2-3-10-55

20090456

AN ANALYSIS OF THE BARRIERS AND OPPORTUNITIES TO CREATE URBAN SENIOR CARE COMMUNITIES IN BALTIMORE CITY

May 2008

Submitted to the Governor and the Maryland General Assembly
by the Task Force to Study the Feasibility of Creating
Urban Senior Care Communities in Baltimore City

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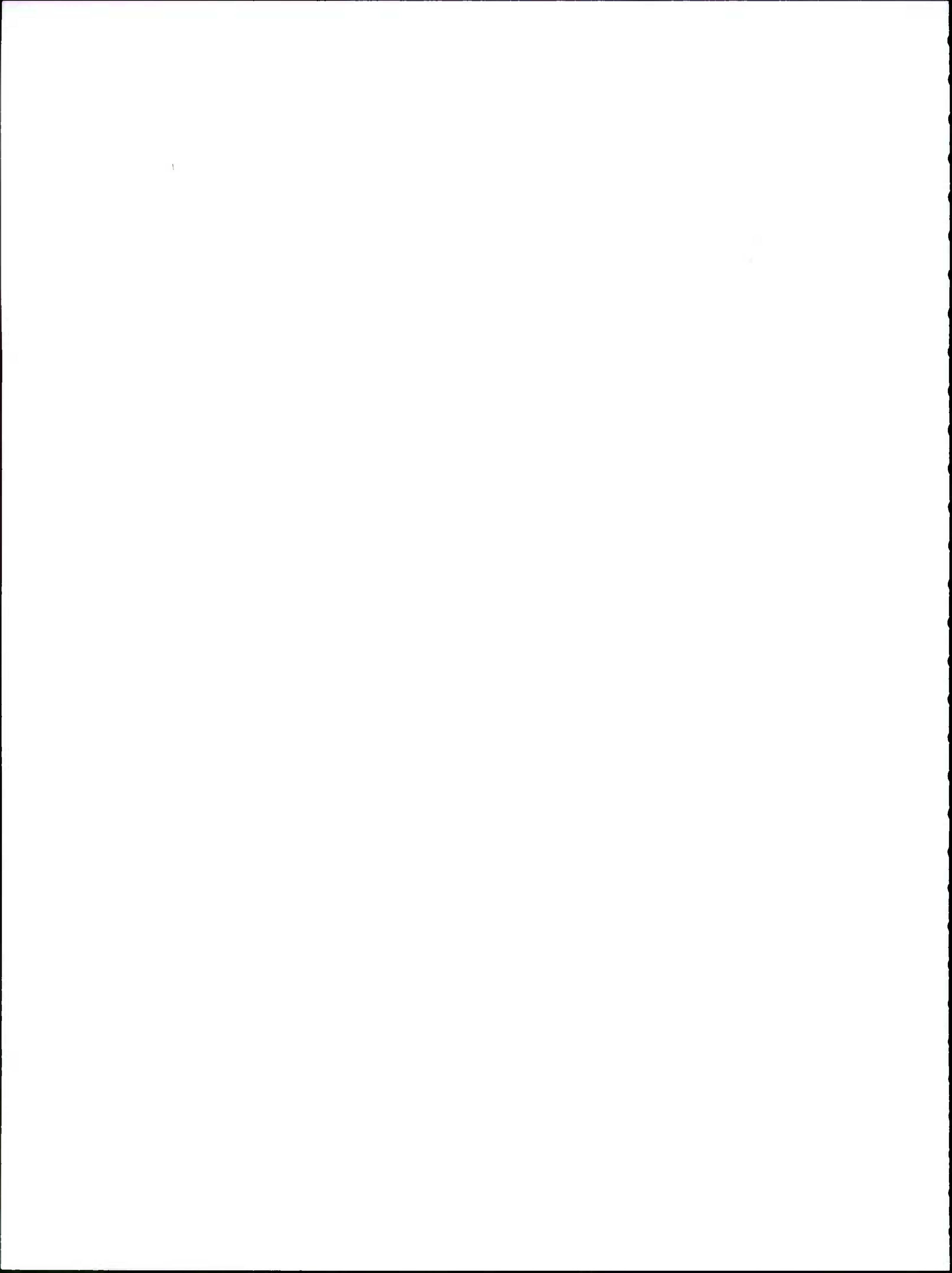

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I. Introduction

America is graying. Baby boomers – the generation of Americans born after World War II – are beginning to retire and will drive strong demand for senior housing and services in the coming years. This national pattern is apparent throughout Maryland, where the number of residents over 65 is anticipated to grow from the 2000 total of 600,000 residents to 1.3 million residents by the year 2030, a growth of 119 percent. Baltimore City, too, shares in this trend, as senior households are expected to grow by 27 percent -- a more modest but still significant increase of 23,800 residents over that same time period. But Baltimore has a distinct and troubling demographic trend: it has a greater proportion of low-income households. This fact adds to the challenge of providing housing and services for the growing number of senior households.

While many seniors choose to stay in their homes where they are comfortable and typically own the home outright, many seek accommodations in age-restricted communities. The development of these communities occurs in response to market demand. They are typically targeted towards moderate- and upper-income households that have the financial resources or equity from their homes to purchase the unit, pay for the ongoing operating costs, and still have the financial capacity to cover their personal medical expenses. Indeed, many such independent living and age-restricted communities have been created throughout Maryland. Many provide a range of amenities such as golf courses, pools, and fitness centers to attract residents and provide active senior living resources.

In addition to these types of active and independent living opportunities, there are also a range of continuing care, assisted living, nursing home, and special needs facilities that are available to provide more intensive support to individuals that have progressing medical and care needs. Some models, such as continuing care retirement communities (CCRC), are developed and designed with a fee structure that covers the housing and health service costs.

The aging of baby boomers comes at an opportune time for Baltimore City. After decades of out migration and population loss, Baltimore City's population is stabilizing. As the City strives to reposition itself, revitalize, and attract new residents, focusing on opportunities arising from the senior demographic may be advantageous – particularly given the City's strong medical facilities.

Building in affordability to service-enriched housing to meet the needs of moderate- and low-income senior households is a challenge. This challenge is compounded by the separately administered housing and medical resource assistance programs provided by federal, state, and local levels of government. Programs like Medicaid, Medicare, and a range of affordable housing resources and tools such as the Low Income Housing Tax Credits (LIHTC) are available to provide housing, medical, and support services to low-income senior households in need. These funding tools and programs, however, are fragmented and difficult to strategically piece together. Too often, such funding dilemmas become the responsibility of the household in need or a property developer/manager.

II. Charge and Overview of the Task Force

Senator Catherine Pugh introduced Senate Bill 861 during the 2007 session of the Maryland General Assembly, which created a task force to study the feasibility of developing urban senior care communities in Baltimore City (Task Force). The Task Force was charged with the following:

A. Study the feasibility of developing senior care facilities in Baltimore City;
B. Investigate the use of tax credits to provide incentives for the private sector to develop senior care facilities; and
C. Investigate the use of Medicaid or Medicare funds for health care services needed by seniors at senior care facilities.

Chaired by Raymond A. Skinner, the Secretary of the Maryland Department of Housing and Community Development (DHCD), the Task Force was composed of representatives from the real estate development and management, health care, senior advocacy, and State government communities including representatives from the Department of Aging (MDoA), the Department of Planning (MDP), and the Department of Health and Mental Hygiene (DHMH). Additional participants included individuals representing interest groups, federal agencies, consulting firms, for-profit and nonprofit developers, as well as representatives from the City of Baltimore.

The Task Force convened four times between November 2007 and January 2008. Members heard presentations on housing and medical resources, service programs, policy barriers, innovative developments, and demographic trends that ultimately determine and impact the feasibility of creating urban senior care communities in Baltimore City.

Given the statutory requirement of the Task Force to examine the use of housing tax credits as well as Medicaid and Medicare, all of which are limited to individuals in need, the Task Force focused its efforts on exploring the available resources and barriers in assembling affordable housing and affordable health and support services in a new senior housing development.

The Task Force does note that the notion of urban senior care communities comes at a time when other efforts to address senior needs are underway. One effort is to help keep seniors in their homes longer. By providing ample access to affordable services and health care for seniors while they are in their own home or even in rental housing that they can afford, such efforts may serve to mitigate movement into and demand for subsidized long-term care facilities down the road. Programmatic reforms that may help achieve this include the Money Follows the Person Demonstration Programs. It is part of a national effort to help states "rebalance" Medicaid expenditures away from long term institutional care towards other methods of service delivery such as waiver programs, personal care, and home health services. Urban senior care communities should not be perceived as a "silver bullet" to solve long term aging needs; rather, as an option available to meet the needs of Maryland's senior population.

III. Findings of the Task Force

A. Market Need for Urban Senior Care Communities in Baltimore City

Nationally, between the year 2000 and the year 2030, the population of residents age 65 and over will double from 35 million to 71.4 million. Members of the baby boomer generation, or individuals born between 1946 and 1964, are becoming eligible for retirement. This national demographic pattern is anticipated to place challenges on the U.S. economy prompting expansive needs for senior housing and services. These challenges are characterized by a 2002 Congressional Budget Office report excerpt:

> As a share of gross domestic product (GDP), spending for Social Security, Medicare, and Medicaid--the three entitlement programs most affected by the looming demographics--appears to be relatively stable over the next five years, growing only modestly. However, 10 years out, the outlook starts to change. The population age 65 or older will be growing rapidly. Although that segment constitutes 12 percent of the population today, according to the Social Security and Medicare trustees it is expected to grow to 18 percent in 2025, 21 percent in 2050, and 23 percent in 2075. At the same time, growth in the nation's workforce is expected to slow, resulting in a more slowly growing economy. By 2035, the number of elderly will double, while the number of workers contributing to Social Security and Medicare will rise by only 17 percent. The ratio of the population ages 65 or older to the population in its prime working years will grow from 21 percent today to 32 percent in 2025 and 42 percent in 2075.[1]

Projected demographics for Maryland and Baltimore City reflect this trend. The number of Maryland residents age 65 and over is expected to grow by 119 percent to 1.3 million residents by 2030. At that time, nearly one out five of Maryland residents will be a senior – up starkly from the composition of roughly 11 percent in 2000. In Baltimore City, the growth in senior population is not projected to be as significant as Maryland's but will nonetheless climb from 85,900 residents to 109,700 residents over that time. This will constitute a growth of 27 percent from 2000 levels.

Table 1: Population Projections by Age Group, 2000 – 2030

United States	2000	2030	Change	Percent Change
Below 65	247,064,000	292,131,000	45,067,000	18.2%
65+	35,061,000	71,453,000	36,392,000	103.8%
Maryland				
Below 65	4,697,179	5,425,360	728,181	15.5%
65+	599,307	1,312,390	713,083	119.0%
Baltimore City				
Below 65	565,233	568,400	3,167	0.6%
65+	85,921	109,700	23,779	27.7%

Source: U.S. Census Bureau and the Maryland Department of Planning

[1] Congressional Budget Office, "The Looming Budgetary Impact of Society's Aging," Long Range Fiscal Policy Brief: Number 2, July 3, 2003. Available online at: http://www.cbo.gov/ftpdoc.cfm?index=3581&type=0&sequence=0

While the overall growth of the senior population suggests significant future demand for senior communities, Baltimore City has the added challenge of meeting affordability needs of its seniors. Though Baltimore City represents about one eighth of Maryland's total population, a third of Maryland's residents living at or below poverty in 2000 were located in Baltimore City. Looking specifically at residents aged 65 and over, Baltimore City is home to 30 percent of Maryland seniors living in poverty. And the poverty rate among seniors in the City of 18 percent is more than double the statewide rate of 8.5 percent.[2]

The federal poverty level, which in 2007 was $10,210 for a single person or $13,690 for a family of two, is an important indicator. Not only does it convey numbers of individuals in need, it also closely tracks the eligibility for medical assistance programs. This is important because the disproportionately high level of poverty in the City remains consistently high for the baby boomer generation and suggests a need for increased services to meet the needs of this population in the future. Table 2 depicts the poverty rate for residents ages 35-54 in the year 2000, which is the closest available data to approximate the baby boomer generation. In fact, when looking at this cohort, the disparity between the City poverty rate and the State rate is three times higher when compared to Maryland as a whole.[3]

Table 2
Poverty Status for Residents Age 35-54, 2000

	United States	Maryland	Baltimore City
Total	82,511,094	1,666,056	182,341
Below Poverty	7,055,078	98,313	33,333
Above Poverty	75,456,016	1,567,743	149,008
Percent Below Poverty	8.6%	5.9%	18.3.%

Source: U.S. Census Data

In Baltimore City, it is also important to consider the many renter households. Renters can not sell their homes to help pay for retirement expenses. In Baltimore City, renter households constitute 50 percent of all occupied housing units: the highest among large jurisdictions in Maryland. When looking only at residents age 65 and over, 36 percent were renters in 2000 in Baltimore City compared to 23 percent statewide.[4]

Housing tenure as well as demographic changes overlaid with the income levels indicates that Maryland and Baltimore City can anticipate a growth in affordable senior related housing, medical, and service needs. The needs, unfortunately, are compounded when taking into account existing affordable housing shortfalls.

In 2003, DHCD completed a study as part of the Governor's Commission on Housing Policy that projected the shortfall of affordable/workforce rental housing to 2014. The projected shortage

[2] The poverty rate for the population ages 65 and over for Maryland NOT including Baltimore City was 6.9 percent in 2000.
[3] The poverty rate for the population ages 35 to 54 for Maryland NOT including Baltimore City was 4.4 percent in 2000.
[4] It should be noted, that even though Baltimore City has a higher percentage of renters aged 65 and over, there are more than 373,000 such households statewide – more than 6 times the City total of 58,000.

reached 156,900 units Statewide, including an estimated shortfall of 25,000 units for seniors. The study found that in Baltimore City, an estimated total of 17,800 units are needed including 3,300 units for seniors. These projected needs, though, only encompass the first few years of retiring baby boomers.

While the study may provide an academic insight into housing needs, the waiting lists for Section 8 and Public Housing in Baltimore City provide a second indicator that suggests there are substantial existing needs for affordable housing at just the forefront of baby boomer retirement. As of December 2007, Baltimore Housing reports that 15,802 individuals are on the waiting list for Public Housing, 11,003 are on the waiting list for Section 8 rental assistance, and 6,011 individuals that are on both lists. Looking only at seniors aged 62 and over, there are 1,011 individuals on the Public Housing waiting list, 959 individuals on the Section 8 waiting list, and 270 individuals on both.

Table 3: Baltimore City Public Housing and Section 8 Waiting List

	Total	Senior (Age 62 and Older)	Non Elderly Persons with Disabilities	Other
Public Housing	15,802	1,011	4,215	10,576
Section 8	11,003	959	6,729	3,315
Total on Both Lists	6,011	2,70	3,374	2,376

Source: Baltimore Housing

This pressing need for affordable senior housing with services is further exacerbated by limited actions of the private market to move into this sector. A 2003 paper by the Joint Center for Housing Studies at Harvard found that:

> "...assisted living is primarily a private-pay industry, characterized by relatively large development firms and operators that cater to high-to-moderate income seniors with a range of housing options. However, increasing attention has been paid to the needs of low-to-moderate income seniors, many of whom already face housing affordability problems and whose physical needs are becoming more pressing as the population ages. These seniors form the market for affordable assisted living, that is, assisted living that makes use of public subsidies to keep the costs affordable to low-to-moderate income residents. This market is difficult to define exactly in terms of income, since costs vary greatly by geographic location and some subsidy eligibility is determined by local income comparisons, but... seniors with incomes up to $15,000 would generally form the market for an affordable product."[5]

Together, current and future demographic patterns, as well as the existing need for affordable housing and services, underscores the need to better prepare for the growth and needs associated with baby boomers. Better linking affordable medical and housing resources to address these needs is critical.

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[5] Schuetz, Jenny, "Affordable Assisted Living: Surveying the Possibilities," Harvard University Joint Center for Housing Studies, January 2003. pg 34.

B. Market Rate Age Restricted Communities vs. Affordable Age-Restricted Communities

Studying the feasibility of creating an urban senior care community in Baltimore City requires an understanding of how market-driven as well as affordable senior housing models work. Understanding the services, structure, and financing model of the market-driven community helps set the framework for what the affordable model should aspire to. While replication of luxury services through government subsidies is not the intent, building in the connectivity of housing and medical services as well as other household support services is the goal. In turn, this would allow low-income seniors to move into senior care communities and access a variety of resources. The provision of such services could serve to enhance a senior's quality of life while also mitigating movement to a more intensive medical and service-oriented facility.

The Task Force examined two senior community models. Erickson Retirement Communities, a national retirement community owner and developer whose headquarters is based in Maryland, provides a strong example of what options are available for moderate and upper income residents. And Stadium Place, an affordable senior community in Baltimore City, provides perhaps one of the best examples of what can be achieved based on the utilization of the existing funding silos of housing, medical, and other support services.

Erickson Retirement Communities – A Private Pay/Market Rate Model
Erickson Retirement Communities was founded in 1983 by John Erickson, who (as quoted from the company's Web site) "rejected the traditional concept of retirement living and struck out on his own to create an exciting lifestyle for people age 62 or better."[6] Offering self-contained life-style amenities and health services, the Erickson model provides age-restricted/continuing care living arrangements to more than 20,000 people. The company both develops and manages these retirement communities, serving primarily middle-income people.

The growing Erickson network currently comprises 20 campuses, with developments in Colorado, Illinois, Kansas, Maryland, Massachusetts, Michigan, New Jersey, Ohio, Pennsylvania, Texas, and Virginia, together are home to more than 20,000 people and employ more than 11,000. The company is currently developing new communities in the Denver area, Kansas City area, and Ashburn, VA. It is also pursuing land acquisition opportunities across the U.S.

Erickson pioneered the 100 percent Refundable Entrance Deposit, which allows new residents to pay upfront for the costs of their units by leveraging equity from their homes or other resources to pay for deposits, which range from $150,000 to $450,000 – depending on apartment size and region of the country. Deposits are then returned to residents if they relocate, or to their estates upon passing. This creates an innovative financing model that protects residents' wealth but can still be leveraged to help pay for the development and other costs of the campus. The deposit or unit costs are then replaced by the next resident who takes over the unit.

Erickson residents also have to pay a monthly minimum rent/fees that range from $2,000 to $5,000 per month, depending on the level of services required. Through this fee for service

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[6] Erickson Communities Website, "One Mans Vision Speaks to Many," Downloaded January 13, 2008. Available online at: http://www.erickson.com/aboutUs/oneMansVision.asp

approach, Erickson residents can tap into accessible health care and other assistance based on their needs. Erickson recently received approval from Centers for Medicare and Medicaid to offer residents of participating campuses the Erickson Advantage health care plan. The Plan is part of the Medicare Advantage demonstration project that provides streamlined health plan options that are a part of the Medicare program.[7]

In addition to the housing and health care services available to community residents, Erickson offers a range of other services, including transportation, grounds maintenance, and housekeeping. The campuses also offer onsite amenities, including restaurants, stores, and fitness centers. Referred to by Erickson as "campuses," Erickson developments are mostly self-sufficient, providing their own security and emergency response service. They also provide their own road repair, snow removal, and other services typically funded by local government.

Erickson reports that each of their developments has "a positive economic impact on the greater communities where they are located, through real estate taxes, capital investment, community expenses, and the creation of about 1,000 new jobs per campus."[8]

Because of the required upfront deposit and the fee for service structure, Erickson Communities are limited in accessibility to low-income seniors or those without significant personal assets. Achieving these levels of affordable housing as well as services is the challenge. However, one development in Baltimore City has taken strides to do just that.

Stadium Place – A Subsidized Housing Model

Govans Ecumenical Development Corporation (GEDCO) was formed in 1984 as a partnership among seven churches in the Govans neighborhood of Baltimore City in response to critical housing needs of aging members of their congregations. GEDCO is now a nonprofit organization supported by 47 Baltimore City churches and community associations, with 17 staff members and 150 volunteers. It owns ten housing developments that offer supportive services to special needs populations, and operates an emergency food pantry and financial assistance center. These services provide housing for 450 people and advocacy and financial assistance for over 7,000.[9] Stadium Place is the largest active project undertaken by GEDCO.

Stadium Place, which is still under development, will ultimately provide housing for more than 500 residents. Currently, about 255 residents live in three separately owned buildings on the campus. GEDCO is the "Master Developer" and coordinator of service provision to the residents of Stadium Place. GEDCO has an ownership or partnership role in each of the residential facilities on the campus, which are developed, owned and financed under separate legal ownership. This provides the opportunity for each ownership entity, within programmatic and regulatory requirements, to apply for various iterations of government assisted housing funds that are separately administered. Co-location of the facilities provides the opportunity to achieve

[7] U.S. Department of Health and Human Services, "Medicare Advantage Plans," Downloaded January 13, 2008. Available online at: http://www.medicare.gov/Choices/Advantage.asp

[8] Erickson Communities Website, "About Us," Downloaded January 13, 2008. Available online at: http://www.erickson.com/aboutUs/

[9] Govans Ecumenical Development Corporation, "About GEDCO." Downloaded December 30, 2007. Available online at: http://www.gedco.org/about_home/

scale and density of eligible residents so that additional supplementary services can be more easily incorporated. When fully completed, Stadium Place will feature subsidized independent living apartments for rent, market-rate condominiums for sale, assisted living arrangements and a long-term care facility. A convenience store, movie theater, beauty salon, and computer labs are mixed among the residential buildings as amenities and to encourage socialization between residents of each building. In addition, the site currently includes a YMCA, day care center, and large playground as stand along facilities which encourages opportunities for the seniors to interact with community members of all ages. The development site will eventually incorporate commercial space as well.

Stadium Place was made possible through the determination and hard work of mission-driven individuals along with funding from a variety of sources, including federal, state and local government agencies. Those resources include:

- HUD Section 202 program
- LIHTC
- Federal grants
- For profit developers
- Nonprofit developers
- Foundation grants
- Equity investments
- Conventional financing
- Low interest loans and mortgage insurance programs
- Private contributions
- Grants and loans from faith based community institutions

Stadium Place offers supportive services to all residents, regardless of financial means. Service Coordinators work with residents to assist them with health/wellness, food services, social/recreational programs, legal services, transportation, and other areas.

Stadium Place demonstrates that an urban senior care community can be created in Baltimore City that achieves affordability as well as provides services. It provides a range of housing options for seniors drawing on tax credits and other government subsidies to provide affordable housing. Its residents do utilize Medicaid, Medicare, and also leverage a range of other services to meet their needs, though medical services are not incorporated into Stadium Place's offered services but are rather defined by the consumer and their individual eligibility.

The connectivity of affordable housing and services in Stadium Place has not been easy, however. Many factors have played into Stadium Place's feasibility, but two stand out: 1) its vision, development, and operation by a mission driven developer; and 2) its unique land development opportunity.

1) Mission Driven Developer
GEDCO brings with it a different set of resources than a private developer brings. It is not driven by financial profits, though financial feasibility is important. GEDCO's unique mission and nonprofit status have provided it the opportunity to create an affordable senior housing community with services that a private developer would not necessarily be motivated to replicate at the same margins.

GEDCO's nonprofit status has helped leverage capital and other resources that for-profit companies would not necessarily be able to leverage. For example, 18 faith-based institutions provided $1.8 million in loans and $325,000 in grants for working capital to fund GEDCO's staff, predevelopment and other costs. The Harry and Jeanette Weinberg Foundation played a strong role helping to fund the YMCA and one of the 202 buildings. It also helps garner a range of volunteers, coordinated by GEDCO's service team, who provide residents with assistance and ongoing services.

2) Land
The 30-acre Stadium Place site was made available after much public debate and political involvement. After a unified effort led by members of the religious community and strongly supported by the residents of the neighborhoods surrounding the old Memorial Stadium, the disposition of property from the City to GEDCO was completed. Demolition of the former stadium was paid for by $5.4 million in state funds. In an urban environment, a fully assembled and clear 30 acre site is rare.

Ultimately, for the private sector to create an affordable urban senior care community, much like Stadium Place, the private sector would need to overcome a series of hurdles.

> "Providers of affordable assisted living have the added difficulties of assembling financing packages to subsidize both development and operations, thus making the facilities affordable to very-low, low and moderate-income seniors. Since assisted living represents a combination of housing, personal care, and supportive services, funding subsidies must usually be obtained from a variety of different government agencies, private lenders and charitable organizations, each with its own set of eligibility rules and funding regulations. At best, the difficulty of assembling such complex financial structures drives up the cost of development; at worst, the contradictory regulations and remaining gaps in affordability make these projects financially infeasible."[10]

Looking at how other states have responded to these challenges can provide Maryland some opportunities to consider.

C. Activities Initiated in Other States

The challenges facing Baltimore City in developing and financing low- and moderate-income senior housing are paralleled in cities across the country. Several states have taken innovative steps, using a patchwork of funding sources and taking advantage of state resources when possible, to fund the construction and to manage housing resources for urban seniors with

[10] Schuetz, Jenny, "Affordable Assisted Living: Surveying the Possibilities," Harvard University Joint Center for Housing Studies, January 2003. Pg 35.

modest means. Below are several examples of states that have devised innovative ways to house low- to moderate-income seniors in high quality living environments.

Massachusetts

The Massachusetts Supportive Housing Initiative, founded in 1999, is administered by the Executive Office of Elder Affairs to create an "assisted living like" environment in state funded public/elderly disabled housing. Since its inception, the program has been expanded to 22 locations. It offers 24-hour a day services including one meal, social activities, medication reminders, housekeeping, case management, and service coordination. Residents who do not qualify for state-funded home care services, based on frailty level and income, are able to privately purchase a full or partial care package based on need.[11]

Assistance is also provided by MassHousing, Massachusetts' state-run housing finance division. MassHousing runs the state's ElderCHOICE program, which provides financing for assisted-living rental housing with supportive services for frail elders. Under the program's guidelines, any developer seeking funds from MassHousing for a development offering support services for elders must set aside 20 percent of the units for individuals earning no more than 50 percent the area median gross income or 40 percent of the units must be set aside for individuals earning no more than 60 percent of area median gross income. In addition, rents charged cannot exceed 30 percent of the area median income limit for the elected set-aside.[12] As a companion to the ElderCHOICE program, MassHousing administers the Elder 80/20 program, which mandates that 20 percent of any MassHousing-funded development for elders who wish to live in independent rental apartments with on-site access to supportive services be set aside for households earning less than 50 percent of the area median income.[13]

At the local level, the City of Cambridge's Cambridge Housing Authority combined low-income housing and historic tax credits, Project-Based Section 8 funding, state funding and the contributions from a number of banks to support the construction of Neville Place, a state of the art, mixed-income community that includes 39 units for low-income residents who pay their monthly fees through a combination of Section 8, Social Security Income and the Massachusetts Medicaid Group Adult Foster Care Program. The project was completed in 2001. Low-income residents with Medicaid pay approximately $200-$300 in rent. Those without pay $1200- $1300. Market rate units range from $2700- $3200.[14]

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[11] Massachusetts Executive Office of Elder Affairs, "Supportive Housing Initiative Overview," Downloaded January 13, 2008. Available online at:
http://www.mass.gov/?pageID=elderstopic&L=3&L0=Home&L1=Housing&L2=Supportive+Housing&sid=Eelders
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[12] MassHousing, "ElderCHOICE," Downloaded January 13, 2008. Available online at:
https://www.masshousing.com/portal/server.pt?open=512&objID=205&&PageID=231&mode=2&in_hi_userid=2&cached=true

[13] MassHousing, "Elder 80/20," Downloaded January 13, 2008. Available online at:
https://www.masshousing.com/portal/server.pt?open=512&objID=205&&PageID=232&mode=2&in_hi_userid=2&cached=true

[14] Conference of Large Public Housing Authorities, "Cambridge Meets Needs of Elderly Residents" Downloaded January 13, 2008. Available online at: 'http://www.clpha.org/page.cfm?pageID=1048. See also: U.S. Department

Another innovative model that leverages public housing operating funds was developed by the New Bedford Housing Authority. Public housing capital funds were used to develop a community center adjacent to an elderly public housing development. Public housing operating funds pay the salary of a full-time manager/service coordinator for the building. The community center has a wide range of services donated by area service providers and serves one meal a day that is provided by the local culinary school.

Michigan

In 2000, Oakland and Macomb Counties created the Affordable Housing Assistance Program, which offers tenant-based vouchers using Medicaid waivers and Housing Choice Vouchers to provide eligible clients with a choice of affordable assisted living housing as an alternative to nursing home care. The program initially capped the percentage of a resident's income devoted to rent at 40 percent. However, it was found that the assisted living costs were much higher. Federal legislation was enacted in 2002 and 2003, however, allowed the program to exceed 40 percent.[15]

Pennsylvania

Pennsylvania has worked to connect the location of their PACE programs (see section VI for an explanation of PACE) to affordable subsidized housing. Pennsylvania's Department of Public Welfare, in conjunction with local partners, proactively works with housing developers and PACE providers to connect each effort. Connecting PACE to affordable housing developments is also encouraged through the state's Qualified Allocation Plan which is used in the competitive award of 9 percent LIHTC. To date, PACE programs have been co-located with two affordable housing developments in the towns of Homestead and Tarentum in the Pittsburgh area (Homestead is a HOPE VI development). Two additional PACE programs are connected to affordable housing in Philadelphia in the developments of Greater Gray's Ferry Estates and Germantown House. Housing resources used to support the developments include public housing resources and the LIHTC.

The Pennsylvania Department of Public Welfare also reports that it has seen dramatic results in reducing the movement of seniors from affordable housing to nursing homes through one innovative effort in Pittsburgh. The University of Pittsburgh Medical Center in partnership with Presbyterian SeniorCare, which owns and manages four senior affordable housing developments, have teamed up to provide targeted case management coupled with routine health status monitoring of the residents. Preliminary findings have suggested that more than 90 percent of the residents of the developments were able to live out the duration of their life in the development rather than in a nursing home. A more detailed study of the preliminary findings is expected.[16]

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of Housing and Urban Development, "Neville Place at Fresh Pond PowerPoint," Downloaded January 13, 2008. Available online at: http://www.hud.gov/offices/pih/pihcc/nevilleplace.ppt

[15] "Affordable Assisted Housing Project," Downloaded January 13, 2008. Available online at: http://www.ezrc.hud.gov/offices/pih/pihcc/affordableassistedhousing.ppt

[16] Pezzuti, Jim, Director, Division of Long Term Care Client Services, Department of Public Welfare, Commonwealth of Pennsylvania, "Telephone Interview," January 10, 2008.

Florida
With the opening of Helen Sawyer Plaza in 1999, the Miami-Dade Housing Authority (MDHA) overcame several funding obstacles and became the first housing authority in the nation to offer assisted living for elderly public housing residents by linking low-income housing subsidies with Medicaid funding. In 1998 MDHA asked the State of Florida Department of Elder Affairs to grant a waiver making Helen Sawyer's assisted living services eligible for Medicaid funding reimbursement.[17] Later that year, Florida's state legislature allocated $1.3 million in Medicaid funding to MDHA for elderly services provided at the Helen Sawyer Plaza Assisted Living Facility. [18]

New Jersey
New Jersey has created the "Assisted Living Program in Subsidized Housing." The program uses a Medicaid waiver that "enables individuals who (1) live in certain publicly subsidized housing; and (2) are at risk of placement in a nursing facility; and (3) meet income and resource requirements to receive a broad array of supportive and health services while residing in their own apartment. An individual continues to be responsible for rent, food and other household expenses." The program, however, limits participation to individuals who are "found to be in need of nursing facility level of care."[19]

Wisconsin
Wisconsin's Department of Health and Family Services and the Housing and Economic Development Authority have teamed with NCB Development Corporation to create "Wisconsin Affordable Assisted Living." This effort creates "Residential Care Apartment Complexes" that provide a combination of housing, meals, and support services for individuals with long term needs. One development created through the initiative is Garden Place in Milwaukee. It combines assisted living units and independent living units. Nearly all of the units are considered affordable through the LIHTC program with a large portion at a level for Medicaid eligible individuals. The development is located in one of five Wisconsin counties served by the Family Care program which provides an entitlement to the Medicaid Waiver funding in a managed care environment.[20]

Helen Sawyer, Garden Place, and the other projects and efforts detailed are merely examples of the benefits of strategically utilizing multiple funding sources and state programs to better connect affordable housing, health, and other supportive services. Taking such steps in Maryland can support the development of new communities like Stadium Place with greater ease

[17] Gardiner, Stephen H.: "Elderly Public Housing and Assisted Living: A Timely Collaboration for Aging Seniors," Center Point Foundation, 2004.
[18] Office of Policy Development and Research/HUD User, "Miami Housing Agency Brings Assisted Living to Frail Elderly," Fieldworks: January/February 2001. Available online at: http://www.huduser.org/periodicals/fieldworks/0201/fworks2.html
[19] State of New Jersey Department of Health and Senior Services, "Assisted Living Program in Subsidized Housing," Downloaded January 10, 2008. Available Online at: http://www.nj.gov/health/senior/alpsh.shtml
[20] The Wisconsin Coming Home Program, "Creating Affordable Assisted Living: A Coming Home Case Study," July 2006. Available online at: http://www.wiaffordableassistedliving.org/demonstrations/GardenPlaceReport06.pdf

by better connecting the resources needed to support the creation of the developments and the longer term needs of residents.

D. Task Force Charge: Investigate the use of Medicaid and Medicare funding for health care services needed by senior care facilities

The federal government, in conjunction with state and local administering agencies, provides a wide array of medical and health-related services and financial assistance for seniors and individuals with disabilities through Medicare and Medicaid. To be eligible for Medicare, a person must be 65 years or older, and that person or their spouse must have paid into the federal social security program for at least ten years. Younger individuals may be eligible for Medicare if they meet the social security requirements and have certain disabilities. Medicare covers a small amount of long-term care for a limited amount of time if the covered person requires skilled nursing, rehabilitation, or hospice care. It does not cover long-term care that is custodial in nature.

Medicaid is additional coverage made available for the poorest elderly. Medicaid income eligibility varies from state to state but generally is tied to the National Poverty Level. The majority of long-term care services are funded through Medicaid. Historically, Medicaid was available solely to individuals living in nursing home facilities. As the cost for providing nursing home care increased, efforts to redirect Medicaid assistance from nursing homes to community-based settings in the home or in assisted living facilities increased.

Medicare

Medicare is a federal insurance program that primarily covers acute care services like medical visits and hospitalizations. Medicare provides a limited amount of coverage for some services that may be described as long-term care. For example, Medicare provides coverage for a skilled nursing home stay of up to 100 days if the insured is receiving rehabilitation or skilled nursing services and if the insured transitioned to the nursing home following a hospital stay of at least three days.[21] Medicare does not cover custodial care in a nursing home. Medicare also covers home care if it involves skilled nursing care or rehabilitation, and hospice or end-of-life care. Medicare insurance is available to individuals 65 or over or individuals with severe disabilities if they have worked and paid into the Social Security fund for a specified period of time.[22]

For purposes of financing the cost of long-term care, Medicare plays a peripheral, but complementary role. Coordination of both acute and long-term care is highly desirable and some providers build upon this principle by offering Medicare covered services as well as long-term care services. Many continuing care retirement communities have medical staff and reimbursement mechanisms by which they can provide Medicare covered services and receive Medicare reimbursement. While this arrangement does not provide a financial reimbursement for traditional long-term care, it does provide the opportunity to coordinate care and maximize

[21] Centers for Medicare and Medicaid Services, "Medicare and You 2008," p. 13. Available online at: http://www.medicare.gov/Library/PDFNavigation/PDFInterim.asp?Language=English&Type=Pub&PubID=10050.
[22] Id.

reimbursement for Medicare covered services which frequently occur simultaneously with long-term care services.

Medicare payment models vary. The predominant Medicare payment model is a fee-for-service by which individual services are reimbursed at a set rate. Medicare Advantage plans are managed care plans that are funded on a per person basis (capitation) for each person enrolled in their plan with the rates being adjusted for age, acuity, and geographic area. The Medicare Advantage capitation payment may allow a provider to add additional support and long-term care services and care coordination that enhances the financial and medical efficiency of care. Meeting the regulatory and financial requirements to become a Medicare Advantage provider is challenging and may not be an option for smaller developer/providers developing campus based senior housing. However, there may be opportunities for smaller provider/developers to build partnerships with Medicare Advantage plans to provide services to their community residents.[23]

Another Medicare managed care option exists within the Program of All Inclusive Care for the Elderly (PACE) program[24], an example of which is operated by Hopkins Bay View. The goal of the PACE program is to assist people to remain independent in the community as long as possible. However, if the person requires nursing home care the PACE program pays. The PACE program is primarily for individuals who are financially eligible for Medicaid and whose diagnostic and functional conditions make them eligible for nursing home care. PACE programs receive a per person payment both from Medicare and Medicaid. The Medicare rate is enhanced based on the frailty and acuity level of participants. The two payments from Medicare and Medicaid for a given individual are used to pay for all services, acute and long-term care for participants. PACE programs can provide services for non-Medicaid eligible people in which case the individual must pay the Medicaid per person payment. The private pay model has been difficult to market. By federal regulation, the PACE program is limited to serving eligible residents within a specified geographic area. The PACE program in Baltimore is limited to fifteen zip codes adjacent to the John Hopkins Bayview Medical Center service site. Participants must agree to disenroll from any other Medicare or Medicaid plan or optional benefit. DHMH notes that the program is under-enrolled and efforts to expand the service have not been successful. As with all DHMH Medicaid programs, to qualify for PACE, the individual must meet the level of care required to qualify for nursing facility services.

To summarize, Medicare can play a role in financing services and providing coordinated medical care for seniors residing in campus based communities. However, with the exception of specially designed programs like PACE, it does not provide financial reimbursement for long-term care. Medicare coverage is limited to acute and skilled nursing care. An additional limitation to using Medicare for low income residents is that some populations may not qualify for Medicare coverage based on their lack of a work history in the United States.

[23] U.S. Department of Health & Human Services, "Medicare Overview," Downloaded January 10, 2008. Available online at: www.medicare.gov/choices/overview.asp

[24] U.S. Department of Health & Human Services Centers for Medicare & Medicaid Services, "Program of All Inclusive Care for the Elderly: Overview," Downloaded January 10, 2008. Available online at: http://www.cms.hhs.gov/PACE/

Medicaid
The Maryland Department of Health and Mental Hygiene oversees the provision of Medicaid services in Maryland through a Medicaid State Plan and through Community-based Service Waivers. The Maryland Medicaid State Plan pays for acute and rehabilitative services and long-term care such as custodial care. Medicaid State Plan long-term care services range from nursing home care to adult day care to care in the person's home; the Medicaid State Plan does not cover facility-based assisted living. Home health care covered by the State Plan includes in-home skilled nursing care, aide services, physical or occupational therapies, and it may cover the cost of medical supplies consumed during the service. State Plan home health care may only be provided in the senior's home and is an entitlement service provided the senior is determined to be "community based Medicaid eligible".

A senior may also receive Medical Assistance Personal Care services provided he or she demonstrates a deficit in self-performance of an "activity of daily living (ADL)," such as bathing, eating, continence, dressing, and mobility. As with State Plan-covered home health care, personal care services are entitlement services and must be provided in the seniors' home. There are no costs to seniors for either State Plan home health care or State Plan medical assistance personal care services. Medicaid will also cover the costs of physician ordered medical equipment or supplies for use in the home.

Medical Day Care is another Medicaid State Plan entitlement service that is provided in licensed adult medical day care facilities. The senior must be determined to require a nursing facility level of care; that is, a medical need, functional or cognitive deficit that qualifies them for Medicaid funded nursing facility services. Medical Day Care provides a minimum of four hours a day of service including nursing, assistance with ADLs, snacks and transportation. This service can be coupled with home health care discussed above.

Finally, Maryland offers several Home and Community-based Medicaid Waivers including one that is specific to seniors, the Medicaid Waiver for Older Adults. Waivers enable Medicaid funds to pay for the coverage of a broad array of home and community-based services (HCBS) for targeted populations as an alternative to institutionalization. The Medicaid Waiver for Older Adults is administered by the MDoA and provides services for adults age 50 or above to live at home or in an assisted living facility. The waiver has reached capacity and interested persons are placed on the Waiver Services Registry. As of December 2007, there were 10,472 people listed on the Waiver Services Registry. DHMH reports that approximately 25 percent of those contacted apply and access the service. Active waiver enrollment is maintained at around 3,000 participants during the year so that the annual limitation of serving 3,750 unduplicated individuals will not be exceeded. Approximately 700 participants enter the waiver program each year. However, an individual who has been in a nursing home, paid for by Medicaid, for at least 30 consecutive days can apply for the Older Adult waiver regardless of the cap.[25]

[25] The state offers six other waiver programs, including the Living at Home and Community Pathways waivers, to assist individuals of all ages with disabilities, including developmental disabilities. All waiver participants have access to the services specific to their waiver as well as traditional Medicaid services including prescription drugs, physician care, and hospital services. Medicaid waivers will cover the cost of a broad array of medical and health care services.

Medicare and Medicaid for Urban Senior Care Communities

Three primary options are available to connect affordable housing and health services in an urban senior care community. They include using 1) provider-based services; 2) Medicaid Waiver Services; and 3) co-locating affordable housing and medical services.

1. Provider-Based Services
   Medicare and Medicaid services can be connected with affordable housing in an urban senior care community but that connectivity is currently based on the eligibility of the individual. Affordable housing can be assembled and subsidized to very low levels through various government programs (See Section VII). However, non-nursing home subsidized medical services through Medicaid and Medicare are not "tied" to a residential unit. An individual is qualified for the housing unit and for the medical services separately. The disconnect between the funding sources makes it difficult to create a senior care community that connects housing, medical, and other services at a facility as is usually provided in retirement communities.

2. Waiver Services
   A second option in connecting affordable housing to medical services can be achieved through greater utilization and potential expansion of the Medicaid Waiver Programs. The Waiver programs, particularly the Older Adults Waiver, allow for the provision of covered services to be administered in places other than institutions. There are many barriers, however, that need to be overcome at both the federal and state levels.

   Some of the barriers to marrying existing affordable housing programs with affordable medical services funded through a Medicaid waiver are systemic and apply across the country. One example of a systemic problem is that Medicaid prohibits the room and board to be considered a covered service. Under federal rules, Medicaid does not cover room and board and therefore cannot be used to help participants cover rent payments for affordable rental or assisted living units. Room and board must be paid by the consumer. In Maryland, the Older Adults Waiver currently limits room and board payments for participants in assisted living facilities to $420 per month. Under the Waiver, a participant can retain up to $486/month of their income to cover room, board, and other personal needs. All other incomes must be paid toward the cost of care. The allowable room and board payment is rarely sufficient to cover the typical rent on an assisted living unit.

   A second barrier relates to the high definition of eligibility for the waivers. Federal law requires that only persons eligible for nursing home care are eligible for waivers.[26] Application of the federal definition is set by a combination of both federal and state laws, standards and practices. These standards and practices may vary by state. An analysis and interpretation of comparative standards is outside the purview of the Task Force. However, exploration of this standard at both the federal and state level warrants attention as it provides a potentially strong opportunity to better connect

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[26] 42 U.S.C. § 1396n(c)(1); see 42 C.F.R. § 435.217

Medicaid services to individuals in an affordable senior care community.

The implications of broadening eligibility levels could be costly as more individuals would be eligible to utilize the program. However, there may be some ways to create cost savings if eligibility standards are expanded. One area for exploration is if greater non-medical services are permitted to be incorporated under the Waiver, assisted living providers may be able to staff residences with more non-medical personnel. A second way to achieve cost savings may be through greater utilization of the Medicaid Waiver for Older Adults. According to a report by the Maryland Department of Health and Mental Hygiene to the Centers for Medicare and Medicaid Services, the average Medicaid cost per nursing home resident is $58,000 while the average cost for a waiver recipient is $30,339.[27] The waiver has a limit on enrollments, set by statute at 7,500 but restricted to approximately 3,000 based on funding availability. Study should be given to whether the less restrictive standard, offset with greater utilization of the Medicaid Waiver for Older Adults, would produce long-term savings while also enabling seniors to avoid unnecessary stays in nursing homes. The feasibility of project-basing waivers, much like Section 8 Housing Choice Vouchers, should also be explored. Preferences for consumer-based waivers may expand the housing choice for the senior who receives the waiver but makes it infeasible to develop affordable assisted living communities.

3. Co-Locating Housing and PACE Programs
   A third option to better connect Medicaid and Medicare services follows Pennsylvania's model. As noted above, Pennsylvania proactively works with housing and service providers to co-locate affordable housing with PACE programs. Only one PACE program is available in Maryland and serves residents of 15 zip codes near Hopkins Bay View Hospital. The National PACE Association argues that better connecting PACE with senior housing "provides seniors with easy access to health care and related services, allows frail elders to age in place, and avoids premature placement in nursing facilities."[28] But co-locating housing and PACE programs is not a silver bullet. PACE program participants must also meet a nursing home level of care. In addition, participants must agree to disenroll from any other Medicare or Medicaid plan or optional benefit.

Development of senior care communities that meet the needs of Maryland poor, frail elderly will require a reevaluation of how medical services connect with affordable housing. While the major hurdles are federal, there is work that can be done at the state level that would facilitate future efforts to create affordable senior care communities.

Other Key Service Resources
Congregate Housing Services Program

[27] Department of Health and Mental Hygiene, "Annual Report for Maryland Home and Community Based Waiver for Older Adults – Control No. 0265.90"
[28] The National PACE Association, "Model State Practices for PACE," February 2004. Available online at: http://www.npaonline.org/website/download.asp?id=208

MDoA has administered a Congregate Housing Services Program (CHSP) in Maryland since 1976. The goal of CHSP is to assist people to remain independent in the community as long as possible. The CHSP program is believed to delay or divert nursing home and assisted living facility transitions. Delaying and diverting such transitions can foremost serve to increase the quality of life for service users but it can also have a positive fiscal impact on both the resident and the government agencies subsidizing the costs of higher care. For instance, the average annual cost to the state for one CHSP participant in 2007 was $2,979 where as the cost of nursing home is approximately $58,000. The average length of stay in CHSP is 2.29 years.

Participating residents must be 62 years of age and older and require assistance with one or more activities of daily living. The average age of CHSP participants is 82 years. Services are provided by nonprofit or for-profit organizations including housing owners, property management companies, or local housing authorities. A standard service package includes 2-3 meals daily, weekly housekeeping and laundry assistance, and an hour or more of personal assistance with activities of daily living like bathing, dressing, making medical appointments, etc. Other programs can be coordinated or added on to CHSP, such as Senior Care, In-Home Aid Services, Medicaid services, acute care, PACE coverage, etc. Fees for the services average $500 but costs are based on a sliding scale based on the household's net monthly income. This element can help to expand programmatic resources by cross-subsidizing payments from higher income participants to lower-income participants.

Case Study – A CHSP Participant Profile

Ms. L is an 85-year-old African-American single female with uncontrolled hypertension, bi-lateral venous insufficiency and leg edema. She also suffers from mild dementia. Since July 2001 Ms. L. has been a resident of Good Samaritan Senior Housing at Belvedere Green in Baltimore City. However in 2006, Ms. L. had multiple hospitalizations. Her chronic medical conditions made it very difficult to perform basic household and personal care functions. In addition, she has no family and no support network. Despite this situation, Ms. L. was resistant to accepting help. In response, the CHSP Coordinator provided counseling to help her accept the supportive services needed to remain living at Belvedere Green. The coordinator also arranged for a psychiatric evaluation for Ms. L. and worked closely with her primary physician. Once Ms. L was medically stable, she accepted CHSP services, i.e., daily meals, weekly housekeeping and laundry, and personal assistance. Since Ms. L has been receiving CHSP services, she does not need a higher level of care. She is managing well and is able to maintain her independent lifestyle.

The program is limited in further application by costs and its $1.7 million budget. There is currently a backlog of 42 buildings on the waitlist. At this time, funding for expansion is awarded through a competitive bid process.

E. Task Force Charge: Investigate the use of tax credits to provide incentives for private sector to develop senior care facilities

Low Income Housing Tax Credit

Across the country and in Maryland, the LIHTC is the primary financing tool for the production of affordable rental housing. Since its creation in 1986, the LIHTC has played a central role in the construction and renovation of hundreds of thousands of units of affordable housing for families and seniors. In Maryland, the LIHTC represents nearly $100 million of annual

investment in affordable rental housing, by far the most valuable resource for this purpose in the state.

Key to the success of the LIHTC is its ability to leverage private-sector resources for affordable housing production. Additionally, the LIHTC brings the rigors and efficiencies of the private sector to the development process, thereby enhancing its ability to produce affordable housing units.

The LIHTC leverages private-sector resources in two ways: first, the LIHTC is a valuable resource in its own right for private sector investors. The LIHTC allows private sector investors to reduce their federal tax liability on a dollar-for-dollar basis, while also providing tax deductions allowable for passive real estate investors. In exchange for these benefits, LIHTC investors provide "equity" toward the cost of acquiring, renovating or constructing affordable housing developments. Second, the LIHTC establishes a conventional real estate ownership structure that enables affordable housing projects to leverage conventional debt financing.

As the marketplace for the LIHTC has grown and matured over the past 20 years, the affordable housing industry has shown that projects financed by the LIHTC are strong performers with relatively low investment risk. As a result, the LIHTC has become a more valuable commodity, providing greater and greater values for affordable housing development. Presently, the LIHTC can typically be expected to provide equity sufficient to provide for approximately 70 percent of the total cost to acquire, renovate, and construction an affordable housing development.

The increasing value of the LIHTC – as well as its ability to leverage conventional debt financing – has been critical to the ongoing success of the affordable housing industry. In an era of declining federal support for affordable housing programs, the LIHTC is a rarity: a reliable source of financing that is embraced by both the public and private sectors.

LIHTC Program Rules

One of the strengths of the LIHTC is its narrow programmatic focus. Only affordable rental housing developments are eligible for the LIHTC. Understanding the definition of "affordability" and "rental housing" is essential in capturing the extent to which the LIHTC can (and cannot) be used for Senior Care Facilities.

"Affordability" relates to both the rents charged to households living in LIHTC-assisted projects and the income level of the household living in an assisted unit. From an income perspective, households living in LIHTC-assisted units must have annual incomes at or below 60 percent of the Area Median Income for the geographic region in which the project is located. And the rents charged for LIHTC-assisted units may not exceed a level affordable to a household with an income of 60 percent of the Area Median paying 30 percent of their monthly income for rent. This dual approach to restricting both the income of households and rents of units ensures that the LIHTC is fulfilling its mission of producing affordable housing for low-income residents.

"Rental Housing" is a more difficult definition to grasp. The LIHTC may only be used for housing units that are qualified as "residential rental property" under the U.S. Tax Code. This

definition specifically excludes hospitals, nursing homes, and other facilities which provide continual and frequent medical, nursing and psychiatric services.

Tax Credit rules also require states to establish a preference for housing for families. Maryland addresses this requirement in its Qualified Allocation Plan (QAP) by providing points for family projects. Projects for seniors, however, have received significant LIHTC allocations. Over the past 10 years, more than 40 percent of the projects funded with LIHTC have been for seniors.

Finally, it is important to recognize that LIHTCs may only be used for affordable housing developments that meet "minimum set-aside" requirements. Specifically, a LIHTC-assisted project must select one of two minimum set-asides: 1) at least 40 percent of the units must be restricted for households with incomes below 60 percent of the Area Median Income (AMI), or 2) at least 20 percent of the units must be restricted for households with incomes below 50 percent of AMI. While most LIHTC-assisted projects select to restrict units in excess of these minimums, the LIHTC is clearly a tool that can be used to create mixed-income communities serving households with a range of incomes.

LIHTCs for Senior Care Facilities

The LIHTC's restrictive definition of rental housing is a challenge for the financing of senior care facilities. In the spectrum of housing options at senior care facilities, the LIHTC is a potential financing tool for independent-living units and assisted living units, but not for nursing home and medical facilities.

The use of the LIHTC for assisted living facilities is an area of great complexity and potential pitfalls. While a number of potential issues are outlined below, the most fundamental barrier associated with using the LIHTC to finance assisted living facilities is the mismatch between the maximum allowable rents and the operating costs. While maximum monthly rents range from $600 to $800 per month for LIHTC projects, the monthly operating costs for assisted living facilities are in the $2,500 to $3,000 range.

In addition to this operating funding mismatch, some of the other barriers in the use of LIHTC for assisted living facilities include:

- <u>Level of Services</u> – as noted above, the LIHTC can only be used for residential rental housing, the definition of which excludes facilities which provide continual and frequent nursing, medical and psychiatric services. Assisted living facilities must be certain to avoid a level of service that encroaches on this definition. However, minimum service requirements to qualify for licensing of the facility by the state may create significant tensions on this issue. Broadening eligibility levels for Medicaid waivers, as discussed in Section VI, could also have implications. Based upon the state of the law in 2004, Novogradac & Company, an accounting firm specializing in the LIHTC concluded that "a project will fail to constitute rental property [see discussion above] if the residents receive continual or frequent nursing, medical, or psychiatric services. The provision of significant non-housing services, including meals and various support services, do not prevent treatment of an Assisted Living Facility as a residential rental property for low-

income housing tax credit purposes if the services do not include continual or frequent nursing, medical, or psychiatric care."[29]

- Unit Design – Meeting the definition of residential rental housing means that units in assisted living facilities would need to include full kitchens and bathrooms. Often, this higher level of amenities is not consistent with conventional designs of assisted living facilities. Specifically, shared-occupancy units and facilities with common kitchens will not comply with the requirements of the LIHTC.

- Service "Optionality" – LIHTC-funded projects cannot "mandate" that residents accept and pay for services outside of their required rent payment. As a result, it is difficult to predict the amount of funding that can be expected from residents to fund the operating funding mismatch noted above.

- LIHTC Income Restrictions and Medicare/Medicaid Funding – The income restrictions on residents of LIHTC projects can conflict with the income eligibility rules for Medicare and Medicaid funding, the primary source of client payment.

- LIHTC Developments Meet Public Purposes but are also Real Estate Investments - LIHTC developments rely not just on the tax credits to leverage equity for financing but often incorporate a range of conventional debt financing that is repaid over time. Though meeting affordability goals, the projects are fundamentally a real estate development and bring with it a market based economic incentive to push rents to the upper limits of what is allowable which serves to maximize the amount of conventional debt that can be leveraged. This is especially true for projects funded solely by bonds and 4 percent credits. However, DHCD's QAP and preferences for income targeting do provide incentives to developers to push down the rents to more affordable levels. In these cases, however, the lower income targeting results in a need for gap financing which is sometimes provided through a local contribution or state rental housing funds. Thus, LIHTCs on their own do not necessarily provide adequate funding to finance an entire development at income levels in line with Medicaid eligibility.

Clearly, the LIHTC is a powerful tool for financing affordable rental housing. However, its flexibility of use is limited and significant barriers exist in its use for Senior Care Facilities. Finding the right fit for the LIHTC as one of many financing tools for a Senior Care Facility is essential to its successful use.

Other Key Housing Resources

Though the Task Force was charged with looking specifically at tax credits to help incentify the private sector to develop senior care facilities, it became evident that several other housing resources should be highlighted. This is particularly true not just because of the limitations of the LIHTC highlighted above but also because these other resources provide a financing alternative, often reach deeper incomes, and are being utilized by other states in conjunction with

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[29] Novogradac & Company, LLC, "Tax Credits & Assisted Living, 2004," Novogradac & Company, 2004, pg 17.

Medicaid to better align medical and affordable housing resources. Additionally, the LIHTC does not provide sufficient funding by itself for the creation of senior care facilities.

State Tax-Exempt Bond Financing
DHCD, through the Community Development Administration, has the ability to issue tax-exempt bonds for affordable rental housing developments. These bonds can be used to fund loans to finance the construction, acquisition and renovation of affordable housing. Their tax-exempt status enables the bonds to carry interest rates approximately one percent to two percent below conventional mortgage rates, making them an attractive vehicle for funding first mortgage debt. The most attractive feature of tax-exempt bonds, however, is their ability to leverage the "automatic" four percent LIHTC. While not as valuable as a the conventional LIHTC, the 4 percent LIHTC can provide equity valued at approximately 30 percent of the total cost of acquiring, renovating and constructing affordable housing.

State Rental Housing Funds
DHCD allocates approximately $18-20 million statewide on an annual basis for affordable rental housing through the Rental Housing Fund. The vast majority of Rental Housing Funds, which include a share of the federal HOME Program appropriation for the state, are awarded in concert with the LIHTC through competitive funding rounds. While these funds are used regularly for senior housing (and were used to fund several phases of the Stadium Place development), the relatively limited amount and highly competitive nature are significant barriers to their reliable use for Senior Care Communities.

Federal Section 202 Supportive Housing for the Elderly
Section 202 housing is the primary U.S. Department of Housing and Urban Development (HUD) program to develop housing designed specifically for older residents. The buildings constructed through the program are age restricted to individuals 62 and older and who have incomes below 50 percent of AMI. According to the AARP, nationally, the average 202 resident's age is 79 and has an average annual income of $10,018.[30]

Section 202 funds come in the form of interest-free capital advances provided to private and nonprofit sponsors. The funds do not have to be repaid as long as the project serves very low-income elderly residents for 40 years. In addition to the capital funds, rental assistance funds are available for limited durations and renewable based on the availability of funds to help cover the difference between the tenant's contribution towards rent and the operating cost for the project.[31] However, resources are limited. Federal appropriations provide for roughly one or two Section 202 awards each year for the entire Baltimore region. In addition, newly approved properties average 60-70 units, so scale is limited. The housing is designed to allow the residents to live

[30] Bright, Kim, "Housing Affordability: Section 202 Supportive Housing for the Elderly," AARP: March 2006. Available online at: http://www.aarp.org/research/housing-mobility/accessibility/fs65r_housing.html
[31] U.S. Department of Housing and Urban Development, "Section 202 Supportive Housing for the Elderly Web Page," Downloaded December 31, 2007. Available at: http://www.hud.gov/offices/hsg/mfh/progdesc/eld202.cfm

independently but in manner that allows the residents to tap into additional support for cleaning, cooking, transportation, and other needs.[32]

HUD's funding goes primarily to the construction and maintenance of the real estate element of the development. While some service assistance is available from HUD, it is limited to newer 202 properties and limited in amount. The HUD Service Coordinator Program is also available to connect residents to supportive services to allow them to continue living independently but it too is limited to an annual competition for the available resources.[33] Section 202 sponsors can provide supportive services on their own but often the nonprofit sponsors have limited capacity to fund the services. This can become an issue as residents capable of independent living at initial occupancy age in place and come to be no longer suitable for an independent living environment. Finally, as a barrier to leveraging universal services for residents, HUD rent limits and calculations serve to prohibit the bundling in of supplementary services, such as meals, as a mandatory component of rent.

HUD's Section 202 Supportive Housing for the Elderly Program is a potential alternative to the utilization of the LIHTC to fund the housing component of an urban senior care community. Supportive services provided by HUD are available but are extremely limited. However, adding services to help residents who are no longer capable of living independently but do not yet qualify for Medicaid is difficult. This is due in part to HUD's rent calculations, rent income limits, and the extremely low-income nature of the residents.

Federal Public Housing Funds
HUD allocates two sources of funds for public housing: capital funds and operating funds. These funds are provided to local housing authorities including the Housing Authority of Baltimore City which will be discussed in the next section. It should be noted, that under "mixed finance" rules, public housing units may be included in a LIHTC development. Public housing operating funds associated with a public housing unit help to subsidize the cost to operate the unit, and there are many examples of supportive services being provided in public housing from around the country.

F. Baltimore City Resources and Regulatory Environment

The Task Force was charged with explicitly exploring the feasibility of creating urban senior care communities in Baltimore City. The resources discussed above can be leveraged throughout any Maryland jurisdiction. This section focuses on housing resources available in Baltimore City and the challenges with accessing those resources for the creation of urban senior care communities in Baltimore City.

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[32] U.S. Department of Housing and Urban Development, "Section 202 Supportive Housing for the Elderly Web Page," Downloaded December 31, 2007. Available at: http://www.aarp.org/research/housing-mobility/accessibility/fs65r_housing.html.
[33] U.S. Department of Housing and Urban Development, "Section 202 Supportive Housing for the Elderly Web Page," Downloaded January 1, 2008. Available at: http://www.aarp.org/research/housing-mobility/accessibility/fs65r_housing.html.

Public Housing
As noted above, several states and housing authorities have moved to better integrate public housing with supportive services funded by Medicaid or by other federal, state, or local funding sources. Baltimore City has one of the largest public housing portfolios in the nation and this housing resource is an alternative means to subsidize the housing component of an urban senior care community. This is particularly true because the income of the population of residents it serves is in line with Medicaid eligibility. In addition, public housing incorporates both operating and capital support from the federal government, although funds are limited and in high demand.

The population served by Housing Authority of Baltimore City's (HABC) public housing units totals more than 20,000 residents including more than 3,000 residents over the age of 62.[34] Senior headed households, however, comprise 28 percent of all households served by public housing. The average household income served by the public housing units ranges depending on the type housing. For example, senior only buildings have an average income of $9,125 while family developments average $12,999.[35]

Seniors have three public housing options. They may live in:

- One of two Senior-only buildings for residents age 62 and older
- Mixed Population buildings that serve persons 62 years and older as well as non-elderly persons with disabilities who are under the age of 62.
- Family developments that serve families – a term that is defined to include elderly persons who are single.

One element to take note of, public housing is provided at a fixed location on property owned by the local housing authority. A local public housing authority is thus a potential partner in the creation of an urban senior care community but such a role would have to conform to regulations issued by the U.S. Department of Housing and Urban Development ("HUD") the local regulatory environment, and resource availability.

Housing Choice Vouchers
The Housing Choice Voucher program, also known as Section 8, is a rental assistance program that is an alternative to public housing for residents with incomes at 50 percent of AMI or less. HABC administers 10,000 Housing Choice Vouchers (which include more than 1,300 households headed by residents over the age of 62.[36] The vouchers provide rental assistance at a rate equal to the difference in the rent charged by the landlord and the participants' rent obligation, which is 30 percent of their adjusted gross income. Landlords may not exceed Fair Market Rents established by HUD and the rents must meet rent reasonableness standards as determined by the PHA. Program participants receive the rental assistance vouchers and they have the choice to live in any housing that meets the requirements of the program where the landlord accepts the voucher.

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[34] Baltimore Housing
[35] Baltimore Housing is the umbrella name for the Housing Authority of Baltimore City (HABC), which manages the City's public housing portfolio, and Baltimore City's Department of Housing and Community Development.
[36] Baltimore Housing

A unique feature of Housing Choice Vouchers is that a housing authority may "project base" up to 20 percent of its allotment so that the vouchers may be targeted to a specific development instead of moving with the tenant. Through the program, a public housing authority can enter in a housing assistance payments ("HAP") contract with the owner of a housing development for a portion of or all of the units in the development for a specified term. The initial term of the HAP contract may not exceed ten (10) years although the parties may agree to extend the contract when the initial term ends. Families from the PHA's waiting list are then referred to the project owner to fill vacancies. Housing Choice Vouchers can be used to subsidize rent in an assisted living community but can not be used to pay for the services.

Other Key Housing Resources
Two additional affordable housing resources controlled by Baltimore City are of significant interest.

1. *PILOTs* - As a mechanism to support the Inclusionary Housing legislation, the Maryland General Assembly approved legislation in 2007 that gives Baltimore City the authority to accept a Payment in Lieu of Taxes (PILOT) to help a developer offset the costs of creating affordable rental housing units in a market rate development.

2. *Tax Increment Financing* - In 2004, Baltimore City gained a unique authority to utilize Tax Increment Financing (TIF) to help finance the creation of "bricks and mortar" construction costs of affordable housing units. TIF can also be used to help finance the infrastructure of a housing development.

Other Services
HABC does offer supplementary services to the residents of public housing units. The services include Family Enhancement Services, which connects residents to counselors, Congregate Housing (discussed in Section VI), the Building Communities Initiative, and the Cybernet Computer Program. A range of services are also provided in partnership with other organizations and resident councils such as PATCH, Golden Age Clubs, as well as Health Education, Screening, and Visiting Nurses. The Building Communities Initiative is of particular note. It is a recent effort to address the growing challenge of social integration of two populations, senior residents and non-elderly persons with disabilities, through utilization of tools such as community boards and volunteers. This Initiative is the result of the increase in the number of non-elderly persons with disabilities and seniors living in the same buildings.

Regulatory Environment – Consent Decrees and Inclusionary Housing
Three layers of regulation are unique to Baltimore City and will have significant bearing on the creation of an urban senior care community. HABC is operating under two consent decrees – known as Bailey and Thompson – that place obligations on the utilization of several key affordable housing resources including public housing funds, LIHTC, and housing choice vouchers. In addition, Baltimore City recently passed an Inclusionary Housing law that requires varying set asides of affordable housing depending on the nature of development and its sources of funds.

1. The Bailey Consent Decree, entered into between HABC, the Maryland Disability Law Center and US Department of Justice in 2004, prohibits HABC from creating any more senior-only housing during the term of the consent decree. It also requires HABC to affirmatively advise non-elderly persons with disabilities that they are eligible to live in the HABC owned mixed population buildings. In addition, the Consent Decree includes requirements on the utilization of Housing Choice Vouchers, LIHTC, and HOME Funds. Required actions include:
    a. The provision of 850 tenant based vouchers to non-elderly persons with disabilities and the creation of 500 units subsidized with project based vouchers for non-elderly persons with disabilities.
    b. For a period of ten years, HABC and Baltimore City are to support the award of LIHTC for those projects that will create a minimum of 15 percent of the total project LIHTC units as one bedroom units reserved for non-elderly persons with disabilities.
    c. For a period of 10 years, 11.5 percent of Baltimore City HOME funds will be used to stimulate the creation of the 500 project based voucher units for non-elderly persons with disabilities through the new construction, acquisition, or rehabilitation of rental housing opportunities.[37]

2. The Thompson Partial Consent Decree, entered into by HABC, the City of Baltimore, HUD and the American Civil Liberties Union of Maryland in 1996, has implications for the utilization of public housing funds from HUD as well as state Partnership Rental Housing Program funds. Acquisition and rehab and new construction of public housing using these funds may only occur in Non-Impacted Areas. Non-Impacted Areas are those census tracts with no more than 30 percent African American, no more than 10 percent below the poverty line, and no more than 5 percent in assisted housing. Only a small percentage of the census tracts in the City meet the definition of Non-Impacted Areas.[38]

3. Inclusionary Housing, passed by Baltimore City Council in 2007, requires the inclusion of affordable housing units for certain types of new development. Three different development scenarios are impacted by the legislation. The first category includes developments of 30 or more units that utilize public subsidies. In this case, at least 20 percent of the units in the project must be affordable with the affordability ranging based on whether or not it is a rental development or a for sale development. If a project is a planned unit development (PUD) that increases the permitted number of units by 30 or more – or if the project is a rezoning that permits residential units where none were previously permitted – at least ten percent of the units in such projects must be affordable in varying tiers. The third category includes projects providing 30 or more units that do not receive any public subsidies or zoning action from the City. In such cases, at least 10

[37] Summary of the Bailey Consent Decree provided to the Task Force by Baltimore Housing officials on December 13, 2007.
[38] Summary of the Thompson partial consent decree provided to the Task Force by Baltimore Housing officials on December 13, 2007.

percent of the units must be affordable to households at or below 120 percent of AMI.[39] Application rules vary and include cost offsets as well as density bonuses depending on the development type and costs.

Together, the consent decrees dictate that the utilization of key housing resources in Baltimore City will necessitate that a proposed public housing development be in Non-Impacted Areas and include units for non-elderly persons with disabilities. In addition, because the affordable housing resources are linked to the achievement of objectives of the consent decrees, capacity to leverage these affordable housing resources may be limited.

The implication of the Inclusionary Housing law on the creation of senior oriented buildings, communities, and homes is unclear. Cost offsets, such as PILOTs, density bonuses, as well as the creation of an Inclusionary Housing Fund are anticipated to be made available to help underwrite the costs of creating affordable housing but not the costs of providing medical and other services. Waivers of the requirements are provided under certain circumstances. Regulations for application of the Inclusionary Housing law are still under development.

Overall, housing resources controlled by the City of Baltimore and the Housing Authority of Baltimore City can provide additional subsidies that align with the income eligibility requirements for Medicaid. However, much of the affordable housing resources in Baltimore City, in addition to the provision of federal LIHTC by the state, are highly intertwined into the two consent decrees. The creation of urban senior care communities utilizing public resources in the near term will likely need to meet the obligations of the consent decrees. In addition, Baltimore City's Inclusionary Housing law adds the potential for further obligations on the developer of a senior care community. It may, by law, build in affordable units into a market driven senior care community. However, the implications of the Inclusionary Housing law as a whole ultimately will depend on the nature of the proposed urban senior care community and the final regulations that are adopted by the City as they apply to the particular development type.

[39] Baltimore City Task Force on Inclusionary Zoning and Housing, "At Home in Baltimore: A Plan for an Inclusive City of Neighborhoods," Citizens Planning and Housing Association, July 2006. See also Laria, Jon, "Baltimore Passes Inclusionary Housing Law," June 19, 2007. Available online at: http://www.ballardspahr.com/press/article.asp?ID=1742

IV. Summary of Task Force Findings and Recommendations

Putting together affordable housing subsidies in connection with Medicaid and Medicare services in an urban senior care community in Baltimore City is a challenging endeavor. A myriad of federal, state, and local regulations accompany the funding sources necessary to build in affordability. The following findings and recommendations are offered for Maryland to consider as first steps towards aligning the disparate resources.

Findings

The number of seniors in Maryland will increase. This will increase demand for senior related housing and services including demand for government assisted housing and medical benefits. These needs may be particularly acute in Baltimore City, where poverty rates are significantly higher. This demand comes in the face of an existing shortfall of affordable housing in Baltimore City and throughout Maryland.

The retirement of baby boomers presents a growth opportunity that Baltimore City can leverage. The City's regulatory environment will place obligations and requirements on the development of an urban senior care community but these obligations are an opportunity to create housing affordable to a broad range of incomes and to meet other needs.

Recommendations:

1. Maryland state and local governments should continue to ascertain the programmatic and fiscal impact retiring baby boomers will have on Maryland. A recent report entitled "Long-Term Services and Supports in Maryland: Planning for 2010, 2020, and 2030" by the Maryland Health Care Commission explores in detail many of the long-term needs and options to assist seniors in Maryland. This report should be fully evaluated by State leaders.
2. MDP and the DHCD should work with City planning and development officials to ascertain the availability of attractive sites that can support an urban senior care community. Site considerations should include proximity to alternative transportation options, neighborhood and cultural amenities, health care facilities, a marketable area, and a site large enough to accommodate 500 to 1500 housing units.

Findings

Because of the historical separation of housing and medical programs, there are three primary options to connect affordable housing and health services in an urban senior care community, including 1) an affordable housing resident utilizing provider based services; 2) expanding Medicaid Waiver services to reach more households; and 3) co-locating affordable housing and medical services.

Programs to reach or expand populations served are created within the two funding and administratively separate silos of housing and medical services. This historical track of development makes it difficult to integrate the two areas, though there is little disagreement today on the need to do so. Some new models have emerged such as continuing care retirement communities which connect housing and health services in one fee, however affordability remains a challenge. There are efforts nationally, as described above, to integrate affordable housing and services but Maryland's achievements in this area are limited. Stadium Place serves

as perhaps the best and still emerging example. Its success has been possible in part through the mission driven role of its developer, a unique land opportunity, as well as its ability to tap into complementary financial and service support mechanisms.

This separation of services is exacerbated by the lack of connectivity between two of the key programs providing services for very low-income households, Medicaid and the Low Income Housing Tax Credit (LIHTC). Medicaid does not cover room and board costs. The LIHTC cannot be used in a nursing home or assisted living facility. Even if the LIHTC could be used, the maximum rents covered by the LIHTC are much lower than monthly assisted living costs.

Utilization of the LIHTC often requires additional state, federal or local subsidies to create a development at a scale with ample units to house Medicaid eligible residents. In addition, the LIHTC preclude the funding of facilities that provide continual and frequent nursing, medical and psychiatric services. Medicaid's high eligibility standard, requiring a person to be eligible for a nursing home level of care, limits program use. Limited federal and state appropriations inhibit the expanding use of the LIHTC as well as Medicaid, particularly the Medicaid Adult Waiver Program.

Alterations to Medicaid and LIHTC programs are difficult because both state and federal statutes and regulations apply to each of the two programs. Nonetheless, housing and service industries and government agencies need to work more closely to expand models and options and to see housing and services as a "whole" in creating integrated operational and financing models. It is particularly important to use this integrated concept for elderly populations as we move forward with national and state initiatives that enable people to age in place.

Maryland is fortunate to have a forum in place that connects various departmental activities to address aging issues. Section 10-301 of the Human Services Article establishes the Interagency Committee on Aging Services which includes the Secretaries of Aging, Disabilities, Health and Mental Hygiene, Housing and Community Development, Human Resources, Labor, Licensing and Regulation, and Transportation. The Committee is charged with developing and updating a plan for providing coordinated health services, social services, transportation, housing and employment services to seniors in the state.

Recommendations:

3. Expand resources for the LIHTC (federal) and the Medicaid Older Adult Waiver Program (state).
4. Consider establishing a special workgroup within the Interagency Committee on Aging to make recommendations on how the state can improve its programmatic linkages between affordable housing developments, Medicaid, services and other publicly funded programs. Participation by local affordable housing providers should be considered.
5. The Interagency Committee on Aging should report, in its annual report, on the steps taken or impediments to addressing:
   a) Efforts to better connect Medicaid and the LIHTC.
   b) "Project basing" Medicaid waivers like Section 8 Housing Choice vouchers. A limited set of providers could set aside a limited percentage of rooms to allow residents to age in place as their needs progress. This would essentially provide the

facility with a steady and reliable stream of income to cover the cost of services provided to the unit's occupant. It also guarantees the availability of an affordable assisted living spot for those seniors who cannot afford to pay market-rate rents.

c) An increase of the amount of income a consumer can retain to cover room and board or raising the amount allowable for room and board in assisted living facilities.
d) An evaluation of any cost savings that can be accrued by better integrating Medicaid and affordable housing resources, particularly the LIHTC, if federal statutory limits were altered.
e) Determining if any overall cost savings to state expenditures on Medicaid programs can be accrued if Medicaid Waivers, which have demonstrated a per person cost savings, are expanded.

Findings

There are a range of complementary and supportive affordable housing and service programs, in addition to the LIHTC, Medicaid, and Medicare, that can be used to support the creation of urban senior care communities. Public Housing, Housing Choice Vouchers, Section 202 housing, and the Congregate Housing Services Program are all key resources that can assist to support housing and service provisions. Each program has its own set of rules and requirements. Some of these resources, such as Public Housing and Section 202 Housing, serve households with income levels that closely align with the eligibility levels of Medicaid. These resources, however, are typically not available for the private sector but are rather under the control of governmental agencies and predicated on the availability of appropriated funds. Although some capital resources can be assembled using these programs, a larger restraint is the lack of guaranteed funding for operations and services.

Mixed-income housing approaches in communities owned by the private sector may provide further opportunities for housing, medical, and service costs to be underwritten. Through a mixed income housing approach, higher income residents can cross-subsidize costs for lower-income residents. This mixed-income approach, on the housing side, is required in some Maryland jurisdictions through inclusionary zoning requirements and mixed-income housing policies. Mixed-income is also supported by the Congregate Housing Service Program, where costs adjust based on income as well as Medicare if the participant has worked and paid into Social Security for a specified period of time. However, services available through Medicaid, Medicaid Waivers, and PACE are limited to income eligibility for Medicaid, which is the Federal poverty level.

Programs such as the Congregate Housing Services Program can serve to mitigate movement from an affordable housing unit into a nursing home, thus opening opportunities for cost savings. The Congregate Housing Services Program manages to provide services to low-income elderly persons at a very low per-person cost when compared to other programs. The elements that make this program a success should be examined.

Recommendations:

6. The Maryland Congregate Housing Services Program model offers a good starting point for developing a plan to integrate housing and services that can be provided in independent living units. Legislative action to expand the program and its funding specifically to assist

developers and providers who wish to build or expand communities for seniors with low and moderate incomes.

7. MDoA should work with federal, state, and local housing agencies to evaluate the feasibility of developing a pilot program that assists developers to integrate building subsidies and service subsidies into an integrated model for new or refinanced senior housing. This would include financial and actuarial models for integrating housing and long-term care services.
8. DHCD, DHMH, MDoA, and local affordable housing providers should explore replication of Pennsylvania's efforts to connect the LIHTC and the PACE programs by co-locating service providers in or near affordable housing that serves the elderly.
9. Housing service providers as well as state and local housing agencies should continue to advocate for expanded funding at federal and state levels for key housing programs including the Congregate Housing Services Program, Public Housing, state Rental Housing Program Funds, and Section 202 Housing.

V. Conclusion

The aging of the Baby Boomers will present new challenges to provide housing, medical, and service benefits to meet the growing senior population. These challenges will be greater in communities such as Baltimore City where there is a need to provide services to meet the needs of low income residents.

Connecting the availability of benefits for individuals of all incomes at a campus like setting would provide a strong option for seniors to consider when exploring retirement. By connecting services and making them easily accessible, it may mitigate movement to nursing homes and other facilities. Stadium Place, in many regards, best achieves this vision of an "urban senior care community." It provides a range of affordable housing opportunities on a campus like setting coupled with a range of services. Medical benefits, however, are accessible through traditional providers and are based upon the eligibility of the individual.

Significant governmental barriers inhibit the connectivity of affordable housing, such as units created by the LIHTC, and medical benefits such as those provided by Medicaid. Those barriers are both financial and statutory and set at and controlled mainly by the federal government.

States like Maryland can, however, work through the existing silos of programs to better connect housing and medical services. Public Housing and Section 202 housing often serve households who are eligible for Medicaid. Coordinating medical benefits for those households could be achieved by co-locating a PACE provider. Opportunities are also available through greater use of waiver services as well.

Programmatic changes and concerted efforts to align resources are needed at all levels of government in conjunction with private sector efforts to be able to address a doubling of the number of seniors in the United States by 2030.

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