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# brief

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# INDEPENDENT AND ASSISTED LIVING:

## Complex Populations Deserving Integrated Housing, Clinical, and Lifestyle Support

asha
American Seniors Housing
ASSOCIATION

ATI ADVISORY
IDEAS TO ACTION IN HEALTHCARE & AGING

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# INDEPENDENT AND ASSISTED LIVING:

## Complex Populations Deserving Integrated Housing, Clinical, and Lifestyle Support

### INTRODUCTION

Nearly 1,600,000 seniors choose independent and assisted living communities as housing options when they want or need some support with daily life but do not need or want to live in an institutional setting like a nursing home.[1] Independent and assisted living communities offer meals, social activities, housekeeping, transportation, and personal enrichment programs, in a maintenance-free living environment. Assisted living also provides residents with personal assistance for activities of daily living like bathing and dressing, and many communities offer memory care (Graphic 1). Independent and assisted living communities offer attractive living options for seniors interested in social engagement opportunities that they cannot get when living in traditional private housing; assisted living further provides support for those who no longer feel comfortable or safe living in traditional private housing. While independent living communities may not provide support for activities of daily living as assisted living communities do, some independent living residents rely on private duty nursing or personal care assistants for necessary support with their daily needs.

***Graphic 1: Spectrum of Seniors Housing Options and Associated Expense with Increasing Services[2]***


[1] All data in this brief are drawn from ATI Advisory's analysis of the 2018 Medicare Current Beneficiary Survey (MCBS).

[2] Additional seniors housing settings not a focus of this brief, and therefore not reflected in the visual, include active adult retirement communities and low-income/ affordable seniors housing.

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The decision to move out of traditional private housing and into independent or assisted living is often a reflection of an individual seeking the enhanced socialization of a senior living community, or no longer feeling safe without the supports and services these communities provide. The decision to move into independent or assisted living also may reflect an individual being unable to coordinate and arrange for the level of medical and non-medical services needed to remain in traditional private housing. Accordingly, across a range of measures, independent and assisted living residents tend to be older and have greater medical and social needs than those who remain in traditional private housing. As a result, policymakers have an opportunity to address the needs of these residents in a more integrated and comprehensive manner to prevent escalation into a more complex, costlier setting. However, these community types are not well understood by policymakers for the beneficial role they can play in the coordination and delivery of healthcare services to residents.

This brief includes an overview of the unique and complex needs of residents in independent and assisted living communities and offers policy suggestions to maximize the ability of these communities to serve their residents.

In summary, policymakers should:

- Provide senior living operators with technical assistance to implement models that promote integration with primary care
- Test pilot programs to improve care and lower costs for Medicare beneficiaries through residential — medical integration
- Test a Senior Living Medicare Advantage Special Needs Plan to allow for community-targeted, integrated models of care

## What are the Needs of Medicare Beneficiaries Residing in Independent and Assisted Living Communities?

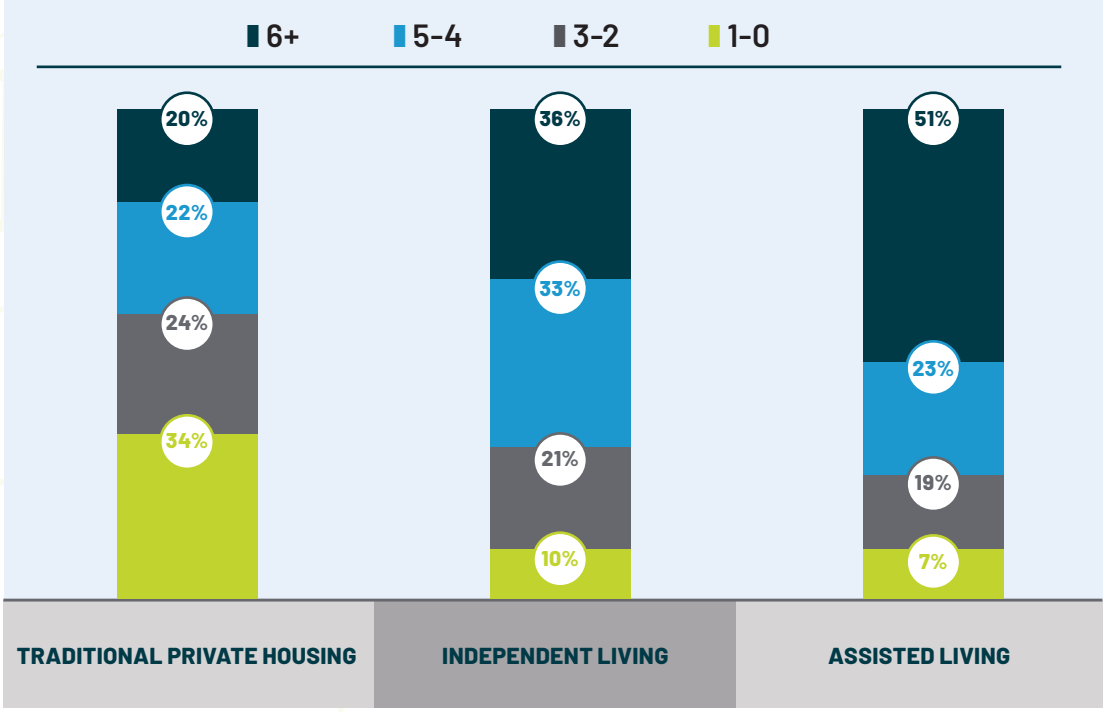
### Independent and Assisted Living Residents Have Greater Health Needs

Residents of independent and assisted living communities are much older than the senior population living in traditional private housing. According to the 2018 Medicare Current Beneficiary Survey (MCBS), the average age of older adult Medicare beneficiaries in traditional private housing is 74, compared to 83 in independent living and 85 in assisted living.[3] Only one of ten seniors living in the community is over 85, but nearly half of independent living residents and 58 percent of assisted living residents are over 85 (data not shown).

[3] All data in this brief are limited to Medicare beneficiaries age 65 and older.

Independent and assisted living residents also have a much higher burden of chronic disease than seniors living in traditional private housing. The typical older adult living in private housing has 3.2 chronic conditions, while independent and assisted living residents average 4.9 and 5.8 chronic conditions, respectively. While one in five older adults in the community has six or more chronic conditions, over a third of independent living residents and more than half of assisted living residents have this level of medical complexity (Figure 1).

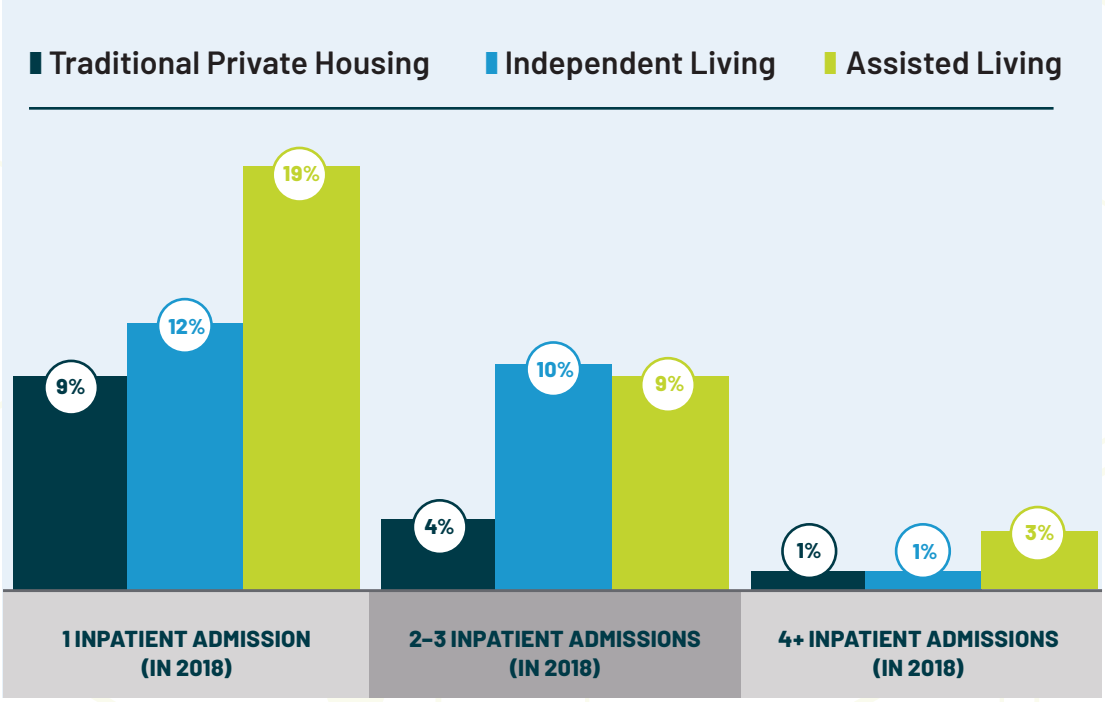
***Figure 1: Distribution of Number of Chronic Conditions by Residential Setting[4]***




Given this level of acuity, residents of independent and assisted living are more likely to be admitted to the hospital than seniors living in traditional private housing. The average number of inpatient admissions are 0.21 per person per year among traditional private housing residents (i.e., 21 inpatient admissions per 100 residents), 0.37 per year among independent living residents, and 0.52 per year among assisted living residents (data not shown). Nineteen percent and twelve percent of assisted and independent living residents have one hospitalization in a given year, respectively, while only nine percent of traditional private housing residents experience one hospitalization. Nine percent and ten percent of assisted living and independent living residents experience two to three hospitalizations, compared with four percent of traditional private housing residents (Figure 2).

[4] Data on number of chronic conditions is drawn from MCBS-linked claims and is limited to Traditional Fee-for-Service Medicare beneficiaries.

*Figure 2: Share of Population Hospitalized by Residential Setting*[5]

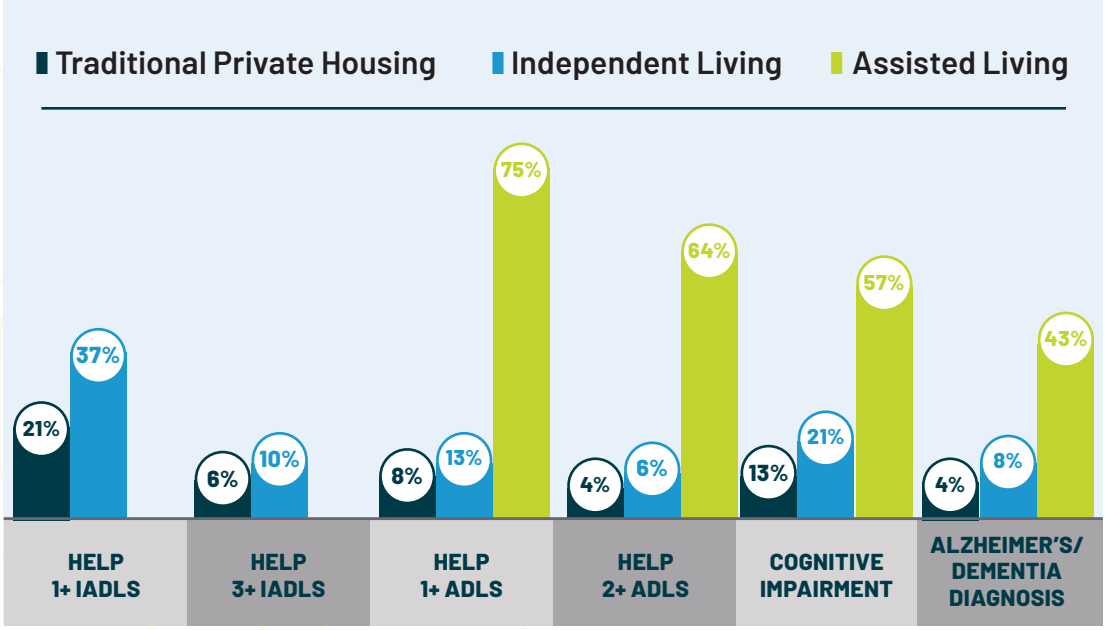



## Independent and Assisted Living Residents Have Higher Cognitive and Functional Impairment

Cognitive impairment and Alzheimer's or Dementia diagnoses are much more common among older adults living in independent and assisted living compared to those living in traditional private housing. Individuals in independent living are twice as likely to have Alzheimer's or Dementia compared to those in private housing and those in assisted living are more than ten times more likely (Figure 3). Older adults living in independent and assisted living also require substantially more support with instrumental activities of daily living (IADLs) like shopping and cooking, as well as activities of daily living (ADLs) like bathing and dressing, than those in traditional private housing.

[5] Utilization data is limited to Traditional Fee-for-Service Medicare beneficiaries.

*Figure 3: Share of Population with Cognitive Impairment by Residential Setting*[6]




## The Medicare Program Spends More on Independent Living and Assisted Living Residents

As a consequence of these greater health needs and higher cognitive and functional complexity, assisted and independent living residents also have higher rates of Medicare Part A and B spending compared with residents of traditional private housing. While Medicare spends an average of $7,639 annually on older adults living in traditional private housing, those living in independent living account for $12,598 in Medicare spending per year and those in assisted living $22,519 per year, on average (Graphic 2).

*Graphic 2: Medicare Part A and B Spending on Residents of Seniors Housing*


[6] Data on need for support with IADLs is not available for residents of assisted living.

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## Moving Forward: Meeting the Higher-Complexity Needs of Independent and Assisted Living Residents

Independent and assisted living communities are important residential settings that can prevent an individual from escalating into a more expensive nursing home setting, and many communities perform assessments and offer care planning. However, the policy environment has limited the ability for innovation in these communities and limited opportunities for seniors living operators to expand their clinical capabilities and integrate with primary care. Those limitations inhibit independent and assisted living communities from addressing the healthcare needs of residents in a manner most likely to prevent escalation to a higher care (and therefore more expensive) setting.

Offering care management or primary care services to residents can result in better and more seamless care for residents and can decrease resident attrition and Medicare spending (e.g., through fewer hospital admissions that result in discharges to skilled nursing facilities). Policymakers should better understand the role of senior living communities in needs assessments, care planning, and condition monitoring, and the impact these have on chronic care management.

***Spotlight: Erickson Advantage***

Erickson Senior Living offers several Medicare Advantage plans to residents of its independent and assisted living communities through a joint venture with a large, national payer. In addition to the core benefits that residents experience by being a part of Erickson Senior Living communities, Erickson Advantage members also have access to a nurse coordinator in each community who supports members by providing care management. When a resident needs assistance, the nurse coordinator communicates with the medical team, reviews records, performs in-home assessments, creates care plans, and organizes family meetings. Erickson Advantage members also have access to a member services representative. In turn, Erickson Senior Living has financial alignment and receives funding to provide both medical care and long-term services and supports (LTSS) to residents enrolled in Erickson Advantage.[7]

***Spotlight: Juniper Communities Connect4Life***

Connect4Life integrates the care and services delivered at Juniper's communities with the care and services delivered by ancillary clinical providers in the community.[8] The program relies on a shared electronic health record system between Juniper and ancillary providers, and services are coordinated through a "medical concierge" system. The model integrates onsite primary care, pharmacy, and lab services with social supports and residential care.[9] In 2019, AllyAlign Health licensed the Connect4Life program to exclusively implement the model as the foundation of the care program that is part of AllyAlign Health's nationwide Medicare Advantage plans.[10]

[7] http://www.ltqa.org/wp-content/themes/ltqaMain/custom/images/Erickson-Case-Report_091916_Final.pdf
[8] https://juniper communities.com/integrated-senior-care/connect4life-overview/
[9] https://www.mcknightsseniorliving.com/home/news/junipers-care-model-connect4life-to-see-national-rollout-under-licensing-agreement/
[10] https://www.prnewswire.com/news-releases/allyalign-health-licenses-junipers-connect4life-care-model-as-foundation-for-senior-housing-medicare-advantage-risk-strategy-300945273.html.

## Policymakers Can Promote Residential – Medical Integration

The role of independent and assisted living communities historically has not been well understood by policymakers, in part because many residents pay for housing and personal care out-of-pocket. But as noted above, the greater health needs and higher functional and cognitive impairment in these residents lead to higher rates of Medicare spending, making these communities an important avenue for healthcare innovation.

Given the vulnerability of independent and assisted living residents and the associated Medicare spending, policymakers should consider opportunities to address these unique and complex needs and reinforce the role of independent and assisted living communities in preventing individuals from moving into a more expensive institutional (nursing facility) setting.

- **Opportunity: Provide technical assistance to seniors housing providers.** Existing models (such as Juniper Communities Connect4Life) have demonstrated success in integrating medical and residential services. For example, an earlier analysis by ATI Advisory found that Medicare could save between $10 and $15.3 billion on annual aggregate hospital spending and between $2,912 and $4,472 on a per capita basis for the 3.4 million frail Medicare beneficiaries ATI Advisory identified as being most similar to the Juniper resident population. The integration of primary care providers into these residential settings allows residents' healthcare needs to be addressed early and often, with the ultimate goal and impact of preventing more expensive care – including hospitalization – down the road. Providing technical assistance and supports to other seniors housing communities could scale existing models and allow access to a greater number of Medicare beneficiaries. Technical assistance could include: promoting currently successful models; creating a business framework for other providers looking to integrate medical and residential services to follow; providing strategic guidance on the structure and design of the integration; educating on the IT and data inputs required; and consulting on the formation of strategic relationships with primary care providers.
- **Opportunity: Test the integration of primary care with senior living.** The Center for Medicare and Medicaid Innovation (CMMI) could test a pilot in independent and assisted living communities to improve care and lower costs for Medicare beneficiaries. This pilot would provide necessary supports to allow a senior living provider to integrate or coordinate their 24/7 monitoring and care models with primary care, to meet the complex and long-term services and supports needs of the vulnerable populations those communities serve. Those supports would include the opportunity to be paid under an alternative payment model and capture a portion of potential savings from the integration. Testing the model through CMMI would also create a formal opportunity for CMS to collect data and evaluate the value of the model.

- **Opportunity: Test a Targeted Special Needs Plan.** CMMI could test a new type of Medicare Advantage Special Needs Plan (SNP) limited to residents of a senior living community, akin to the Erickson Advantage program. This Senior Living SNP would be similar to an institutional or institutional-equivalent (IE) SNP but unlike I/IE-SNPs, would not be limited to individuals who meet state eligibility requirements for needing an institutional level of care (ILOC). A Senior Living SNP would allow a targeted model of care to serve residents in a single community before they qualify for nursing facility care, align incentives to allow independent living and assisted living communities to bring a primary care component directly to all residents including pre-ILOC, integrate that care with personal care and other services residents already receive, and help to prevent escalation into a more complex level of need.

The complex care needs of frail older adults living in independent and assisted living communities surpass the needs of those living in traditional private housing. Equipping senior living communities to better address and integrate the medical needs of their residents can help prevent escalation into costlier settings of care by allowing for intervention early and as needed, and preventing the development of more expensive medical needs. Policymakers have an opportunity to promote this residential-medical integration for the 1.6 million Medicare beneficiaries residing in independent and assisted living communities, and eliminate silos that create misaligned financial incentives.

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## About This Work

This study is part of a broader effort to quantify and detail the demographics and experiences of older Medicare beneficiaries living across a spectrum of housing options. ATI Advisory, in partnership with the American Seniors Housing Association (ASHA), evaluated survey responses and claims data for Medicare beneficiaries included in the 2018 Medicare Current Beneficiary Survey (MCBS). The MCBS is an annually fielded, nationally representative survey commissioned by the Centers for Medicare and Medicaid Services (CMS). Sample data were weighted to reflect the Medicare population.


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