



Joint HHS, HUD, and USDA Informational Bulletin

DATE: August 19, 2020

**SUBJECT: Living at Home in Rural America:
Improving Accessibility for Older Adults and People with a Disability¹**

This Joint Informational Bulletin provides state Medicaid agencies, state and local housing agencies, state and local public health agencies, and other health and housing entities with information to better understand existing federal resources and programs that are intended to improve health and housing outcomes in rural America. These resources may address reducing physical environmental barriers in the home, increasing safety, minimizing the risk of falls, and supporting a person's ability and desire to remain in his or her own home.

The information in the Bulletin is intended to support and encourage state agencies to more effectively coordinate existing federal resources related to home accessibility across multiple sectors within their states as part of their efforts to increase home safety and accessibility for older adults and people with disabilities living in rural communities. Given that the population of older adults and people with a disability in need of long-term services and supports (LTSS) is disproportionately larger in rural versus urban areas² the Department of Health and Human Services (HHS), the U.S. Department of Housing and Urban Development (HUD), and the U.S. Department of Agriculture (USDA) are issuing this Informational Bulletin to provide state agencies and other interested stakeholders with information about federal resources that may help individuals living in rural areas to remain in their homes and communities.

Multiple federal programs and resources support people with a disability and older adults with low incomes to live in and age-in-place in rural America. These aforementioned federal agencies and their respective resources and programs can be found in Appendix A-F of this Informational Bulletin.

This Bulletin also supports the HHS Rural Health Task Force, an HHS-wide effort on improving health care and access for rural America. This includes the efforts by the Centers for Medicare & Medicaid Services (CMS), the Administration for Community Living (ACL), the Centers for Disease Control and Prevention (CDC), and the Health Resources and Services Administration

¹ This communication is printed, published, or produced and disseminated at U.S. taxpayer expense.

² Andrew Coburn, Eileen Griffin, Deborah Thayer, Zachariah Croll, Erika C. Ziller. "Are Rural Older Adults Benefiting from Increased State Spending on Medicaid Home and Community Based Services?" *Maine Rural Health Research Center*, June 2016.

(HRSA), to improve health care in rural America, by leveraging collaborative partnerships, awareness campaigns, and grant programs both on a federal level, and at a regional, state, and local level.

Background

More than 60 million Americans—approximately 19 percent of the U.S. population—live in rural areas.^{3,4} Research indicates that individuals living in rural America tend to face greater challenges than those living in urban areas, particularly with respect to socio-demographic factors, health status, and access to the healthcare delivery system.⁵ Despite these challenges, rural communities have considerable strengths that contribute to overall community well-being. According to the Gallup-Sharecare Well-Being Index,⁶ rural Americans experience a greater sense of pride in the community, high feelings of safety and security, and a stronger sense of purpose in comparison to urban Americans.⁷

Older adults and people with a disability represent a significant percentage of rural residents. Rural counties make up nearly 85 percent of the 1,104 “older-age counties”—those with more than 20 percent of their population age 65 or older.⁸ Those older than 85 years represent the fastest growing segment of the U.S. population, and much of that population growth is expected to occur in rural areas.⁹ According to the [U.S. Census Bureau's 2013-2017 American Community Survey 5-Year Estimates](#), approximately 9 million people living in rural America – 15.1 percent of the rural population – are people with a disability.¹⁰

Medicare and Medicaid enrollment in rural communities is broad. Medicaid covers nearly one in four nonelderly individuals in rural areas.¹¹ Data from the 2018 Medicare Beneficiary Survey analyzed by the Medicare Payment Advisory Commission indicated that about one-fifth of Medicare beneficiaries live in rural areas.¹² Rural Medicare beneficiaries are more likely to be dually eligible for Medicare and Medicaid than urban Medicare beneficiaries.¹³ Demographic data indicate that the population of older adults in need of long term services and supports (LTSS), including home and community-based services and institutional care, is disproportionately larger in rural versus urban areas.¹⁴

³ What is Rural America? U.S. Census Bureau. Retrieved from: <https://www.census.gov/library/stories/2017/08/rural-america.html>

⁴ The federal government uses two major definitions of “rural,” along with many variants that are also available. One is produced by the U.S. Census Bureau and the other by the Office of Management and Budget. See: <https://www.hrsa.gov/rural-health/about-us/definition/index.html>

⁵ Healthcare Access in Rural Communities. Retrieved from: <https://www.ruralhealthinfo.org/topics/healthcare-access>

⁶ The Well-Being Index measures Americans' perceptions of their lives and their daily experiences through five interrelated elements that make up well-being: sense of purpose, social relationships, financial security, relationship to community, and physical health. <https://www.gallup.com/175196/gallup-healthways-index-methodology.aspx>

⁷ State of American Well-Being, 2017 Community Well-Being Rankings. https://wellbeingindex.sharecare.com/wp-content/uploads/2018/03/Gallup-Sharecare-State-of-American-Well-Being_2017-Community-Rankings_vFINAL.pdf

⁸ Rural America at a Glance 2018, U.S. Department of Agriculture. Retrieved from: <https://www.ers.usda.gov/webdocs/publications/90556/eib-200.pdf>

⁹ Coburn, A., Lundblad, J., Rural Long-Term Services and Supports: A Primer, Nov 2017. Retrieved from: <http://www.rupri.org/wp-content/uploads/LTSS-RUPRI-Health-Panel-2017.pdf>

¹⁰ Retrieved from: <https://www.ruralhealthinfo.org/topics/people-with-disabilities#howmany>

¹¹ Foutz, J., Artiga, G., Garfield, R., The Role of Medicaid in Rural America, Issue Brief, Kaiser Family Foundation, April 2017. Retrieved from: <https://www.kff.org/medicaid/issue-brief/the-role-of-medicaid-in-rural-america/>

¹² Health Care Spending and the Medicare Program, June 2018, Medicare Payment Advisory Commission. Retrieved from: http://www.medpac.gov/docs/default-source/data-book/jun18_databookentirereport_sec.pdf

¹³ Bennet, K., Robertson, A., Probst, J., “*Characteristics, Utilization Patterns, and Expenditures of Rural Dual Eligible Medicare Beneficiaries*”, November 2014, South Carolina Rural Health Research Center.

¹⁴ Coburn, A., Lundblad, J., Rural Long-Term Services and Supports: A Primer, Nov 2017. Retrieved from: <http://www.rupri.org/wp-content/uploads/LTSS-RUPRI-Health-Panel-2017.pdf>

According to the AARP 2018 Home and Community Preferences Survey: A National Survey of Adults Age-18 Plus:

- Nearly three-quarters of rural adults say they want to remain in their communities and homes as they age.
- Almost half of rural adults report that they will stay in their current homes and never move compared to only a third or less of urban and suburban adults who say they will never move from their current homes.
- Nearly two in five rural homeowners report that major modifications to their homes are needed to accommodate aging needs.¹⁵

Homeownership is more prevalent in rural communities than in urban communities. Over 83 percent of rural and older adult households are owner-occupied, compared to approximately 79 percent of all older adult households and 66 percent of all households nationally. The vast majority of rural older adults live in single-family units that were built in earlier decades. These structures may not be well suited to meet the needs of aging adults and people with a disability.¹⁶ Homes that are in need of repairs and maintenance and that have use and accessibility issues make it harder for older adults and people with a disability to bathe, use stairs, enter and exit, or meet other daily needs.¹⁷ Falls and their related complications are a hazard for independent living and are the leading cause of both fatal and non-fatal injuries among adults over age 65.¹⁸ These barriers may compel older adults and people with a physical disability to move to an institutional setting such as a nursing home. Programs and resources that help individuals make their homes more accessible and usable facilitate independent living, improve quality of life, and promote community integration.

This Informational Bulletin identifies existing federal resources and opportunities that states may be interested in utilizing to increase independence and help an individual to remain in his or her home. For example, raising or lowering a countertop can help an individual to prepare his or her own food; installing a roll-in shower and grab bars may assist an individual to independently bathe; installing a ramp, chairlift, or motion detecting lights and widening doorways supports an individual by increasing stability, preventing falls, and maximizing independent mobility.¹⁹ Improving home accessibility for older adults and people with a disability represents an important step toward building sustainable home and community-based services capacity in rural communities. Each of the agencies described in the Appendices is available to provide technical assistance to stakeholders in implementing programs to improve home accessibility and health outcomes, and to facilitate beneficiary independence.

¹⁵ 2018 Home and Community Preferences Survey: A National Survey of Adults Age 18-Plus, A Look at Rural Communities, June 2019, AARP. Retrieved from: https://www.aarp.org/content/dam/aarp/research/surveys_statistics/liv-com/2019/home-community-preferences-rural-communities.doi.10.26419-2Fres.00231.010.pdf

¹⁶ Homes on the Range: Homeownership Rates Are Higher in Rural America, U.S. Census Bureau, Dec. 2016. Retrieved from: https://www.census.gov/newsroom/blogs/random-samplings/2016/12/homes_on_the_range.html

¹⁷ Housing an Aging Rural America: Rural Seniors and their Homes, Housing Assistance Council, October 2014.

¹⁸ Important Facts about Falls Centers for Disease Control and Prevention (CDC). Retrieved from: <https://www.cdc.gov/homeandrecreationalafety/falls/adultfalls.html>

¹⁹ Retrieved from: https://eldercare.acl.gov/Public/Resources/Factsheets/Home_Modifications.aspx

Appendix A

Centers for Medicare & Medicaid Services (CMS)

Medicaid

States have various pathways to improve home accessibility for Medicaid-eligible individuals. Below we highlight several options for states to enable individuals to have their medical needs met at home while helping to support accessible home environments through their Medicaid programs. States have flexibility to cover a variety of optional services under their Medicaid state plans; however, a state Medicaid program generally cannot limit coverage exclusively to rural areas. A waiver of the statutory “statewideness” provision generally would be needed to limit services to certain geographic areas within a state.²⁰

Federal Medicaid law requires states to provide certain mandatory Medicaid state plan benefits under sections 1902(a)(10) and 1905(a) of the Social Security Act (the Act) and 42 Code of Federal Regulations (CFR) 440.210 and 440.220. Additionally, pursuant to section 1905(a)(4)(B) and (r)(5) of the Act, the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit requires that states provide all medically necessary section 1905(a) services coverable under the Medicaid program to certain eligible children under age 21.

States can also choose to provide other optional benefits under state plan authority, as well as through waiver authority under section 1915 of the Act, or they can offer additional non-mandatory benefits under demonstration project authority under section 1115 of the Act. States have a certain degree of flexibility in determining which non-mandatory benefits to provide under these authorities. In most cases, state flexibility is limited by section 1902(a)(1) of the Act and 42 CFR 431.50 (statewideness), section 1902(a)(17) of the Act and 42 CFR 440.230 (requirements regarding the amount, duration, and scope of covered services), and section 1902(a)(10)(B) of the Act and 42 CFR 440.240 (comparability of services within and among eligibility groups), among other provisions. These requirements apply unless the statute makes them non-applicable to the specific benefit or CMS waives the requirement.

Some Medicaid benefits that could help improve home accessibility and health outcomes for Medicaid-eligible individuals are described below.

Mandatory Medicaid Benefits

Medicaid Home Health Services. The Medicaid home health benefit is authorized by section 1905(a)(7) of the Act, and defined in regulations at 42 CFR 440.70. It is a mandatory benefit for the categorically needy eligibility groups and for individuals entitled to skilled nursing facility services in the medically needy eligibility groups, as described in 42 CFR 440.210(a)(1) and 440.220(a)(3), respectively. An important stand-alone component of the Medicaid home health benefit is medical supplies, equipment, and appliances, under 440.70(b)(3). The regulation defines “Equipment and appliances” as items that are primarily and customarily used to serve a medical purpose; generally, are not useful to an individual in the absence of a disability, illness, or injury; can withstand repeated use; and can be reusable or removable. This paragraph also notes that “State Medicaid coverage of equipment and appliances is not restricted to the items

²⁰ Social Security Act § 1902(a)(1), 42 U.S.C. § 1396a(a)(1).

covered as durable medical equipment in the Medicare program.” Items that meet the criteria for coverage under the home health benefit should be covered as such. Structural or home modifications are not covered under the Medicaid home health benefit. Coverage determinations for medical supplies, equipment, and appliances are based on medical necessity criteria as established by the state and as applied to the individual’s particular need. States can have a list of preapproved medical equipment and supplies, but are prohibited from having absolute exclusions of coverage on medical equipment, supplies, or appliances.

Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC). Medicaid RHC and FQHC services are defined in section 1905(a)(2)(B), 1905(a)(2)(C), and 1905(l)(1) and (2) of the Act, and include certain services listed in section 1861(aa) of the Act, as described in section 1905(l)(1) and (2). FQHCs and RHCs generally serve medically underserved populations and areas. Medicaid-covered services provided by FQHCs and RHCs include primary and preventive services provided by physicians, nurse practitioners, physician assistants, clinical psychologists, and clinical social workers, as well as other ambulatory services included in the state plan. If applicable, Medicaid-covered RHC and FQHC services also include part-time or intermittent nursing care and related medical supplies (other than drugs and biologicals) furnished by a registered professional nurse or licensed practical nurse under a written plan of treatment to persons in an area where CMS has certified that there is a shortage of Home Health Agencies.

Optional Medicaid Benefits

Physical and Occupational Therapy Services. States have several options for providing physical therapy and occupational therapy services. While there are several Medicaid authorities available to states, we will highlight a few of the commonly used benefits here. States may provide these services under the therapy benefit authorized under section 1905(a)(11) of the Act and defined at 42 CFR 440.110. States may also provide these services under rehabilitative services authorized under section 1905(a)(13)(C) of the Act and defined at 42 CFR 440.130(d). Lastly, physical and occupational therapy services, as well as speech pathology and audiology services, may be included in the home health benefit at the state’s option, as described at 42 CFR 440.70(b)(4).

Case Management and Targeted Case Management. States can choose to furnish case management services under sections 1905(a)(19) and 1915(g) of the Act and 42 CFR 440.169, to assist Medicaid-eligible individuals in gaining access to needed services. This state plan benefit is optional for both categorically needy and medically needy groups, unless the state opts to define the ambulatory services it must provide to certain medically needy groups to include it. If a state elects to cover case management under the Medicaid state plan, states can also opt to provide this benefit without regard to the statewideness and comparability requirements at section 1902(a)(1) and (a)(10)(B) of the Act, in which case the benefit is referred to as targeted case management (TCM). This means that states can target the benefit to specific populations, as described in section 1915(g)(1) of the Act, such as Medicaid-eligible individuals living in rural communities. Case management services, as defined in section 1915(g)(2) of the Act and 42 CFR 440.169, means services that assist eligible individuals to gain access to needed medical, social, educational, and other services. Case management services must include all of the following: comprehensive assessment and periodic reassessment of an eligible individual’s

needs; development and periodic revision of a person-centered care plan; referral to services and related activities to help the eligible individual obtain needed services; and monitoring activities. Case management can also include assisting individuals transitioning from a medical institution into a home in the community. Case management can assist individuals with gaining access to community-based home accessibility resources, or linking an individual to other needed medical, social, and educational services to help an individual live independently in the community.

Section 1915(c) Home and Community Based Services Waiver Programs. States have the option to apply for section 1915(c) home and community-based services waivers (HCBS waivers) to establish programs intended to enable beneficiaries who meet an institutional level of care to receive long-term care services and supports in their home or community, rather than in an institutional setting. Section 1915(c) allows states to waive certain Medicaid requirements (i.e., statewideness, comparability, and income and resource rules applicable in the community), and thus, allows states to furnish services to target populations by age or diagnosis.

Section 1915(c) also allows states to provide benefits in the community to eligibility groups who otherwise might receive Medicaid coverage only for institutional services. States may utilize this authority to provide home accessibility adaptations to the private residence of the beneficiary or his or her family that are required by the beneficiary's service plan and necessary either to ensure the beneficiary's health, welfare, and safety or to enable functioning with greater independence in the home. Such adaptations could include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that accommodate the medical equipment and supplies that are necessary for the welfare of the beneficiary. Such adaptations may not include those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant.²¹ Additionally, Medicaid coverage does not extend to supporting room and board costs or other benefits that are not directly related to the provision of HCBS. HCBS waiver programs can offer service coordination or case management in order to facilitate access to home accessibility supports and needed services.

Section 1915(i) State Plan Benefit. A section 1915(i) State Plan Amendment (SPA) allows states to provide HCBS to individuals who meet state-defined needs-based criteria that are less stringent than institutional criteria (and, if chosen by the state, target group criteria) as set forth in 42 CFR Part 441 Subpart M. The section 1915(i) benefit also gives states the option of establishing additional needs-based criteria for specific HCBS. States could use the section 1915(i) benefit to offer specific HCBS, including those described above under section 1915(c) HCBS waiver programs, to specific target populations by age, disability, diagnosis, and/or Medicaid eligibility group.

Section 1915(j) Optional Self-Directed Personal Assistance Services. Section 1915(j) self-directed personal assistance services (PAS) means personal care and related services, or home and community-based services otherwise available under the state plan or a 1915(c) waiver program that are provided to an individual who has been determined eligible for the PAS option. Self-directed PAS also includes, at the state's option, items that increase the individual's independence or substitutes (such as a microwave oven or an accessibility ramp) for human

²¹ 1915(c) Waiver Technical Guide: https://wms-mmdl.cms.gov/WMS/help/35/Instructions_TechnicalGuide_V3.6.pdf

assistance, to the extent the expenditures would otherwise be made for the human assistance. Individuals' budgets may be used to purchase goods and services, supports, or supplies related to a need or goal identified in the individuals' state-approved person-centered service plans. Some examples of allowable purchases may include a wheelchair accessible ramp or a home modification to widen doorways, or installation of grab bars.²²

Section 1915(k) Community First Choice Optional State Plan Benefit. The purpose of the section 1915(k) Community First Choice (CFC) benefit is to provide certain individuals, who meet an institutional level of care, the opportunity to receive necessary personal attendant services and supports in a home and community-based setting. There are required services that must be included in all CFC programs, as well as additional services that may be included at the state's option.²³ States electing CFC are required to cover the following services, subject to the conditions described above: (1) services and supports to assist in accomplishing activities of daily living (ADLs), instrumental activities of daily living (IADLs) and health-related tasks, through hands-on assistance, supervision, and/or cueing; (2) acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs and IADLs and health-related tasks; (3) back-up systems or mechanisms to ensure continuity of services and supports; and (4) voluntary training on how to select, manage, and dismiss attendants. The optional services states may cover in their CFC benefit include: (1) expenditures for transition costs (such as first month's rent and utilities or bedding, basic kitchen supplies, etc.) necessary for an individual transitioning from an institutional setting to a home and community-based setting and (2) expenditures relating to a need that increases an individual's independence or substitutes for human assistance, to the extent that Medicaid expenditures would otherwise be made for human assistance.

Section 1115 Demonstrations. States may also utilize section 1115 demonstration authority to test home and community-based service strategies. Since section 1115 demonstrations are intended to give states the flexibility to pilot new approaches that are likely to assist in promoting the objectives of the Medicaid program, states have a great deal of flexibility to design their demonstrations accordingly, subject to CMS approval. States could, for example, elect to pilot home accessibility services to a specific target population or in a limited geographic area. Some states, such as Washington, have used section 1115 demonstration authority to offer home accessibility services as part of a broader HCBS strategy targeted to older adults who are "at risk" of requiring Medicaid for long-term care services. The Tailored Supports for Older Adults (TSOA) program, funded under Washington's section 1115 Medicaid Transformation Project demonstration, establishes a new eligibility category and benefit package for individuals "at risk" of future Medicaid long-term services and supports who currently do not meet Medicaid financial eligibility criteria.²⁴

²² For more information on section 1915(j) see <https://www.medicaid.gov/medicaid/hcbs/authorities/1915-j/index.html>

²³ For more information on section 1915(k) see <https://www.medicaid.gov/medicaid/hcbs/authorities/1915-k/index.html>

²⁴ For more information about the Tailored Supports for Older Adults (TSOA) program, see <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wa/wa-medicaid-transformation-ca.pdf>; Washington State Health Care Authority, Long-term Services and Supports Manual, Tailored Supports for Older Adults, <https://www.hca.wa.gov/health-care-services-supports/program-administration/tailored-supports-older-adults-tsoa-0>

Medicaid Managed Care Strategies for Providing Mandatory and Optional Benefits

When states use a risk-based managed care delivery system, a state can choose to cover any of the services described above within the managed care plan contract. In addition, a managed care plan may voluntarily choose to provide additional home accessibility services that are not covered under the state plan, but the cost and utilization of such additional benefits may not be used in developing capitation rates for the managed care plan, unless they explicitly qualify as an in-lieu of service as defined in 42 CFR 438.3(e)(2).²⁵

Section 1915(b) waiver programs are used by states to implement a managed care or a fee-for-service selective contracting delivery system for state plan benefits. States using this authority also have the ability to add additional services, beyond those covered in the state plan. Section 1915(b)(3) authority allows a state to share the savings resulting from the use of more cost-effective medical care with Medicaid beneficiaries by providing them with additional state plan services, or additional services under a concurrent section 1915(c) waiver program. These savings must be expended for the benefit of Medicaid beneficiaries enrolled in the section 1915(b)(3) waiver, and may be used in the provision of home accessibility services for enrollees to prevent falls, increase safety and independence, and avoid institutionalization.

Medicare

Medicare is the federal health insurance program for people who are 65 or older, certain people under age 65 with disabilities, and people with End-Stage Renal Disease (ESRD), which is permanent kidney failure requiring dialysis or a transplant. The different parts of Medicare help cover specific services: Medicare Part A (Hospital Insurance) covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care; Medicare Part B (Medical Insurance) covers certain doctors' services, outpatient care, medical supplies, and preventive services; and Medicare Part D provides prescription drug coverage.²⁶

Medicare Advantage Plans, sometimes called "Part C" or "MA Plans," are an "all in one" alternative to Original Medicare. They are offered by private companies approved by Medicare. People who join a Medicare Advantage Plan still have [Medicare](#). These "bundled" plans include Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance), and usually Medicare prescription drug coverage (Part D).²⁷

Medicare Advantage plans can offer supplemental benefits that are not covered under Medicare Parts A or B if they diagnose, compensate for physical impairments, diminish the impact of injuries or health conditions, and/or reduce avoidable emergency room utilization. For example, plans may offer non-Medicare-covered safety devices to prevent injuries in the home and/or bathroom. Examples of safety devices include: shower stools, hand-held showers, bathroom and stair rails, grab bars, raised toilet seats, temporary/portable mobility ramps, night lights, and stair treads. The benefit may include a home and/or bathroom safety inspection conducted by a

²⁵ An in-lieu of service is defined as any service or setting that is provided instead of the covered service or setting in the contract. States must determine that the alternative service or setting is a medically appropriate and cost effective direct substitute for the covered service and cannot require the managed care plan to provide such services.

²⁶ <https://www.medicare.gov/sign-up-change-plans/getting-started-with-medicare>

²⁷ <https://www.medicare.gov/sign-up-change-plans/types-of-medicare-health-plans/medicare-advantage-plans/how-do-medicare-advantage-plans-work>

qualified health professional, in accordance with applicable state and federal requirements, to identify the need for safety devices and/or modifications, as well as the applicability of the device or modification to the specific enrollee's needs and home.²⁸

Additional Resources

The CMS Office of Minority Health (OMH) has several resources to help people with disabilities access quality health care. The tools include videos, a fact sheet, a resource inventory, and data highlights. Specifically, the resource “Getting the Care You Need: A Guide for People with Disabilities” provides information for consumers with disabilities on their rights with regard to accessing healthcare, as well as checklists to prepare for and follow up after medical appointments. The video series, “Navigating Health Care with a Disability: Our Stories,” features people with disabilities describing their experiences accessing health care. The series also explains how health care organizations and providers can improve accessibility and care for people with disabilities.

²⁸ Medicare Advantage Organizations and Section 1876 Cost Contract Plans, April 27, 2018, CMS. <https://www.nahc.org/wp-content/uploads/2018/05/HPMS-Memo-Primarily-Health-Related-4-27-18.pdf>

Appendix B

Administration for Community Living (ACL)

The Administration for Community Living (ACL) helps older adults and people with disabilities to live independently and participate fully in their communities. ACL's mission is to maximize the independence, well-being, and health of older adults, people with disabilities across the lifespan, and their families and caregivers. By funding services and supports, and with investments in research and innovation, ACL helps make this mission a reality for millions of Americans.

Several ACL programs support efforts to facilitate housing assistance, accessibility, home repair, and modifications. For example:

- State No Wrong Door Systems which include Centers for Independent Living, Area Agencies on Aging, Aging and Disability Resource Centers, State Units on Aging, and Tribal Organizations provide assistance in securing housing, including home modifications, and other services necessary to improve the ability of older adults and individuals with disabilities to live and work independently in the community.
- The National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR) funds a Rehabilitation Engineering Research Center (RERC) on Universal Design and the Built Environment that is working to advance accessibility and universal design of housing.
- The State Assistive Technology (AT) Act programs introduce people to the array of assistive technology available to assist them to continue to live at home and engage in community life. The AT Act programs also demonstrate how to use the technology, train people to use the technology, and offer short term loans of AT to try the technology before making a purchase.

Centers for Independent Living

ACL administers the Centers for Independent Living (CIL) Program, providing 354 discretionary grants to CILs, which are consumer-controlled, community-based, cross-disability, nonresidential, private nonprofit agencies that provide independent living (IL) services. At a minimum, centers funded by the program are required to provide the following IL core services:

- Information and referral;
- IL skills training;
- Peer counseling;
- Individual and systems advocacy; and
- Services that facilitate transition from nursing homes or other institutions to community living, diversion assistance for people at risk of entering institutions, and the transition of youth who have completed their secondary education or otherwise left school, to post-secondary life.

To learn more about CILs and to access a directory visit <https://acl.gov/programs/aging-and-disability-networks/centers-independent-living>.

Research

ACL regularly funds projects involving housing, accessibility, safety, and social isolation. Currently, ACL funding supports a Rehabilitation Engineering Research Center (RERC) on Universal Design and the Built Environment that is working to advance accessibility and universal design of housing. Another ACL-funded RERC, *Improving Safety and Activity Independence in the Home/Community following Traumatic Brain Injury*, is designed to improve safety, increase activity and participation, lessen family burden, and improve life quality through use of self-report measurement paired with technology-based environmental feedback that informs on ability, realistic “next step” goals, treatment, and progress. ACL also funds several projects at the University of Montana Rural Institute on Disability. One of these, a Research Rehabilitation and Training Center on Disability in Rural Communities, has continued for over 30 years. This RRTC generates knowledge from research to better understand how to ensure that people with disabilities can live effectively in rural communities. Additionally, NIDILRR also funds two studies to gather data to develop interventions that will help reduce the effort required of people with mobility disabilities to carry out certain activities within the home, and ultimately increase community participation. The combined findings of all-rural focused NIDILRR-funded studies underscore the business case for mitigating barriers to access and social isolation for older adults and people with disabilities.

To learn more about projects funded by NIDILRR visit:
<https://naric.com/?q=en/ProgramDatabase>

Older Americans Act Programs (OAA)

ACL administers the Older Americans Act (OAA) of 1965. The OAA funds a broad array of services that enable older adults to remain in their homes and communities for as long as possible. These include services to help older people access supports, such as transportation and case management, as well as home- and community-based long-term services and supports like personal care and adult day care services. The OAA programs can assist older individuals to obtain adequate housing, including residential repair and renovation projects designed to enable older individuals to maintain their homes. In addition, the OAA National Family Caregiver Support Program can assist with home modifications so caregivers are better able to continue providing care. The 2020 reauthorization of the OAA contains several provisions to promote the ability of older adults to age in place, including the establishment of a committee tasked with coordinating efforts to promote safe and accessible living environments and requiring a Government Accountability Office study and report focused on home modifications. Services under the OAA are provided by a network of federal, state, tribal and community-based local agencies.

Area Agencies on Aging, Tribal Organizations, and Aging and Disability Resource Centers can provide information and referral services for home modifications including offering home safety assessments to identify priority modification needs. These agencies may also provide information on public and private financing options to assist with home modifications, and provide links to home accessibility programs and qualified contractors. Visit the Eldercare Locator at eldercare.acl.gov to locate an agency in your community.

State Assistive Technology Act Programs

Assistive technology (AT) is used to modify homes, increase independence and mobility and enhance accessibility. There is a wide array of AT available in the market from low-tech items like “reachers,” “door jamb expanders,” and ramps to higher tech items such as sensors and voice- activated thermostats and lighting, to name a few. ACL administers the State Assistive Technology Act (AT) Program funded under section 4 of the Assistive Technology Act of 2004. All 50 states, 4 U.S. territories, the District of Columbia and Puerto Rico receive formula grant funding to support programs that increase knowledge about, access to and acquisition of assistive technology devices and services for individuals with disabilities and older adults. AT Programs serve individuals with disabilities of all ages through device demonstrations, device loans, device reutilization, training, technical assistance, public awareness, information and referral, and assistance with obtaining funding for AT, including home modifications. Most of the AT Programs conduct activities that can provide resources for home modifications and accessibility. Many states have financial loan programs specifically for AT, home modifications and vehicle modifications. Some AT Programs also administer programs or collaborate with other entities that provide other types of funding assistance for home modifications and home accessibility. AT Programs provide device demonstration centers that can include access to a wide variety of devices and equipment related to environmental adaptations to make homes more accessible. AT Programs also provide short-term device loans for individuals to borrow devices to try out and device reutilization programs that can be a resource to help make homes more accessible for persons with disabilities and older adults.

To learn more about the State Assistive Technology Act Program and to access a directory visit the Assistive Technology Act Technical Assistance and Training (AT3) Center at <https://www.at3center.net>.

State Councils on Developmental Disabilities

ACL provides funding to support State Councils on Developmental Disabilities across the United States and its territories that work to address identified needs by conducting advocacy, systems change, and capacity building efforts that promote self-determination, integration, and inclusion. Key activities include conducting outreach, providing training and technical assistance, removing barriers, developing coalitions, encouraging citizen participation, and keeping policymakers informed about disability issues. For example, Georgia’s State Council on Developmental Disabilities has a “Real Homes” priority which focuses on promoting accessible, affordable housing, including the production of visitable homes including one no-step entrance, 32” clear passage through all interior doors and at least a half bathroom that a wheelchair user can maneuver in. This initiative promotes making these three features standard through voluntary implementation, market forces and advocacy. To learn more about State Councils on Developmental Disabilities visit <https://acl.gov/programs/aging-and-disability-networks/state-councils-developmental-disabilities>.

State Protection and Advocacy Systems

Under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (DD Act), each state and U.S. territory has a protection and advocacy system (P&A) designated by the state’s governor. The DD Act and other authorizing statutes give the P&As authority to advocate for the rights of individuals with disabilities. The DD Act states that each P&A must have the authority

to “pursue legal, administrative, and other appropriate remedies or approaches to ensure the protection of, and advocacy for, the rights of such individuals within the State.” 42 U.S.C. §15043. The P&As use a range of remedies to advocate for individuals with developmental disabilities, including self-advocacy assistance, negotiation and litigation. Federal law authorizes P&As entities to protect the rights of individuals with developmental and other disabilities using different tools, including advocacy, investigation of abuse, and monitoring of settings where people with disabilities receive services. For instance, Disability Rights New Jersey assisted a 59-year old man with Asperger’s Disorder and insulin-dependent diabetes who was residing in a nursing facility. His discharge consideration included Managed Long Term Services and Supports (MLTSS), a separate program under the state’s HCBS waiver program. Disability Rights New Jersey held multiple meetings to discuss options for discharge. This man eventually received appropriate support including access to a housing subsidy. There are 57 P&As - one in every state and U.S. territory as well as one serving the Native American population in the four corners region. For more information on the P&As, please visit <https://acl.gov/programs/aging-and-disability-networks/state-protection-advocacy-systems>.

University Centers for Excellence in Developmental Disabilities Education, Research & Service

ACL supports University Centers for Excellence in Developmental Disabilities Education, Research, and Service (UCEDDs), a nationwide network of independent but interlinked centers, representing an expansive national resource for addressing issues, finding solutions, and advancing research related to the needs of individuals with developmental disabilities and their families. UCEDDs provide training in support of the goals of maintaining housing and preventing homelessness for people with disabilities in the community. For example, Hawaii’s UCEDD has formed the Hawaii Visitable Housing Coalition, which operates a website that serves as a one-stop shop for visitable housing resources in Hawaii, as well as a listserv to connect those working on visitability in Hawaii, develops educational resources and sessions on the topic, and educates the public and legislators on the benefits of visitable housing.

To learn more about UCEDDs and to access a directory visit <https://acl.gov/programs/aging-and-disability-networks/national-network-university>

Appendix C

Centers for Disease Control and Prevention (CDC)

The Centers for Disease Control and Prevention (CDC) serves as the national focus for developing and applying disease prevention and control, environmental health, and health promotion and health education activities designed to improve the health of the people of the United States. CDC has several programs to support older adults throughout the United States, and in rural America. These programs and resources help make individuals' homes safer, increase independence, ensure safety, minimize the risk for falls and support individuals' ability and desire to remain in their homes and participate in community living.

The [Stopping Elderly Accidents, Deaths, and Injuries \(STEADI\)](#) initiative helps healthcare providers develop a standardized process on how to screen patients for fall risk, assess the at-risk patient's modifiable risk factors, and intervene to reduce identified risks using effective risk factor-specific interventions to reduce older adult falls in communities.

STEADI resources for patients include: [Stay Independent Brochure](#); [What You Can Do to Prevent Falls Brochure](#); and [Check for Safety Brochure](#), which includes a checklist for individuals to find and fix home hazards.

STEADI resources for providers include: [Algorithm for Fall Risk Screening, Assessment, and Intervention](#), which walks through how to assess a patient's fall risk, educate patients, selecting interventions, and follow up; [Preventing Falls in Older Patients: Provider Pocket Guide](#), an easy to use tool that summarizes key points of fall prevention; [Talking About Falls Prevention with Your Patients](#); [Fall Risk Checklist](#); [Fall Prevention Patient Referral Form](#); [Integrating Fall Prevention into Practice](#); [Recommended Programs Form](#) to refer older adults to community programs that can help increase strength and balance; and [A CDC Compendium of Effective Falls Interventions: What Works for Community Dwelling Older Adults](#), a collection of effective fall interventions to address older adult falls in communities.

[The Coordinated Care Plan to Prevent Older Adult Falls](#) (CCP), offers primary care providers, practices, and healthcare systems a framework for implementing a Stopping Elderly Accidents, Deaths, and Injuries, or STEADI-based clinical fall prevention program in primary care settings to manage older patients' fall risk. Although developed for primary care, the CCP and STEADI-based programs can be implemented in different healthcare settings; and the [CDC STEADI: Evaluation Guide for Older Adult Clinical Fall Prevention Programs](#) describes key steps to measuring and reporting on the success of implementing a STEADI-based clinical fall prevention program. Evaluating the implementation and use of STEADI-based programs can help providers and organizations increase the quality of care provided to their older patients, and demonstrate program related successes and areas for improvement. CDC recommends providers use the CCP and Evaluation Guide simultaneously to ensure effective reporting on the clinical fall prevention program's overall success.

[STEADI-Rx](#), offers community pharmacists instruction on how to screen, assess, and intervene to reduce fall risk among their clients. STEADI-Rx is based on CDC's STEADI initiative and incorporates the [Joint Commission of Pharmacy Practitioners' Pharmacists' Patient Care](#)

[Process](#). STEADI-Rx includes a 3-step framework, or algorithm, for integrating fall screening and prevention into pharmaceutical care and a suite of tools that can be used to assist pharmacy staff in completing each step. It was developed by geriatric pharmacists, healthcare providers, and fall prevention experts committed to helping reduce fall injuries among older adults.

The [MyMobility Plan](#) is a tool developed to encourage older adults to take action now to remain safe, mobile and independent as they age. The MyMobility Plan provides resources for older adults to help manage their health to maintain mobility, make their homes safer to prevent falls, and consider alternative transportation as they age. Related content includes a supporting [fact sheet](#) about medicines and their potential side effects that may increase fall or motor vehicle crash risk and [promotional and social media materials](#) to share and promote the planning tool.

Appendix D

Health Resources and Services Administration (HRSA)

The Health Resources and Services Administration (HRSA) provides resources and research on public health supports and interventions to help older adults living in rural areas age in place. The Federal Office of Rural Health Policy (FORHP) administers many of these rural programs and advises the U.S. Department of Health and Human Services on rural policy issues.

The HRSA FORHP-funded [Rural Health Information Hub](#) is a national clearinghouse on rural health issues designed to support health care delivery and population health in rural communities. States can find resources regarding evidence-based programs and promising practices to prevent falls and support community living for older adults on Rural Health Information Hub pages such as [Rural Aging – Models and Innovations](#) and [Rural Aging – Resources](#).

FORHP also supports the [Rural Health Research Gateway](#) to increase the amount of impartial, policy-relevant research on health and related issues in rural communities. FORHP-funded Rural Health Research Centers have published dozens of policy briefs, white papers, reports, and scholarly journal articles on issues related to [rural aging in place](#).

States may also find other HRSA programs useful for addressing the health needs of community-residing older adults in rural areas.

Additionally, HRSA funds health centers and other community-based organizations that deliver high-quality and comprehensive primary care services. HRSA-funded health centers also provide case management and enabling services. These services may be designed to meet patients' ongoing needs, including assessment of varied factors affecting health (e.g., housing, education, etc.), counseling, referrals to address assessed needs, and periodic follow up. These case management responsibilities can help health centers connect rural older adults to housing and other resources necessary to maintain their safe community living arrangements. In fact, care coordination for older adults is one of several [health center promising practices](#) that HRSA tracks to support continuous quality improvement at funded health centers.

Some FQHCs specialize in serving special populations through the Health Care for the Homeless Program. The Health Care for the Homeless Program provides funding to health centers that serve people experiencing homelessness. These programs furnish intensive services to meet the specific needs of medically complex individuals. Health Care for the Homeless grantees are required to provide substance use disorder services in addition to the required primary health services.

HRSA's [Ryan White HIV/AIDS Program](#) provides a comprehensive system of HIV primary medical care, essential support services, and medications for low-income people with HIV who are uninsured and underserved. Home health care is the provision of services in the home that are appropriate to an eligible client's needs, including clients in rural areas, and are performed by licensed professionals. Activities must relate to the client's HIV disease and may include preventive and specialty care.

Rehabilitation services may include physical, occupational, and speech therapy that are provided to improve or maintain a client's quality of life and optimal capacity for self-care in accordance with an individualized plan of HIV care.

Non-Medical Case Management Services (NMCM) is the provision of a range of client-centered activities focused on improving access to and retention in needed core medical and support services. NMCM provides coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, and/or other needed services. NMCM may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible.

The [Geriatrics Workforce Enhancement Program \(GWEP\)](#) improves health care for older adults by transforming clinical training environments and maximizing patient and family engagement in health care decisions. This program integrates geriatrics and primary care delivery sites and systems by requiring grant recipients to incorporate the principles of the Age-Friendly Health Systems Initiative (what matters most to the older adult, medications, mentation, and mobility), value-based care, and alternative-payment models. A key component of the success of this program is the development of reciprocal partnerships between academia, primary care, and community-based organizations to address social determinants and other gaps in health care for older adults. The program provides training across the educational continuum focusing on geriatrics training in inter-professional and team-based care to increase quality of care and provider satisfaction.

Faculty with expertise in geriatrics are needed to train the workforce and provide specialized care to improve health outcomes for older adults. HRSA funds the [Geriatrics Academic Career Awards \(GACA\) Program](#) to support the career development of junior faculty in geriatrics. The goals of the program are for the GACA grant recipient to develop the necessary skills to lead health care transformation in a variety of settings, including in rural and/or medically underserved setting, as well as age-friendly settings that provide inter-professional training in clinical geriatrics.

HRSA also has developed training on dementia to assist practicing health professionals, caregivers, families and patients in better understanding dementia and its impact, HRSA developed two [education and training curricula](#) on dementia. The Alzheimer's Disease and Related Dementias curriculum offers continuing education credits for health professions faculty, students, primary care practitioners, members of the inter-professional geriatrics care team and direct service workers. The modules in the caregiving curriculum are designed to assist primary care providers in addressing caregiver needs of persons living with dementia and to help family and other caregivers of persons living with dementia take care of their own health and better cope with the challenges of caregiving. Both curricula are open access and the materials can be downloaded and modified to be used to meet local training needs.

Appendix E

U.S. Department of Housing and Urban Development (HUD)

The U.S. Department of Housing and Urban Development (HUD) provides resources and programs for home repair and rehabilitation to help older adults and individuals with disabilities living in rural areas to age in place or remain at home.

Title I Property Improvement Loan Program – insures loans up to \$25,000 for light or moderate rehabilitation of properties.

Section 203(k) Rehabilitation Mortgage Insurance – enables homebuyers and homeowners to finance the purchase (or refinancing) of a home and the cost of its rehabilitation through a single mortgage or to finance the rehabilitation of their existing home.

Section 184 Indian Home Loan Guarantee Program – can be used, both on and off native lands, for new construction, rehabilitation, purchase of an existing home, or refinance.

HOME Investment Partnerships Program (HOME) – allows participating jurisdictions to assist existing low-income homeowners with the repair, rehabilitation, or reconstruction of owner-occupied units through a grant or loan, and to rehabilitate or newly construct housing for low-income homebuyers, and for down-payment or other financing to assist homebuyers to purchase homes as their principal residence.

Community Development Block Grant (CDBG) – can be used by states and units for local government to provide grants, loans, loan guarantees, interest subsidies, or other forms of assistance to homeowners for the purpose of repairs, rehabilitation, or reconstruction.

Section 202 Housing for the Elderly – state agencies could encourage nonprofits to apply for Capital Advance Funds in response to a Notice of Funding Availability (NOFA), and there are many existing properties in rural areas that are well suited for aging in place.

Section 811 Housing for Persons with Disabilities - state agencies could encourage nonprofits to apply for Capital Advance funds in response to a NOFA, or they could apply to participate in the State Project Rental Assistance Program, and there are existing properties in rural areas that are in the community and accessible.

FHA Multifamily Mortgage Insurance - loan guarantees available for rehabilitating rental properties.

Reasonable Accommodations

Both privately owned and publicly assisted housing must meet certain [housing accessibility requirements](#). Further, participants in federally-assisted housing must meet requirements for nondiscrimination on the basis of disability. The “[reasonable accommodation](#)” process is the primary method by which a person with a disability who is a tenant in federally-assisted housing can request a home modification or other reasonable accommodation such as having a service animal.

Section 504: Frequently Asked Questions

(https://www.hud.gov/program_offices/fair_housing_equal_opp/disabilities/sect504faq#_Reasonable_Accommodation)

HUD-DOJ Statement on Reasonable Modifications under the Fair Housing Act

(https://www.hud.gov/sites/documents/DOC_7502.PDF)

Appendix F

U.S. Department of Agriculture (USDA)

USDA offers loans and grants to low and very low-income applicants to modernize, repair and make accessible alterations to homes in rural areas for both single family housing and affordable multi-family rental housing. Program eligibility requirements must be met for applicants to receive assistance. In many instances, USDA can leverage funds with other agencies or non-profit organizations to make the necessary repairs or modifications.

USDA programs for providing home repair, rehabilitation and home modifications are administered through the Rural Housing Services (RHS), a division within the USDA – Rural Development agency. These programs include the Rural Home Loans (Section 502 Direct), Single Family Home Loan Guarantees (Section 502 Guarantee), Single Family Housing Repair Loans & Grants (Section 504), Housing Preservation Grants, Multi-Family Housing Loan Guarantees, Housing Preservation & Revitalization Demonstration Loans & Grants and Farm Labor Housing Direct Loans & Grants. Below are short descriptions of each program with a link to Fact Sheets for further details.

Single Family Section 502 Direct Home Loan Program

Assists low- and very-low-income applicants obtain decent, safe and sanitary housing in eligible rural areas by providing payment assistance to increase an applicant's repayment ability. To be eligible, at a minimum, applicants must have an adjusted income that is at or below the applicable low-income limit for the area where they wish to buy a house and they must demonstrate a willingness and ability to repay debt.

Program Fact Sheet: https://www.rd.usda.gov/sites/default/files/fact-sheet/508_RD_FS_RHS_SFH502Direct.pdf

Generally, rural areas with a population less than 35,000 are eligible. The USDA Income and Property eligibility website, <https://eligibility.sc.egov.usda.gov/eligibility/welcomeAction.do>, can be access for complete details.

Applicants should contact local Rural Development Offices <https://www.rd.usda.gov/contact-us/state-offices> about eligibility requirements.

Single Family Section 502 Home Loan Guarantees

Assists approved lenders in providing low- and moderate-income households the opportunity to own adequate, modest, decent, safe and sanitary dwellings as their primary residence in eligible rural areas. Eligible applicants may build, rehabilitate, improve or relocate a dwelling in an eligible rural area. The program provides a 90% loan note guarantee to approved lenders in order to reduce the risk of extending 100% loans to eligible rural homebuyers.

Applicants must contact an approved lender. Information about approved lenders may be obtained by contacting a Guaranteed Loan Coordinator, <https://www.rd.usda.gov/contact-us/state-offices>, in the appropriate state.

Single Family Housing Repair Loans & Grants

Programs provide loans to very-low-income homeowners to repair, improve, or modernize their homes or provides grants to elderly very-low-income homeowners to remove health and safety hazards.

Program Fact Sheet: https://www.rd.usda.gov/sites/default/files/fact-sheet/508_RD_FS_RHS_SFH504HomeRepair.pdf

Generally, rural areas with a population less than 35,000 are eligible. Applicants may check the address of their home, <https://eligibility.sc.egov.usda.gov/eligibility/welcomeAction.do>, to determine eligibility online.

Housing Preservation Grants

Provides grants to sponsoring organizations for the repair or rehabilitation of housing occupied by low- and very-low-income individuals and families. Applications are accepted on an annual basis through a NOFA in the Federal Register.

Program Fact Sheet: https://www.rd.usda.gov/sites/default/files/fact-sheet/508_RD_FS_RHS_HPG.pdf

Generally, rural areas and towns with 20,000 or fewer people are eligible. Check eligible addresses, <https://eligibility.sc.egov.usda.gov/eligibility/welcomeAction.do>.

Multi-Family Housing Loan Guarantees

Program works with qualified private-sector lenders to provide financing to qualified borrowers to increase the supply of affordable rental housing for low- and moderate-income individuals and families in eligible rural areas and towns. Private lenders may apply for a loan guarantee on loans made to an eligible borrower who is unable to obtain commercial credit on reasonable terms without the guarantee. Loans guaranteed through this program are serviced through the private lender that makes the loan, just as they would be without a guarantee.

Program Fact Sheet: https://www.rd.usda.gov/sites/default/files/fact-sheet/508_RD_FS_RHS_MFGuarantee.pdf

Housing Preservation & Revitalization Demonstration Loans & Grants

Restructures loans for existing Rural Rental Housing projects to help improve a project's physical condition and preserve the availability of safe affordable rental housing for low income residents. Preserve and improve existing Rural Rental Housing projects in order to extend their affordable use without displacing tenants through increased rents.

Program Fact Sheet: https://www.rd.usda.gov/sites/default/files/fact-sheet/508_RD_FS_RHS_PreservationRevitalization.pdf

A two-phase application process starts with pre-applications accepted on an annual basis through a NOFA in the Federal Register. Selected pre-applications are invited to submit final applications.

Mutual Self-Help Housing Technical Assistance Grants

Provides grants to qualified organizations to help them carry out local self-help housing construction projects. Grant recipients supervise groups of very-low- and low-income individuals and families as they construct their own homes in rural areas. The group members provide most of the construction labor on each other's homes, with technical assistance from the organization overseeing the project.

Program Fact Sheet: https://www.rd.usda.gov/sites/default/files/fact-sheet/508_RD_FS_RHS_MSHHousingTechAsst.pdf

Generally, rural areas with a population less than 35,000 are eligible. The USDA Income and Property eligibility website, <https://eligibility.sc.egov.usda.gov/eligibility/welcomeAction.do>, can be accessed for complete details.

Applicants should contact local Rural Development Offices <https://www.rd.usda.gov/contact-us/state-offices> about eligibility requirements.