Accommodative Housing for Older Persons and Persons with Disabilities: A Non-Proprietary Multidisciplinary Collaborative Proposal[1]

By Joseph J. Ranni

I. An Historical Lack of Accommodative Housing

Older adults and persons with disabilities are all too often unable or no longer able to live in their homes. Tragically, once a person begins that journey, they become separated from their spouse, family and community. These individuals transition from their homes to senior housing or assisted living and finally to nursing homes. There is a need for accommodative housing that facilitates appropriate care and maximum quality of life by providing the ability to remain in a desirable home environment that maintains family structure and connection to communities. There is a further need to preserve assets and resources to avoid Medicaid or if nursing home Medicaid eligible lost pursuant to poverty requirements. This article is focused upon those needs with a method of addressing them with the potential of reducing Medicaid costs. It is time for community-based alternatives that are not dependent upon government funding or large-scale investment. Rather than a cycle of dependency, the following proposal presents an opportunity to shift from transitional custodial care and facilitate greater personal and financial independence.

II. Proposal

Many people move into custodial care because their homes can no longer accommodate their functional limitations or service needs. Upon selling their home in preparation for the move, planned or eventual impoverishment begins. In addition to the financial consequences of moving to congregate care, a person sheds home, spouse and community when they are least capable of mentally and physically adjusting to new environments with increasing levels of dependency.

The proposal was developed with the goal of encouraging the development of housing through privately-owned small condominium community residence suites of accommodative design where couples can age in place through end of life. The accommodative design also allows opportunities for young adults with disabilities to live in integrated communities, perhaps with their aging parent. Additionally, these residences can be incorporated with affordable housing, retirement communities, or designed for particular social or religious affiliations. Rather than requiring the substantial investment for custodial care, the

small economy of scale makes the residence suitable for any urban or rural community.

A. Accommodative Residence Composition and Features

1. **Private Home Ownership**: The proposed condominium residence ownership is an exempt resource asset.[2] A primary strategy in elder planning is preserving assets through home investment. Consequently, the proposal allows for the preservation of resources and liquidity avoiding impoverishment and the need for custodial care.

   The proposed residence would consist of up to 12 fully accessible suites, all connected directly with interior common areas. The suite would be of a universal accommodative design with private bedrooms, bathroom, sitting area, and hazard-free kitchenette. Exterior features would include easy access to secure porches, patios, courtyards and barrier-free walkways with memory care protections. The suites could have amenities and accommodate an individual or a couple. Alternatively, in an expanded residence, the suites could accommodate a second bedroom for a child with a disability, a caregiver or an adult child accompanying parents.

   The residences will provide only non-medical supportive services such as freshly prepared food, security, and common area housekeeping/maintenance.

2. **Monthly Expenses:** Suite owners would be responsible for their monthly expenses the same as if they were living in a private residence. Consequently, the typical Social Security, pension, IRA etc. income can be used to pay a monthly expense that would be utilized for the maximum benefit and at the discretion of the individual. Residences can be complex or simple with different attributes and amenities as people may choose based upon personal resources and preferences. Monthly expenses will vary the same as a retirement community, condo/coop or homeowners' association.

B. Consistent with Current Medicaid Service Provider Regulations

Personal care planning, management and services will be provided through existing licensed managed care entities[3] and/or CDPAP.[4] Importantly, the care provided would be no less than the care that would be available at home currently. However, there is the potential for more or better care through the small-scale service environment and extended community-based services.

Each resident will have the right to choose a care services provider or arrange services as currently exist. Non-Medicaid residents can pool their resources and obtain care services at reduced cost compared to remaining at home. Medicaid residents will live in an appropriate environment with amenities while receiving maximum personal benefit from their exemptions while costs are reduced by their being co-located.

III. Community Medicaid

While Governor Hochul has recently proposed significant policy changes to eligibility, they are too undefined at present and would not become effective until Jan. 2023.[5]

Many people utilize elder planning to qualify for Medicaid benefits as their needs exceed their financial resources. This proposal militates against self-impoverishment as individual resources can be used for an appropriate environment in which they can better provide for their own needs and avoid dependency.

The principles behind Community Medicaid began decades ago.[6] In 1965, responding to a concern regarding a lack of community social services for older persons, Congress passed the Older Americans Act (OAA).[7] The OAA supports a range of community services for older individuals and their caregivers, fulfilling the mission of helping older adults age with dignity at home and in the community.

If a person needs more than 12 hours of care a day they are referred for a heightened medical/service evaluation as to whether their needs can be met, though "overnights" typically require the least assistance.[8] This necessity is subject to a heightened review by an independent assessment through New York Medicaid Choice and an Independent Practitioner Panel to determine if more than 12 hours is necessary. These two assessments are then referred to the local county Department of Social Services or MLTCP to determine if remaining home is a safe placement. Split shit, 24/7 and staffing resources are considered. If not, then it is referred back to New York Medicaid Choice for a third assessment/evaluation. Of course, an appeal procedure exists for denials.[9]

A decade later the "Willowbrook Decree" deinstitutionalized state hospitals through community-based services providing comprehensive health services, socialization, and oversight as an alternative to permanent institutional confinement.[10] Supportive programs serve a variety of persons with chronic and acute care needs, including people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses. There are symmetries in policy, principles and goals despite the heavily segmented agencies, programs, and funding sources to avoid custodial care regardless of the type of disability or age of onset.

Community Medicaid was established under the Affordable Care Act[11] and is a combination of nursing home/custodial care avoidance programs including Home and Community Based Services waiver programs that provide Medicaid beneficiaries services to age in place rather than in an institution or another isolated setting.[12] In contrast

with nursing home Medicaid, which requires total impoverishment, a Community Medicaid recipient can retain home ownership and maintain limited financial resources and income exempt from eligibility consideration.[13]

An individual qualifies for Community Medicaid when they are medically, resource and income eligible, and have filed an application. To be medically qualified, a person must require "hands-on" or "arm's reach" functional assistance with at least three activities of daily living ("ADLs").[14] Financial eligibility follows prescribed asset and income thresholds. An individual is only allowed $934 income per month and $16,800 of non-exempt assets.[15] In the situation of a couple, where both spouses require Medicaid, an income limit of $1,367 is applied and the couple is allowed only $24,600 of non-exempt assets.[16]

Prior to filing an application to qualify for Community Medicaid, the individual must "spend down" resources below the asset eligibility limit. Many individuals have "excess" monthly income above the $884 limit from pensions, IRAs, annuities, trusts or the like, which is commonly directed to a state licensed "pooled" trust. This administers payments consistent with regulations and is used for monthly expenses towards housing, food, utilities, and other expenses that benefit the individual.[17]

Once the application is filed, two personal assessments are conducted. The first assessment is performed through a state-designated entity which evaluates the needs of the individual, taking into account available and willing family and community support. Once the assessment is completed, individuals have the choice of utilizing a Managed Long-Term Care Plan (MLTCP) [18] or a Consumer Directed Program (CDPAP).[19] Next, an assessment is conducted by the Managed Long-Term Care Plan (MLTCP) to determine method, manner and scheduling of service delivery. Under CDPAP the individual (or their proxy) is responsible to hire assistance and direct the specific services provided under the guidance of a state licensed Fiscal Intermediary.

A. Managed Long-Term Care Plan (MLTCP) and Consumer Directed Personal Assistance Programs (CDPAP)

Managed Long Term Care Plans (MLTCP) are state licensed insurance plans which are paid a monthly "capitation" rate to approve and provide Medicaid home care and other long term care services.[20] to individuals who are chronically ill or disabled and who wish to stay in their homes.[21] Only those services deemed medically necessary are provided.[22] After the MLTCPs conduct the second assessment they generally subcontract out the services.[23] The services extend to nutritional and environmental support functions.[24] and do not include safety monitoring, supervision or cognitive prompting.[25] At present, there is a chronic shortage of caregivers and many "hard to service" areas have wait lists resulting in people remaining in nursing homes despite being able to return home.[26]

MLTCPs through a subcontractor or CDPAP facilitate services to chronically ill or physically disabled individuals who have a medical need for either help with activities of daily living (ADLs),[27] instrumental activities of daily living (IADLs),[28] or skilled nursing services.[29] In contrast to MLTCPs, which determine the method and manner in which services will be provided, CDPAP allows the "consumer" or their proxy to integrate ADLs and IADLs as they direct. CDPAP requires the consumer to engage, train and manage their caregiver. A Fiscal Intermediary (FI) provides oversight to ensure that the person chosen is qualified and can perform the obligations. The FI verifies hours, that services are actually provided, and disburses funds.[30] Due to the shortage of caregivers, some MLTCPs are recommending CDPAPs in "hard to service" areas. However, unless they are a relative, few people are able to identify a caregiver.

There are similar custodial care avoidance programs including Home and Community Based Service (HCBS) which helps both people with disabilities and older adults avoid congregate care by providing waivers to receive services for which they would otherwise be ineligible. Additionally, Programs of All-Inclusive Care for the Elderly (PACE)[31] and Community First Choice Option (CFCO)[32] offer coordinated medical and care planning to enable individuals to remain in their communities rather than in a nursing home setting.[33] To do so, the program integrates medical professionals with the care needs and services provided to the individual.[34]

PACE offers many potential opportunities to integrate with this proposal across a broad spectrum of disabilities and supported housing models and is proposed to be dramatically expanded under the proposed 2022 budget.[35] PACE provides comprehensive interdisciplinary coordination of care management, service delivery and socialization between the medical professionals and care providers. While PACE is often utilized with central services in the "hub" and varying levels of care residences as "spokes," it also encompasses Alternative Care Settings (ACS) which can include private homes or the residences proposed herein.[36]

All of these programs have the purpose of custodial care avoidance with the goal of reducing Medicaid costs while preserving the least restrictive living environment. The proposal is consistent with these goals with the potential of improving both living conditions and reducing costs.[37]

IV. Regulations for Adult Homes, Enriched Housing, Assisted Living, and Continuing Care Retirement Communities (CCRC)

New York's Department of Health licenses four types of adult care facilities which offer varying levels of custodial care, supervision and personal care to persons with functional and/or cognitive impairments based upon func-

tional impairment. The lowest level of care is provided by adult homes, followed by enriched housing programs, and assisted lving residences (ALRs).[38] CCRCs are private pay communities providing accommodative residences and services.

Adult homes provide limited personal and residential care, three meals a day, activities, assistance with medication, and supervision.[39] Facilities must employ an administrator, a case manager, personal services staff, an activities director, and at least one person qualified to provide first-aid must be on-duty at all times.[40]

Enriched housing programs provide long-term residential care to adults who are typically 65 years of age or older. The care is provided in community-integrated settings that resemble independent housing units. An enriched housing operator is required to provide only one hot meal a day in a group setting.[41] The facility is required to have a program coordinator, a case manager, and personal care staff to assist residents.[42]

Assisted Living (AL) refers to an entity that provides housing, on-site monitoring, and personal care services and/or home care services (directly or indirectly) in a home-like setting adults.[43] AL residences must provide for 24-hour on-site monitoring, case management, coordination of health care, medication, personal care and food services.[44] AL residences can be certified to provide for nursing services.[45] The facility must have an administrator, a case manager, and resident aides to provide personal care assistance. Further, facilities certified to provide enhanced assisted living must also have licensed practical nurses, registered nurses, and home health aides.[46] To serve Medicaid clients, additional nursing and therapeutic services must be provided based upon the recipient's initial and interval assessments.[47]

Continuing care retirement communities (CCRCs) provide a privately purchased coop home-like environment with a wide range of services. Residents pay monthly maintenance and services fees[48] and have a choice of available care options the cost of which will not increase unless additional services are needed which were not anticipated.[49] CCRCs allow older individuals to easily transition between housing and Assisted Living/ nursing home care facilities based upon individual needs and remain in the same community.[50]

V. Alternative Community-Based Housing and Small Economies of Scale

Feasibility of the proposal is demonstrated by alternative community-based housing innovations of which the Green House Project (GHP) is a national operational example. GHP provides development assistance for entities to create person-centered small residences of the design described above. While GHP residences are often clustered and operated as part of nursing homes, by utilizing the architectural design concept and changing the financial model to private ownership, these residential units could stand alone or be clustered depending on the specific community. Where government funds or substantial investment were formerly necessary for large economies of scale to support custodial care, the change in funding obviates that financial need and would create a local development opportunity for possibly the same cost as a small housing subdivision or urban renovation. The Green House Project is also mentioned approvingly in the proposed 2022 New York Budget.[51] The proposed budget seeks to address the challenges in housing and community based service delivery. Beyond the GHP, the budget also references consideration of innovative proposals that can be developed.[52] As usual, solutions lie in pieces for cooperative assembly.

Studies show that there are many advantages to small residences, specifically during the pandemic.[53] While the GHP model utilizes modified responsibilities of caregivers allowing for staffing efficiencies in smaller environments,[54] the proposal anticipates utilizing family and community-based services to supplement the caregiving and provide avenues for IADL and normative activity integration through expanded access by and to the individual.

The proposal provides an opportunity for Medicaid costs to be reduced through smaller service delivery economies of scale and custodial care avoidance. "Overnights" and more fluid care delivery can occur as services would be shared by CDPAP residents or MLTCPs who would be able to provide services to multiple persons. Of course, more discussion should occur as to the possibilities to promote co-located individuals choosing the same providers to maximize care or perhaps the resident's counsel/condo board could choose a MLTCP annually for all residents.

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VI. Licensing of the Residences

Consistent with current regulations, there should be review of architectural plans, financial feasibility and operator character and competence. Notwithstanding, the lack of custodial care eliminates many of the reasons for extensive licensing as care giving planning, management and delivery would be provided by licensed professionals as currently exists and discussed *supra*.

The proposal would provide common non-care services that are not uncommon in condominium plans. While food preparation, common area housekeeping, security, and ground maintenance would be provided, these are services typical to many communities.

There has been concern that acute care needs requiring advanced skilled nursing services could not be economically administered in the proposed residence. As mentioned above, many programs provide for chronic and acute needs of persons to remain in community-based residences, whether privately owned or government funded. In collaboration, there were also discussions of the division of labor; duties; nature of care and availability of community-based solutions such as visiting professionals, companion care or less skilled care givers. These issues dovetail with the staffing crisis and the need to expand family contribution and community support. Regardless, in principle the more people involved or accessible can only improve the quality of life and ability to service an individual's diverse needs.

VII. Conclusion

As noted in the NYSBA Task Force Report, solutions exist but have been unrecognized to date.[55] This proposal is not unique in concept as it draws from many existing segmented programs. However, it is distinctive in the sense that it utilizes private funds to create and maintain the accommodative living environment for appropriate service delivery. Consequently, the proposal provides an alternative consistent with existing goals, policies and regulations that may help older adults and people with disabilities avoid personal and economic dependency. There would be greater independence provided through asset preservation and utilization that may minimize the need for public benefits or be accessed through community services. For those Medicaid eligible, the smaller scale permits more economical and appropriate service delivery. Most importantly, loved ones remain together in a home from which they would never have to move with supports, services and amenities that will provide a better quality of life.

Endnotes

1. The following proposal is the result of a multi-disciplinary pro bono collaboration and is non-proprietary.
2. *See New York Medicaid Eligibility for Long Term Care: Income and Asset* Limits, American Council on Aging, https://www.medicaidplanningassistance.org/medicaid-eligibility-new-york/.
3. Managed Long-Term Care (MLTC) is intended for seniors who require a skilled nursing facility level of care but prefer to live at home or in an assisted living facility. Long-term care supports are provided to promote independence, including personal care assistance, adult day care, meal delivery, and home modifications. *See New York Medicaid Eligibility for Long Term Care: Income and Asset* Limits, American Council on Aging, https://www.medicaidplanningassistance.org/medicaid-eligibility-new-york/.
4. Consumer-Directed Personal Assistance Program (CDPAP) is a program option available for seniors who are enrolled in the MLTC program or the Community First Choice Option. Through this, program participants are able to hire a personal care assistant of their choosing, including relatives. *See New York Medicaid Eligibility for Long Term Care: Income and Asset* Limits, American Council on Aging, https://www.medicaidplanningassistance.org/medicaid-eligibility-new-york/.
5. https://www.budget.ny.gov/pubs/archive/fy23/ex/book/briefingbook.pdf pgs. 37-41.
6. *See Policy Options for Integrating Health and Housing for Low-Income Older Adults* (July 2021). Service-enriched housing and a wellness/coordination benefit under Medicare were recommended in Massachusetts, Michigan, and Pennsylvania.
7. *Older Americans Act*, Administration for Community Living, https://acl.gov/about-acl/authorizing-statutes/older-americans-act.
8. http://www.wnylc.com/health/index.php?View=news&EntryID=85#summary.
9. 18 N.Y.C.R.R. 505.14(b).
10. *New York State Association for Retarded Children, Benevolent Society for Retarded Children, et al., v. Mario Cuomo*, 72 Civ. 356,357 (E.D.N.Y. Mar. 11,1993).
11. *See Affordable Care Act*, Medicaid.gov, https://www.medicaid.gov/about-us/program-history/index.html.
12. *Home & Community Based Services*, Medicaid.gov, https://www.medicaid.gov/medicaid/home-community-based-services/index.html.
13. *Id.*
14. Activities of daily living (ADLs) is a term used by health care professionals to refer to the basic self-care tasks an individual performs on a day-to-day basis. Some ADLs include, personal hygiene, dressing, and self-feeding. *See* Jeff Hoyt, *Activities of Daily Living (ADLs)*, Seniorliving.org (Apr. 14, 2021).
15. *See New York Medicaid Eligibility for Long Term Care: Income & Asset Limits*, Medicaidplanningassistance.org, https://www.medicaidplanningassistance.org/medicaid-eligibility-new-york/.
16. *Id*.
17. *Medicaid Spend-Down*, NY Health access, http://www.wnylc.com/health/entry/46/.
18. *See infra*–Section I.B.
19. *See infra* Section I.C.
20. http://www.wnylc.com/health/entry/114/.
21. *See Managed Long-Term Care (MLTC)*, Department of Health, https://www.health.ny.gov/health_care/managed_care/mltc/.
22. 42 C.F.R. § 438.210 (2016).
23. *Id.*

24. *New York Codes, Rules and Regulations*, Title18: Part 505.14(a)(1)(5)(i): Personal Care Services. https://regs.health.ny.gov/volume-c-title-18/9748687/section-50514-personal-care-services.

25. *See Rodriguez v. City of New York*, 197 F.3d 611,617 (2d Cir., 1999). MLTC Policy 16.07.

26. In the opinion of collaborators, this is an area where there can be both an expansion of existing services. Additionally, it can provide a solution to the existing void concerning the integration of ADL, IADL and normative activities.

27. *Supra* note 7.

28. Instrumental Activities of Daily living (IADLs) are those activities that allow an individual to live independently in a community, although they are not necessary for functional living. They include tasks such as cooking, cleaning, transportation, laundry, and managing finances. *See* Guo and Sapra, *Instrumental Activity of Daily Living*, National Center for Biotechnology Information (Nov. 27, 2020), https://www.ncbi.nlm.nih.gov/books/NBK553126/.

29. *See Consumer Directed Personal Assistance Program (CDPAP)*, Department of Health, https://www.health.ny.gov/health_care/medicaid/program/longterm/cdpap.htm.

30. *Id.*

31. *See Program of All-Inclusive Care for the Elderly*, Medicaid.gov, https://www.medicaid.gov/medicaid/long-term-services-supports/program-all-inclusive-care-elderly/index.html.

32. https://www.health.ny.gov/regulations/state_plans/status/non-inst/approved/docs/app_2015-10-23_spa_13-35.pdf.

33. *Id.*

34. Some of the benefits include, but are not limited to adult day care, dentistry, social services, occupational therapy, and physical therapy. For a more comprehensive list, *see Programs of All-Inclusive Care for the Elderly Benefits*, Medicaid.gov, https://www.medicaid.gov/medicaid/long-term-services-supports/pace/programs-all-inclusive-care-elderly-benefits/index.html.

35. Department of Health and Human Services Center for Medicare and Medicaid Services, 2016, Clarification on the Requirements for Alternative Care Settings in the PACE Program, Medicare Drug & Health Plan Contract Administration Group.

36. Gov. Kathy Hochul, 2022, State of the State, A New Era for New York. https://www.governor.ny.gov/sites/default/files/2022-01/2022StateoftheStateBook.pdf.

37. A policy priority is to improve health outcomes and avoid hospitalizations (especially achieving Medicare savings), will have reinforced infrastructure and incentive to produce those goals. https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_alignment_paper_final.htm.

38. *New York Codes, Rules and Regulations*, Title 18, Part 485: Adult Care Facilities, General Provisions. http://w3.health.state.ny.us/dbspace/NYCRR18.nsf/56cf2e25d626f9f785256538006c3ed7/f23f2715415f7168852567220076902 5?OpenDocument&Highlight=0,485.

39. *New York Codes, Rules and Regulations*, Title18, Part 487: Adult Care Facilities, Standards for Adult Homes. http://w3.health.state.ny.us/dbspace/NYCRR18.nsf/56cf2e25d626f9f785256538006c3ed7/cf61b f0d8ac1b0fa852567220076903f?OpenDocument&Highlight=0,487.

40. *Id.*

41. *New York Codes, Rules and Regulations*, Title18: Part 488: Adult Care Facilities, Standards for Enriched Housing. http://w3.health.state.ny.us/dbspace/NYCRR18.nsf/56cf2e25d626f9f785256538006c3ed7/9dfd1 07afc3034c1852567220076904c?OpenDocument&Highlight=0,488.

42. *Id.*

43. Again, these adults may not be related to the assisted living provider. *See* Public Health Law § 4651 (2021).

44. *New York Codes, Rules and Regulations*, Title 10, Chapter X, Part 1001: Adult Care Facilities, Assisted Living Residences. https://www.health.ny.gov/facilities/assisted_living/adopted_regulations/docs/assisted_living_res idences_laws_and_regulations.pdf.

45. This includes assessment and evaluations; monitoring and supervision nursing care and treatments; and medication administration and management. *Id.*

46. *See Compendium of Residential Care and Assisted Living Regulations and Policy: 2015 Edition*, Office of the Assistant Secretary for Planning and Evaluation, Jun. 14, 2015, https://aspe.hhs.gov/reports/compendium-residential-care-assisted-living-regulations-policy-2015-edition-0.

47. *Id.*

48. For an example of one such retirement community on Long Island, *see* Peconic Landing, https://www.peconiclanding.org/.

49. *See Continuing Care Retirement Communities & Fee-For-Service Continuing Care Retirement Communities*, NYS Department of Health, https://www.health.ny.gov/facilities/long_term_care/retirement_communities/continuing_care/.

50. *How Continuing Care Retirement Communities Work*, AARP.org, https://www.aarp.org/caregiving/basics/info-2017/continuing-care-retirement-communities.html.

51. Gov. Kathy Hochul, 2022, State of the State, A New Era for New York. https://www.governor.ny.gov/sites/default/files/2022-01/2022StateoftheStateBook.pdf

52. *Id.*

53. *See* Susan C. Reinhard and Edem Hado, *Small-House Nursing Homes*, AARP, https://www.aarp.org/content/dam/aarp/ppi/2021/small-house-nursing-homes.pdf.

54. *See* Sharkey *et al.*, *Frontline Caregiver Daily Practices: A Comparison Study of Traditional Nursing Homes and The Green House Project Sites*, Journal of the American Geriatrics Society (2010).

55. *See Rep. and Recommendations of the Task Force on Nursing Homes and Long-Term Care*, New York State Bar Association (June 2021).