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Senior Housing and Long Term Care Shortfalls for Low-Income Americans

Introduction

Senior Consulting, LLC and its affiliates ("SC") have provided care and housing services for predominately low income seniors directly and in support of clients throughout the continuum of care to both for profit and nonprofit providers. Over an extended period of time, SC has conducted extensive research on long term care and senior housing trends throughout the United States. SC also completed research on post-acute discharges in many states, including the majority of California hospitals. In addition, SC researched trends and compiled related databases on operators of five or more facilities or communities regionally and nationally that primarily own and operate in these three categories; 1) Skilled Nursing Homes ("SNF") 2) Assisted Living Facilities ("ALF") and 3) Independent Living ("IL"), Retirement Communities with care services, Continuing Care Retirement Communities ("CCRCs"), and other senior housing options, including affordable senior housing. This includes 557 companies and organizations, with at least 18,000 locations, both for profit and nonprofit providers.

Within the continuum of care, from acute hospitals to housing, there are two general types of providers, either nonprofit or for profit. Nonprofit providers fall into three general categories, in some cases governmental, but mostly those that are church affiliated or those that are not. Nationally, many studies have concluded that nonprofit providers do a much better job of doing just that, providing for the physical, social and emotional well being of their patients and residents. Our various analyses agree with that conclusion. To follow are some general findings for each of the three general categories of care/housing for seniors, with some background on Acute Hospitals.

Acute Hospitals

For hospitals, nonprofit providers are typically church affiliated with origins tied to the mission of the local or regional church groups. There are also many county or governmental acute hospitals nationwide, although not very common in many states, as well as many hospitals sponsored or affiliated with Universities. There are many large for profit operators as well. On a state-by-state basis, there is a substantial difference in the amount of for profit operators versus nonprofit operators, with many states having all or mostly nonprofit Hospitals.

From the May 2005 Government Accountability Office ("GAO") Report, "In 2003, of the roughly 3,900 nonfederal, short-term, acute care general hospitals in the United States, the majority—about 62 percent—were nonprofit. The rest included government hospitals (20

percent) and for-profit hospitals (18 percent). States varied—generally by region of the country—in their percentages of nonprofit hospitals. For example, states in the Northeast and Midwest had relatively high concentrations of nonprofit hospitals, whereas in the South the concentration was relatively low. Nonprofits have dominated in the large, general hospital area, while the for-profits have more commonly been smaller, more specialized hospitals. For example, in his book "America's Nonprofit Sector: A Primer," Lester Salamon's data indicated that the 50% of hospitals that were nonprofit contained 56% of the hospital beds, and accounted for 70% of total hospital expenditures.

Catholic Hospital systems, often with extensive services including long term care, are among the largest in the USA. Collectively, Catholic Hospitals would represent the largest "chain" versus the largest for profit operators. Many other denominations including Baptist, Presbyterian, Lutheran and Methodists have sponsored or operate Hospitals across the USA. HCA, Inc., Tenet Healthcare Corporation and HealthSouth Corporation, the three largest for profit Hospital operators in the Country, have all been charged by the Federal Government with Medicare Fraud for billions of dollars.

As substantiated in SC's May 2006 report, Medicare Transfer Discharges-Improving Post Acute Discharges, which reviewed the majority of post acute discharges from California Hospitals in 2004, Hospitals and their communities would benefit greatly from including both Transitional Care Units and Long Term Care Facilities in their system, the latter subject to factors including reimbursement in combination with wage levels that are in line with freestanding SNFs.

Long Term Care Facilities

Long Term Care is typically provided in the home for wealthy Americans. For much of the middle and upper middle class, home health care remains an option for long periods of time before needing what has been referred to as "Institutional Care" in Skilled Nursing Facilities. Long Term Care Facilities are predominately Skilled Nursing Facilities ("SNF"), and secondly, Assisted Living Facilities ("ALF"). SNFs provide 24 hours a day nursing care, predominately for the frail elderly. ALFs provide care to frail residents, typically requiring less nursing care and having fewer medical needs than SNF patients. The overwhelming majority of SNF and ALF facilities are operated by for profit operators. Nationwide, there are three key differences between ALFs and SNFs:

- ALFs are much less, if at all, an intuitional setting, unlike most SNFs, which have much less living space and typically shared patient rooms. ALFs typically have small apartments without full kitchens, often studio and sometimes one-bedroom. The quality of life is substantial better in ALF versus SNF environments.

- Most SNF patients are Medicare or Medicare patients, while the overwhelming majority of ALF patients or residents are Private Pay or Private Insurance.

- While Medicaid is the primary source of payment for SNF operators, Medicaid reimbursement to ALFs is either not available or available on a limited basis in the majority of states in the nation.

Skilled Nursing Facilities

Senior Consulting has researched many trends with SNFs, including multi-facility operators, those with five or more facilities. The largest has well over 300 facilities, and several have at least 200. In researching National and State Associations and many private sources, we have compiled a database on the majority of multiple-facility operators, a total of 250 operators, yet only fifteen are nonprofit organizations. There are almost 100 for profit operators of at least 15 facilities, 20 of at least forty facilities and seven with over 100, yet the largest nonprofit owner operates only 15 SNFs, not including Care Initiatives with 46 and the Lutheran Good Samaritan Society, which has 60 plus SNFs, many part of retirement communities.

The Centers for Medicaid and Medicare ("CMS") reports in one of many "OSCAR" reports that as of June 2006, 66.1% of all Nursing Homes are for profit, 6.0% are Government, and only 27.9% are nonprofit. 52% of the Nursing Homes are reported to be owned by operators of two or more facilities, a statistic we believe should be much higher, since many principals that own facilities do so in separate and distinct corporations or ownership entities. In Senior Consulting, LLC's March, 2006 report entitled California Skilled Nursing Facilities, Statewide Occupancy and Payer Mix, we identified many chains including one with 11 facilities that would not be identified as such in the CMS report.

In California, where most hospitals are nonprofit or governmental and a higher percentage operate Nursing Facilities detailed data is available. From "Nursing Homes: A System in Crisis", a 2004 report by the California HealthCare Foundation, "About 78% of the nursing homes in California are owned by for-profit organizations, while 18% are nonprofit, and 4% are operated by a government entity such as a city or county. In 2002, freestanding, for-profit facilities had lower staffing levels (3.3 hours Nursing PPD versus 4.1), higher staff turnover rates (70% versus 49%), and more violations of health and safety regulations (11 versus 8) than nonprofit facilities." California statistics are influenced by many hospital operators of SNFs that have higher staffing ratios due to higher acuity patients and lower turnover of staff due to higher hospital wages. However, fewer violations of regulations is a definite indicator that nonprofit SNF providers in California are better operators.

CMS requires electronic reporting of information for all Nursing Homes that are Medicare and Medicaid certified. As of June 2006, there were 1,432,864 patients in US nursing homes for the prior year, with 65.21% of those patients Medicaid patients and 13.19% Medicare. Medicare patients are typically short-term stay; patients that are rehabbing or may return home, or patients that will become Medicaid patients after their collective 100 days of stay at Hospitals and SNFs are used within a calendar year. Only 21.60% were private pay or private insurance. Our concern is for the average daily occupancy of 934,402 Medicaid patients, a number projected to grow year by year as our society continues to age and the "Baby Boomers" become older senior citizens.

For the fifth year in a row, the American Health Care Association (ACHA) engaged BDO Seidman, LLP to complete a report on Medicaid funding in SNFs, the latest a June 2006 publication, A Report on Shortfalls in Medicaid Funding for Nursing Home Care. The data includes 80% of the Medicaid patient days in the country. The bottom line was "…the estimated shortfall in total facility nursing facility Medicaid funding was estimated at almost

$4.4 billion in 2004." This was the equivalent of $12.58 per patient day, and projected to increase in 2006. While this has alarming impact to patient care on a national level, there was a substantial variance in the state-by-state differences, from a single state without a shortfall to six states of over $20.00 per day, including New York with the highest of $24.39 per day.

There are many serious issues that affect the quality of care in nursing homes, including a nationwide shortage of nurses, compounded in a nursing home environment as hospitals and other providers pay higher wages. Nursing Homes typically have two nursing aides for every one nurse, and aides provide more than 80% of the direct patient care. They are grossly underpaid. Many State agencies that inspect nursing homes are understaffed, with complaints on abuse and other serious issues sometimes going months without oversight to primarily for profit operators with corporate budget expectations.

Care issues in nursing homes are widely publicized, but what about the emotional and psychological well-being of residents? Federal law (42 CFR 483.15) requires that all skilled nursing facilities (SNFs) provide "medically related social services to attain or maintain the highest practicable resident physical, mental and psychosocial well-being." Nursing homes with more than 120 beds are required to employ a full-time social worker with at least a bachelor's degree in social work or "similar professional qualifications." Facilities with 120 beds or fewer must still provide social services, but do not need to have a full-time social worker on staff.

A 2002 report by the Department of Health and Human Services, the Office of Inspector General, entitled Psychosocial Services in Skilled Nursing Homes concluded that "Some 39 percent of the residents with psychosocial needs had care plans that were inadequate to meet those needs; Forty-one percent of those with psychosocial needs addressed in their care plans did not receive all of their planned psychosocial services, and 5 percent received none of these services; and a total of 45 percent of social workers reported barriers to providing psychosocial services, including not having enough time, burdensome paperwork, and insufficient staff."

In conclusion, the system of providing for seniors in Skilled Nursing Facilities is in need of a major overall. Medicaid regulations and reimbursement need to be revamped, and nonprofit providers should be given preferential treatment, but as a society, do we care enough to make that happen?

Assisted Living Facilities

Assisted Living is a relatively new long term care option, or at least as a term, with the development of ALFs over the last twenty years reaching a peak in the latter half of the 1990s. A common definition is "a supportive housing facility designed for those who need extra help in their day-to-day lives but who do not require the 24-hour skilled nursing care found in traditional nursing homes." The growth of Assisted Living has led to a wave of new facilities, buildings that have more common areas than nursing facilities, smaller apartments, as well as a more home-like environment overall.

ALF residents require assistance with Activities of Daily Living (ADL), such as help with eating or bathing as two examples. The average resident is 83 years old, with approximately half the residents having memory impairments. Many have medical needs, and most of the

care is provided by Nursing Aides, as is the case in a licensed nursing home, although there are substantially less licensed nurses on staff.

As of the end of 2004, 41 States and the District of Columbia licensed Assisted Living according to the U. S. Department of Health and Human Services March 31, 2005 report entitled, "State Residential Care and Assisted Living Policy: 2004." From this same Report, "Licensing requirements and definitions of assisted living varied substantially, particularly in the level of medical and nursing services provided. States fall on a continuum from low to high thresholds for nursing home admission. Some states require a person to need assistance with only two ADLs, while others may require that a person be totally dependent in three or more ADLs. Some states require individuals to have a combination of medical conditions, needs and functional limitations; others require only certain medical needs. Of the 45 states whose criteria were reviewed for this study, two used medical criteria only; 13 used medical and functional needs; eight used an assessment score based on a combination of medical and functional needs; and 22 used ADL thresholds."

These very different Assisted Living models, which is often confusing to consumers, include the following Models summarized from this same Report, with some of these approaches that are not mutually exclusive and may be combined:

Institutional Model. This model has minimum building and unit requirements; typically, multiple occupancy bedrooms without attached baths, and shared toilets, lavatories, and tub/shower areas. Generally, states permit these facilities to serve people who need assistance with activities of daily living (ADLs), but they either do not allow nursing home eligible residents to be admitted or do not allow facilities to provide nursing services. Historically, this model did not allow residents who met the criteria for placement in a nursing home to be served. However, as residents have aged in place, some states have made their rules more flexible to allow a higher level of service.

Housing and Services Model. This model licenses or certifies facilities to provide a broad range of long-term care services in apartment settings to persons with varying service needs, some of whom may be nursing home eligible. The state allows providers to offer relatively high levels of care; although licensed facilities may set their own admission/ retention polices within state parameters and may choose to limit the acuity of its residents. Depending on the state, some or all of the needs met in a nursing home may also be met in residential care settings. By creating a separate licensing category for this model and retaining other categories, states distinguish these facilities from board and care facilities.

Service Model. This model licenses the service provider, whether it is the residence itself or an outside agency, and allows existing building codes and requirements--rather than new licensing standards--to address the housing structure. This model simplifies the regulatory environment by focusing on the services delivered rather than the architecture. Approaches for regulating services may also specify the type of buildings, apartment or living space that can qualify as assisted living.

Umbrella Model. This model uses one set of regulations to cover two or more types of housing and services arrangements: residential care facilities, congregate housing, multi-unit or conventional elderly housing, adult family care, and assisted living.

Multiple Levels of Licensing. Some states set different licensing requirements for facilities in a single category, based on the extent of the assistance the facility provides or arranges and on the type of residents served. The state categorizes low, moderate, and high-need residents based on criteria for health and wellness, functional status, medication and treatment, behavior, psychological health, and social/recreational needs. The state may grant a limited number of waivers to facilities allowing them to serve residents who develop needs that exceed the facility's licensing level.

While 70% of the patients in Nursing Homes and Residential settings received Medicaid benefits as of calendar year 2004, according to this Report, there were a total of 1,432,864 patients as of June 2006. The aforementioned Report concludes "only 121,000 patients in these states were eligible for Medicaid waivers that allowed residential care in over a four-year period." This includes ALFs and other residential care settings, and does not address the variances in care provided in ALFs on a state-by-state basis. Therefore, it is likely there is less than one Assisted Living resident with Medicaid receiving the quality of life benefits that Assisted Living offers for every 100 Nursing Homes patients. In many ALFs, depending on State regulations and other factors, there are additional nurses on staff and/or call, and many residents receive the care and attention needed that would typically be in a nursing home setting, provided a resident has the ability to pay, as this option would rarely be extended to Medicaid eligible patients.

While the definitions of Assisted Living vary at times when it comes to care options, two constants are definitive; the typical design and additional living space of Assisted Living Facilities greatly enhance the quality of life when compared to the institutional settings of skilled nursing homes that care for the overwhelming majority of low-income seniors in need and there are improved psychosocial benefits to residents.

Senior Housing Options

There are various types of senior housing, including affordable senior housing, much of which is sponsored by governmental agencies or church organizations. Independent Living is another option; typically apartments with meals provided and limited services such as activities and transportation. Retirement Communities are either rental communities or require entry fees such as Continuing Care Retirement Centers (CCRC), usually offering Independent Living and Long Term Care options, and are often nonprofit operators. Both are aimed at middle or upper-income seniors. Active Adult Communities usually include patio homes or larger homes without the continuum of care of assisted living and/or skilled nursing, and are typically for profit operators, as is a new breed of a more upscale senior housing including condominiums with amenities. These options are also aimed at the middle and upper class and therefore are not the focus of this Report.

While some for profit developers help meet the need for low to moderate income seniors, often with the use of Tax Credits and in partnering with governmental agencies, nonprofit

housing development agencies develop the majority of low and very low-income senior housing. These agencies include Community Development Corporations ("CDC"), and other community housing development organizations. Funding includes Federal programs such as those available under Section 202, Section 236 rental and Section 221. There are many other

underutilized State and Federal programs, as well as programs that should be expanded to increase the availability of affordable senior housing.

From testimony to The Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century on September 24, 2001 by Thomas W. Slemmer, President of National Church Residences, one of the nation's largest not-for-profit sponsors and managers of affordable housing for seniors, “More than 7.4 million elderly households pay more than they can afford for their housing, including the 1.4 million with worst case housing needs...a majority of these households are on fixed incomes and receives no housing assistance. Unfortunately, low income elderly people seeking housing are faced with multi-year waiting lists exacerbated by the shrinking supply of suitable, affordable housing as some owners convert existing units to market rate housing. According to a recent AARP study, there were nine people over 62 years old waiting for every Section 202 unit in 1999. That number has undoubtedly grown since then. The dynamics of fixed incomes, high costs and an ever-increasing aging population needing a range of supportive and health care services compounds the limited supply of affordable housing options. This need for supportive services, appropriate community space, and service coordination applies to the 1.5 million elderly households who currently live in federally-subsidized housing, with an average age of about 75 years, as well as those in need of housing assistance.”

Supportive services such as many provided in ALFs for aging-in-place residents in existing affordable senior housing properties is another major dilemma for millions of seniors. As an alternative to nursing aides in an ALF setting, most seniors are eligible for Medicaid or Medicare reimbursement for home health aides to address ADL issues and other needs, like companionship and food shopping as examples.

From the August 4, 2005 White House Conference on the Aging, listed as Priority Issue #1 and #2, “The issue of senior housing needs clearer definition and standards of categories and services for each type facility” and “Securing available and affordable senior housing for low and moderate income seniors.” <u>The extensive existing and growing need for affordable senior housing and supportive services in existing affordable and low-income senior housing is undeniable.</u>

In August 2006, SC completed a nationwide analysis of for profit, nonprofit and church owners or sponsors of five or more senior housing options, which included assessment of the twelve largest denominations. There were 69 for profit operators, 36 nonprofit operators not affiliated with religious denominations, and 118 church affiliated organizations, or 223 total. There very few national nonprofit providers of senior housing, with the three that are by far the largest in diversity of properties being National Church Residences, Retirement Housing Foundation and Volunteers of America.

Research included all Web sites available through Catholic Charities USA, which was at least 90% of the Dioceses in the USA, and 160 of their affiliated Catholic Charities organizations, as well as the access to all Methodist and Presbyterian regional operators. Most other denominations did not have national databases or Web sites to access, and others did not have user-friendly Web sites to access affiliated charities or housing providers. Therefore, we estimate there are 250-275 owner/operators of at least five senior housing sites. In addition, there were many regional church and private nonprofits that operating fewer than five CCRCs, although many of these communities were large.

The regional missions of groups of congregations vary, including many invaluable social services for the homeless, children, counseling and so much more besides the consideration of seniors in general, or senior housing in particular. There are distinct differences between the missions of various Christian denominations in providing senior housing and care. The religious faiths that had the most regional congregations and organizations operating at least five locations as identified in the aforementioned SC Analysis, with the number of members as of 2004, rounded to the nearest 50,000, the latter as reported by the National Survey of Religious Identification (NSRI) and the follow-up study, the American Religious Identity Survey (ARIS), the largest and most comprehensive surveys of their kind, are as follows:

1) Lutheran Church: 25 organizations and 13,500,000 members
2) Methodist/Wesleyan: 22 organizations and 20,000,000 members
3) Catholic Church: 19 organizations overall, including two that are predominately SNF and 74,800,000 members
4) Presbyterian Church: 19 organizations and 6,200,000 members
5) The United Church of Christ/Churches of Christ: 8 organizations and 5,600,000 members
6) Judaism: 7 organizations and 4,000,000 members
7) Baptist: 7 organizations and 47,750,000 members

These denominations and others have 118 organizations with at least five locations and four with over 50 locations, an estimated 4,000 or more locations, not including smaller organizations or larger organizations that sponsor or operate one to four locations. Of these denominations, the Lutheran, Presbyterian and United Church of Christ have demonstrated the greatest commitment to affordable senior housing. The Mennonites, while having only one million members nationally, provide a wide range of senior housing and care options, both national in scope and beyond the needs of its members.

It is evident that strong visionary leadership in combination with a Board of Trustees that is committed to expanding services overall and beyond their constituents can result in smaller regional providers that can grow to become preeminent providers such as Sears Methodist Retirement Communities in Amarillo, TX or the Catholic Charities of Syracuse, a couple of many examples in the SC Analysis of senior housing operators.

There is an unofficial, but established national network of quality nonprofit operators of senior housing, predominately church affiliated, many that also operate long term care facilities as a second priority. In addition, there are many foundations, including Private and Community Foundations, which have provided grants to initiate affordable housing development for seniors and the entire community; another area in which SC has conducted national research including over 150 major foundations. In concert with many regional developers and CDC, and with increased Federal and State initiatives, this network of foundations and providers can be expanded to meet the unmet needs for affordable senior housing, as well as the supportive services needed to care for existing aging populations.

Recommendations and Conclusions

There are many recommendations and conclusions that could be drawn from our ongoing research, all of which are available to the reader with additional supporting research upon request. Key conclusions are as follows:

1) Skilled Nursing Facilities - We owe it to our seniors to do a better job in nursing facilities, including improving wages for caregivers such as nursing assistants, mandating minimum hours for patient care as some states have done, improving reimbursement and accountability through national Medicaid reform to better care for medical and psychosocial needs. Part of the solution is initiatives that reduce the number of for profit operators and increase the number of nonprofit providers.

2) Assisted Living - Assisted Living is a much better option than Skilled Nursing for seniors, and is rarely available to low-income seniors. There are supportive alternatives, including improving the availability of home health aides and existing community social services through coordination of existing governmental and nonprofit agencies in affordable housing developments and in the home.

3) Assisted Living should be more of a medical model, with more nurses available on a per patient, as needed basis, yet less hours per patient day than a nursing home and still limiting patients with diagnoses and care issues that require 24/7 nursing care to skilled nursing homes.

4) Assisted Living and Senior Housing options need to be defined nationally, and standards set in all communities that provide care and services.

5) We need more affordable housing for seniors and those with disabilities, for both low- and moderate-income seniors, with increased Federal limits on certain types of funding and expanded roles and coordination of existing nonprofit providers.

6) Affiliated social service agencies of many faiths do a wonderful job of providing care and housing to seniors, and their efforts should be measured, as can the various needs within communities. Their growth should be fostered and supported to expand affordable housing, supportive services in existing senior housing and long term care.

7) Working within their existing network of charities and beyond, in grants and commitment, many Private, Public and Community Foundations can do more for seniors, particularly for affordable senior housing and supportive services.

8) Seniors are our greatest underutilized assets, with so much to give back to many generations, including children of all ages. Intergenerational programs and volunteerism need to be fostered and developed.

9) Increased advocacy is needed to gain governmental, church and charitable support for improving long term care, affordable senior housing and support services for poor seniors. Our politicians need to know that our seniors are important, that more must be done for seniors today, as well as establish the groundwork for the aging Baby Boomers of tomorrow.