy of primary importance regarding assisted living is Medicaid.

The most important potential resource for affordable assisted living is commonly referred to as Medicaid waivers, which are essentially transfers of nursing entitlements to assisted living. According to *State Assisted Living Policy: 2002*, published by the National Academy for State Health Policy, as of November 2002 there were at least 102,000 participants in various state Medicaid waiver programs. As of October 2002, 41 states had programs. Although this is only approximately 2% of the potential market, the trend is toward expansion of these programs. The reason: it saves money.

Waiver programs reduce cost

The Assisted Living Federation of America (ALFA) cites several states that appear to have proved that Medicaid waiver programs have curbed increases in Medicaid long-term care costs. The states showing that the Medicaid waiver programs actually reduce healthcare costs, according to ALFA, include Oregon, Washington, Colorado and Maine. These states have shown that the Medicaid funding of assisted living has not caused people to participate who would otherwise not enter a nursing home, the so-called "woodwork effect."

The programs are fulfilling their intended purpose of keeping people out of nursing homes who do not need the medical nursing services, but need the assistance with daily living. Medicaid waiver funding, depending on the sophistication of the program and the amount of reimbursement from the state, can be an operating subsidy, but also can be capitalized as additional loan or other proceeds for development. Most state Medicaid waiver programs are sophisticated enough to allow flexibility for the use of other capital subsidies such as low-income housing tax credits (LIHTC).

Some state-assisted living programs add other components to the monthly reimbursements. The Illinois Sup-

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portive Living Facility (SLF) program, for example, provides additional rent and food components within the overall reimbursement. The rent component is paid from Supplemental Securities Income (SSI). The food component is funded by food stamps under the SLF program. The ultimate amount of reimbursement is generally set by geographic location under the particular state program involved. Although there may be a relationship between reimbursement rates in a particular geographic location to the general costs in that area, the amount of reimbursements generally does not depend on actual cost.

The failure to tie the actual costs to the reimbursement can make the development of certain facilities a challenge, since development and operating costs vary by location. Operation costs are affected by the local labor pool, including unemployment rates, the degree of organization of labor, the local availability of workers, desirability and availability of employee housing, and similar characteristics of the labor pool and the location. For example, location may affect security costs. Pathway Senior Living of Des Plaines, Ill., has been a pioneer in developing affordable assisted living. It opened four assisted living facilities, and has a half dozen on the drawing board. According to E. James Keledjian, an owner of Pathway, certain urban locations lend themselves to significantly increased security costs. Pathway has discovered increased security needs, and consequently increased costs, in its urban locations in Joliet and Calumet City, Ill. The other factor is the varying development costs of locations for assisted living facilities. Land costs can be a large factor in certain locations. In other locations, where development is being encouraged by municipalities or other groups, the land may be free for the offering.

Local market conditions influence

As with most real estate ventures, the market for residents plays an essential role in assisted living housing. But the existence of the Medicaid waiver may have unexpected effects on the behavior of the market. Where a strong market for conventional market-rate assisted living units exists, a mixture of "market rate" units and "affordable" units may be highly desirable. As residents spend their savings and income, they may move from market rate to affordable beds. This is the common nursing home phenomenon of "spending down" to qualify for Medicaid.

But what about the locations where there are a high number of eligible residents? Does the availability of prospects assure a strong market? Logically, since the residents' costs may be paid entirely by Medicaid and other state programs, the assumption seems reasonable that potential residents would automatically flock to get into the facility. This may not be so. The mere existence of the state program will not ensure that residents will want to move to a facility. Potential residents and their families may need to be educated as part of the marketing program. Families that are caring for an elderly relative may have gotten used to receiving the small SSI check, and may not be ready to give that up. Relatives of the potential resident may not be ready to accept that they cannot care for their loved one. The existence of significant referral sources seems to be a key to the marketing success of these facilities. Successful marketing may only be possible when the family is ready to place their loved one in a nursing home.

Medicaid funding of assisted living is a necessary condition for the development of affordable assisted living facilities. But given the varying cost in different locations and the reimbursements that are not set to actual costs, Medicaid funding alone is not a sufficient condition to finance affordable assisted living. In most instances, to make affordable assisted living a reality rather than an oxymoron, additional subsidies are needed. Some of these are discussed below.

Developing affordable assisted living

There are numerous programs that help fund and subsidize affordable housing. Affordable assisted living facilities could qualify for some of these programs if assisted living is considered "housing." Although residents of an assisted living project live at the facility, the same can be said for nursing homes. Generally, because of the high-level services provided, an assisted living facility is more of an operating business than the simple owning and operating of rental real estate. Keledjian views himself as being in the hospitality business when operating his assisted living facilities. Are these facilities like apartments? Or are they health care facilities, like nursing homes or hospitals? The answers to these questions determine what subsidies the facilities qualify for.

In 1998, the Internal Revenue Service (IRS) provided a partial answer to the question of how to classify assisted living facilities when it published Revenue Ruling 98-47, 1998-2 CB 399, otherwise known as the "IRS ruling." The IRS ruling is important not only because it provides an easy way to determine what is residential rental housing, but most importantly, it determines what facilities qualify for certain types of bonds and the low-income housing tax credit. The LIHTC is a subsidy for equity investors in low-income housing projects. Section 42 of the Internal Revenue Code of 1986, the longest section in the entire code, is devoted to this housing program.

The IRS ruling distinguishes between a "residential rental facility" and

"health care facility." While both types of facilities could qualify for issuance of tax-exempt bonds, only a residential rental facility qualifies for LIHTCs. Qualifying for LIHTCs could mean the prospect of obtaining LIHTC equity funding. The amount of equity financing generated by the LIHTC is generally between 25 to 75% of the development cost. The range depends on several factors, including:

- Whether the credits are obtained by issuance of tax-exempt bonds (so-called "4% credits") or by an allocation from the appropriate state agency (so-called "9% credits").
- The percentage of low-income residents in the facilities.
- Whether the facility is located in certain areas that give a boost in the credit amount. The IRS ruling has been pivotal in the ability to develop affordable assisted living though the use of the LIHTC subsidy. It is useful, therefore, to review the facts and holding of the IRS ruling.

The IRS ruling involved a continuum of care with three separate, hypothetical buildings – building X, Y and Z. Each building was similarly constructed, with each unit having complete facilities for living, sleeping, eating, cooking, bathing and sanitation. All residents entered into a lease and received the basic services. Services and monthly fees varied according to the level of care. The most services and largest fees were charged to residents of building "Z." The least amount of services and fees were for building "X." The basic services included: laundry; housekeeping; regular daily meals in common dining areas; 24-hour monitored emergency call service using call buttons and two-way communication devices in each unit; planned social activities; and scheduled transportation to commercial areas, hospitals, shopping centers and doctors' offices. Each building had a common eating facility that provided for the residents' special needs and allowed for the monitoring of the overall well-being, nutrition and health of each resident.

Building "X" had only basic services. Building "Y" had basic services and supportive services, including: assistance by medical management technicians in medication management and intake; maintenance of detailed medical records; consultation with a nurse about health concerns and medication plans; and assistance by non-medically certified aides each day that included getting in and out of bed and chairs, walking, using the toilet, dressing, eating, bathing and routine checks by staff members. Some residents required continual assistance, but not continual or frequent nursing, medical or psychiatric services.

Building "Z" had all the services of building "Y," but also had registered nurses on staff 12 hours a day, licensed practical nurses on duty 24 hours a day, and licensed nurses aides available 24 hours a day

The IRS ruling held that although building "X" and building "Y" had significant non-housing services, because there was no continual or frequent nursing and medical or psychiatric services, the buildings were classified as "residential rental facilities," not "healthcare facilities." Conversely, building "Z" was deemed a "healthcare facility," not a "residential rental facility." The significance is that after the IRS ruling, we can structure assisted living facilities as either a residential "rental facility" or as a "healthcare facility," depending on the level of services.

If we structure the facility as a "residential rental facility," it can qualify for LIHTCs. The key to this significant subsidy is to make sure that there are no continual or frequent nursing, medical or psychiatric services provided by the facility. Most assisted living facilities can comply with the requirements to be a "residential rental facility" and, therefore, qualify for LIHTC. ●